6
Global Health Security and Its Discontents

Since the initial deliberations in 1946 regarding the need for a new universal health organization, a strong correlation has existed between public health and international security. Having said this, the WHO secretariat's explicit adoption of security-related concepts and language to reframe its public health mandate is a fairly recent phenomenon that only emerged from 2001 onwards. Moreover, the WHO did not lead the charge to securitize public health – this was accomplished by a host of other actors. Admittedly, one of the WHO's proximal principals – the United States – was a key player in advocating this new way of viewing acute, fast-moving health issues (Smith III 2014), but the WHO secretariat itself lagged well behind, in some quarters even initially staunchly resisting the push to reframe public health in security terms. It is in this regard that the events of the mid-1990s, both within and external to the WHO, marked a distinct turning point. The WHO secretariat's advancement of the phrase 'global health security' in its 2001 report to member states signalled its firm embrace of this new worldview, and for more than a decade the WHO has been on the path of re-casting its public health mandate in a security frame.

Importantly, however, not everyone has welcomed the WHO's reframing efforts. Critics have emerged from a variety of quarters, but most notably from two distinct groups: academe; and even more disconcerting for the WHO secretariat, from a small but vocal sub-set of its member states. This chapter will examine the criticisms of the WHO's securitizing moves that have emerged, the purported benefits and drawbacks of such measures, and how the WHO secretariat has in turn responded by effectively attempting to now downplay, even desecuritize, its health-as-security mandate. The chapter then concludes with a discussion on what this trend may mean for the future and, in

A. Kamradt-Scott, *Managing Global Health Security*

particular, how securitization's discontents may adversely affect – and potentially again re-shape – the WHO's new approach to managing global health security.

Securitization's discontents

It took some years after the WHO secretariat produced its 2001 report entitled *Global health security – epidemic alert and response* in which it argued for endorsement of GOARN and finalization of the IHR revision process to 'maintain global public health security' (WHO 2001d, p. 2, see also Fidler 2005), but criticisms have since emerged of the IO's decision to securitize its public health activities. As noted above, these critiques have emanated from two key groups of actors that include members of the global academic community and a limited but notably vocal sub-section of the WHO's member states.

A host of public health and politics/IR scholars have progressively materialized to criticize the fusion of health and security, noting various problems and potential dangers associated with securitization. Somewhat ironically, the bulk of academic critique has emerged from scholars based predominantly within high-income countries, and particularly from within the United Kingdom and the United States – two countries that have served as proximal principals to the WHO secretariat in strongly supporting the health-as-security agenda (UK Government 2008, WHO EB 2009, 2010a, 2013). While admittedly this trend indubitably reflects the power imbalances inherent within the academic profession, which in turn is reflective of a broader north–south divide (see Canagarajah 1996, Murphy and Zhu 2012), it is equally important to note that few criticisms of the health-as-security agenda have yet surfaced from scholarly communities located within the 'global south'.

By and large the criticisms that have appeared have generally followed three key trajectories. The first line of critique arises from Foucauldian and post-structuralist scholars that claim the health-as-security discourse is largely reflective of Western, high-income countries' neo-colonial predisposition towards protecting themselves against 'the rest'. Accordingly, by virtue of this fact, commentators such as King (2002), Ingram (2005), Collier and Lakoff (2008), Lakoff (2010), Lowe (2010), Abraham (2011), Stephenson (2012), and Stevenson and Moran (2015) advocate that the securitization of public health issues exposes yet another configuration of dominant interests manipulating and controlling the less powerful, replicating a form of governmentality and authority over the body politic. Often implicit within these critiques – and at

times, less so – is the contention that because securitization predicates Western, high-income countries' interests above others, it is morally or ethically bankrupt. Yet others writers, such as Elbe (2010a, 2010b) and Elbe et al. (2014) trace that the securitization of health has had an equal and converse impact on security actors, leading to a medicalization, and even pharmaceuticalization, of the security sector.

A second common denunciation that often appears in the literature points to the potential distorting effects of the securitization of public health issues. In this, critics such as Greenberg (2002), Cohen et al. (2004), McInnes and Lee (2006), Aldis (2008), Rushton (2011), Youde (2012), and DeLaet (2015), amongst others, have pointed to the fact that the securitization of acute, fast-moving health issues (i.e. infectious diseases and/or bioweapons) has resulted in a disproportionate emphasis being placed on their prevention and control to the detriment of other, more pressing health matters. Even within the context of infectious disease outbreak control, scholars have pointed to the fact that some diseases attract more resources than others creating, in effect, a hierarchy of disease 'threats', with those that possess the ability to also threaten high-income countries commanding the greatest attention, while those that affect only the populations of low-income countries receiving considerably less. The underlying premise of these critiques is therefore one of social justice, which is recurrently aligned with the above critique of powerful interests manipulating the agenda.

The third line of critique that has emerged, which is often conflated with one or both of the above issues, is the actors (and their concomitant attitudes and authority) that securitization attracts. More specifically, concern amongst health-as-security detractors has tended to focus on the involvement of security sector personnel (i.e. police, military, intelligence) and the potential erosion of health/medical authority. The format in which such concerns are raised may vary, but usually takes the form of anxiety being expressed over the potential erosion of public health/humanitarian principles and/or human rights in order to respond effectively to the perceived 'threat' (see, for example, the arguments highlighted by Elbe 2006, Feldbaum et al. 2006, Calain 2007, Aldis 2008, Selgelid and Enemark 2008, Enemark 2009, McInnes and Rushton 2010, Ingram 2011, Smith 2013b). Importantly, however, the underlying cause of these concerns is the risk that by including non-health experts, the authority of medical/health professionals (as self-appointed guardians of these humanitarian principles and rights) and their ability to directly shape the response to a health problem will in some way become compromised, resulting in inadvertent or unintended outcomes.

Having said this, not all the antagonism towards the comingling of health and security has arisen from the health/humanitarian community and its supporters. On the converse side, although often more circumspect, security sector personnel have also been critical over what has been described as the 'medicalization' of security (see Elbe 2010a, 2010b), noting that health concerns are not 'core business' for the sector (Bernard 2013, p. 158). While such criticisms are understandable to a degree, equally they ignore the long historical association between military and security interests and the spread of disease (see, for example, Saengdidtha and Rangsin 2005, Bresalier 2011, Watterson and Kamradt-Scott 2015). Nonetheless, when viewed collectively, it is apparent that there continues to be widespread disquiet about the blurring of health and security boundaries, either due to the potential for unintended consequences, the intensification of existing inequalities and power imbalances, or the infringement of existing authority and principles.

Perhaps most intriguing is that amongst the wide variety of protagonists decrying the securitization of health, very few have taken aim at the WHO. This, it has to be acknowledged, is somewhat peculiar given that the WHO secretariat has been one of the most prominent securitizing actors of health issues. Indeed, as Stephenson (2012, p. 97) observes, securitization has now become so dominant that 'security is not presented as a mere dimension of or justification for the work of public health; it *is* public health' (emphasis original). Yet while some commentators initially criticized the WHO secretariat for its management of the 2003 SARS outbreak, arguing that its actions constituted IO agency slack (Fidler 2004, Cortell and Peterson 2006), its actions in securitizing health issues has attracted very little direct criticism. Even those academics who have adopted a more critical perspective have been rather muted in their reproach of the WHO. For instance, Stevenson and Moran (2015, p. 331) have noted in their work that the advancement of the health-as-security agenda has placed the IO in an 'awkward position of shifting the basis for investing in disease surveillance programs from humanitarian grounds towards safeguarding national security and international trade'. Yet even though these authors go on to question whose interests are served by the WHO's narrow definition of health security (ibid., pp. 332–336), the organization itself escapes further rebuke. Oswald (2011, p. 28) has similarly observed that the WHO secretariat has 'promoted a narrow and state-centered health security concept that was also influenced by the events of 11th September 2001, and by the potential threats of biological weapons and terrorism'. Here again though, while Oswald goes on to advocate for a broadening and deepening of the

WHO's conceptualization of health security, additional direct criticism of the IO responsible is absent.

Likewise, in their work Jin and Karackattu (2011, p. 181) have noted that the WHO secretariat has benefitted considerably from the securitization of health in terms of additional powers and authority, but that 'it may be counterproductive to global health governance'. In more precise terms, noting the actions of specific members of the WHO secretariat (including former Director-General Brundtland) in securitizing infectious diseases, these scholars argue:

> By strengthening global surveillance, [the] WHO consolidates its authoritative role and normative power and developed countries win enough time to take preventive and pre-emptive measures against infectious diseases spreading from developing countries. The recognition that [the] WHO's surveillance prioritizes the security concerns of developed countries dampens the intention of developing countries to cooperate with [the] WHO, rendering problematic the efficacy of the surveillance system. (ibid., p. 185)

Jin and Karackattu (ibid.) further contend that the 'WHO's securitization of infectious diseases . . . is not motivated by global health promotion but by the narrow security interests of developed countries'. Beyond these comments, however, the WHO secretariat largely evades further blame for its securitization activities. Rather, the authors stress at multiple junctures that the secretariat 'has been trying to keep itself away from sensitive security issues' (ibid., p. 182, see also pp. 181, 184).

To date, the two notable exceptions to this trend have been the works of Davies (2008) and Hanrieder and Kreuder-Sonnen (2014). In her work, Davies (2008, p. 296) asserts that 'the WHO has been a primary actor in constructing the emerging discourse of infectious disease securitization, and western states in particular have been quick to engage with this discourse'. Davies goes on to argue that both the IO and developed states have directly benefited from the health-as-security frame, with high-income countries using the organization as a shield to help protect their own citizens, while the WHO has strengthened its credentials as the paramount authority in global health governance (ibid., p. 309). Although the empirical lineage of events outlined earlier in this book suggests that the IO was in fact quite late to adopt the health security discourse, Davies attributes the organization with having been complicit with this agenda, ostensibly to 'entrench' and increase 'its power to the point where it now presides over the global response to infectious

disease outbreaks' (ibid., p. 312). Davies argues that in doing so, however, the WHO has compromised its moral authority so much so that it has potentially damaged its ability to assist developing countries respond to outbreaks (ibid., p. 296).

As noted above, the second source of overt criticism of the WHO has arisen from Hanrieder and Kreuder-Sonnen (2014). Attributing wide-sweeping powers of compulsion to the WHO secretariat, these authors argue that the IO utilized its newly endorsed emergency powers under the IHR (2005) to perpetrate a series of 'grave shortcomings' in its overall management of the 2009 H1N1 influenza pandemic (ibid., p. 12), even purportedly 'forcing' governments to inappropriately procure large stockpiles of influenza vaccines and antivirals via its declaration of a pandemic (ibid., p. 10). They subsequently go on to contend that the IO's new 'emergency powers are not only the products but also drivers of securitization' (ibid.), suggesting that there is an incentive for the WHO secretariat to declare further emergencies to justify their new authority, but they also argue for a series of additional oversight mechanisms to prevent future abuses of IO power.

Although Hanrieder and Kreuder-Sonnen's critique is subject to exaggeration and a limited understanding of the WHO's constitutional oversight mechanisms that are already in place,[1] their explicit criticism of the IO (and to a lesser extent Davies') is nonetheless somewhat rare amongst the scholarly community, prompting the question of why this is the case. Three conceivable explanations may be offered. The first possible reason is that both the public health and politics/IR scholars have unanimously concluded that the WHO is ultimately the sum of its parts with very little IO autonomy and that, accordingly, explicit criticism of the WHO secretariat's actions in securitizing certain health issues would be unjustified and unwarranted. Said another way, academe have acknowledged that the IO is subordinate to the directions and policy shifts of its principals, and given that the bulk of member states supported the health-as-security frame, the WHO secretariat was obliged to re-cast its public health mandate in security terms. Crucially, however, while it is accepted that a significant proportion of scholars working in this field may have engendered such a worldview, this explanation is arguably the least convincing as it discounts both the possibility of the WHO developing independent preferences that it may then seek to act upon (IO agency slack) as well as the prospect that the scholarly community holds divergent views and opinions.

The second, more plausible explanation is the influence that the WHO exerts. As noted in Chapter One, the WHO secretariat has at times been

referred to as 'the medical mafia'. This descriptor, while usually used in the pejorative sense, nonetheless speaks to the composition of WHO employees, the majority of whom are medically trained professionals. These staff thereby form part of what could be described as a global epistemic community of health professionals – an epistemic community that, historically, has time and again been shown to be very reluctant to criticize its own members, usually due to a perceived professional courtesy. While this phenomenon may not necessarily extend to those on the outside of this community (namely to affect politics/IR scholars), many within the global public health community view the WHO as undertaking vitally important work and so could be reluctant to engage in overt criticism of the IO's actions. Fiona Godlee (2014), a well-known commentator on the WHO and now editor-in-chief of the *British Medical Journal*, has observed, for instance, that those who follow the WHO's work closely often possess an 'underlying loyalty to the concept. No one wants to see the organization disappear. Rather what it needs is adequate funds and strong leadership to do the job'. On the converse side, it has also been suggested that those who have criticized the WHO in the past have been intentionally prevented from gaining further access (Anonymous 2005), which suggests that some scholars may be reticent to admonish the IO due to concerns over perceived or actual retribution.

Equally, the work of Gagnon and Labonté (2013) alludes to a slightly different albeit related third possibility. In tracing the development of the United Kingdom's *Health is Global* white paper, which strongly promoted the health-as-security frame, the authors interviewed several officials that suggested that academic researchers had benefitted personally from 'piggybacking' onto the agenda (ibid., p. 6). As one interviewee characterized this trend:

> They (academic researchers) got invited to cabinet committees to sit at tables with four-star generals in a way that they weren't able to previously – academic researchers suddenly found that they could advocate for research funding because they were talking about things that might kill millions of people, like AIDS. (ibid., as quoted)

Another interviewee similarly observed, 'The security of health agenda has gone unchecked and unchallenged because too many people have too much to gain from it' (ibid., as quoted). While admittedly Gagnon and Labonté's research was limited to exploring the development of a national policy, it is equally reasonable to assume that a similar trend

may have been replicated – at least to some degree – at the international level due to the prestige often associated with serving on international advisory panels such as the WHO expert committees. Accordingly, it may be that within some academic circles there is a practice of self-censorship underway to avoid the risk that it may jeopardize future professional standing.

The same concerns could not, however, be said to affect the IO's principals. As member states, even the organization's most distal principals have little to fear from the WHO secretariat, and this has been particularly reflected in the debates surrounding the IO's securitization of its public health mandate. In March 2007, for instance, prior to the official release of the 2007 World Health Report, the foreign affairs ministers of Brazil, France, Indonesia, Norway, Senegal, South Africa, and Thailand assembled in Oslo to discuss strategies to elevate health as a foreign policy issue. At the conclusion of the meeting these governments released what is now described as the 'Oslo Declaration', which outlined a series of 10 agenda items that included some 45 action points that would – theoretically – assist in raising health issues in international affairs. Yet despite the fact the very first agenda item was entitled 'Capacity for global health security', it was also observed that no consensus existed amongst the assembled foreign ministers as to what this phrase meant, and further elucidation would be sought at the next WHA (see Amorim et al. 2007).

Evidently, however, that illumination was not forthcoming. Indeed, within months of the release of the 2007 World Health Report that unambiguously announced the IO's adoption of the health-as-security frame, member states had assembled in Geneva, Switzerland, to commence negotiations on resolving a diplomatic impasse that had emerged following Indonesia's decision to cease sharing H5N1 virus samples with the GISN over a 'breakdown of mutual trust' (Sedyaningsih et al. 2008). The dispute highlighted the expanding disjuncture that was emerging between collective global health security and national security interests, for as attention increasingly focused on the 'global threat' from H5N1, member states moved to secure access to drug supplies to protect their respective populations. The outcome of this trend served to exacerbate the tensions between wealthier countries that could afford to enter into advance purchase agreements with pharmaceutical manufacturers to guarantee supply of these drugs and those countries that lacked the financial means to do so. The diplomatic quarrel arose when Indonesia then attempted to purchase influenza pharmaceuticals in late 2006 and was advised that it confronted a queue, even though samples provided

by Indonesia to the WHO had been used to make the vaccines and the country was recording the highest number of human-related H5N1 deaths. In response, Indonesia announced that it would cease sharing H5N1 samples and called on the WHO to reform the influenza technical cooperation network to ensure that all participating countries gained equitable benefits. While condemned by a number of commentators from high-income countries claiming that the world was being held to ransom (Holbrooke and Garrett 2008), Indonesia's position found favour with a number of other low-income countries that confronted the same challenges.

The four-day meeting in November 2007 was thus the first official IGM to discuss the diplomatic impasse and try to develop a solution to address the concerns of Indonesia and like-minded countries. Throughout the meeting high-income countries, via a representative from the EU, attempted to pressure Indonesia into resuming its virus-sharing activities, citing that it was an obligation under the IHR (2005). Yet when the EU attempted to insert language on 'global health security' into the draft text on virus sharing, it prompted a 'heated controversy' before being rejected by a number of low- and middle-income countries that included Indonesia, India, Brazil, and Thailand (Sangeeta 2007, Tayob 2008). Ultimately it took a further three IGMs as well as an additional three IGWG meetings before consensus was finally reached – the 2011 PIP Framework that was endorsed by the 64th WHA on 2 May 2011. Significantly, no mention of 'global health security' or its derivatives were included.

In fact, disagreement over the WHO's adoption of the health-as-security frame escalated and was replicated in other forums, including the WHO's EB. At the 122nd EB in 2008 – the first EB meeting after the release of the 2007 World Health Report – the delegate from Brazil went to considerable lengths to stress that there was no consensus about the use of the phrase 'global health security' or its meaning (WHO EB 2008a). The representative further expressed Brazil's strong objection to the connections the WHO secretariat was making with the IHR (2005), and in particular the claim that the revised framework was 'an important instrument for ensuring that the goal of international public health security' was met (ibid., p. 58, see also Tayob 2008). As the representative later stated, the 2007 report included 'confrontational language that was more appropriate to the UN Security Council than to the International Health Regulations (2005)' (ibid., p. 151). While no objections were raised by other member states at that juncture, when the topic of climate change arose, Thailand also joined Brazil in condemning the use of

the phrase 'global health security' (ibid., p. 67). As a consequence, while the resolution on climate change retained a reference to global health security, the EB resolution that was later passed on progressing the IHR's implementation made no mention of health security, at the global level or otherwise.[2]

Likewise, discord over the WHO secretariat's adoption of health-as-security additionally emerged and was reflected in discussions regarding the IO's official programme of work. Traditionally, every 10 years member states agree upon the overall strategy, priorities, and focus of the WHO's work for the coming decade. These 10-year strategic frameworks (otherwise referred to as the organization's 'General Programme of Work') then serve as the basis upon which medium-term six-year planning documents are developed, which in turn inform the IO's biannual funding and immediate assignments. In 2006, the 11th General Programme of Work 2006–2015 strategy document was released (WHO 2006e). This document, which was entitled 'Engaging for Health', made frequent reference to the WHO's global health security agenda and identified '[b]uilding individual and global health security' as the IO's second topmost category of work (ibid., see pp. ii, 14–15) (see also Table 6.1 for a full list of categories). Giving further weight to the importance of this objective, '[s]trengthening global health security' was acknowledged to be a key priority in the IO's medium-term strategic plan over the 2008–2013 period (ibid., p. iv).[3]

As a result of these declared priorities various country strategies were developed,[4] but in May 2013 member states again met in Geneva in the context of the 66th WHA to review the ongoing planning and development of the IO's 12th General Programme of Work (WHO 2013b). Some years on, the strategic document that outlines the WHO's future priorities remains in draft format; yet it is intriguing to note that at a meeting in February 2012 the IO's principals agreed that the organization's next programme of work would be arranged differently around five 'programmatic' areas – communicable diseases; non-communicable diseases; promoting health through the life-course; health systems; and preparedness, surveillance, and response – and a sixth work area pertaining to the IO's corporate services (ibid., p. 33) (see also Table 6.1). Even more intriguing was that with this change in direction the only reference to the concept of health security that was made in the first draft of the strategy document (submitted to the 65th WHA in May 2012) described the goal of 'collective security against health threats' (WHO 2012c, p. 9). No mention was made of the IO's mandate to ensure global health security, nor indeed did the phrase

Table 6.1 WHO work programme priorities

Categories	11th General Programme of Work	12th General Programme of Work (2013 Draft)	12th General Programme of Work
1	Investing in health to reduce poverty	Communicable diseases	Universal health coverage
2	Building individual and global health security	Non-communicable diseases	Millennium Development Goals
3	Promoting universal coverage, gender equality, and health-related human rights	Promoting health through the life-course	Non-communicable diseases
4	Tackling the determinants of health	Health systems	Implementing the International Health Regulations (2005)
5	Strengthening health systems and equitable access	Preparedness, surveillance, and response	Medical products
6	Harnessing knowledge, science, and technology	Corporate services	Social, economic, and environmental determinants of health
7	Strengthening governance, leadership, and accountability	–	

Sources: WHO (2006e); WHO (2013b); Cassels et al. (2014)

appear in any of the usual progress reports produced that year in relation to the implementation of the IHR (2005), pandemic preparedness, or the IO's role in humanitarian emergencies (see WHO 2012d, 2012e, 2012f).[5] Similarly, the phrase 'global health security' does not appear once in the 48-page draft document tendered at the 66th WHA, and only two references were made to 'health security' – once in relation to the IHR (2005), with the second appearing at the end of a statement of intent pertaining to preparedness, surveillance, and response (WHO 2014g, pp. 30, 33). Such omissions, while notable in light of the WHO secretariat's previous sponsorship of the global health security discourse, are not particularly surprising when also taking into account the discussions that transpired since 2011 regarding the WHO reform process.

Indeed, by 2009 the impact of the previous year's global financial crisis and the associated downturn of voluntary and assessed contributions was already being felt by a number of UN agencies, including the WHO (WHO EB 2010b, WHO 2010c, Leach-Kemon et al. 2012). The fiscal tightening subsequently led the WHO director-general to initiate an organization-wide review of its programmes and spending priorities, the findings of which were then tabled in a report and presented at the 128th EB in January 2011 (WHO EB 2010c),[6] ahead of the 64th WHA in May that same year (WHO 2011d). Following member states' deliberations, a new and extensive programme to reform the IO was given preliminary approval. Throughout 2011 a series of regional consultations were held with member states in which they examined the recommended streamlining of the WHO's core priorities and activities.

As recounted by the WHO secretariat in a series of reports submitted to a special session of the EB in November 2011, the majority of member states endorsed the overall recommendations and proposed direction for reforming the IO. Although the draft documentation that governments were supplied is not all publicly available, for the purposes of this book it can be ascertained from the secretariat reports that some adjustments had been made to the terminology regarding the WHO's core priorities. For example, whereas the IO's 11th General Programme of Work and the organization's 2008–2013 medium-term strategic plan had explicitly identified global health security as a core priority (see above), reflecting the concerns that had been previously raised by some member states, the WHO secretariat outlined yet another re-alignment to its overall approach for attaining the highest possible level of health for all peoples, advocating that five principles or 'pillars' of primary

healthcare be used to inform its future activities (WHO EB 2011a, p. 3). As outlined in one of the reports, these included:

(a) reducing exclusion and social disparities in health;
(b) organizing health services around people's needs and expectations;
(c) integrating health into all sectors;
(d) pursuing collaborative models of policy dialogue; and
(e) increasing stakeholder participation. (ibid.)

To accomplish these objectives, the WHO secretariat proposed that the IO's activities be realigned around 'five core business areas' that were broadly described as: health systems and institutions, health development, health security, convening for better health, and evidence on health trends and determinants (ibid., pp. 3–4). As can be observed though, in describing these new foci all reference to 'global' was removed; and the references that were made to 'health security' (see also WHO EB 2011b, p. 5; 2011c, p. 3) sought to draw upon the definition that had been provided in May 2011 at the 64th WHA, which described the concept as:

> the strengthening of *national* and *international* capacity to reduce peoples' vulnerability to public health risks and to implement appropriate action when adverse events occur. Threats may arise from disease outbreaks such as cholera, pandemic influenza or SARS, or from physical causes such as radiation. Many threats are acute, but others are more long term (for instance, the impact of climate change or environmental pollution). Natural disasters, conflict and its aftermath pose similar challenges through their direct impact on individuals and the risks to health that arise from the disruption of essential services and the breakdown of state structures. (WHO 2011d, p. 8, emphasis added)

Even so, some member states still appeared dissatisfied with this compromise, stressing the need for the WHO secretariat to review the 'proposed core areas of work to determine whether they will respond in a manner that addresses the current needs of health systems' and to engage in 'further discussion based on a more in-depth analysis of the needs of the Member States' (WHO EB 2011c, pp. 5, 9). Yet other countries were even more explicit, arguing that 'more funds be channelled to areas that deal with non-communicable diseases, maternal and child health, and health systems, which [they] considered as being of overriding importance' (WHO EB 2011a, p. 5).

By 2014 it appeared that the WHO secretariat had almost entirely willingly jettisoned its utilization of the health-as-security discourse.[7] The one notable exception to this trend was the production of a report on antimicrobial resistance (AMR) that the secretariat published in April 2014 that identified 'AMR is a global health security threat that requires concerted cross-sectional action by governments and society as a whole' (WHO 2014i, p. xiii). Beyond this, as reflected in an article published by three senior WHO officials, Cassels, Smith, and Burci (Cassels et al. 2014), – global health security and any associated derivatives had been entirely removed from the WHO's priorities. Rather, the IO's key objectives were now identified as advancing universal health coverage, addressing current and future health-related MDGs, non-communicable diseases, implementing the IHR (2005), increasing access to medical products such as pharmaceutical and other health technologies, and addressing the social, economic, and environmental determinants of health (ibid., p. 203). Even in relation to the IHR, which had previously been frequently associated with the pursuit of global health security, the descriptors had reverted to expressing technocratic, technical terminology that would minimize the risk of antagonizing those member states dissatisfied with the health-as-security discourse.

It thus appears that the disgruntlement over the organization's promotion of global health security persisted amongst some of the IO's principals. No doubt concerned over the potential repercussions that might ensue if this issue was left unaddressed – such as the imposition of yet further economic, legal, or political mechanisms of control – the WHO secretariat capitulated to the small but vocal minority of member states by moderating its use of the health-as-security rhetoric. Indeed, as can be observed from the above analysis, since 2007 there has been a progressive winding back of the IO's global health security framing efforts, with the secretariat seeking to again re-cast its mandate and activities in a more technical, apolitical light. Such moves could be interpreted by some as the secretariat intentionally engaging in IO slippage; and yet the converse argument could also be made that the WHO is rather responding to the expressed preferences of its member states and dutifully following their directions. Certainly, given that consensus evidently does not exist, the IO has sought to distance itself from the health-as-security discourse and thereby circumvent any disruption to its activities. In the remainder of this chapter, the implications of these moves and counter-moves will be examined in greater detail, with particular attention given to the impact on the role and function of the WHO's disease eradication mandate. In this, recent history may offer an indication of what is to come.

So, what happens now?

There is little question that the securitization of health issues perpetrated over the past few decades has yielded considerable benefits. Indeed, even the staunchest critics of the health-as-security discourse have acknowledged the advantages that securitization brings in the form of heightened political awareness and engagement, which in turn frequently leads to the allocation of significant financial resources to address the perceived threat (see, for example, Ingram 2005, Collier and Lakoff 2008, Abraham 2011). In this regard, the successful securitization of specific health issues such as pandemic influenza, HIV/AIDS, and biological weapons substantiates the notable benefits that can accrue. Leaving aside for a moment whether in fact the connections that have been efficaciously drawn between acute hazards to human health and national/international security can now be 'un-made' (see Concluding Remarks), the desecuritization of health issues is likely to have a deleterious impact – at least to some extent – on the WHO's disease eradication mandate.

The framing of certain health issues in security terms actively contributed to health being recognized as a legitimate foreign policy issue (McInnes and Lee 2006). High-income countries the world over subsequently recognized that by assisting their less wealthy compatriots to improve their disease surveillance capacities and health systems, they in turn would help themselves by decreasing the risk of diseases spreading to their territories and respective populations. This oft-repeated refrain that diseases do not respect human-imposed borders and enlightened self-interest proved to be a powerful motivating force, encouraging governments to look for ways and means to aid low- and middle-income countries build and strengthen their health infrastructure. It has been in this context that the WHO has benefitted tremendously for a time from high-income countries' anxieties, as Davies (2008) accurately identifies in her critique. For while the field of global health has become increasingly crowded with the influx of multiple new actors, the WHO has continued to retain its overall reputation as the world's leading technical agency in international health matters.

Said another way, particularly since the start of the new millennium there has been a direct correlation between the level of financial and political support that the WHO has received and the securitization of health issues. That the WHO secretariat would have collectively recognized this phenomenon and subsequently further encouraged its development through the release of policy documents and key publications in academic journals is entirely consistent with most theories of IO

pathology, and thus should come as no particular surprise. Accordingly, while some critics may seek to suggest that the organization's activities simply reflected the interests of the most powerful and influential (proximal) member states, implying that the WHO is merely a puppet whose strings are being pulled, it is equally plausible that this was one instance where the collective preferences of the IO and the vast majority of its masters aligned closely, if not entirely. It is also in this same regard, however, that in the event the WHO secretariat seeks to now distance itself too much from the health-as-security discourse, there will likely be financial and political repercussions.

It is important to recall, for instance, that there have been unprecedented levels of growth in official development assistance (ODA) and non-governmental funding for health over the past few decades. Between 1990 and 1997, ODA and non-governmental funding grew by 49 per cent, from US$5.74 billion to US$8.54 billion. Between 1998 and 2012, however, ODA and non-governmental funding such as philanthropic donations for health increased by over 230 per cent to peak in 2012 at US$28.2 billion (IHME 2012, Lidén 2014). While a substantial proportion of this growth can be attributed to other factors such as the creation of the MDGs and associated global health partnerships like the Global Fund to Fight AIDS, TB, and Malaria, it has to be equally acknowledged that the securitization of specific acute health hazards provided additional impetus for high-income countries to significantly increase financial contributions.

For the WHO, while the organization's biannual budget more than doubled over the 10-year period from US$1.6 billion in 1998–1999 to US$4.2 billion in 2008–2009 (Sridhar and Gostin 2011), the vast majority of these increases were provided in the form of extrabudgetary voluntary contributions. In 1998–1999, for instance, voluntary contributions rested at approximately 48 per cent of the IO's total funds (ibid.), but by 2010–2011 75 per cent of the WHO's programmes were funded by extrabudgetary funds, and some 91 per cent of these monies were reserved for specific donor-driven priorities (van de Pas and van Schaik 2014, p. 197). Earmarked extrabudgetary funds later increased to a total of 77 per cent of the IO's funding arrangements in 2014–2015 (Gautier et al. 2014, pp. 172, 177). Equally significant for the purposes of this book, between 2008 and 2009 approximately 60 per cent of the IO's extrabudgetary funds were allocated explicitly for the prevention and control of infectious disease (Sridhar and Gostin 2011, p. 1586), and this overall trend has continued (see Sridhar et al. 2014).

Even taking into account the criticisms that have emerged post-2007, therefore, it remains highly improbable that the WHO secretariat would suddenly announce to the international community that it was no longer prepared to describe its disease eradication mandate in security terms. Such a course of action would have little benefit, as it would be unlikely to assuage the concerns of its critics while simultaneously risking that member states would reallocate extrabudgetary funds to other organizations. Further, such a path would be unwise, particularly given that the majority of member states continue to appear reasonably comfortable with the concept and its use. Throughout various EB meetings, for instance, governments as diverse as Chile, Kuwait, Lithuania, Morocco, the People's Republic of China, Somalia, and the Syrian Arab Republic have indicated their support of the WHO's use of global health security by adopting its terminology to advocate for particular programmes or policies (WHO EB 2010a, p. 96; 2011d, p. 129; 2012, pp. 144–153; 2013, pp. 140–146). These governments thus join others that include Australia, Switzerland, the United States, and the 28 members of the EU that have consistently supported the health-as-security frame (WHO EB 2011d, pp. 132–134; 2013, pp. 142–146).

Moreover, in what must be an especially perplexing situation for the IO some member states have exhibited inconsistency towards this issue. For example, in 2007 Sri Lanka observed that 'one of the Secretariat's functions was to provide technical expertise to Member States in order to ensure global health security' (WHO EB 2007, p. 111), yet in 2011 the same government was calling for more clarity on the concept and discouraging its use (WHO EB 2011d, p. 134). Likewise, in 2007 Thailand and Indonesia indicated their solidarity with Brazil in questioning the WHO's use of the phrase 'global health security' (Sangeeta 2007). Yet in 2009 Indonesia engaged the same terminology to push for a resolution to the Israel–Palestine conflict as well as advocate for more resources to strengthen health systems (WHO EB 2009, pp. 58, 77), whereas Thailand even went so far as to state in 2013, following the adoption of the 2011 PIP Framework, 'The Secretariat should continue its efforts to increase the influenza vaccine supply in the interests of global health security. Legal complexities should not be allowed to block the global health security movement' (WHO EB 2013, p. 147).

It can be clearly observed, therefore, that there is still considerable ambiguity amongst the WHO's principals as to the benefit and utility of the health-as-security discourse. However, where some might anticipate that the WHO secretariat would take advantage of this equivocality to

drive forward its own agenda, intentionally engaging in agency slack, the IO has instead quietly reversed course. In fact, to date the route that the WHO secretariat appears to have adopted following the criticisms that emerged from 2007 onwards has been to downplay the health-as-security frame, which it has done by simply avoiding it and selecting instead to re-cast the activities previously described as essential to global health security – such as the IHR (2005) – in technocratic language.

The ultimate outcome of the WHO secretariat's decision to reframe its disease eradication mandate and activities in more conventional public health terminology remains to be seen. Given the role that securitization had though in elevating health as a legitimate foreign policy issue at the turn of the new millennium, it can be anticipated that the IO's unwillingness to now utilize and promote its health-as-security mandate may result in some unintended consequences. Arguably, however, here the greatest risk is to the WHO.

There is a genuine possibility, for instance, that by actively suppressing the health-as-security discourse, some member states – and particularly the IO's proximal principals that have been very supportive of this agenda – will interpret this move as the WHO shirking its delegated responsibilities. Were this to occur, it is likely that they would again begin to question the IO's continued relevance in a manner consistent with the events of 1994 that prompted the creation of UNAIDS. Although somewhat speculative, a close reading of the speeches delivered by Director-General Margaret Chan after the WHO reform process was launched in 2010 reveals that at least some elements of the secretariat appear to be acutely aware of the risk to the organization's reputation.

In 2011, for example, in a speech delivered at the EB special session on WHO reform, the director-general observed, 'These are issues where our reputation stands or falls depending on how nimble and capable we are in addressing these challenges or paving the path for others to do so' (WHO EB 2011e, p. 1). The issues that Dr Chan was referring to included the five 'flagship' reform priorities that had been collectively agreed by member states and which notably included (at that time) health security. The director-general went on to state:

> WHO made much of its reputation fighting infectious diseases, bringing many to their knees. Rest assured: we will never let down our guard. We know how quickly infectious diseases, even when apparently close to control, can take advantage of any opportunity to resurge with a vengeance. (ibid.)

In making this speech, which occurred even as the WHO secretariat was censoring its use of 'global health security' throughout various policy documents and reports, the director-general sought to highlight that while the IO's rhetoric had altered, in reality its practices would not dramatically change. Additional speeches delivered by the WHO director-general from 2012 to 2014 further corroborate this conclusion.

As noted earlier, the WHO secretariat has frequently pronounced the IHR (2005), and in particular real-time disease surveillance, as fundamental to global health security. Addressing the 65th WHA in May 2012 the director-general remarked in her opening speech that progress continued apace in implementing the IHR core capacities, due to the IO's 'sophisticated electronic surveillance system' that gathered disease intelligence in real-time. The director-general further stated, 'We are rarely taken by surprise. WHO can mount an international response within 24 hours . . . No other agency can do this' (WHO 2012g, p. 3). The following year, in responding to member states' interventions at the 66th WHA regarding progress in implementing the IHR (2005), the director-general underlined that the WHO's coordination role under the revised framework was 'essential' due to the fact that 'a coordination mechanism was required in order to bring together the world's assets and determine whether any new pathogen would pose a public health risk of international concern' (WHO 2013c, p. 12). The IHR (2005), which the director-general then described as 'a legal framework for strengthening the global defence system against new and emerging infectious diseases' (ibid.), needed urgent funding though, to ensure that the IO's effectiveness and assistance to countries was not compromised.

Similarly, the growing prevalence of AMR is an issue that had been previously identified by the WHO as a direct concern to global health security (see Hardiman 2003, WHO 2007a, p. xi). National governments such as the United Kingdom, Sweden, and the United States have likewise explicitly described increasing resistance as a threat to global health security and advocated global action (WHO 2013d, Gostin and Phelan 2014). Yet in her opening speech to the 67th WHA in 2014, while no reference to global health security was made, the WHO director-general stressed that:

> We learned, too, how much the world needs an organization like WHO. Within the framework of our leadership priorities, WHO is shaping the health agenda as needs evolve, and using multiple mechanisms and partnerships to meet these needs. If anything, the relevance of this Organization has increased . . . WHO constantly

> monitors evolving trends and sounds the alarm when needed. For communicable diseases, one of the most alarming crises is the rise of antimicrobial resistance, which WHO documented in a report last month. This is a crisis that now affects every region of the world, and it is only getting worse. (WHO 2014g)

These statements reflect the ongoing petition by the WHO secretariat to member states that the organization remains committed to fulfilling its delegated responsibilities, even though the discourse surrounding the IO's disease eradication mandate may have been reworked again. It is also in this regard, however, that the changes to the WHO's delegation contract that were instituted by member states while revising the IHR may prove to be the most significant challenge for the IO.

As outlined in Chapter Four, several adjustments were made to the WHO's disease eradication delegation contract throughout the process of the IHR IGWG that have affected the manner in which the IO fulfils its duties. While some elements of the WHO's new approach to managing global health security were enshrined and protected under the revised IHR framework, such as the IO's ability to utilize non-government sources of information to identify disease outbreaks and the ability to 'name and shame' governments, equally member states moved decisively to circumvent the WHO secretariat possessing too much autonomy that might adversely impact state sovereignty. New legislative control mechanisms were inserted that place procedural limitations on the WHO secretariat unilaterally declaring a PHEIC, and member states also clarified the types of recommendations they believed the IO was best qualified to issue.

In the context of the 2009 H1N1 influenza pandemic, the WHO secretariat appeared to function well even with these new constraints, and its management of the event was not – at least at first glance – unduly compromised. No doubt the new requirement for the director-general to convene and consult with the IHR Emergency Committee prior to making any notable decisions proved at times to be frustrating for elements of the secretariat that wanted rapid and decisive action to halt the spread of the virus. But equally, in another sense the IHR Emergency Committee proved to be an important shield for the WHO director-general against criticisms that later arose, as her decisions and determinations were backed by an independent expert panel. Likewise, the WHO secretariat's ability to issue recommendations and policy advice in real-time was not especially curtailed. Throughout the pandemic the IO was observed to constantly update the information and advice it was providing,

issue new case definitions and advice on treatment, and recommend measures that governments could take to help reduce the number of infections.

Having said this, it is clear that in other respects the WHO secretariat was overly cautious to avoid the risk of antagonizing its member states. This was most clearly observed in relation to the IO's evident lack of willingness to criticize those governments that imposed temporary travel restrictions on Mexican and North American citizens (irrespective of whether or not they had been at risk of physical exposure), applied trade import bans on pork and pork products (even though there was no evidence to suggest a risk of transmission), and decimated pig populations for no other stated reason than to assuage public fear. In practice, therefore, the WHO secretariat – and particularly the director-general – resiled from its role as government assessor and critic that it had performed throughout the 2003 SARS outbreak, presumably because it was concerned that such actions may result in the IO being subjected to new political, legislative, or financial constraints.

In defence of the WHO, it could be argued that the 2009 H1N1 pandemic was the first test of the revised IHR framework, and so the organization was in the process of ascertaining the boundaries of its newly revised authority. Although such an assertion largely ignores the precedents established by the IO's successful management of the 2003 SARS outbreak, it would be reasonable in this context to allow the organization further opportunity to demonstrate how it would fulfil its updated mandate. Even in this respect though, the WHO secretariat did not have long to wait before further opportunities presented themselves in the form of yet another novel coronavirus and an unprecedented outbreak of EVD.

In late September 2012, authorities in the United Kingdom informed the WHO secretariat that a new coronavirus had been detected in a patient transferred from Qatar. The pathogen responsible had already been isolated by a clinic in The Netherlands following a previous fatality in Saudi Arabia, so this second case raised concerns that a new, albeit small outbreak may be underway (WHO 2013e). In response, the WHO secretariat encouraged governments throughout the region and beyond to undertake increased surveillance; over the coming months, further isolated cases were identified across a number of Middle Eastern countries. By 23 May 2013 the IO had received reports of 44 confirmed cases that included 22 fatalities throughout Jordan, Qatar, Saudi Arabia, and the United Arab Emirates, but cases had also been detected in France, Germany, Tunisia, and the United Kingdom (WHO 2013f). The extent of

the outbreak subsequently prompted an expert panel to give the new disease a name – the Middle East Respiratory Syndrome (MERS-CoV) (WHO 2013g).

In many respects, the WHO's management of the MERS-CoV outbreak initially replicated many of the organization's now-standard functions. Immediately upon receipt of the UK authorities' report, for example, the WHO secretariat instigated its real-time epidemic intelligence coordinator role by collecting data on confirmed and suspected cases, as well as information on the measures governments were taking to treat patients. This information was then collated and analysed to inform the WHO's recommendations, which were constantly revised and updated as new information came to light (WHO 2013h).[8] In an attempt to avoid a repeat of measures taken throughout the 2009 H1N1 influenza pandemic, guidelines based on available evidence were produced and disseminated on various related topics such as infection control, technical assistance was rendered (WHO 2014h), and advice was issued with virtually every update that screening at airports was unnecessary and that trade and travel restrictions were unwarranted.

Nonetheless, by July 2013 the number of cases had continued to progressively grow, indicating that the outbreak was far from controlled. Confronted with some 80 laboratory-confirmed cases and 44 deaths (WHO 2013i), the director-general invoked the IHR (2005) for a second time and convened the IHR Emergency Committee, which met for the first time on 9 July 2013 (WHO 2013j). Citing a lack of sufficient information, the Committee reconvened via teleconference a week later on 17 July (and, at least at the time of writing, has met an additional five times) to review the epidemiological situation and make a determination on whether the conditions to declare a PHEIC had been met. At the emergency committee's seventh meeting on 1 October 2014 the expert panel again confirmed that as there was no evidence of sustained human-to-human transmission and that, accordingly, while continued vigilance was deemed essential, declaration of a PHEIC was not justified (WHO 2014j).

Even from the brief summary provided above, it can be observed that the WHO's management of the MERS-inspired public health crisis is very different from the organization's response to SARS. From an epidemiological standpoint there are very good reasons for this, none the least because unlike SARS the MERS-CoV pathogen has yet to achieve the ability to transmit readily between humans. Were this to change, it can be anticipated that the IO's response to the disease – not to mention member states' – would alter dramatically. Even so, it is clear that the

WHO has approached the management of this new health hazard in a very orderly manner, ensuring that it has fully complied with the procedural requirements under the revised IHR (2005) to consult with all relevant parties affected by the disease prior to issuing advice and recommending how governments respond. Furthermore, in reviewing various statements made by senior members of the WHO secretariat, it is also apparent that the additional checks and balances instituted by member states throughout the IHR revision process has made the IO even more cautious in its approach.

For example, at the 66th WHA on 23 May 2013 the WHO secretariat and Saudi Arabia's Ministry of Health arranged a special presentation on MERS-CoV for the assembled government representatives. At the briefing, Saudi Arabia's Deputy Minister for Health, Dr Z. A. Memish, identified that one of the key challenges his country and other affected countries encountered in controlling the virus' spread was the inability to develop an effective diagnostic test. This situation had arisen though, Dr Memish relayed, as a direct consequence of a laboratory in The Netherlands that had chosen to patent the virus and sign a contract with a pharmaceutical manufacturer that restricted access to the pathogen for other research laboratories without a strict legal agreement in place (otherwise known as 'material transfer agreements') (WHO 2013k). Yet, despite the fact that Dr Keiji Fukuda, WHO Assistant Director-General for the Health Security and Environment Cluster, and WHO Director-General Chan publicly urged member states to ensure that intellectual property considerations should not be permitted to adversely affect public health (ibid., p. 13), no additional criticisms – either of the laboratory, the pharmaceutical manufacturer, or of the countries in which these organizations were based – were made. Similarly, when questioned the following day over the fact that the WHO secretariat had failed to issue any travel advisories for affected countries, particularly in light of the upcoming hajj in Saudi Arabia, Dr Fukuda responded by noting that 'making such recommendations was one of the Secretariat's most difficult tasks' (WHO 2013c, p. 11). Dr Fukuda went on to observe that while he and his staff wanted to ensure that all necessary steps were taken to prevent the pathogen's further spread, they 'also recognized that travel was the lifeblood of many countries' (ibid.).

These comments are remarkable because they indicate that the WHO secretariat has become far more circumspect in how it carries out its disease eradication delegation contract, apparently even in relation to the actions allegedly perpetrated by non-state actors. It will be recalled, for instance, that the Chinese government's actions in 2003 in

attempting to hide the true nature of their SARS epidemic provoked a sharp rebuke from WHO Director-General Brundtland and several senior members of her staff. While some speculated after the event that the director-general was so critical only because she was not seeking re-election for a second term (Anonymous 2005), Dr Brundtland maintained that her actions were based on a 'lifetime of experience' and that the organization had responded appropriately 'given its mandate' (Brundtland 2006). More than a decade later, however, after the IHR revision and in the wake of the IO being accused of being inappropriately influenced by commercial interests into declaring a pandemic, the WHO secretariat finds itself in a more tightly controlled and regulated environment.

It is in this regard that the above comments also suggest that the measures instituted by member states to limit the IO's autonomy have proved largely successful, not only in ensuring that the WHO secretariat is prevented from taking unilateral action (such as declaring a PHEIC) but also in guaranteeing that the IO consults far more closely and regularly with countries prior to issuing recommendations. At the same time, in the specific context of MERS-CoV, it does not appear that the new procedures the WHO secretariat is required to follow have unduly hampered its management of the crisis; but as noted earlier, epidemiologically MERS-CoV is currently a very different pathogen from SARS or a novel influenza strain. Regrettably, the extent of the IO's new measured, guarded approach to managing global health security is also now being firmly tested in the context of a fast-moving and virulent health hazard – EVD.

At the time of writing, the international community is confronted with an unprecedented outbreak of Ebola in West Africa that has already resulted in more than 21,700 people infected and over 8,600 deaths. This outbreak, which is already the largest in recorded human history, originally began on 26 December 2013 in a remote border region between Guinea, Liberia, and Sierra Leone (WHO 2014k), but remained largely undetected for almost three months until the ministry of health in Guinea reported to the WHO a total of 49 cases and 29 fatalities on 23 March 2014 (WHO 2014l). Within a week, the Liberian and Sierra Leonean health authorities reported additional cases (WHO 2014m, 2014n), and over the coming weeks the virus continued to spread before eventually appearing in Nigeria, Senegal, and the United States.[9] Upon receiving notification of the outbreak, utilizing GOARN, the WHO assembled and dispatched foreign medical teams to assist local health authorities. Médecins Sans Frontières (MSF), which already had

personnel in-country assisting with a malaria outbreak, responded by establishing healthcare facilities in affected areas (WHO 2014k). As the weeks progressed though, the number of infected persons seeking care overwhelmed MSF's resources, and so in an attempt to garner more awareness of the unfolding humanitarian crisis and obtain additional help, the NGO began issuing press releases calling for international assistance.

To a large extent, however, the calls from MSF went unheeded by the WHO and the wider international community until September 2014.[10] On 7 and 8 August, in response to reports that Ebola cases had begun to appear in neighbouring Nigeria, the WHO director-general convened the IHR Emergency Committee via teleconference (WHO 2014o). The committee unanimously agreed that a PHEIC was underway, and urged those countries affected to declare a state of national emergency and implement disaster management plans, while all other countries were encouraged to increase surveillance. The committee also recommended that travel restrictions should not be imposed on affected countries, reportedly in recognition that it would harm international relief efforts. Yet in a rather questionable decision, the IHR Emergency Committee did not call for international assistance to help contain the outbreak and recommended that the situation only be reviewed again in three months' time (ibid.).

By late August 2014 the outbreak had resulted in over 3,000 infections and 1,500 deaths (WHO 2014p). Overwhelmed, and in an extraordinary move for the NGO, on 2 September 2014 MSF called for military intervention to help contain the outbreak (Hussain 2014), even as senior UN leaders were gathering in Washington, DC to discuss how to escalate international assistance in light of the growing humanitarian crisis (WHO 2014r). On 16 September 2014 President Obama announced his country's commitment to deploy 3,000 military personnel to West Africa to help construct Ebola treatment facilities and train local health workers (Mason and Giahyue 2014). This commitment, which in early October was expanded to potentially 4,000 personnel (Stewart 2014), was replicated on a smaller scale by other governments deploying military forces to aid containment efforts, including the United Kingdom, France, Germany, and eventually China. Importantly, however, on 18 September the UN Security Council passed resolution 2177 (2014) declaring the Ebola outbreak 'a threat to international peace and security' (UN 2014b). At the same time, the UN established the first-ever public health mission: the United Nations Mission for Ebola Emergency Response (UNMEER).

The passage of resolution 2177(2014) and the creation of UNMEER has been interpreted as a stunning indictment of the WHO's failure in responding to the EVD crisis (Fidler 2014). Public criticisms of the WHO's handling of the Ebola outbreak began to emerge from July 2014 onwards[11] and ranged from the delay taken in convening the IHR Emergency Committee, to 'a culture of stagnation' (Gostin, cited in Gale and Lauerman 2014), to the dysfunctional relationship between the central headquarters and the African regional office. In mid-October 2014 an internal document was leaked to the world's media in which the WHO acknowledged that several factors had contributed to its mismanagement of the outbreak, including serious incompetence (Cheng 2014). In response to the unexpected disclosure, the WHO released its own statement on 18 October, stressing that the report had not been 'fact-checked' and that 'A full review and analysis of global responses to this, the largest-ever Ebola outbreak in history, will be completed and made public once the outbreak is under control' (WHO 2014q).

There is little question that the WHO's handling of the Ebola outbreak in West Africa will be scrutinized extensively in the months and years to follow. Although some commentators have attempted to support the WHO, noting how the organization has been subject to extensive budget cuts that have hampered its operational response capabilities (see Fink 2014a), equally the failure of the IO to fulfil its health-as-security delegation contract will be viewed poorly by proximal and distal principals alike. One small indication of the level of member state dissatisfaction has already materialized with the replacement of the African regional office's director in November 2014 (AFRO 2014), but it is unlikely the political ramifications will cease there. Certainly the content of the internal report has confirmed what many critics have highlighted for years regarding the dissected nature of the WHO into effectively seven independent entities, and the ineptitude and duplication this structure creates.

Having said this, in the opening months of the 2014 West African Ebola outbreak the WHO was observed to institute its now-standard approach to global health security, fulfilling a number of roles in real-time wherever possible. For example, the IO continued to collect epidemiological intelligence and convert this information into policy-relevant advice as soon as information was reported to the WHO. Whereas the timeliness of the data and advice was perhaps not as 'real-time' as during previous outbreaks, some of the delays that were experienced can equally be attributed to the poor health infrastructure within the affected West African countries. In addition, the WHO facilitated the deployment of

expert teams to assist countries with instituting containment measures, but when queried by a *New York Times* reporter in early September 2014, WHO Director-General Margaret Chan stressed, 'we are not the first responder. You know, the government has first priority to take care of their people and provide healthcare. W.H.O. is a technical agency' that did not provide 'direct services' (Fink 2014b).

The lack of direct action and leadership displayed by the WHO throughout the opening months of the EVD crisis was indubitably one of the key reasons for the creation of UNMEER. However, given that the WHO has consistently emphasized its ability to manage global health security since 2001, its incompetence within the context of the 2014 Ebola outbreak to assist governments contain the disease in a timely manner – either by providing resources in the initial weeks or raising the alarm sufficiently to rapidly assemble an international coalition – will reflect very negatively upon the IO's reputation. At the time of writing, UNMEER had been established for less than a few months, but it has already demonstrated the leadership that many in the international community would have been expecting to see emerge from the WHO. UNMEER has, for example, led the campaign for the quarantine and isolation of potential cases and the safe burials of victims within a 60-day timeframe (World Bank 2014). It has also coordinated the multiple UN agencies and non-government and civil society organizations now engaged within those countries affected by Ebola. While the health targets were developed in collaboration with the WHO and the IO continues to play a key technical role (UN 2014c), it was the Head of UNMEER, Anthony Banbury, who had exhibited leadership, assumed responsibility for coordinating the international response, and been consistently calling for more resources and personnel to fight Ebola, even as the WHO and its director-general have been eerily absent.

While the humanitarian crisis continues unabated there will be little time allocated to apportioning blame, as all partners are appropriately focused on containing this outbreak and saving lives. In the aftermath though, it can be anticipated that several investigations will be launched into the WHO's handling of the 2014 West African Ebola outbreak and the actions of the organization's secretariat. It is only then, perhaps, that some of the details as to why the IO has failed so spectacularly to fulfil its delegation contract and mandate in this context will emerge. Given the leaked internal report, attention will understandably focus on the relationship between the African regional office and the central headquarters in Geneva, but questions as to why it took so long to convene the IHR Emergency Committee, and why its second meeting was only

convened days after the UN Security Council resolution was passed, will be lines of inquiry that must be pursued. If member states are also consistent with past behaviour, it can be expected that in successive WHA meetings they will seek to impose additional control mechanisms on the WHO secretariat in the wake of the EVD crisis. Exactly what form those mechanisms may take – politico-legal, economic, technical, or socio-legal – is unclear, but it is improbable that the IO will escape unscathed.

Equally though, not all the blame can be attributed solely to the WHO and its regional office. In many respects, member states – and particularly some of the IO's proximal principals – must conceivably accept some of the blame for the WHO's mishandling of this latest PHEIC. It must be recalled, for instance, that the division of the WHO into seven organizations was the result of an historical anomaly whereby the Americas' regional office pointedly refused to be subsumed into the new universal health agency. The PASB/PAHO intransigence on this matter, and its insistence on no small measure of autonomy to decide upon its priorities and budgetary expenditure, set the precedent for the remaining regional structure of the IO. Added to this, the budget cuts that the organization has been subjected to via the WHO reform process of recent years have been extensive, and have been openly acknowledged to have caused staff reductions and the cancellation of programmes. As also explored in Chapter Four, following the 2003 SARS outbreak member states went to considerable lengths to convey to the secretariat that there are limits to the IO's autonomy that they are prepared to accept – a message that has evidently been heard by the organization's director-general and senior staff. While, therefore, mistakes and even IO slippage may have transpired in the Ebola response, the mismanagement of the crisis in the initial months and the dysfunction that ensued should have perhaps been anticipated, given the economic and politico-legal constraints that member states had previously imposed. Although it is dubious that member states will accept any responsibility for the IO's actions, what is apparent is that the WHO's management of the 2014 Ebola outbreak will likely feature prominently in providing new interpretations of the IO's authority both now and in the foreseeable future.

Conclusion

It took some years, but following the WHO secretariat's decision to reframe its public health mandate in security terms, a number of criticisms have emerged. As this chapter has shown, the critiques surfaced

from two primary groups that included the academic community and a small but vocal number of member states. Even so, for almost a decade the WHO secretariat largely avoided being directly censured for its actions in promoting the securitization of certain select health issues, with much of the blame being attributed to powerful Western interests pressuring the WHO behind the scenes. While there may initially have been some validity to these claims, equally certain elements of the WHO secretariat (including its senior leadership) embraced the concept of global health security and utilized the health-as-security frame to successfully lobby for new powers and financial support to fulfil the organization's disease eradication delegation contract.

Nonetheless, in a move that would surprise many who view IOs as self-seeking aggrandizers, when criticisms later did emerge of the WHO's securitization efforts, rather than take advantage of member states' indecision the IO quietly and systematically initiated a process to reframe its activities again in a discourse more congenial to its disgruntled principals. In so doing though, the WHO now conceivably confronts a dangerous predicament whereby it risks being accused of shirking its delegated responsibilities by those member states that are supportive of the health-as-security agenda. While the agent continues to stress that it is only the rhetoric that may have changed, the WHO secretariat is also contending with new procedural measures designed to limit its autonomy in responding to disease outbreaks and, as recent events have revealed, these control mechanisms are having a demonstrable impact on the IO's performance. The future of the WHO's approach to managing global health security is thus again under question, and it is to this topic that the conclusion to this book now turns.