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Master's Thesis of International Studies

A Comparative Analysis of The World Health Organisation's Policy Agenda-Setting and Decision-Making across Pandemics: Smallpox, SARS, and COVID-19

세계보건기구(WHO)의 팬데믹 정책 어젠다 설정 및 의사결정 비교분석: 천연두, 사스, 코로나 19

February 2023

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A Comparative Analysis of The World Health Organisation's Policy Agenda-Setting and Decision-Making across Pandemics: Smallpox, SARS, and COVID-19

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Submitting a master's thesis of International Studies

February 2023

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Abstract

This thesis is a qualitative comparative case study analysing the policy agenda-setting and decision-making processes of the World Health Organisation (hereafter WHO) across the smallpox, SARS, and COVID-19 health crisis. To understand the influences endogenous and exogenous factors have on WHO policies and choices, the research used The Garbage Can Model of Organizational Choice and The Multiple Streams Framework. These findings were coupled with reform initiatives to determine what factors contributed to or hindered the performance of the WHO-led programmes. Findings from the three case studies show that Member States' refusal to comply with legally binding WHO regulations was the recurring exogenous problem that resulted in the failure of numerous WHO programmes. This is a recurring pattern across health crises since Member States are not directly penalised for non-compliance. The reason for non-compliance was divergent WHO and Member State interests, and the decision to forego collective security to pursue national interests was motivated by socioeconomic and political factors. Successful disease eradication was achieved when national interests converged and were supported by reformed programme policies.

Keywords: World-Health-Organisation, Policy-Agenda-Setting, Decision-Making, Smallpox, SARS, COVID-19

Student Number: 2020-21170

Acronyms and Abbreviations

AC	Assessed contributions
DG	WHO Director-General
EB	Executive Board
GOARN	Global Outbreak Alert and Response Network
IHR	International Health Regulations (2005)
IO	Inter-governmental Organisation
IOAC	Independent Oversight and Advisory Committee
IPPPR	Independent Panel for Pandemic Preparedness and Response
NFP	National Focal Point
PHEIC	Public Health Emergency of International Concern
PPPs	Public Private Partnerships
SARS	Severe Acute Respiratory Syndrome
SEP	Smallpox Eradication Programme
SARS-CoV2, COVID-19	Coronavirus Disease 19
UN	United Nations
UNSC	United Nations Security Council
VC	Voluntary contributions
WHA	World Health Assembly, Health Assembly
WHEP	World Health Emergencies Programme

WHO	The World Health Organisation

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Chapter I: Introduction

The World Health Organisation has undertaken the role as today's modern-day global health leader. Responsible for fulling its objective of attaining the highest possible level of health for all peoples, the systematic procedures undergone to attain such objectives are arduous and often time-consuming. The policy agenda-setting and decision-making procedures in WHO are critical junctures to the development of important decisions to mitigate public health crises and achieve target goals for health that contribute to global security. These two stages of policymaking are crucial for WHO and the global community in the context of health because the outcomes can be used to create critical pre-emptive preparedness responses and protocols to mitigate global health catastrophes, which have negative effects on every aspect of society and daily life.

The proclaimed global health leader of today has received immense pressure and carried great responsibility over history to successfully manage disease outbreaks and protect the wider public from health threats. Amidst the existing burden, a variety of endogenous and exogenous obstacles impose further restrictions on the already complex process. Endogenous factors are internal and specific to WHO, such as financial insecurity, fragmented governance, and internal bureaucratic red tapes. Exogenous factors are external, such as political interferences, national bureaucratic red tapes, and non-compliance issues to WHO regulations owing to national interest. Notorious for enforcing legally binding agreements without full compliance from Member

States, WHO often struggles to maintain its credibility in the international community due to criticism regarding their dependence on soft power to enforce responsibilities and regulations. As a result, the lack of cooperation coupled with endogenous and exogenous challenges has only debilitated WHO's response to the prevention of early disease containment as witnessed with the COVID-19 pandemic.

Health crises have not only demonstrated detrimental effects to health but also cause drastic socioeconomic and political impacts. This bleeds into the discourse of security, where human's innate prerequisite for survival is to serve one's self-interest. Although traditionally, States have been concerned with security threats that were usually of defence and military nature. As the fatal disease has spread, the state's security interests have momentarily shifted towards human security, where they are motivated by the need to survive in this global arena. State's responses to the COVID-19 pandemic were undoubtably enacted based on the premises of self-interest and survival, guided by socioeconomic and political benefit. This caused a shift from pursuing collective interest and security, resulting in recurring noncompliance issues to WHO's regulations. To understand how these endogenous and exogenous elements ultimately affect Member States' convergence or divergence in national interests and the effectiveness of WHO led programmes, this thesis seeks to identify the correlating issues across the three cases. Thus, the main question addressed in this thesis is as follows:

How do emergent health concerns worsen to such a degree as seen with COVID-19, despite the lessons learned from responding to previous health crises?

Given WHO's long history and experiences in handling health crises, hypothetically, current policy agenda-setting and decision-making procedures should be at their most reformed state. WHO highly prioritises evidence-based information and decisions, having established independent review committees to analyse the effectiveness of their own practices. Recommendations for improvement are suggested by the committees, thus, minor reforms should ideally occur, equating to increased effectiveness as relevant adjustments and introduction of additional policies would have been introduced to complement the former. As WHO uses set methodologies, application of recommendations should theoretically be a rapid process. Thus, the following questions help fill the gaps that arise from addressing the main question:

What lessons have not been learnt from prior handlings of health crises that present themselves as recurring issues?

What improvements must occur for the reform of the world's only institution in managing global pandemics to be effective and successful?

Despite WHO exercising hard power through legally binding instruments, why do Member States continue to evade them?

Genesis and Organisational Structure of WHO

WHO is a specialised agency of the United Nations (UN), its establishment stemming upon unified agreement on the vital importance of a global health leader at the International Health Conference held in San Francisco in 1945.[1] Health considered a condition of stability and well-being, WHO was established in 1948 with its headquarters based in Geneva, Switzerland, as a directing and coordinating authority on international health, to unite States with a common purpose.[2] Unlike the other specialised agencies of the UN, WHO has its own governance structure, with both a decentralised and regionalised nature.[3]

WHO's role as a global health leader is responsible for fulfilling its objective of attaining the highest possible level of health for all peoples that is built on three focal pillars: (i) universal health coverage, (ii) managing health crises and (iii) improving health and wellbeing.[4] The foundation of the legal structure of WHO is governed by the Constitution, which outlines WHO's extensive mandate as the fundamental objectives of WHO, detailing the roles

[1] World Health Organization. 1948. "Summary Report on Proceedings, Minutes and Final Acts of the International Health Conference Held in New York from 19 June to 22 July 1946." *Official Records of the World Health Organization No. 2*. https://apps.who.int/iris/handle/10665/85573.
[2] Ibid.
[3] Beigbeder, Yves. 2017. *The World Health Organization. Achievements and Failures*. Global Governance. New York: Routledge. 3.
[4] Burci, Gian Luca, and Claudia Nannini. 2018. "The Office of the Legal Counsel of the World Health Organization." *SSRN Electronic Journal*. 1-38. https://doi.org/10.2139/ssrn.3229184. 13.

and responsibilities that extend onto its legal working forces around the globe.[5] The 26 functions of WHO are listed in Article 2 of the Constitution to help achieve the objectives, grouped into the following categories: (i) strengthening national health services, (ii) an operational role, (iii) environment work, (iv) normative role, (v) a research function, (vi) a training function, and (vii) an information function.[6]

WHO's core functions can be summarised into three categories: (i) normative functions, (ii) directing and coordinating functions, and (iii) research and technical cooperation functions.[7] WHO operates as an authoritative and a political provider of intelligence through its different modes of delivery. This authoritative status is consigned to WHO as States consent to membership. With such a vast array of responsibilities, WHO's General Programme of Work is developed every few years to keep WHO accountable and stay on track in achieving its "high-level strategic vision" for that period, clearly defining priorities, and outlining its direction and coordination responsibilities to attain its vision.[8]

Organised as a 3-level organisation, WHO is composed of the World Health Assembly (WHA), the Executive Board (EB) and Secretariat, with

[5] Ibid.
[6] Beigbeder, Yves. 2017. *The World Health Organization. Achievements and Failures*. Global Governance. New York: Routledge. 4.
[7] Müller, Gustavo, Melanie Ruelens, and Jan Wouters. 2021. "The Role of the World Health Organization in the COVID-19 Pandemic." Accessed September 5, 2022. https://ghum.kuleuven.be/ggs/documents/final-metaforum-research-report-7-12-21.pdf. 17.
[8] Burci, Gian Luca, and Claudia Nannini. 2018. "The Office of the Legal Counsel of the World Health Organization." *SSRN Electronic Journal*. 1-38. https://doi.org/10.2139/ssrn.3229184. 13.

regional bodies spread around the globe.[9] The WHA of quasi-legislative function comprises of delegates from each of the 194 Member States.[10] Pursuant to Article 3 of the Constitution, membership remains open to all States.[11] Associate Members are a separate category of membership who are permitted full participation in events but lack the right to vote.[12] Member States gather annually to overview the functioning of WHO and to guide important decisions regarding future programmes of work and budgetary policies.[13] Each Member State is appointed a delegate, according to its qualifications in the field of health and level of expertise, with no more than three present at a given time.[14] In the case of more than one delegate present, a head delegate is allocated.[15]

The WHA is the supreme decision-making body of WHO and holds the authority to dictate the organisation's policies and adopt legally binding documents vis-a-vis WHO Member States.[16] Two main committees exist, which are committees A and B.[17] Committee A is delegated with programme and budget matters, whilst committee B is delegated with administrative, financial, and legal matters.[18] During decision-making procedures, each Member State is

[9] Ibid, 4.
[10] World Health Organization. 1989. *Constitution*. Geneva: World Health Organization. 3.
[11] Ibid.
[12] Ibid, 4.
[13] Ibid, 5.
[14] Ibid.
[15] Ibid.
[16] Müller, Gustavo, Melanie Ruelens, and Jan Wouters. 2021. "The Role of the World Health Organization in the COVID-19 Pandemic." Accessed September 5, 2022. https://ghum.kuleuven.be/ggs/documents/final-metaforum-research-report-7-12-21.pdf. 18.
[17] WHO Office of the Legal Counsel. 2016. "International Regulatory Co-operation and International Organisations: The Case of the World Health Organization (WHO)." Accessed September 1, 2022. https://www.oecd.org/gov/regulatory-policy/WHO_Full-Report.pdf. 22.
[18] Ibid.

entitled to a single vote. When deciding on what important questions to legally implement, such as the adoption of conventions or agreements, a decision is made when a two-thirds majority of the Member States present vote in accordance with the matter.[19] The determination of extra categories of questions is an exception to this norm, where a choice will be determined based on the majority of Members present and voting.

The EB consists of 34 high skilled and technically qualified professionals acting as the executive organ of the WHA, elected according to equitable geographical distribution.[20] The EB's functions are outlined in Article 28 of the Constitution, with each member designated a term of three years with a third of memberships renewed annually.[21] The board meets twice a year, once in January to prepare agendas and resolutions for the forthcoming WHA meeting, and once again in May or June as a follow-up to the first meeting.[22] The WHA acts on the expert advice of the EB, and the EB ultimately acts on the decisions and policies made by the Health Assembly.[23]

The Secretariat comprises the Director-General (DG) who is elected by the WHA, and other technical and administrative staff as is required by the DG.[24] The DG is appointed to a five-year term and is largely responsible for

[19] World Health Organization. 1989. *Constitution*. Geneva: World Health Organization. 7.
[20] Ibid, 8.
[21] Ibid.
[22] Ibid.
[23] Ibid.
[24] Ibid, 9.

preparing reports requested by the two governing bodies, the EB and WHA.[25] The DG also carries autonomy in making independent policy initiatives, though they should be subject to review followed by approval by the governing bodies.[26]

The Regional Committee is composed of six regions: Africa, the Americas, the Eastern Mediterranean, Europe, South-East Asia, and the Western Pacific.[27] Each regional office comprises a Regional Director who is elected by the Member States in the region by majority vote but is officially appointed by the EB.[28] The regional office enjoys a great deal of autonomy in its programme, budget, and staffing matters, which has often been criticised by scholars for jeopardising the authority of the DG, weakening programme coherence and accountability.[29] On the other hand, this decentralisation of WHO activity acts as a key characteristic in strengthening collaboration with domestic authorities. Policies that are to be formulated by regional committees must pertain relevance to the region according to Article 50 of the Constitution.[30] The country offices are spread across 150 locations, its heads

[25] Beigbeder, Yves. 2017. *The World Health Organization*. *Achievements and Failures*. Global Governance. New York: Routledge. 6.
[26] Ibid, 7.
[27] Ibid.
[28] Ibid.
[29] Ibid.
[30] WHO Office of the Legal Counsel. 2016. "International Regulatory Co-operation and International Organisations: The Case of the World Health Organization (WHO)." Accessed September 1, 2022. https://www.oecd.org/gov/regulatory-policy/WHO_Full-Report.pdf. 24.

appointed by Regional Directors with a role in being a primary advisor to the government in health matters.[31]

Another vital part of the organisation is the expert advisory panels and committees. These highly qualified health professionals are typically assigned to a field that matches their competence, providing technical information and guidance as needed or upon request.[32] They help the organisation evaluate its current procedures and make suggestions in support of the shifting realities and difficulties it continually faces.[33]

The two main financing sources that WHO uses to manage its budget are through assessed contributions (ACs) and voluntary contributions (VCs).[34] ACs are sourced from a percentage of a Member States gross domestic product, revisited, and approved every two years at the WHA.[35] This payment serves as a requirement for membership into WHO and remains a key source of funding, despite making up only a quarter of WHO's funding.[36] VCs are made up of contributions from Member States in addition to their current ACs, as well as from philanthropic foundations, governments, other IGOs, UN organisations, pharmaceutical companies, the private sector, and other sources.[37] The nature of VCs is unpredictable, which at times have affected effective planning and

[31] Beigbeder, Yves. 2017. *The World Health Organization*. *Achievements and Failures*. Global Governance. New York: Routledge. 8.
[32] Ibid.
[33] Ibid.
[34] World Health Organization. 2020. "How WHO is Funded." Accessed September 9, 2022. https://www.who.int/about/funding#:~:text=Assessed%20contributions%20(AC)%20are%20a,20%25%20of%20the%20total%20budget.
[35] Ibid.
[36] Ibid.
[37] Ibid.

implementation of programmes. Most VCs are earmarked for programmes and priorities that are driven by the preferences of donors opposed to the preferences of WHO.[38]

WHO's greatest hindrance to strengthening their authority in decision-making is due to the heavy reliance non-State actor contributions, heavily watering down the independent nature of the organisation. When WHO prioritises vertical programmes, such as battling certain diseases, it may lose control of its operations and violate the concept of primary healthcare, which tends to draw more attention from its funders.[39] Horizontal programmes, such as the improvement of national health services tend to gain less interest from these benefactors.

The financial administration of WHO is governed by the Financial Regulations.[40] The programme budget which guides the organisations programmes and activities is prepared by the DG as per Article 55 of the Constitution, specifically prepared in US dollars.[41] Upon consideration of the programme budget by the EB, the budget proposals will then be shared with the WHA along with any recommendations the EB proposes.[42] The DG is

[38] Reddy, Srikanth K., Sumaira Mazhar, and Raphael Lencucha. 2018. "The Financial Sustainability of the World Health Organization and the Political Economy of Global Health Governance: A Review of Funding Proposals." *Globalization and Health* 14 (119): 1-11. https://doi.org/10.1186/s12992-018-0436-8. 3.
[39] Beigbeder, Yves. 2017. *The World Health Organization. Achievements and Failures*. Global Governance. New York: Routledge. 10.
[40] World Health Organization. 2003. *Financial Regulations and Financial Rules*. Geneva: World Health Organization. 1.
[41] World Health Organization. 2020. *Basic Documents*. Geneva: World Health Organization. 14.
[42] World Health Organization. 2003. *Financial Regulations and Financial Rules*. Geneva: World Health Organization. 1-2.

tasked the role of establishing Financial Rules, which provide guidelines and limits for implementation of the Financial Regulations.[43] In recognition of the need to improve WHO's financing in alignment, predictability, flexibility, transparency and broadening contributor base, a Financing Dialogue consisting of several integrated events and activities was arranged between Member States and key non-State stakeholders through decision WHA66(8).[44] The Financing Dialogue aims to ensure consistency between enhancing the quality and effectiveness of WHO's output and programmes budget. The online portal 'The Programme Budget' allows insider access into WHO's plans and procedures, the allocated funding of these projects and the completion status.[45]

Governance Structure and Modus Operandi of WHO

WHO reflects a classical approach to treaty-based centre of government co-operation. WHO dictates its hard law through the form of conventions or agreements, and regulations concerning five specific areas: (i) sanitary and quarantine requirements and other procedures designed to prevent the international spread of disease, (ii) nomenclatures with respect to diseases, causes of death and public health practices, (iii) standards with respect to diagnostic procedures for international use, (iv) standards with respect to the

[43] Ibid.
[44] WHO Office of the Legal Counsel. 2016. "International Regulatory Co-operation and International Organisations: The Case of the World Health Organization (WHO)." Accessed September 1, 2022. https://www.oecd.org/gov/regulatory-policy/WHO_Full-Report.pdf. 26.
[45] World Health Organization. 2017. "*Ten Years of Transformation: Making Who Fit for Purpose in the 21st Century*." Geneva: World Health Organization. 18.

safety, purity and potency of biological, pharmaceutical and similar products moving in international commerce, and (v), advertising and labelling of biological, pharmaceutical and similar products moving in international commerce.[46] Negotiation processes between conventions or agreements and regulations are separate.[47]

WHO has often been criticised for not asserting their hard power more often, and thus far has only rectified one international convention and two regulations, WHO Framework Convention on Tobacco Control (WHO FCTC), the International Health Regulations 2005 (IHR) and the Nomenclature Regulations.[48] Despite these instruments carrying legal binding power, such instruments will not apply to Member States that decide to "opt-out", though they must be proactive with their decision as they will be automatically bound.[49] With the voting system running on a practice of agreement based on acquiring two thirds of votes, Article 20 of the Constitution directs Member States to notify the DG of the action undertaken within eighteen months upon accordance with the agreement.[50] An annual report should thus be made to the DG regarding legislative and administrative actions made to demonstrate

[46] World Health Organization. 1989. *Constitution*. Geneva: World Health Organization. 7.
[47] Gostin, Lawrence O., Devi Sridhar, and Daniel Hougendobler. 2015. "The Normative Authority of the World Health Organization." *Public Health* 129 (7): 854-863. https://doi.org/10.1016/j.puhe.2015.05.002. 3.
[48] Taylor, Allyn Lise. 1992. "Making the World Health Organization Work: A Legal Framework for Universal Access to the Conditions for Health." *American Journal of Law & Medicine* 18 (4): 301-346. https://doi.org/10.1017/S0098858800007322. 301.
[49] Gostin, Lawrence O., Devi Sridhar, and Daniel Hougendobler. 2015. "The Normative Authority of the World Health Organization." *Public Health* 129 (7): 854-863. https://doi.org/10.1016/j.puhe.2015.05.002. 3.
[50] World Health Organization. 1989. *Constitution*. Geneva: World Health Organization. 7.

progress.[51] In the case of non-accordance, the Member State should subsequently submit to the DG reasons for non-acceptance.[52] Thus, the term binding is open to flexible interpretation by Member States choosing when and where to adopt said agreements, which have been deemed due to inexistent consequences for nonadherence.

Soft law or otherwise, WHO's soft power presents itself in the form of non-binding recommendations such as, strategies, global plans of action, road maps or frameworks.[53] Non-binding recommendations have been found to play a greater role in handling health issues as they are able to be incorporated into legislation, regulations, or guidelines at the national level.[54] Article 23 of the Constitution allows WHO authority to make recommendations, with Article 62 requiring annual reports from Member States that detail the actions taken to comply with the recommendation.[55] Although soft norms do not hold the equivalent weight as hard power carries, they are still instilled through legal and policy tools, and can account as the building blocks for future legally binding instruments.

[51] Ibid.
[52] Ibid.
[53] Burci, Gian Luca, and Claude-Henri Vignes. 2004. *World Health Organization*. The Hague: Kluwer Law International. 126.
[54] Gostin, Lawrence O., Devi Sridhar, and Daniel Hougendobler. 2015. "The Normative Authority of the World Health Organization." *Public Health* 129 (7): 854-863. https://doi.org/10.1016/j.puhe.2015.05.002. 853.
[55] World Health Organization. 1989. *Constitution*. Geneva: World Health Organization. 15.

WHO's Process of Policy Agenda-Setting

Policy agenda-setting is the most critical juncture for the process of policy development, as it greatly influences the trajectories of decision-making procedures. The agenda is a collection of problems that the participants of policy development believe are crucial that exert indirect or direct impacts to decision-making processes.[56] The process of developing policies and putting them into effect is gradual and typically separated into different stages. The stages of policy agenda-setting vary from framework and author, but most generally are composed of the following stages: (i) problem formation and agenda-setting, (ii) policy formation, (iii) policy implementation and (iv) policy evaluation.

Agendas change over time to suit different objectives, but the most important aspect to policy agenda-setting is ensuring that policies, produced for the first time or revised, are meticulously curated, and implemented to generate tangible and effective outcomes. Simple to execute but effective policies are integral to any organisation, as they offer a clear direction for achieving the goal and combatting problems that arise as the process progresses. To achieve organisational goals, WHO needs to hold accountability for its motivations, acting promptly and logically. Without an effective and methodological structure, instruments, or will, policy agenda-setting procedures end up unnecessarily prolonged or postponed, with no useful policy attained.

[56] Kingdon, John W. 2014. *Agendas*, *Alternatives*, *and Public Policies*. Second edition. London: Pearson Education Limited. 69.

Global institutions such as WHO only possess the power to formulate broad policy guidelines, which must then be further translated into laws or policies at the national and subnational levels. As with the case of WHO, a traditional and independent role of a single policymaker does not exist, as the process of developing policies is a collective one, involving all Member States that make up the WHA. The WHA is the default decision makers of WHO, and when it comes to agenda solutions or setting priorities, the WHA scores agenda items from the immediate which is operational, to the long term, that is strategic.[57] Decision-making procedures are governed by the "one state, one vote" principle, and in most cases, a simple majority that is greater than 50% of Member States support should be reached to implement the decisions.[58]

Gian Luca Burci, former legal counsel at WHO describe resolutions as having, *"political weight, as an agreed statement of policy that can be used domestically by governments as well as by industry, political parties, NGOs."*[59] These draft decisions and resolutions are passed over from the EB and deliberated in advance of the WHA conference or through to the last days of the meeting. The aim is to collectively decide on an appropriate method to resolve the issue while sharing a clear vision to reach the target. Following the WHA conference, the DG is contacted to produce specific implementation plans, with the goal of presenting the final plan to the assembly and transferring it to the secretariat's

[57] Patnaik, Priti. 2022. "The World Health Assembly: What It Does, Why It Matters." Accessed October 4, 2022. https://globalhealthnow.org/2022-05/world-health-assembly-what-it-does-why-it-matters.
[58] Ibid.
[59] Ibid.

bureaucracy for execution.[60] However, when deciding on implementation of conventions and agreements, amendments to the Constitution, suspension of voting rights and services of Members, a two thirds majority of the Members present and voting is required, an exception to the simple majority rule.[61]

Most frequently, the complete implementation of the final WHO resolutions will need that they be adopted at the national level, where these health issues will be added to the political or policy agenda. The ability of these resolutions to be used as a political resource is applied at national levels via the Ministry of Health, who applies the health policy through law.[62] National governments identify certain criteria before an issue is deemed significant enough to gain attention and resources. The certain criteria that should be met are: (i) severity of the health issue, (ii) clear explanation detailing the cause of the issue, (iii) a perception that the problem is soluble, and (iv) expectation that the problem will be addressed by public authorities.[63] This calls for thorough research and adequate evidence to back up the claim that the problem is significant and demands attention.

Research and evidence-based problems can be presented as a policy brief, which is intended to give policymakers evidence on many potential policy

[60] Bhattacharya, Sanjoy. 2008. "The World Health Organization and Global Smallpox Eradication." *Journal of Epidemiology & Community Health* 62 (10): 909-912. https://doi.org/10.1136/jech.2006.055590. 910.
[61] World Health Organization. 1989. *Constitution*. Geneva: World Health Organization. 16.
[62] World Health Organization. 2019. *What Are the Conditions for Successful Health Policy Implementation? Lessons Learnt from WHO's Regional Health Policy Health 2020: Policy Brief.* Geneva: World Health Organization. 37.
[63] McInnes, Colin, Kelley Lee, and Jeremy Youde, eds. 2020. *The Oxford Handbook of Global Health Politics*. Oxford: Oxford University Press. 330.

options without giving direct policy advice or a guide for putting the chosen policy into practise.[64] To strengthen the global framework for health emergency preparedness, response, and resilience, policy makers at the national and sub-national levels can implement the necessary measures outlined in WHO's policy briefs, which are generated using previously published technical information.[65]

The term global health diplomacy helps capture pandemic politics more accurately, and is defined by Kickbusch, Silberschidt and Buss (2007) as the "*…multi-level and multi-actor negotiation processes that shape and manage the global policy environment for health*."[66] Due to the impacts of globalisation on public health, global health diplomacy facilitates the shifting international affairs and political landscapes.[67] The broad implications health issues concern States with have inevitably allowed for national interest to play a great factor in the effectiveness of WHO's decisions and resolutions, overall, testing the authority of the global leader.

WHO's Process of Decision-Making

The process of decision-making is another important but vastly varied process across IOs and is defined by David Easton (1965) as the system and

[64] World Health Organization. 2019. *What Are the Conditions for Successful Health Policy Implementation? Lessons Learnt from WHO's Regional Health Policy Health 2020: Policy Brief.* Geneva: World Health Organization. 2.
[65] Ibid.
[66] Ibid.
[67] Kickbusch, Ilona, Gaudenz Silberschmidt, and Paulo Buss. 2007. "Global Health Diplomacy: The Need for New Perspectives, Strategic Approaches and Skills in Global Health." *Bulletin of the World Health Organization* 85 (3): 230-232. https://doi.org/10.2471/BLT.06.039222. 230.

mechanism that transforms political inputs, the demand and support, into political outputs (policy).[68] Decision-making has strong correlations to regime-effectiveness, the extent at which international cooperation can success in reducing or solving shared problems. Making decisions is the initial step in putting effective measures into action, with the capacity to accept policy decisions serving as the link between the process and the outcome. However, the outcomes of decision-making process do not necessarily reflect the IO's performance in its entirety but rather helps provide insight into the overall performance of the IO.

Transparency in all stages related to decision-making processes such as implementation of the decision and the information concerning the decision-making stage are principles of good governance as elaborated by the International Law Association.[69] Good governance in the context of health has been defined as the decision-making processes that the global community can utilise to identify and set detailed objectives, and mechanisms that can be used to carry out the decisions.[70] Stronger global health governance proponents emphasise the absence of an infrastructure that would allow State and non-State players to coordinate their programme objectives. Broad participatory

[68] Veen, Tim. 2011. *The Political Economy of Collective Decision-Making: Conflicts and Coalitions in the Council of the European Union*. First edition. Berlin: Springer. 13.
[69] Eccleston-Turner, Mark, and Adam Kamradt-Scott. 2019. "Transparency in IHR Emergency Committee Decision Making: The Case for Reform." *BMJ Global Health* 4 (2): 1-3. https://doi.org/10.1136/bmjgh-2019-001618. 2.
[70] Ibid.

decision-making, a focus on consensus, accountability, and transparency are some of these traits that acts as a cornerstone to excellent governance.[71]

Considering the sheer size of WHO, the process of decision-making varies across the many levels of WHO, considering the participants and their level of authority. On the basis that WHO is governed on the principal that each state is entitled to their own vote during decision-making procedures, the process is a timely one as the final say is voiced by the WHA as a collective. A phenomenon known as pooling occurs when separate states lose their ability to make decisions, believed to speed up decision-making processes.[72] However with WHO, Member States are unable to veto WHO's decisions, nor does WHO have the authority to obstruct Member States from adopting decisions.[73] With the absence of pooling, the possibility of impasse during decision-making is increased as voting within WHO is predicated on consensus before any resolution or conclusion can be imposed.

Decisions made within smaller group committees were found to perform better than those made at the WHA in terms of reaching consensus and avoiding impasse.[74] To ensure efficiency and shorten the time between problem identification and policy execution, the policy-making process should ideally be

[71] World Health Organization. 1998. "Good Governance for Health." Accessed September 15, 2022. https://apps.who.int/iris/handle/10665/65021.
[72] Keohane, Robert O., and Stanley Hoffmann. 1991. *The New European Community*. *Decisionmaking and Institutional Change*. Boulder: Westview Press. 7.
[73] Tulp, Sophia. 2022. "WHO Health Regulations Don't Infringe on US Decision-Making." Accessed September 30, 2022. https://apnews.com/article/Fact-Check-WHO-National-Sovereignty-038069150355.
[74] Reinalda, Bob, and Bertjan Verbeek, eds. 2004. *Decision Making Within International Organisations*. First edition. London: Routledge. https://doi.org/10.4324/9780203694336. 247.

rapid and organised, though this is idealistic considering the magnitude of WHO. Rather, over the course of the agenda-setting process, incremental choices will result in modest and steady progress. Even though not all WHA decisions are legally binding, they are still significant because they reflect political consensus and set precedents for future policy direction.

Given that WHO is the central repository for health data, the organisation unquestionably utilises extensive and evidence-based research in all aspects of its decision-making processes.[75] WHO's definition of evidence-informed decision-making is that it "*...emphasizes that decisions should be informed by the best available evidence from research, as well as other factors such as context, public opinion, equity, feasibility of implementation, affordability, sustainability, and acceptability to stakeholders. It is a systematic and transparent approach that applies structured and replicable methods to identify, appraise, and make use of evidence across decision-making processes, including for implementation.*"[76] Evidence-informed decision-making can also help to minimise the research-to-policy gap, which results from a lack of institutional resources and capacities to transform knowledge into policy and practise.[77] Such evidence exists broadly in the categories of tacit evidence, which is mostly informal knowledge, or scientific evidence, which is methodological, systematic, explicit, and replicable.[78]

[75] World Health Organization. 2021. *Evidence*, *Policy*, *Impact: WHO Guide for Evidence-Informed Decision-Making.* Geneva: World Health Organization. 1.
[76] Ibid.
[77] Ibid, 10.
[78] Ibid.

Factors Affecting Policy Agenda-Setting and Decision-Making

Making decisions presents a variety of difficulties, particularly in organisations with a large membership. The scale of WHO clearly demonstrates the variety of national interests that its Member States hold that are distinct from one another, based on a variety of reasons such as socio-cultural determinants, economic interests, and public health concerns. Economic, and national security concerns have increasingly influenced policy agenda items in the field of health, replacing the traditional influences of health equity standards, human rights norms, and physical disease effects.[79] In the face of intense lobbying and advocacy, the science of public health has come to coexist with the art of diplomacy, and concrete national interest balances with the overarching concern of the greater international community.[80] Existing political challenges may interfere with policy making processes, particularly with shifts in administrations as these political transitions can create political space for social issues to arise which changes the national agenda.

Politics is without a doubt another critical factor that debilitates WHO's authority and effectiveness as a global health leader, as it affects decision-making as well as how the imposed decisions are carried out. In particular,

[79] McInnes, Colin, Kelley Lee, and Jeremy Youde, eds. 2020. *The Oxford Handbook of Global Health Politics*. Oxford: Oxford University Press. 330.
[80] Kickbusch, Ilona, Gaudenz Silberschmidt, and Paulo Buss. 2007. "Global Health Diplomacy: The Need for New Perspectives, Strategic Approaches and Skills in Global Health." *Bulletin of the World Health Organization* 85 (3): 230-232. https://doi.org/10.2471/BLT.06.039222. 230.

pandemic politics are the epitome of the challenges WHO is affected by.[81] An example can be witnessed from the United States of Americas sudden announcement of their withdrawal from WHO amid tense US-China ties which was effectively made worse by criticism against WHO's favouritism of China amongst lingering trade disputes. US' withdrawal had significant ability to disrupt the scope of WHO's activities and future course of current resolutions amid the existing heightened political tensions being one of its greatest donors. This will be further elaborated in the COVID-19 case study, but this example of a political challenge encapsulates the difficulty to predict and prepare for such events, which carries significant ability to disrupt the scope of WHO's activities and future course of current resolutions.

Despite WHO regarded as the global health leader, it is no longer the only organisation with responsibility for global health issues considering the constantly changing global health landscape. Over the past few decades, the number of diverse non-State global health actors has considerably expanded to reduce the complexity of the growing health issues. WHO's engagement with stakeholders such as foundations, intragovernmental and nongovernmental organisations, health partnerships, professional associations, civil society, and WHO collaborating centres helps alleviate the enormous weight WHO bears on its own. To fulfill their significant role in global health, WHO proactively

[81] Peters, Michael A., Stephanie Hollings, Benjamin Green, and Moses Oladele Ogunniran. 2020. "The WHO, the Global Governance of Health and Pandemic Politics." *Educational Philosophy and Theory* 54 (6): 707–716. https://doi.org/10.1080/00131857.2020.1806187. 707.

engages with these non-State actors to advance public health, encouraging and endorsing the independent activities of these non-State actors that help protect and advance public health.[82]

However, WHO's budget is considerably smaller than that of these stakeholders, which occasionally has a significant impact on how decisions are made. WHO's budgetary resources can only go so far, thus stakeholders can use their VCs as justification for their voice to be given more weight to influence WHO discussions and decisions in favour of advancing their own objectives for international health policy. While interacting with various stakeholders, WHO needs to determine the risks and advantages and balance them while still upholding its moral integrity, reputation, and public health mandate.[83] Therefore, interactions with these outside influences ought to be conducted in conformity with the WHA's constitution, resolutions, and decisions to remain true to WHO's objectives.

The engagement of WHO with non-State actors can also increase the likelihood of an institutional conflict of interest arising. These conflicts of interest are most likely to occur when non-State actors' interests clash with interests of WHO, such as their independence and objectivity in establishing policies, norms, and standards. Informal and formal social norms and practices of powerful stakeholders have the potential to disrupt agendas and amplify or

[82] World Health Organization. 2020. *Framework of Engagement with Non-State Actors*. Geneva: World Health Organization. 1.
[83] Ibid.

silence institutional voices. However, the rise of these influencer stakeholders such as, the Bill and Melinda Gates Foundation as well as public private partnerships (PPPs) through The Global Fund, GAVI and UNITAID has at times challenged the role of WHO as a central global health leader, as WHO's efforts risk duplication with fragmented responses.[84] In this light, WHO needs to strategically avoid the influence of these non-State actors over WHO's decision-making process, nor let it prevail over its interests.

Conflict of interest is defined as a situation where the presence of secondary competing interests or divided loyalties threaten an individual's primary obligation and can exist in financial or non-financial and direct or indirect ways.[85] Contestation can exist over defining the issue, priority setting of interventions and advocacy of strategies which can all lead to fragmentation and overall serve as a blockade to advancing global health issues to the policy agenda-setting stage.[86] In a similar notion, conflict of interest can be otherwise be seen as national interest, where the concept of power majorly influences policy agenda-setting and decision-making as it become interest driven by stakeholders or Member States conforming to national interest.[87] Cox and

[84] Reddy, Srikanth K., Sumaira Mazhar, and Raphael Lencucha. 2018. "The Financial Sustainability of the World Health Organization and the Political Economy of Global Health Governance: A Review of Funding Proposals." *Globalization and Health* 14 (119): 1-11. https://doi.org/10.1186/s12992-018-0436-8. 2.
[85] World Health Organization. 2016. *Addressing and Managing Conflicts of Interest in the Planning and Delivery of Nutrition Programmes at Country Level: Report of a Technical Consultation Convened in Geneva, Switzerland, on 8–9 October 2015*. Geneva: WHO Document Production Services. 31.
[86] McInnes, Colin, Kelley Lee, and Jeremy Youde, eds. 2020. *The Oxford Handbook of Global Health Politics*. Oxford: Oxford University Press. 334.
[87] Cox, Robert W., Harold K. Jacobson, Gerard Curzon, Victoria Curzon, Joseph S. Nye, Lawrence Scheinman, James P. Sewell, and Susan Strange. 1973. *The Anatomy of Influence*. *Decision Making in International Organization*. New Haven: Cambridge University Press. https://doi.org/10.2105/ajph.2014.302455. 199.

Jacobson (1973) define this power as, "the aggregate of political resources available to an actor", influence defined as the "modification of one actor's behaviour by that of another".[88]

Greater preference heterogeneity has the potential to obstruct decision-making processes, according to Axelrod and Keohane (1985).[89] Kraft and Furlong (2010) additionally explicate that issues with low level saliency paired with high levels of conflict will without a doubt have the worst chance of reaching the decision agenda.[90] With divergent interests, a conflict of interest can inevitably develop. Critical factors during conflict of interest are the power between stakeholders and the positions held in the organisation, as well as level of importance in decision-making. This necessitates an additional intervention to the already taxing process to settle the conflict of interest, postponing protracted proceedings. The benefits to effective conflict of interest management are many, as it ensures integrity in the decision-making stages, earning the public's trust to attain public health goals. Therefore, in an effort to control conflicts of interest, WHO strives to rely on factual data that is supported by evidence in order to prevent biased judgments during the processes for formulating policy agendas.

[88] M. Goverde, Henri J., Philip G. Cerny, Mark Haugaard, and Howard H. Lentner, eds. 2000. *Power in Contemporary Politics*. *Theories, Practices, Globalizations*. London: Sage Publications. 136.
[89] Axelrod, Robert, and Robert O. Keohane. 1985. "Achieving Cooperation under Anarchy: Strategies and Institutions." *World Politics* 38 (1): 226–254. https://doi.org/10.2307/2010357. 229.
[90] Kraft, Michael E., and Scott R. Furlong. 2017. *Public Policy*. *Politics, Analysis, and Alternatives*. Sixth edition. Thousand Oaks: CQ Press. 116.

Chapter II: Literature Review

The nature of this study inevitably comes with certain setbacks. As will be introduced, the approaches utilised in this study are niche to the field, thus the use of existing data is inevitably constricted. During the process of the literature review, two significant gaps in the literature were discovered.

Firstly, the suggested theoretical frameworks used in this thesis study are severely constrained when applied to examine WHO in the existing literature. Instead of focusing on how they affect and function at different levels of international government, the vast majority of research using these frameworks tend to do so at the national level. Existing research specifically examines how decision-makers and other factors affect how the international agenda is determined and how it is translated into action. The number of resources that serve as a baseline for supporting evidence or as a comparison is restricted as this thesis seeks to depart from previous literature by applying these frameworks to the level of intergovernmental organisations.

The second gap is how there is little to no comparative analyses across different cases to help forecast trends that result in the outcomes of crises. This is a result of studies concentrating primarily on isolated case studies to understand the accomplishments and shortcomings of WHO in managing crises. The examination of other variables as a potential element of cause is then constrained, as the issues uncovered are tied directly to reform recommendations. Focusing on areas requiring improvement and reform are not necessarily uninvited as they help address relevant areas of improvement

that refines the overall function of WHO, in which the global community reaps the benefits. Despite taking a comparative approach, this study also greatly benefits from current literature that examines individual cases. As previous findings are contrasted with the results of this study, the key findings from the body of existing literature that explain the reason for success or failure in each of the three examples are helpful to this research. This comparison helps trends be recognised, depicting whether they remain true or are subject to change.

Sommerer et al. (2022) was the first to conduct a comparative analysis of its kind on the decision-making performance of 30 IOs between 1980 to 2011.[91] Decision-making performance measures how well an IO can produce policy outcomes through its primary decision-making body amid pressure to address endogenous or exogenous challenges. To understand why certain IOs are either efficient or plagued by deadlock in decision-making, they examined how the institutional design characteristics of IOs have an influence on decision-making procedures.[92] Exogenous factors such as pooling, delegation of authority to supranational institutions, and the access of transnational actors were factored to see how they affected decision-making performance. Depending on the theoretical lenses these factors were considered in, the differences in opinion were drastic regarding the factors ability to improve or hinder decision-making procedures. Delegation when viewed in the lens of rationalist institutionalist

[91] Sommerer, Thomas, Theresa Squatrito, Jonas Tallberg, and Magnus Lundgren. 2022. "Decision-Making in International Organizations: Institutional Design and Performance." *The Review of International Organizations* 17 (4): 815-845. https://doi.org/10.1007/s11558-021-09445-x. 818.
[92] Ibid, 817.

scholarship was argued as an ability to improve decision-making procedures, as it offers various advantages to international cooperation by facilitating the resolution of challenges requiring collective action.[93] However, differing views deemed delegation to perversely affect decision-making, as it opened windows for actors to pursue personal agendas and interests.[94]

The study concluded that the combined effects of institutional design characteristics greatly affect decision-making performances, where neither positive nor negative consistent trends in IO decision-making was found. WHO's decision-making performance compared against other IOs were found to be steady during the first half of the observation period. From 2000 onwards, WHO underperformed for several years, the output of decisions declining gradually, however decisions doubled between 2000 and 2003.[95] The study concludes that the coupling of exogenous factors and institutional design had positive effects on the performance of decision-making.

Applicable Theoretical Frameworks

Garbage Can Model of Organisational Choice

The Garbage Can Model of Organisational Choice is a paradigm for determining policy priorities and decision-making that clarifies the disorganised reality of organisational decision-making processes in a structured

[93] Ibid, 822.
[94] Ibid.
[95] Ibid, 830.

environment.[96] The idea that decision-making processes are not carried out in rational or linear ways, but rather that a range of various interests, ambitions, and ideas get thrown into a single conclusion, is the chaotic nature of decision-making that this model alludes to.[97] Goal ambiguity, which is widespread in complex organisations, is the cause of this process since the interplay of the disparate concepts will result in a choice that is difficult to predict. The decision point is produced by the ideas in the garbage can in combination with the elements of timing and chance. Hence, this neo-institutionalist theory explains changes rather than continuity.

This model uses four streams—problems, solutions, participants, and choice opportunities—to explain how policy agenda-setting and decision-making work.[98] When conditions or problems are regarded intolerable, change is anticipated from those in charge of making decisions. The solutions stream considers the notion that in organisational problem resolutions, the question is not known until the solution has been discovered first.[99] These solutions are responses that are independent from the issue, formulated before the problem has been identified.[100] Participants can join and withdraw at any time, however,

[96] Cohen, Michael D., James G. March, and Johan P. Olsen. 1972. "A Garbage Can Model of Organizational Choice." *Administrative Science Quarterly* 17 (1): 1-25. https://doi.org/10.2307/2392088. 1.
[97] Ibid.
[98] Ibid, 3.
[99] Ibid.
[100] Ibid.

the distribution of participants entrances will depend on the attributes of the choice being left as much as it does on the features of the new choice.[101]

As for the case of WHO, the Member States who participate in decision-making do not necessarily have the freedom to withdraw themselves at any moment. Rather, their participation is permanent so long as they remain a member to the organisation. The so-called withdrawal of these members can be seen in their decision to disagree with the decision at hand, which at times require formal documentation conveyed to WHO stating their rationale for non-compliance according to Article 20 of the WHO Constitution.[102] Finally, choice opportunities are regarded as the organization's expectation to create the behaviour or decision when an opening for change arises, usually due to changes in the political climate, political discourses, or unexpected events.[103]

The next four fundamental variables each reflect a function of time: (i) a stream of choice, (ii) a stream of issues, (iii) a rate of flow of solutions, and (iv) a stream of energy from participants.[104] A decision structure is said to be paired with the entrance time, which describes how the choice in the first stream is activated for evaluation.[105] Several issues are assumed in the second stream, and each is distinguished by an entrance time, the amount of energy required to resolve the choice to which the problem is associated, and an access structure,

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[101] Ibid.
[102] World Health Organization. 1989. *Constitution*. Geneva: World Health Organization. 7.
[103] Cohen, Michael D., James G. March, and Johan P. Olsen. 1972. "A Garbage Can Model of Organizational Choice." *Administrative Science Quarterly* 17 (1): 1-25. https://doi.org/10.2307/2392088. 3.
[104] Ibid.
[105] Ibid.

or the list of potential options the problem has access to.[106] The third stream is concerned with the rate at which solutions enter the system, which is influenced by the amount of time and various energies used to address the same problem.[107] The final stream assumes many players, each of whom is distinguished by a time series of energy available for the organisation to make decisions.[108] The combination of all these variables composes of the unruly and non-chronological structure to decision-making, the reality of organisational policymaking**.**

The Multiple Streams Framework

John Kingdon developed the Multiple Streams Framework (MSF) in 1984, elaborating the various components that must interlock for the policy agenda-setting stage to occur.[109] Originally developed to explain federal policy change in the United States of America, the framework is now used broadly to help analyse policy agenda-setting at various settings involving different stakeholders. The MSF assesses the pre-decisional stages of the policy process, where an issue should be assigned a defined agenda. The framework is made

[106] Ibid.
[107] Ibid.
[108] Ibid.
[109] Lodge, Martin, Edward C. Page, and Steven J. Balla, eds. 2015. *The Oxford Handbook of Classics in Public Policy and Administration.* Oxford: Oxford University Press. 555.

up of the following five elements: (i) problem stream, (ii) policy stream, (iii) politics stream, (iv) policy entrepreneur, and (v) policy window.[110]

The problem stream is crucial because it provides the justification for the agenda choice, considering perceptual and interpretive components in addition to external circumstances or events.[111] The components of the problem stream comprise of the following: (i) load, (ii) indicators, (iii) focusing events, and (iv) feedback.[112] Load refers to the quantity of fundamental issues addressed, whereas indicators are how stakeholders detect and monitor these issues, used in in two major ways: (i) to assess the magnitude of a problem, and (ii) to see how the issue has changed.[113] Focusing events are the unexpected occurrences in policy problems such as a crisis or disaster that helps reinforce the problem to receive the right attention.[114] Lastly, feedback offers information on the current performance of existing programmes in formal or informal ways that may affect the way a future agenda is deciphered upon and implemented.[115]

The second component of the MSF, the policy stream, produces alternatives for the agenda based on expert ideas, proposals, or solutions. These alternatives do not necessarily have consensus, but rather portray a majority

[110] Kingdon, John W. 2014. *Agendas*, *Alternatives*, *and Public Policies*. Second edition. London: Pearson Education Limited. 20.
[111] Ibid, 109-110.
[112] Angervil, Gilvert. 2021. "A Comprehensive Application of Kingdon's Multiple Streams Framework: An Analysis of the Obama Administration's No Child Left Behind Waiver Policy." *Politics & Policy (Statesboro, Ga.)* 49 (5): 980-1020. https://doi.org/10.1111/polp.12432. 983.
[113] Ibid.
[114] Ibid, 19.
[115] Ibid.

agreement on prominence.[116] Nevertheless, these proposals have a better chance of survival when they are practical and technically feasible, align with the values of stakeholders, and the availability of resources if implemented.[117]

The third component, the political stream, flows independently from the problem and policy streams according to its own dynamics and regulations, playing a significant role in advancing or preventing high agenda status.[118] This stream mostly consists of party ideology that is found within institutions, relating to elements like changes in government, turnover in the legislature, and shifts in the "national mood" that influence the body politics perception of problems and solutions.[119] Consensus building in the political stream is likewise governed by bargaining rather than persuasion.[120] These considerations significantly influence agendas as they determine which policy initiatives are allocated more attention and which are postponed until a more opportune time.

The policy entrepreneur is an individual with the capacity to recommend policies who is motivated by their ideologies or passions and tenacious in developing their proposals. Policy entrepreneurs traverse the political landscape, promote ideas, and invest time and resources to enhance

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[116] Kingdon, John W. 2014. *Agendas, Alternatives, and Public Policies*. Second edition. London: Pearson Education Limited. 144.
[117] Angervil, Gilvert. 2021. "A Comprehensive Application of Kingdon's Multiple Streams Framework: An Analysis of the Obama Administration's No Child Left Behind Waiver Policy." *Politics & Policy (Statesboro, Ga.)* 49 (5): 980-1020. https://doi.org/10.1111/polp.12432. 984.
[118] Kingdon, John W. 2014. *Agendas, Alternatives, and Public Policies*. Second edition. London: Pearson Education Limited. 163.
[119] Howlett, Michael, Allan McConnell, and Anthony Perl. 2014. "Streams and Stages: Reconciling Kingdon and Policy Process Theory." *European Journal of Political Research* 54 (3): 419–434. https://doi.org/10.1111/1475-6765.12064. 3.
[120] Kingdon, John W. 2014. *Agendas, Alternatives, and Public Policies*. Second edition. London: Pearson Education Limited. 159.

the likelihood that an idea will be placed on the agenda. Through the process of framing, policy entrepreneurs can implicate the problems in policies that require a solution through interpretations, in which defining the problem becomes a political exercise. To get their concept on the agenda, policy entrepreneurs invest time and resources into navigating the political landscape. Since WHO does not specifically hold the role of a policy entrepreneur, IOs like WHO are the focus of these efforts.

The policy window is a crucial phenomenon that emerges when the three independent streams, problem, policy, and politics merge together, arising from both predictable and unanticipated events.[121] The formation of the policy window, which is when and only when policy is taken seriously, connects an existing political willingness to address the issue to both politics and the problem.[122] These windows appear infrequently and do not stay open for long periods, closing due to several reasons, such as: (i) actors believing the problem has been addressed through decision and enactment, although they have not, (ii) actors failing to receive action, therefore creating unwillingness to make further investment of resources and time, (iii) the event prompting the window may have moved on, ending the honeymoon phase, (iv) change in personnel, and (v) no available alternative existing.[123] This window has the

[121] Howlett, Michael, Allan McConnell, and Anthony Perl. 2014. "Streams and Stages: Reconciling Kingdon and Policy Process Theory." *European Journal of Political Research* 54 (3): 419–434. https://doi.org/10.1111/1475-6765.12064. 421.
[122] Ibid.
[123] Kingdon, John W. 2014. *Agendas*, *Alternatives*, *and Public Policies*. Second edition. London: Pearson Education Limited. 169.

capacity to develop circumstances that affect the results of policy decisions by impeding or facilitating the process. Once the issue is acknowledged and tied to a practical solution, joined with favourable political forces, a situation known as coupling occurs.[124] However, factors ought to be considered that may enable or prevent coupling, such as political, institutional, and economic conditions.[125]

Inherent Limitations

WHO is an invaluable resource for global health initiatives and has an endless array of topics under its umbrella of health. The structure of this thesis which executes a comparative analysis across specific cases is not frequently utilised by WHO review panels in their analysis'. Rather, individual health crises are delved into by the specialised WHO committees to analyse the successes and improvements required that are specific to the topic at hand, with occasional references made to prior crises. The factors being studied within the three cases are not only confined within the scope of the individual case itself but is intricately linked to an array of other factors and cases. The comparative analysis nature of this study made data collected extremely tedious and time consuming as each endogenous and exogenous factor were studied and linked with the realms of politics specific to national interest.

[124] Ibid, 20.
[125] Ibid.

A limitation to this study is the access to accurate data and information. A lot of the information required to construct this paper are scattered across hundreds of pages of paperwork produced by WHO, where data was difficult to pinpoint by solely using WHO Archives. More than 3 linear kilometres of papers, mostly textual paper documents including correspondence, contracts, and statistical reports are stored in these Archives, which may only be accessed in person. Most of these documents are only able to be consulted after a 20-year period due to reasons of confidentiality, hence limitations in conducting the research utilising only primary WHO resources posed many challenges. Thus, many non-WHO published scholarly articles have been used to help aid this analysis on WHO.

As politics is another element to this study, there are limitations in access to state sensitive information that would help address and support the case studies to draw accurate conclusions. The cases not only explore the operation and performance of WHO, but how Member States cooperated with WHO, behaved individually at national levels as well as the global level with other States. Owing to the origins of the disease in the cases, the involvement of certain Member States will naturally be greater than others. China is a State central to the cases being explored. As socialist states have earned a reputation for limiting the release of state sensitive information, the information that is released by China and used in this study should be considered with this factor in mind.

Lastly, as the discourse on COVID-19 and its policy responses and is continually evolving, the analysis of this study is limited to currently available empirical data. Additionally, this study takes on a policy-agenda setting and decision-making focus, the connection between the two stages may not necessarily run as fluid as discussing all stages of the policymaking in chronological order would be able. To provide more in-depth analysis on a focused topic and cover more ground in the study of the research question within the confines of this thesis paper, it was decided to limit the policy making framework to these two.

Methodology

To better comprehend the policy agenda-setting and decision-making processes used by WHO for the three key disease outbreaks of smallpox, SARS, and COVID-19, a combination of qualitative and quantitative research methods was applied. These three distinct case studies are used to apply the methodology to comprehend causality—the relationship between causes and effects. In particular, the independent variable (the cause) is the indirect and direct influence of non-State and State actors that undermine the authority of WHO, and the dependent variable (the effect) is the disorganised process of setting policy agendas and making decisions that result in outcomes that do not produce effective results. An explanation of the outcomes is produced via

process tracing, which collects, analyses, and organises data in chronological order.

The process tracing approach will help uncover and pinpoint trends that reoccur across the three cases to help identify the problem, reason for cause as well as WHO's response. The case study first analyses the underlying frameworks of policy agenda-setting and decision-making to understand how WHO formulates their policy agendas and the process of making these decisions. Subsequently, the three distinct crises, smallpox, SARS, and COVID-19 were selected as a comparative element to compare and contrast the policy agenda-setting and decision-making processes across the events. The reasoning for the selection of these cases is several. As WHO celebrated their greatest success with the eradication of smallpox, this case was selected to analyse how endogenous and exogenous factors coupled with the elements of the theoretical framework led to this feat. Secondly, SARS promulgated the first major reform for pandemic preparedness and response, hence this case was selected to understand what methods were recommended and implemented. Lastly, COVID-19 was selected as it is considered WHO's greatest public health challenge in the 21st century. This case will be used to identify which lessons from smallpox and/or SARS were carried over, the success of its implementation, and what challenges remain to this day for WHO.

Despite incorporating both qualitative and quantitative data, this study largely depends on the former to identify the pertinent information needed to address the research questions. For the purpose of analysing the aspects of the

theoretical frameworks that are relevant to developing policy agendas and decision-making, primary and secondary sources are used to compile empirical data to conduct a comprehensive literature review. This paper draws on a sizable number of primary sources generated by WHO, including policies, meeting minutes, high-level meeting materials, and published educational materials. Secondary sources include articles covering political news, literature on WHO and its analysis, such as theoretical frameworks and educational scientific papers that interpret the information provided by WHO from a variety of viewpoints.

Lastly, Kingdon's MSF will largely be used to examine each case study. However, not all elements of this framework align with WHO's process of policy agenda-setting and decision-making. All elements that make up the frameworks have still been included in this paper as to provide no exclusion of details to present to the reader a full overview of the concepts. However, as not all the frameworks' elements apply to WHO, some have been purposefully omitted during analysis as they are not only inapplicable to WHO but would expand the scope of this study greatly.

The three elements that are applied, which are the problem, policy, and politics streams nevertheless are used accurately as originally defined and intended by the author. The merging of these three streams which produces the policy window is specifically studied, whilst considering the endogenous and exogenous factors that may affect the possibility for junction. National interest playing a significant factor to the success or failure of WHO resolutions, the

convergence or divergence of national interest will be detected as the key to defining whether the handling of each health crises was a success or failure.

Chapter III: Case (1) Smallpox

Problem stream

Smallpox was one of the most feared diseases of the 20th century. Caused by the variola virus that existed for some 3000 years before, it was defined as an acute contagious disease by WHO. Due to its ability to spread rapidly from travel and trade, the disease quickly became a global health issue becoming seriously pervasive. In 1967 alone, there were 10 to 15 million cases spread throughout 31 nations, with 1.5 to 2 million fatalities each year. The smallpox outbreak devastated countries, placing heavy burdens on public health infrastructures, economically taxing nations all the while driving high mortality rates uneasy to manage. With the alarming rates of infection and the severity of the symptoms, Member States recognised the need of global action against the disease, turning to WHO.

Numerous attempts had been undertaken prior to WHO strategising and officially pursuing the Smallpox Eradication Programme (SEP). Owing to several reasons, all attempts failed to be pursued largely owing to the witness of 4 previously failed attempts at eradication which targeted hookworm, yellow fever, and yaws.[126] In 1950, the Pan American Sanitary Organization made the first call for the regional eradication of smallpox across the Americas but was met with little success due to lack of campaigning and slow progress.[127] Later in

[126] Henderson, D. A., and Petra Klepac. 2013. "Lessons from the Eradication of Smallpox: An Interview with D. A. Henderson." *Philosophical Transactions of the Royal Society B: Biological Sciences* 368 (1623): 1-7. https://doi.org/10.1098/rstb.2013.0113. 1.
[127] Fenner, Frank, D. A. Henderson, I. Arita, Z. Jezek, and I. D. Ladnyi. 1988. *Smallpox and Its Eradication*. Vol. 6. Geneva: World Health Organization. 419.

1953, Dr. George Brock Chrisholm, the first DG of WHO, proposed that Member States undertake a global eradication effort, but Member States rejected the idea on the grounds that it was simply too idealistic.[128] Finally, upon their unexpected return to the World Health Organisation in 1958, the Soviet Union proposed the eradication of smallpox. Due to the Soviet Union's success in controlling smallpox regionally, their suggestion was received with greater excitement at the ensuing WHA meeting.[129] Despite lingering concerns, political opposition and scepticism surrounding the potential for success amongst Member States and public health officials, WHO decided to adopt the resolution to commit to the global eradication of smallpox during the 12th WHA in 1959.[130]

The start of WHO's journey for smallpox eradication was not easy. Endogenous factors have continuously posed challenges to WHO since the organisation's foundation. The lack of financial resources that strains the potential of WHO's programmes and resolutions has been one of the many lingering concerns, well recognised by both internal staff as well as external stakeholders. The implementation of the SEP was met with heavy disapproval, as investing already limited VCs into a new programme as opposed to other

[128] Henderson, Donald A. 2011. "The Eradication of Smallpox – An Overview of the Past, Present, and Future." *Vaccine* 29 (December): D7–D9. https://doi.org/10.1016/j.vaccine.2011.06.080. D8.
[129] Henderson, D. A., and Petra Klepac. 2013. "Lessons from the Eradication of Smallpox: An Interview with D. A. Henderson." *Philosophical Transactions of the Royal Society B: Biological Sciences* 368 (1623): 1-7. https://doi.org/10.1098/rstb.2013.0113. 2.
[130] World Health Organization. 1959. "Twelfth World Health Assembly, Geneva, 12-19 May 1959: Resolutions and Decisions: Plenary Meetings: Verbatim Records: Committees: Minutes and Reports: Annexes." Accessed September 13, 2022. https://apps.who.int/iris/handle/10665/85719.

projects such as the concurrently running malaria eradication programme was expected to not produce any fruitful progress. The financial burden for Member States to shoulder the cost of the unpredictable success of the programme was significant. Despite this and in serious need of financial support, WHO went to the extent of sending out letters to Member States and external stakeholders seeking VCs, which was met with little response.[131] UNICEF, a consistent donor to WHO expressed lack of faith in WHO's abilities, pertinent on the basis of having previously supported the malaria eradication programme which reaped little success.[132] Concurrent management of two eradication programmes and receiving earnest support remained a continual challenge to WHO.

Inadequate infrastructure of WHO was another challenge to WHO, as WHO carries a great responsibility to help Member States prepare their health infrastructures to stand against the weight of the effects of public health crises. Member States all have varying levels of existing endemic and pandemic preparedness against public health crises, the quality of health infrastructures and interventions highly dependent on their economic capabilities. The challenge of this endogenous factor grapples with WHO continuously as limited financial resources can only go so far in terms of producing quality work and employing the right amount of personnel to help support regional locations and ensure the correct running of the programme.

[131] Fenner, Frank, D. A. Henderson, I. Arita, Z. Jezek, and I. D. Ladnyi. 1988. *Smallpox and Its Eradication*. Vol. 6. Geneva: World Health Organization. 393.
[132] Ibid.

Bureaucratic red tapes are an exogenous factor to the WHO, impeding performance by prolonging the implementation of decisions, which are further complicated by the intertwining of international, regional, and national processes. As the decision-making structure of WHO can be deemed fragmented, as the organisation is composed of hundreds of Member States and stakeholders, bureaucratic red tapes further complicate and prolong the process. Negotiations are made more difficult as they are linked with intricate structures of national governance, where policy impositions in a simplified top-down approach is neither feasible nor ideal. Deployment of WHO personnel into regional locations to perform WHO work is also restricted and delayed, as the process requires clearance from federal authority.[133] WHO's responses to health crises already undergo a timely an intricate process, however, it can be further complicated dependent on the cooperation of Member States. In a situation where timely reporting of health emergencies by Member States to WHO is of crucial importance, the intricate processes that pertain to bureaucratic red tape may be used to the advantage of Member States.

In a globalised society, the expansion of economic connection and collaboration amongst nations has immensely contributed to advance peace, stability, and health. However, due to fear of social and economic consequences and loss of credibility, Member States may decide to intentionally withhold

[133] Bhattacharya, Sanjoy. 2008. "The World Health Organization and Global Smallpox Eradication." *Journal of Epidemiology & Community Health* 62 (10): 909-912. https://doi.org/10.1136/jech.2006.055590. 911.

sensitive information. This is done so to uphold their desire for national interest, in fear of reaping negative consequences that have complications to their trade and travel. This exogenous factor accurately portrays the lack of control WHO has in its ability to impose its measures onto Member States, despite how important the measures are in contributing towards the success of the programme.

As for determining and contributing towards the success of WHO resolutions and programmes, national interest as an exogenous factor plays a significant factor. This is simply due to the nature of WHO programmes implementing measures that may not be in the national interest of Member States, that are aimed to benefit the wider community. National governments on the other hand are ever more inclined to invest resources into mitigating issues concerned at the regional level and implementing measures that would incur them no loss in comparison to other Member States. The national political priorities of these Member States ultimately influence their engagement with the regional and international efforts. Hence, during a time of uncertainty and a general distrust in public health measures due to political realities of public health, Member States ought to eschew the limited rewards of national interest and concentrate on ensuring everyone's survival through collaborative policy initiatives. The divergence of national interests coupled with the endogenous

and exogenous factors led to a very dragged out and ultimate costly failure of the first phase of the SEP (1959 to 1966).[134]

Policy stream

The SEP suffered a loss of interest between 1959 and 1966, owing to WHO and Member State's preoccupation with the ongoing malaria eradication as well as witnessing the 4 previous failed attempts at eradication, targeting hookworm, yellow fever, and yaws.[135] However, after the programme earned a resurgence of interest following the USA's commitment to assisting regional smallpox elimination, Member States began to voice their concerns to WHO as they believed sufficient progress towards the SEP was not being made to truly ensure the success of the programme. Unsatisfactory feedback were expressed from delegates, criticising the slow pace of progress at the 18th WHA in 1965.[136] The USSR went as far to label the malaria eradication programme as the "favourite daughter of WHO", whilst the SEP was treated as the "foster child", wishing for a "real programme" where concrete measures should have been included in the 1966 programme.[137]

[134] Fenner, Frank, D. A. Henderson, I. Arita, Z. Jezek, and I. D. Ladnyi. 1988. *Smallpox and Its Eradication*. Vol. 6. Geneva: World Health Organization. 172.
[135] Henderson, D. A., and Petra Klepac. 2013. "Lessons from the Eradication of Smallpox: An Interview with D. A. Henderson." *Philosophical Transactions of the Royal Society B: Biological Sciences* 368 (1623): 1-7. https://doi.org/10.1098/rstb.2013.0113. 1.
[136] Ibid, 408.
[137] Ibid.

Member States advocated for clearer programme objectives and a renewed budget to eliminate the disease within 10 years to the WHO DG.[138] The need for an intensified SEP was recommended by the EB on January 1966, 6 years into the initial eradication programme.[139] The WHA thus adopted a resolution on 13 May of 1966 that would launch the smallpox eradication campaign becoming the highest priority for WHO's global strategy.[140] This resolution was narrowly approved by two votes and had a $2.4 million annual budget which would require supplementation by national budgets and VCs to fund the 10-year smallpox eradication plan.[141]

The smallpox programme was a vertical campaign for eradication, working alongside existing national health structures as part of a collegial structure.[142] With WHO operating as a three-level organization, though work is conducted on an apolitical basis, the organisation is obliged to collaborate at the national level with the local governments to observe the policies administered.[143] WHO is tasked with the challenge of persuading governments and donors to incorporate WHO programmes into national health programmes. WHO cannot compel national governments to carry out programmes, rather,

[138] Henderson, Donald A. 2011. "The Eradication of Smallpox – An Overview of the Past, Present, and Future." *Vaccine* 29 (December): D7–D9. https://doi.org/10.1016/j.vaccine.2011.06.080. D8.
[139] Fenner, Frank, D. A. Henderson, I. Arita, Z. Jezek, and I. D. Ladnyi. 1988. *Smallpox and Its Eradication*. Vol. 6. Geneva: World Health Organization. 416.
[140] World Health Organization. *Smallpox eradication*. No. EM/RC16/5. 1966. 2.
[141] Henderson, Donald A. 2011. "The Eradication of Smallpox – An Overview of the Past, Present, and Future." *Vaccine* 29 (December): D7–D9. https://doi.org/10.1016/j.vaccine.2011.06.080. D8.
[142] Beigbeder, Yves. 2017. *The World Health Organization. Achievements and Failures*. Global Governance. New York: Routledge. 92.
[143] Di Ruggiero, Erica, Joanna E. Cohen, Donald C. Cole, and Lisa Forman. 2015. "Public Health Agenda Setting in a Global Context: The International Labor Organization's Decent Work Agenda." *American Journal of Public Health* 105 (4). e58–e61. https://doi.org/10.2105/ajph.2014.302455. e59.

Regional Directors and WHO staff have the task of encouraging national programmes to these higher-level government officials. Horizontal programmes on the other hand address policy and structural considerations, the vertical programme approach stimulates ongoing discussion for single-disease programme priority and are generally favoured by donors.[144] When handling the smallpox outbreak, WHO handled it as a time-limited special programme due to existing health care systems simply being incompetent.[145]

The intensified plan to eradicate smallpox was subsequently released in 1967. To create and direct a more effective programme to fill the gaps of the current programme, additional resources would be required to fulfill the new targets for the intensified programme. The DB deliberated further on the development of a more comprehensive report before presentation to the EB, and at the following 19th WHA on May of 1966, the EB agreed in principle to recommend to the WHA the creation of a separate appropriation for the smallpox programme in the regular budget.[146] Once the idea was proposed before all Member States, a divide in opinions were expressed during voting, where two-thirds majority of Members present were required to approve the new budget.[147]

[144] Beigbeder, Yves. 2017. *The World Health Organization. Achievements and Failures*. Global Governance. New York: Routledge. 92.
[145] Fenner, Frank, D. A. Henderson, I. Arita, Z. Jezek, and I. D. Ladnyi. 1988. *Smallpox and Its Eradication*. Vol. 6. Geneva: World Health Organization. 1351.
[146] Ibid, 393.
[147] World Health Organization. 1989. *Constitution*. Geneva: World Health Organization. 7.

The programme strategy was broadly composed of three components, being: (i) a systemic mass vaccination programme, (ii) surveillance-containment, and (iii) distribution of surveillance reports to all programme participants, as well as to health officials on a regular and frequent basis.[148] Once the project was implemented, a substantial acceleration of activities were witnessed compared to previous years.[149] WHO prepared the Handbook for Smallpox Eradication in Endemic Areas which included basic strategies and principles in July, and surveillance reports were extensively distributed in September.[150]

The systemic vaccination programme was the focal programme objective, concentrating on providing mass immunisations for those who were vulnerable in endemic nations.[151] Based on technical guidance and material support from WHO and other agencies, national health professionals carried out these programmes.[152] Although programmes were expected to begin within a few weeks to a month, most took 6 to 18 months to implement as an agreement ought to be reached between national governments and WHO.[153] Depending on the size of the country, programmes were anticipated to be

[148] Henderson, Donald A. 2011. "The Eradication of Smallpox – An Overview of the Past, Present, and Future." *Vaccine* 29 (December): D7–D9. https://doi.org/10.1016/j.vaccine.2011.06.080. D8.
[149] Fenner, Frank, D. A. Henderson, I. Arita, Z. Jezek, and I. D. Ladnyi. 1988. *Smallpox and Its Eradication*. Vol. 6. Geneva: World Health Organization. 517.
[150] Ibid, 518.
[151] Henderson, Donald A. 2011. "The Eradication of Smallpox – An Overview of the Past, Present, and Future." *Vaccine* 29 (December): D7–D9. https://doi.org/10.1016/j.vaccine.2011.06.080. D8.
[152] Fenner, Frank, D. A. Henderson, I. Arita, Z. Jezek, and I. D. Ladnyi. 1988. *Smallpox and Its Eradication*. Vol. 6. Geneva: World Health Organization. 484.
[153] Ibid, 485.

accomplished within a period of one to three years.[154] It was estimated that approximately 300 million people would require vaccination annually in endemic and adjacent countries, requiring a budget of US$3 to 6 million, double that of what was already allocated for the SEP. Initiatives were already underway, with endemic countries producing vaccines for local use, producer countries making vaccine donations to WHO, and bilateral programmes supplying these vaccines to developing countries.[155]

To ensure funds were available to dedicate for technical assistance, WHO implemented the policy that excess vaccines provided outside of endemic productions and bilateral aid would be financed by VCs.[156] However, the initiation of vaccine donations as part of the 12th WHA resolution was met with great contribution by Member States, vaccination donations substantially increased.[157] Between years 1958 and 1966, a total of 47,062,500 doses were donated to WHO. Of these, 25 million that were pledged by the USSR upon proposing the SPE in 1958 were supplied between 1960 and 1964.[158] Between 1961 and 1966, the USSR further supplied approximately 700 million doses of vaccines in bilateral donations.[159]

Surveillance-containment comprised of measures that merged with local conditions such as integrating mass vaccination campaigns with mandated

[154] Ibid, 486.
[155] Ibid, 541.
[156] Ibid.
[157] Ibid.
[158] Ibid.
[159] Ibid.

weekly case reporting from all healthcare facilities, as well as updates on reports on the outbreak's containment by specialised containment teams. As the logistics of the mass vaccination programme was demanding and techniques unfamiliar, the programme was slow to start.[160] As the synergy of these two programmes when conducted simultaneously in the early stages of eradication produce the desired intended effects, prioritisation of order of the two varied across Member States.[161] Reporting structures varied amongst Member States and often did not follow the suit of WHO recommendations. Collated data may vary in its accuracy, as how the disease was categorised and logged into the system had some variance.[162] Containment measures before 1967 also varied from country to country.[163] With the aid of widespread vaccination campaigns and surveillance and containment strategies, all but five countries were able to stop the transmission of the disease.[164] Following September 1973, when WHO developed a more complex system for case detection and containment, these methods experienced major change.[165]

As developed countries directed their focus more heavily on vaccination interventions, developing countries were simply not equipped with the right resources or infrastructure, hence focusing on surveillance and containment.[166]

[160] Ibid, 342.
[161] Ibid, 541.
[162] Ibid, 497.
[163] Ibid, 498.
[164] Ibid.
[165] Ibid, 503.
[166] Strassburg, Marc A. 1982. "The Global Eradication of Smallpox." *American Journal of Infection Control* 10 (2): 53–59. https://doi.org/10.1016/0196-6553(82)90003-7. 55.

Specialised and skilled staff were required to coordinate strategy and tactics of the programme to modify and tailor the methodology of the programme to suit local needs. Reporting and surveillance systems were developed to take appropriate measures, such as detecting cases, and preparing containment measures.[167] Delivery of surveillance reports included weekly reporting of case numbers, latest developments, practical methods, and approaches to solving problem areas.[168]

Due to its administrative organisational structure and processes that are primarily intended to provide technical aid rather than material assistance, WHO can be seen as being rather restricted. Contrarily, the smallpox needed the provision of significant material aid, as well as improved cooperation for managing resources and carrying out programmes. Surveillance monitoring was a key "technique" learnt and prioritized by WHO from the smallpox outbreak. WHO upon receiving 19 recommendations from the Global Commission for the Certification of Smallpox Eradication, developed the system for post-eradication smallpox surveillance.[169]

[167] Fenner, Frank, D. A. Henderson, I. Arita, Z. Jezek, and I. D. Ladnyi. 1988. *Smallpox and Its Eradication*. Vol. 6. Geneva: World Health Organization. 367.
[168] Ibid, 495.
[169] Jezek, Zdenek, L. N. Khodakevich, and John F. Wickett. 1987. "Smallpox and Its Post-eradication Surveillance." *Bulletin of the World Health Organization* 65 (4): 425-434. https://doi.org/10.1016/s0399-077x(85)80205-5. 425.

Politics stream

When the intensified SEP was announced by WHO, a large majority of Member States were well onboard with the programme, despite concerns remaining about the logistics of the programme's execution. What initially began as a programme with diverging interests and minimal progress successfully turned around as national interests aligned. Though national interests converged to pursue the intensified SEP, the rationale to do so by national governments could potentially be politically driven, as governments may tend to avoid settling on preventative services in public health matters as they are deemed less appealing politically.[170] Whatever the political intent may be, the severity and extensive spread of the disease made for easier decision-making by national governments to partake in the collaborative project.

As the three different streams as part of the MSF merged, the policy window was formed, which is when and only when the policy is taken seriously. The formation of this policy window occurred when the need for an intensified SEP was acknowledged, which was tied to a more clearly defined practical solution with existing political willingness supporting the programme. An intensified SEP was required as a result of the original SEP's failure, which led to Member States' intense dissatisfaction with WHO over the lack of advancement in the problem stream. The intensified SEP with more precisely stated resolutions and recommendations, which was adopted after discussion

[170] Fenner, Frank, D. A. Henderson, I. Arita, Z. Jezek, and I. D. Ladnyi. 1988. *Smallpox and Its Eradication*. Vol. 6. Geneva: World Health Organization. 1364.

of the matter with the WHA and EB, is emblematic of the policy stream. Member States gave their political support, which is the political stream, and were happy with WHO's efforts and revised plans to carry out the new programme.

Successes and failures of smallpox

Although the merging of the three streams creates an environment for policy action to be pursued, it does not necessarily guarantee success of whatever action is implemented. In the case of the SEP however, the programme was able to experience a successful outcome, owing due to favourable factors. It was the development of an IO that could serve as a platform for the expression of a global policy and that could engage governments and citizens in fostering and coordinating efforts to achieve a common goal that was a crucial element to the success of smallpox eradication. WHO's democratic structure is an advantage, essential for bringing Member States together to confront global public health issues and create policies and activities that transcend across political boundaries. No other agency could have secured the necessary collaboration, international commitment, and involvement to accomplish a target of this magnitude.

Success of the smallpox programme can be partially due to the lessons learnt from previous health crises. As with the malaria programme, it required a separate malaria service, which specified the duties and responsibilities of all

programme personnel at various levels. However, the smallpox programme decided to incorporate each national programme's administrative structure and operational pattern into the affected nations' socio-cultural contexts and healthcare systems, which were curated by local staff members and WHO counterparts.

The strategic intensified plan was presented in terms of clear and measurable objectives rather than authoritative instructions.[171] As more confidence was instilled into WHO as more supportive voices rose to the surface, more proactive involvement in the WHO programme could be witnessed by Member States. These Member States cooperated accordingly, actively participating in the programme by implementing their own pilot eradication projects.[172] These pilot programmes greatly helped the WHO in refurnishing their programme as time went on, as these locally implemented programmes helped address and uncovered ground-level problems.[173]

The dedication and knowledge of a substantial group of national and international specialists contributed to the ongoing improvement of the programme's operations. This was accomplished by creativity and adaptability, considering alternative tactics and planning for adjustments as more experience was acquired. The programme was supported by ongoing research that

[171] Henderson, D. 1987. "Principles and Lessons from the Smallpox Eradication Programme." *Bulletin of the World Health Organization* 65 (4): 535-546. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2491023/pdf/bullwho00075-0106.pdf. 545.
[172] Fenner, Frank, D. A. Henderson, I. Arita, Z. Jezek, and I. D. Ladnyi. 1988. *Smallpox and Its Eradication*. Vol. 6. Geneva: World Health Organization. 486.
[173] Ibid.

provided evidence-based justifications. Experts from throughout the world contributed their knowledge and experience, and they regularly provided WHO with their discoveries to aid in eradication. Each national programme was unique as a result, and they all evolved over time.

Member States helped provide resources to meet WHO's programme objectives were one of the many contributing factors towards the successful WHO programme. Although WHO was prepared to provide vaccines at no cost during the SEP, certain African countries were found to have expressed no interest in receiving assistance. After an investigation, it was discovered that the Regional Office made little effort to promote programmes, inform national authorities of the programme's financial implications, or specify the level of assistance WHO would offer. Roadblocks in the seamless integration of WHO policies emerged when decisions were transmitted down to the regional level, where it was reported that Regional Directors were eager to assert their autonomy to modify policies to meet specific local needs.

The gap in bureaucratic support was shown to impede the success of the programme, even though adjustments may be required to maximise the effects of a policy.[174] However when word of assistance was well communicated to national health officials, an overflow of letters requesting assistance was sent in. Therefore, once national governments were apprised of the aid available,

[174] Bhattacharya, Sanjoy. 2008. "The World Health Organization and Global Smallpox Eradication." *Journal of Epidemiology & Community Health* 62 (10): 909-912. https://doi.org/10.1136/jech.2006.055590. 911.

compliance was often obtained easily. Lessons were learned as part of the process as WHO carried out the required actions, and these lessons served to ensure the success of the intensified programme, which will also significantly help prepare for and mitigate against future public health crises. As the first phase of the SEP revealed, a lack of preparation only leads to a costly failure, which results in the public health professionals in charge of the projects losing credibility.

The Global Commission for the Certification of Smallpox Eradication declared that smallpox had been eradicated globally in December 1979.[175] The smallpox disease was successfully declared eradicated on 8 May of 1980 by the 33rd WHA.[176] To date, this is one of the most notable successes in the history of public health for WHO.

Chapter IV: Case (2) SARS

Problem stream

The severe acute respiratory syndrome coronavirus (SARS), initially discovered in November 2002 in Guangdong, China, was the first communicable disease of the twenty-first century.[177] SARS typically starts as a

[175] Fenner, Frank, D. A. Henderson, I. Arita, Z. Jezek, and I. D. Ladnyi. 1988. *Smallpox and Its Eradication*. Vol. 6. Geneva: World Health Organization. 1321.
[176] Ibid, 538.
[177] Wilder-Smith, A., Chiew, C., & Lee, V. 2020. "Can We Contain the COVID-19 Outbreak with the Same Measures as for SARS?" *The Lancet Infectious Diseases* 20 (5): E102-E107. https://doi.org/10.1016/S1473-3099(20)30129-8. E102.

high fever, when symptoms including headaches, body pains, and respiratory issues develop before eventually progressing to pneumonia.[178] The rare coronavirus was zoonotic in origin, having been acquired through animal-to-human contact as it had never been identified in humans.[179] This presented an immediate challenge to WHO, in quickly collating data to understand the novel virus to prepare appropriate and rapid interventions. A feature of the illness was that the virus was not contagious until several days after the onset of the initial symptoms, and most contagious when the most severe symptoms arose.

WHO's response to SARS began on the 10th of February 2003, when WHO asked the Ministry of Health of Chinese to verify the reports received about an outbreak of severe pneumonia cases.[180] The Chinese Ministry of Health reciprocated, formally informing WHO about the outbreak of the acute respiratory syndrome in mid-February, which had already reached 300 cases and 5 fatalities.[181] However, China's report to the WHO was met with criticism owing to significant delays in reporting. It is believed the Ministry of Health China conducted a report on the disease and had sent it off for proofing, however, health officials did not have access to the report marked "top-secret",

[178] Müller, Gustavo, Melanie Ruelens, and Jan Wouters. 2021. "The Role of the World Health Organization in the COVID-19 Pandemic." Accessed September 5, 2022. https://ghum.kuleuven.be/ggs/documents/final-metaforum-research-report-7-12-21.pdf. 62.
[179] Ibid, 24.
[180] Stacey Knobler, Adel Mahmoud, Stanley Lemon, Alison Mack, Laura Sivitz, and Katherine Oberholtzer, eds. 2004. *Learning from SARS. Preparing for the Next Disease Outbreak: Workshop Summary*. Washington: The National Academies Press. https://doi.org/10.1604/9780309594332. 6.
[181] World Health Organization. 2003. "Update 95 - SARS: Chronology of a Serial Killer." Accessed September 9, 2022. https://www.who.int/emergencies/disease-outbreak-news/item/2003_07_04-en.

causing a three-day delay as no authorised public health official was present to open the document.[182]

Bureaucratic red tape issues as witnessed with the smallpox crisis can be seen replicated with the SARS case, which delayed the reporting of SARS cases to WHO.[183] These issues are exhibited through the impediments of information flow in the Chinese governmental hierarchy, lack of coordination among fragmented governmental departments, and a political system where the importance of solving problems internally outweighs any acknowledged importance of external aid.[184] These systemic failings were not exclusive to China, but was recognised in a number of countries also.[185]

To aid China's response, WHO delivered technical assistance to the Chinese officials, working in collaboration to conduct joint investigations in outbreak ridden regions. However, WHO experts were initially denied access to the location of outbreak to conduct these investigations. This is believed to have occurred due to the Chinese government attempting to downplay the extent of the epidemic, silencing journalists from reporting about the outbreak, and ordering Chinese doctors to hide patients with SARS from WHO experts. These actions can be translated into China deferring their report to WHO, with expectations that cases would either disappear gradually or could be managed

[182] Stacey Knobler, Adel Mahmoud, Stanley Lemon, Alison Mack, Laura Sivitz, and Katherine Oberholtzer, eds. 2004. *Learning from SARS. Preparing for the Next Disease Outbreak: Workshop Summary*. Washington: The National Academies Press. https://doi.org/10.1604/9780309594332. 120.
[183] Ibid, 10.
[184] Ibid.
[185] Ibid.

under local control. This behaviour is a replication of what occurred during the smallpox pandemic, where reporting is delayed as Member States may fear negative social and economic consequences, as well as losing credibility within the international community from being perceived as incompetent with inadequate healthcare systems.

The delay in reporting to WHO by the Chinese government was widely critiqued, the untimely reporting considered lost valuable time. Grandiose costs are associated with this loss of time, including the uncontrollable spread of disease within a country, excessive disease transmission, increased suffering and mortality and escalation of negative social and economic implications. The motive behind the decision to delay a report can be considered an action conducted in favour of a Member States own national interest, a strategised tactic that isn't simply an uncalculated mishappening or accidental tardiness. This action of self-interest severely debilitates WHO's ability to quickly address the time-sensitive problem by consigning appropriate action.[186]

WHO formally issued a global alert on March 12, 2003.[187] The first spread of the disease outside of China is believed to have begun on the 21st of February 2003 when healthcare workers in Hong Kong contracted the disease from an infected physician.[188] The disease spread fast to Singapore, Vietnam, Canada,

[186] Michelson, Evan S. 2005. "Dodging a Bullet: WHO, SARS, and the Successful Management of Infectious Disease." *Bulletin of Science, Technology & Society* 25 (5): 379–386. https://doi.org/10.1177/0270467605278877. 382.
[187] World Health Organization. 2006. "*SARS: How a Global Epidemic Was Stopped*." Geneva: World Health Organization. 8.
[188] Ibid, 49.

Ireland, and the United States. According to estimates from the WHO, this super spreader is thought to have been the source of more than 8,000 suspected SARS cases worldwide.[189] The threat of SARS clearly demonstrated that it does not discriminate against the developed or developing economies, where contrarily, the most sophisticated urban hospitals were the targets of disease spreading.[190]

In light of the SARS outbreak, inadequacies in China's public health infrastructures were exposed, such as insufficient state funding, ineffective surveillance systems, and severe shortages of facilities and medical personnel ready for an epidemic infectious disease breakout.[191] To address these inadequacies to improve their emergency response system, the Chinese government allocated funding for SARS prevention and control, established a case reporting framework, and even dismissed the mayor of Beijing and Minister of Health who was believed to have had handled the crisis improperly in the first few months.[192] Not only are the response measures inadequate in China, but as was exposed by the 1995 Ebola outbreak, global public health surveillance measures were found to be ill prepared at every level in responding to emerging and epidemic prone diseases.[193] No system was able to provide pre-emptive warnings of unusual disease events, nor were there

[189] Ibid, 8.
[190] Ibid.
[191] Ibid, 10-11.
[192] Ibid, 11.
[193] Ibid, 51.

appropriate infrastructure to detect and diagnose these events.[194] These series of concerns stemming from the Ebola outbreak led to the recognition during SARS management, that the foundations of infectious-disease control required innovation.

Reforms were carefully considered and planned to increase ability to handle a variety of operational concerns. This was done to battle the more complicated problems that develop while coordinating an international outbreak response as crises have become increasingly transboundary in nature. The Global Outbreak Alert and Response Network (GOARN), a WHO surveillance network comprised of over 250 technical institutions and networks was founded in April 2000 to address these concerns.[195] When a public health emergency emerges, the global network responds by striving to provide prompt and efficient help to prevent and control infectious disease epidemics.[196] The wide network system makes it possible to quickly collect and deploy specialised personnel and technological resources for on-the-spot support and emergency investigations.[197] GOARN facilitated the expansion and formalisation of the capacity of responses to SARS, being the focal driving force behind WHO's global response to SARS.

[194] Ibid.
[195] World Health Organization. 2022. "GOARN." Accessed August 23, 2022. https://goarn.who.int/.
[196] Ibid.
[197] World Health Organization. 2006. *SARS: How a Global Epidemic Was Stopped*. Geneva: World Health Organization. 52.

The global response was coordinated by Dr David Heymann, the Executive Director of Communicable Diseases from 1998 to 2004.[198] In order to rapidly expand understanding and clinical management of the newly zoonotic illness, WHO depended on the GOARN to establish four unique response networks.[199] These were: (i) a senior management team that guided the WHO on its travel advice and global alerts, (ii), a global network of researchers working together in a virtual lab to find the disease agent, (iii), a body of health officials aiming to develop therapeutic guidelines for treating the disease, and (iv), a network of epidemiologists offering up-to-date data on the diseases spread.[200] Further, GOARN employed and coordinated an array of logistical response efforts globally in the form of: (i) set standards, (ii) standardised protocols, (iii) alert and verification processes, (iv) communications, (v) response coordination, (vi) specialist equipment, (vii) medical supplies, (viii) emergency evacuation, (ix) research, (x) evaluation, and (xi) media relations.[201]

GOARN was able to successfully handle the transboundary crisis by coordinating information and response at the global level. Considering that Member States each have independent sovereignty which makes inter-jurisdictional coordination arduous, GOARN was able to create a systematic

[198] Ibid, 50.
[199] Ansell, Chris, Arjen Boin, and Ann Keller. 2010. "Managing Transboundary Crises: Identifying the Building Blocks of an Effective Response System." *Journal of Contingencies and Crisis Management* 18 (4): 195–207. https://doi.org/10.1111/j.1468-5973.2010.00620.x. 201.
[200] Ibid.
[201] Beigbeder, Yves. 2017. *The World Health Organization. Achievements and Failures*. Global Governance. New York: Routledge. 38-39.

mechanism for balancing national and international strategic interests.[202] Most importantly, the pillar to GOARN's success was its ability to dispatch operational GOARN teams to affected regions, where critical and verified information could be rapidly relayed back to WHO headquarters.[203] This aided the regional response and preparation teams WHO Regional Offices established to carry out activities to contain the illness, as GOARN helped respond to the needs expressed by local governments. By gathering daily data from the field and sending this verified information to local responders, WHO was able to provide real-time communication to Member States and stakeholders, greatly assisting informed decision-making.[204] A senior management group consisting of high-level officials was established as a means of facilitating discussions for worldwide responses options.

The etiological agent of the disease was conclusively identified to be SCoV, discovered by the laboratory network.[205] Given that there was no existing treatment yet for the disease, the global surveillance network would continue to aid with data collection as WHO was working towards creating viable treatment options. However, existing data was far too insufficient to even begin the process of evaluating treatments. Due to this problem, it became

[202] World Health Organization. 2006. *SARS: How a Global Epidemic Was Stopped*. Geneva: World Health Organization. 52.
[203] Ansell, Chris, Arjen Boin, and Ann Keller. 2010. "Managing Transboundary Crises: Identifying the Building Blocks of an Effective Response System." *Journal of Contingencies and Crisis Management* 18 (4): 195–207. https://doi.org/10.1111/j.1468-5973.2010.00620.x. 202.
[204] Ibid, 201.
[205] Stacey Knobler, Adel Mahmoud, Stanley Lemon, Alison Mack, Laura Sivitz, and Katherine Oberholtzer, eds. 2004. *Learning from SARS. Preparing for the Next Disease Outbreak: Workshop Summary*. Washington: The National Academies Press. https://doi.org/10.1604/9780309594332. 13.

urgently clear that generic protocols should be created as preventative stages to improve existing SARS measures and to prepare for future outbreaks.

On the basis that the disease was being spread due to air travel with no existing cure, WHO and GOARN's policy responses were suggestions in containment and control measures, such as quarantine or isolation methods and contact tracing. In conjunction to these travel measures, Member States were expected to carry on with their reporting responsibilities. Despite some Member States having complete control over their reporting duties, other Member States with fragile healthcare systems simply were not equipped with the right infrastructure or resources to establish surveillance and reporting mechanisms. This revealed another area of concern for WHO to help Member States restructure and strengthen public health infrastructures to strengthen surveillance and reporting responsibilities.

Policy stream

The necessity to revise the IHR, a legally binding piece of international law aimed at enhancing global health security has been acknowledged since the 1990s, when infectious illnesses threatened to emerge and re-emerge. Although dialogue was present, there was little to no advancements made for reform. In May 1995, the 48th WHA acknowledged the need for a reform in this area, with

the first ever resolution on emerging infections strategized by WHO to improve novel disease recognition and responses.[206]

Formerly recognised as the International Sanitary Regulations, it was first created and adopted in 1951 based on initiatives employed by the International Sanitary Conferences during the 19th century. Once renamed to the IHR, the Health Assembly enacted these regulations in 1969 originally focusing on six illnesses.[207] This legal tool binds 196 States Parties as well as two non-WHO Member States.[208] Article 2 of the IHR states that its purpose and scope is, "to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade."[209] These regulations must be ratified by Member States in accordance with the WHO Constitution in order to be in effect. Unless they specifically notify the DG within a certain time frame their reason for opting out, Member States are held liable to comply with the regulations.[210] Despite the IHR having legal binding power, the decision ultimately lies within the hands of Member States whether to comply or not. This is owing to WHO Secretariat's lack of legal ability to sanction

[206] World Health Organization. 2018. *International Health Regulations (2005)*. Geneva: World Health Organization. 10.
[207] World Health Organization. 2021. *WHO's Work in Health Emergencies. Strengthening Preparedness for Health Emergencies: Implementation of the International Health Regulations (2005*). Geneva: World Health Organization. 18.
[208] Ibid.
[209] World Health Organization. 2018. *International Health Regulations (2005)*. Geneva: World Health Organization. 10.
[210] Ibid.

noncompliant Member States directly, instead, its jurisdiction is restricted to regulatory functions exclusively.[211]

Prior to the SARS outbreak, WHO considered the need for creating a worldwide surveillance network system for infectious illnesses that would simultaneously address issues with disease control. The primary line of defence against the spread of infectious illnesses internationally has been acknowledged to be from strengthening epidemiological surveillance and disease control initiatives at the national level. Thus, to strengthen the information sharing system, Member States were asked to appoint an IHR National Focal Point (NFP) to engage with WHO and establish and maintain crucial capacity for surveillance and response, including at specific points of entry.[212] The NFP must be reachable 7 days a week, 24 hours a day and 365 days a year to WHO IHR Contact Points that have been designated to each of the six regional offices.[213] The amended IHR's conclusions would depend on the implementation of the extension from technical to political levels. Another mechanism that counters the issues of delayed reporting by Member States is that the IHR allows WHO permission to gather information about disease-related incidents from non-governmental sources and to seek official

[211] The Independent Panel for Pandemic Preparedness and Response. 2021. "The World Health Organization: An Institutional Review." Accessed September 10, 2022. https://theindependentpanel.org/wp-content/uploads/2021/05/Background-paper-15-WHO-Institutional-review.pdf. 38.
[212] World Health Organization. 2009. "International Health Regulations (2005) Toolkit for implementation in national legislation." Accessed October 9, 2022. https://cdn.who.int/media/docs/default-source/documents/emergencies/ihr-toolkit-for-implementation-in-national-legislation3cceba0c-4580-48a4-9d4e-2b17a2146b66.pdf?sfvrsn=60aea14d_1&download=true. 7.
[213] Ibid.

confirmation of the data, steering away from State monopoly.[214] This information may then be relayed to other Member States to warn them as needed.

The issue of inadequate sharing of information during the early phase of the SARS outbreak was voiced on a global scale at the 56th WHA, reigniting dialogue seeking revision of the IHR to address these concerns and implement the relevant measures.[215] This presented a policy opportunity that would lead to the expedited revision of the IHR, amidst a situation that was clearly demonstrating the limitations of the legal framework. During the 56th WHA, Member States requested the WHO Secretariat to finalise the draft for the complete revision of the IHR, requesting its presentation to the WHA for approval at the next annual meeting. The WHA formed the Intergovernmental Working Group for Member States in 2003 to assist in drafting a draft report of the IHR. Subsequently six months later the Interim IHR Draft was made available for governmental and non-governmental assessment and comments.[216]

The utmost importance WHO stresses on timely reporting is so that they may quickly analyse the situation and formally declare a Public Health Emergency of International Concern (PHEIC), a cornerstone of the IHR. As the

[214] Fidler, David. 2020. "The World Health Organization and Pandemic Politics." Accessed October 1, 2022. https://www.thinkglobalhealth.org/article/world-health-organization-and-pandemic-politics.
[215] World Health Organization. 2003. *Revision of the International Health Regulations: Severe acute respiratory syndrome (SARS)*. Geneva: World Health Organization. 6.
[216] World Health Organization. 2005. "Revision of the International Health Regulations." Accessed September 13, 2022. https://apps.who.int/iris/handle/10665/20353.

reporting of diseases are only made possible when the diagnosis if known, the inclusion of criteria that would define what consists of a PHEIC was requested by the Health Assembly. Member States are mandated to take immediate action to prevent the spread of disease across international borders by notifying WHO of a PHEIC within 24 hours upon recognition of a potential PHEIC.[217] Article 1 of the IHR defines PHEIC as, "an extraordinary event which is which is determined…to constitute a public health risk to other States through the international spread of disease and to potentially require a coordinated international response."[218]

Upon declaration of a PHEIC, WHO should be prepared to offer temporary advice in the form of soft law instruments to provide nations with the necessary knowledge and precautions to handle the public health emergency. Affected Member States are required by law to act quickly in response to the declaration by adopting these recommendations, which are non-binding in nature and time-limited to three months. However, the lengthy process of curating temporary recommendations not only slows down decision-making and guidance at critical junctures, but it also becomes a highly politicised process. The process becomes politicised as recommendation may cause significant impacts on economic, social, political, and other factors, leaning towards the national purview.

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[217] Lencucha, Raphael, and Shashika Bandara. 2021. "Trust, Risk, and the Challenge of Information Sharing during a Health Emergency." *Globalization and Health* 17 (1): 1-7. https://doi.org/10.1186/s12992-021-00673-9. 1-2.
[218] World Health Organization. 2008. *International Health Regulations 2005*. Third edition. Geneva: World Health Organization. 9.

As part of the IHR amendment in 2005, the recent changes mandate the DG to consult with the IHR EC before formally declaring a PHEIC. International experts make up the IHR EC, which provides the DG with technical recommendations on potential PHEICs after conducting a technical assessment using a predetermined algorithm and legal requirements.[219] This challenges the traditional politicisation of rule-making and standard-setting by providing the DG with such grand authority, an example of governance by information.[220] An example of this authority is how the DG can declare a PHEIC despite objection by the outbreak ridden Member State. The WHA designates the explicit authority to WHO to publish information regarding outbreaks with pandemic potential promptly without requiring prior approval of national governments. This significantly speeds up the lag between the initial recognition of the PHEIC and official reporting owing to the series of exogenous factors.

The revised and broadened IHR was approved by the 58th WHA on May 23, 2005, and became effective on June 15, 2007, after the SARS outbreak ran its course.[221] The revised edition pertains to all hazards to public health, as opposed to the former version's limited coverage of diseases which would have

[219] Mullen, Lucia, Lawrence O. Gostin, and Jennifer Nuzzo. 2020. "An Analysis of International Health Regulations Emergency Committees and Public Health Emergency of International Concern Designations." *BMJ Global Health*. 5 (6): 1-7. https://doi.org/10.2139/ssrn.3640766. 2.
[220] von Bogdandy, Armin, and Pedro Villarreal. 2020. "International Law on Pandemic Response: A First Stocktaking in Light of the Coronavirus Crisis." *SSRN Electronic Journal* 2020 (7): 1-25. https://doi.org/10.2139/ssrn.3561650. 12.
[221] World Health Organization. 2018. *International Health Regulations (2005)*. Geneva: World Health Organization. 1.

legal irrelevance to SARS and other emerging infectious diseases not on the list. This revision increases flexibility the chances of attaining global health security by veering away from disease specific approaches and broadening the scope of diseases the IHR can respond to. To support the full implementation of the Regulations, Member States were requested to provide statements regarding the minimum capacity required in specific sectors WHO could aid them with for appropriate implementation of the Regulations.

The IHR ensures global health security by holding national governments accountable for timely and accurate reporting. The regulations do not provide any infrastructure for surveillance, but rather reporting is left solely to the goodwill of Member States. However, issues of information censorship and in handing over sensitive information inhibit WHO's ability to perform efficiently at their full scope, exacerbating issues surrounding political sensitivity. These exogenous factors fundamentally rooted in organisational obstacles such as the polarity in political structures, norms, and tendencies in Member States significantly debilitate WHO's work.

Table 1. Evolution of the International Health Regulations from 1951 to 2010.[222]

IHR Component	**1951 to 2007**	**2007 to 2010**

[222] Katz, Rebecca, and Julie Fischer. 2010. "The Revised International Health Regulations: A Framework for Global Pandemic Response." *Global Health Governance* 3 (2): 1-18. https://blogs.shu.edu/ghg/2010/04/01/the-revised-international-health-regulations-a-framework-for-global-pandemic-response/. 3-4.

Scope	Cholera, Plague, Yellow Fever, and Smallpox (removed after eradication); Control at Borders.	Public Health Emergency of International Concern; Detection and Containment at Source.
Communication	Countries fax reports to WHO.	IHR National Focal Points (NFP) and WHO's secure website.
Notification	Report to WHO within 24 hours.	Report to WHO within 24 hours. 72 hours to respond to follow up requests.
Coordinated Response	No mechanism for coordinating international response to contain disease.	Assistance in response/recommended measures.
Authority	WHO not able to initiate an enquiry: dependence on official country notifications.	WHO can initiate requests for information based unofficial sources. Can ask for additional information.
National Capacity	Provide disease inspection and control at ports of entry.	Provide disease inspection and controls at ports of entry. Meet minimum core capacity or detection, reporting and assessment.

Response Capabilities	Pre-determined public health controls at points of entry.	Flexible, evidence-based responses adapted to nature of threat.

The disease had a significant impact to all societal levels, with the temporary closures of selected borders, schools, hospitals, and businesses.[223] Considering the rise in international travel and trade, the emergence or re-emergence of disease threats on a global scale, as well as other public health concerns, revisions to the IHR were made by developing specific measures for international borders to prevent and minimise cross-border transmission of diseases. These revised travel measures would help alleviate some of the extreme measures Member States were implementing as these revised safety measures would cause the least disruptions. In accordance with Article 43 of the IHR, WHO does not preclude State Parties from implementing their own measures, however, they should not be more restrictive of international traffic, nor be more invasive or intrusive to persons than the reasonable available alternatives could already achieve in attaining the appropriate level of health protection.[224]

[223] World Health Organization. 2006. *SARS: How a Global Epidemic Was Stopped*. Geneva: World Health Organization. 50.
[224] World Health Organization. 2018. *International Health Regulations (2005)*. Geneva: World Health Organization. 28-29.

Politics stream

Against the collective fight against the global health issue, the issues of politics unavoidably impinge the discourse of mutual collective security. China first took centre stage due to their criticised efforts to promptly notify WHO of the disease due to bureaucratic red tapes and national interest. Despite acknowledging that the illness originated in China, Chinese officials tried to minimise the scope and severity of the SARS outbreak.[225] This is possible due to China perceiving SARS as a threat to their social and political stability rather than a hazard to public health, explained by the fact that state policy actions are ultimately conditioned by a States need for survival whether socio-politically or economically.[226]

However, the SARS outbreak is thought to have achieved notoriety as a result of actors who expressed worries about their economic and social issues being jeopardised or who saw a potential benefit from a specific ailment receiving attention.[227] Economic and social issues are as much of a pivotal threat as security of a militarised nature is. By acknowledging the concept that injury to one is seen as an injury to all, Member States were able to work together towards the collective good that would benefit all. Despite infrastructure issues

[225] Stacey Knobler, Adel Mahmoud, Stanley Lemon, Alison Mack, Laura Sivitz, and Katherine Oberholtzer, eds. 2004. *Learning from SARS. Preparing for the Next Disease Outbreak: Workshop Summary*. Washington: The National Academies Press. https://doi.org/10.1604/9780309594332. 13.
[226] Patrick, Hosea Olayiwola, Ernest Nene Khalema, Rhoda Titilopemi Inioluwa Abiolu, and George Mbara. 2021. "National Interest and Collective Security: Assessing the 'Collectivity' of Global Security in the Covid-19 Era." *Humanities & Social Sciences Reviews* 9 (2): 499–507. https://doi.org/10.18510/hssr.2021.9248. 503.
[227] McInnes, Colin, Kelley Lee, and Jeremy Youde, eds. 2020. *The Oxford Handbook of Global Health Politics*. Oxford: Oxford University Press. 334.

that unavoidably made reporting or containing difficult for some Member States, the idea of working independently by fulfilling one's mandated obligations to neutralise the security challenge worked well to defuse the security threat and public health concern.

WHO generally steers clear of public criticism as it puts the relationship between the IO and Member State in a difficult position that could lead to tension in upcoming cooperation efforts. However, WHO was not swayed, and the WHO team in Beijing publicly expressed their strong concerns regarding inadequate reporting of SARS cases on 16th of April 2003.[228] China later acknowledged its errors in the initial handling of SARS considering the media attention it had received. This shift to full crisis acknowledgement could be viewed as a response to related political and economic issues once more, re-establishing legitimacy in the eyes of the concerned local and international publics.[229] Extraordinary alliance would have failed without the full cooperation of China, the epicentre of the epidemic.[230] Collective security is well observed through the swift success of SARS containment. Only when there is a convergence of national interest can collective security be truly pursued and be effective.

[228] Ibid, 14.
[229] Christensen, Tom, and Martin Painter. 2004. "The Politics of SARS – Rational Responses or Ambiguity, Symbols and Chaos?" *Policy and Society* 23 (2): 18–48. https://doi.org/10.1016/s1449-4035(04)70031-4. 44.
[230]Stacey Knobler, Adel Mahmoud, Stanley Lemon, Alison Mack, Laura Sivitz, and Katherine Oberholtzer, eds. 2004. *Learning from SARS. Preparing for the Next Disease Outbreak: Workshop Summary*. Washington: The National Academies Press. https://doi.org/10.1604/9780309594332. 10.

The chaotic nature of decision-making processes as explicated by the Garbage Can Model of Organisational Choice could help explain the inefficient delays the IHR reform incurred. Once again, the idea that decision-making processes are carried out in rather irrational and non-linear ways is a large component that can be seen with the SARS case. Although dialogue existed surrounding the concern for IHR reform, the bulk of such conversations only arise as other issues are concurrently occurring. This potentially diverges the attention away from discussing the issue that has already been placed on the agenda prolonging and delaying the policymaking process. Hence, when different interests and ideas from multiple Member States get thrown into a single conclusion, a resolution to that said policy agenda is expected to arise, albeit, the fruition of the objective may be delayed, as witnessed with the IHR reform, in which dialogue was promulgated once more due to the SARS phenomenon.

Successful implementation of top-down enforcement of community containment combined with strong political will aided effective eradication of the disease in successful countries that were proactive.[231] Governments instituted whole-of-government strategies with their command structures being clearly defined following a tiered system.[232] The most effective national

[231] Wilder-Smith, A., Chiew, C., & Lee, V. 2020. "Can We Contain the COVID-19 Outbreak with the Same Measures as for SARS?" *The Lancet Infectious Diseases* 20 (5): E102-E107. https://doi.org/10.1016/S1473-3099(20)30129-8. E102.
[232] The Independent Panel for Pandemic Preparedness and Response. 2021. "COVID-19: Make It the Last Pandemic." Accessed September 10, 2022. https://theindependentpanel.org/wp-content/uploads/2021/05/COVID-19-Make-it-the-Last-Pandemic_final.pdf. 31.

response systems were those where authority in decision-making were straightforward that went hand in hand with available capacity to coordinate efforts across the many actors, such as levels of government and formal advisory structures. Adaptability was a key component contributing to overall effectiveness and high-level coordination ability of State Parties.

Successes and failures of SARS

As of 2004, there were no confirmed SARS infections anywhere in the world, and in July 2005, WHO declared the virus contained.[233] This marks another significant feat for WHO in global infectious disease control. As the previous chapter analysed the successes of the SEP, the lessons learnt by WHO have been carried through into the SARS response. The key response recognised from the smallpox crisis used to apply to the SARS response is the heavy emphasis on the importance of surveillance measures and timely information sharing. Appropriate and suitable measures were taken to address these two concerns which have been reoccurring time and time again.

The stress placed on the importance of rapid information sharing has been constant through WHA meetings and led to the creation of the GOARN. The synergy between new surveillance measures and the GOARN system allowed for a more real-time and collaborated approach to handling the

[233] Centers for Disease Control and Prevention. 2016. "SARS (10 Years After)." Accessed October 3, 2022. https://www.cdc.gov/dotw/sars/index.html.

outbreak, minimising certain effective costs. Subsequently, those voicing their opinions on the necessity of extensive and timely surveillance measures helped promulgate necessary dialogue and created an appropriate political climate that led to the eventual development of the PHEIC following the SARS outbreak, another core pillar to the IHR. The global community was swiftly alerted by WHO upon receiving verified information, and the mobilisation of resources were rapid as well as cooperation with non-State actors as seen through the GOARN.

Despite the IHR undergoing revisions post-SARS due to the concerns raised during the outbreak, effective implementation of the IHR revisions was still underway. The successful containment of SARS is believed to be due to luck and favourable conditions such as the characteristics of the disease, despite the political interferences and early conditions preconditioning the event of a globally widespread outbreak. Yet again, the exogenous factors WHO is challenged by continue to thwart successful implementation of reform efforts.

WHO's management of the SARS outbreak was overall positively assessed as the organisation managed and contained the outbreak within some six months. A total of 29 countries were impacted by the disease during its outbreak, which resulted in a total of 8096 cases of infection and 774 fatalities.[234] The disease being novel in nature with no cure promulgated a chain reaction of concerns from Member States. The voicing of opinions in unisons promulgated

[234] Ibid.

conversation regarding the reform of the IHR to suit cosmopolitan situations which ultimately led to its revision.

Chapter V: Case (3) COVID-19

Problem stream

SARS-CoV-2 otherwise well-known as COVID-19 is a disease of zoonotic origin that emerged in December of 2019 in Wuhan, China.[235] WHO was made aware of the disease on 31 December 2019, and its Country Office met with the Chinese National Health Commission on 3 January 2020 who presented their views to WHO.[236] Through the IHR Event Information System, WHO alerted all Member States on 5 January 2020 about the pneumonia outbreak.[237] Between 20 to 21 January 2020, WHO conducted their first mission in Wuhan upon WHO Country Office reaching agreement with the Chinese authorities on 15 January 2020.[238] From the 22nd to 23rd of January 2020 WHO DG convened the first meeting of the IHR EC, where the decision to declare a PHEIC was split, in which several committee members voiced that the declaration would be premature as the disease was restrictive and binary in nature.[239] COVID-19 was officially declared a PHEIC by the DG on 30 January 2020 according to Article 12 of the Regulations, the DG announcing that the concern revolved around the

[235] Topcuoglu, Nursen. 2020. "Public Health Emergency of International Concern: Coronavirus Disease 2019 (COVID-19)." *The Open Dentistry Journal* 14 (1): 71-72. https://doi.org/10.2174/1874210602014010071. 71.
[236] The Independent Panel for Pandemic Preparedness and Response. 2020. "An Authoritative Chronology of the COVID-19 Pandemic." Accessed September 10, 2022. https://recommendations.theindependentpanel.org/public-chronology.
[237] Ibid.
[238] Ibid.
[239] World Health Organization. 2020. "Statement on the Second Meeting of the International Health Regulations (2005) Emergency Committee Regarding the Outbreak of Novel Coronavirus (2019-nCoV)." Accessed September 12, 2022. https://www.who.int/news-room/detail/30-01-2020-statement-on-the-second-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-outbreak-of-novel-coronavirus-(2019-ncov).

inability of weaker health systems to manage the virus, rather than the situation in China.[240]

As the IHR emphasises unnecessary interference to traffic and trade deeming it ineffective and counterproductive, the IHR EC did not incorporate travel or trade restrictions. The default stance on travel bans were severely questioned by Member States. Policy decision on travel bans by States do serve the purpose of the national health prism, however it contravenes the idea of a collective and supports the lookout for 'self-survival'.[241] Extensive criticism exhibits the intense political environment that surrounds the legally binding tool, challenging WHO and their responsibility. WHO required Member States exercising measures interfering with international traffic to inform and provide a rationale for their choice in conduct according to Article 43 of the IHR. As example, temporary border closures were implemented by many Member States to protect their own homeland security even though these measures were advised against by WHO.

Compliance issues have been reoccurring, challenging WHO's authority time and time again. Member States were quick to not abide the temporary recommendations made during the COVID-19 pandemic to seek their own national interests and failed to provide appropriate rationales for their actions. As temporary recommendations are non-binding, Member States are given

[240] Ibid.
[241] Patrick, Hosea Olayiwola, Ernest Nene Khalema, Rhoda Titilopemi Inioluwa Abiolu, and George Mbara. 2021. "National Interest and Collective Security: Assessing the 'Collectivity' of Global Security in the Covid-19 Era." *Humanities & Social Sciences Reviews* 9 (2): 499–507. https://doi.org/10.18510/hssr.2021.9248. 505.

leeway to stray away from a coordinated and collaborative international response, foregoing global solidarity movements. The failure to report the imposition of such restrictions pre-empted WHO's monitoring role, the attempt to support a proportionate risk assessment, as well as a naming and shaming effect.

The organisation has faced severe criticism regarding its handling of the COVID-19 pandemic, particularly in the timeliness of declaring the disease as a PHEIC. The delay is a repetition of WHO's untimeliness of the West Africa Ebola outbreak, which they were condemned for their fourth month delay for a PHEIC declaration when relevant IHR criteria had already been met.[242] The delay was also witnessed in the previous chapter regarding the SARS management, however the delay was considered outside of WHO's control. Excessive and unnecessary delay only lulls governments into a false sense of security and exacerbates the incoming consequences.

Funding issues continue to reoccur with WHO. Without the contribution of Member States and donors, the management of COVID-19 solely by WHO would surely be set up for failure. Pandemic preparedness was under-funded, in which rapid deployment of medical interventions could not be immediately jumpstarted, such as dispensing medical supplies, commencing diagnostics and

[242] Eccleston-Turner, Mark, and Adam Kamradt-Scott. 2019. "Transparency in IHR Emergency Committee Decision Making: The Case for Reform." *BMJ Global Health* 4 (2): 1-3. https://doi.org/10.1136/bmjgh-2019-001618. 2.

therapeutics and ensuring equitable supply of vaccines.[243] As an independently led WHO project would not have had the capacity nor funds to lead a medical intervention to effectively vaccinate all populations, the aid of global collaboration made the development of vaccines, a core pillar of disease eradication a possibility. COVAX being co-managed by WHO, the Coalition for Epidemic Preparedness Innovations (CEPI), Gavi, and UNICEF, is the vaccines pillar of the Access to COVID-19 Tools (ACT) Accelerator.[244] The ACT Accelerator forged the way to accelerate the development, manufacturing process, and equitable access to all COVID-19 tests, therapeutics, and vaccines.[245] These global public-private partnerships are developed at the crossroads of economic and public health interests, inherent to any possibility of successful management of the COVID-19 pandemic.

Numerous concerns that arose during the COVID-19 pandemic were not only related to systemic problems at WHO but also in a significant way to pandemic politics between Member States in the global setting. As their actions and policy responses in the collective fight against the disease cannot be separated from self-interest motives, the U.S. and China, who have been engaged in a constant hegemonic power struggle, appear to have posed a variety of political challenges to WHO before and during COVID-19. Although

[243] The Independent Panel for Pandemic Preparedness and Response. 2021. "COVID-19: Make It the Last Pandemic." Accessed September 10, 2022. https://theindependentpanel.org/wp-content/uploads/2021/05/COVID-19-Make-it-the-Last-Pandemic_final.pdf. 13.
[244] World Health Organization. 2022. "COVAX." Accessed September 4, 2022. https://www.who.int/initiatives/act-accelerator/covax.
[245] Ibid.

China submitted its report late and impeded transparent information sharing, the Secretariat's deferential attitude towards China was criticised. President Trump used this as grounds for freezing WHO financing in 2020, which is within the bounds of a justification for national interest.[246] In other words, it was decided that WHO's appraisal of China was deemed excessive, albeit with strategic intention or not. The U.S. government formally informed the UN Secretary-General of its intention to withdraw its membership on July 6, 2020.[247]

With the United States currently contributing significantly more than any other Member State, its withdrawal might have had a significant impact on COVID-19's future progress and the capacity of WHO to carry out the necessary action plans to actively combat the illness. However, because withdrawal was not permitted until July 2021, the U.S. was mandated by law to complete paying its financial obligations for that fiscal year.[248] As the policy decisions made during the pandemic would be essential in shaping the course of the post-COVID-19 era of global politics, Trump's accusations and motivations against China were political in nature and were utilised to assure his re-election in the 2020 US elections.[249]

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[246] Gostin, Lawrence O., Harold Hongju Koh, Michelle Williams, Margaret A. Hamburg, Georges Benjamin, William H. Foege, Patricia Davidson et al. 2020. "US Withdrawal from WHO Is Unlawful and Threatens Global and US Health and Security." *The Lancet* 396 (10247): 293-295. https://doi.org/10.1016/S0140-6736(20)31527-0. 293.
[247] Ibid.
[248] Ibid, 294.
[249] Sullivan, Kate. 2020. "Impact of COVID-19 on the 2020 US Presidential Election." Accessed September 10, 2022. *https://www.idea.int/sites/default/files/multimedia_reports/impact-of-covid19-on-the-2020-us-presidential-lections-en.pdf*. 1.

Every level of society has been negatively impacted by the COVID-19 pandemic. The elderly and those who are immunocompromised are most affected by the disease's physical effects, which include high rates of morbidity and mortality. As COVID-19 progressed, the emphasis diverged from the effects on health and towards an economic viewpoint. Global supply chains were disrupted as the outbreak was primarily central to China in the beginning, causing widespread economic turmoil. National governments have introduced social distancing policies in an effort to substantially lower transmission rates, flatten the infection curve, and lessen the burden on already overburdened healthcare systems. Local businesses have been forced to shut down for extended periods of time, consumption patterns have been altered, and unemployment rates have reached all-time highs as a result of the mandatory social distance standards. A simultaneous recession was caused by the combined impacts, which only amplified existing global issues.

Lockdowns and other once widely accepted public health measures were faced with pandemic fatigue as the new policy image centred on the economy replaced the earlier emphasis on public health. The pandemic tiredness symptoms increased for the millions of people affected by the preventative health measures implemented by governments, as some Member States' actions lasted more than a year. When it came to pandemic preparedness and response, WHO faced significant political opposition from the public, national governments, and experts. This reopened the discussion about further

implementing improvements to the organisation's current management and programmes.

To assess WHO operations and provide evidence-based recommendations for future policies, independent committees including the Independent Panel for Pandemic Preparedness and Response (IPPPR) and the Independent Oversight and Advisory Committee (IOAC) were established.[250] The recommendations formulated in response to the COVID-19 issue often build on the knowledge gained from dealing with other public health emergencies like SARS and MERS. The World Health Emergencies Programme (WHEP), the revised IHR that was implemented in 2005, and improved governance procedures are examples of how these proposals have been implemented. Because of this, WHO was able to use the appropriate response models while modifying them to fit the unique characteristics of the novel coronavirus.

The IHR provides a solid framework for pandemic preparedness, but there have consistently been problems with the promptness of the WHO response system—or lack thereof, for which Member States are also held accountable. This weakness was also critiqued by the IPPPR, which found that the methods followed were far too slow to ever generate the appropriate and

[250] Müller, Gustavo, Melanie Ruelens, and Jan Wouters. 2021. "The Role of the World Health Organization in the COVID-19 Pandemic." Accessed September 5, 2022. https://ghum.kuleuven.be/ggs/documents/final-metaforum-research-report-7-12-21.pdf. 66.

preventative responses to deal with the quickly spreading respiratory virus.[251] This has repeatedly been cited as a reason to initiate new changes to the existing IHR, as Grayling's private surveys of external stakeholders and WHO staff members in 2012 and 2015 revealed.

The Wuhan epidemic sufficiently met the requirements for declaration of a PHEIC when the first meeting of the IHR EC was held, the IPPPR said after analysing the management of COVID-19.[252] Regarding the alert, verification, and notification processes that are a part of the IHR, the IPPPR discovered a key point of system failure. The IHR's warning system imposes a significant notification lag since data must first be methodically sent through national government systems before WHO is notified.[253] Once more, issues related to bureaucratic red tape can be linked to the COVID-19 case as witnessed with the smallpox and SARS outbreaks.

The slow response reveals a lack of coordination with erratic or non-existent plans of action, and the respective governments' decision-making procedures drastically undervalue science. Leaders' dismissal of the opportunity to develop coherent plans aimed at preventing local transmissions by undervaluing scientific facts is another example of poor leadership.

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[251] World Health Organization. 2021. *WHO's Work in Health Emergencies. Strengthening Preparedness for Health Emergencies: Implementation of the International Health Regulations (2005*). Geneva: World Health Organization. 17.

[252] World Health Organization. 2021. *WHO's Work in Health Emergencies. Strengthening Preparedness for Health Emergencies: Implementation of the International Health Regulations (2005*). Geneva: World Health Organization. 17

[253] The Independent Panel for Pandemic Preparedness and Response. 2021. "COVID-19: Make It the Last Pandemic." Accessed September 10, 2022. https://theindependentpanel.org/wp-content/uploads/2021/05/COVID-19-Make-it-the-Last-Pandemic_final.pdf. 52.

Examples of such poor leadership were demonstrated in those nations with capable infrastructure, but greater rates of illnesses and fatalities resulting from disorganised and tardy approaches. As a result, the IHR has assumed its broader emergency responsibilities as the primary institutional hub of the response, outside the purview of the Regulations, which may cause them to lose focus on their primary responsibilities.

Although some States voluntarily choose to disregard the temporary recommendations, other States were failing to take the essential actions with inefficient responses and an absence of preparedness because they lacked the fundamental capabilities to stop the spread of illness. Lack of accountability can only lead to repeating subpar results as another epidemic approaches, given national governments are the major duty-bearers for pandemic responses. This may be a result of WHO's poor governance practises, as addressing governance problems ultimately resolves and averts a health sector crisis. Both the current COVID-19 pandemic and earlier health emergencies have demonstrated implementation challenges, which have time and time again tested the WHO's ability to manage a pandemic of this magnitude.

Gian Luca Burci, a former WHO legal advisor, reminds us that the IHR are not meant to guide global response to a pandemic of the scope and complexity of COVID-19.[254] They were created to prevent catastrophes of this magnitude, lower the risk of an uncontrolled spread, and prevent the

[254] Burci, Gian Luca. 2020. "The Legal Response to Pandemics." *Journal of International Humanitarian Legal Studies* 11 (2): 204-217. https://doi.org/10.1163/18781527-01102003. 216.

subsequent collapse of multilateral governance.[255] In other words, the IHR should be the first line of defence against potential global disease transmission rather than the only response to emergent crises. To ensure the programme's success, cooperation must supplement these already-in place safeguards.

The "wait and see" attitude that many other Member States had for the month that followed the official PHEIC declaration was another factor that worsened the pandemic's intensity.[256] Although the WHO encouraged Member States to develop robust containment tactics, they were not put into action right away. Despite the fact that the WHO's recommendations are produced with the interests of all States in mind, they are not entirely universal in the sense that they cannot be swiftly and seamlessly implemented at the national level. Sufficient support for health and non-health measures to identify, prevent, and respond in accordance with the IHR must be provided by adequate national legislation.

Reluctance to implement WHO's aggressive containment policy is assumed to be a result of Member States' worries about economic decline in favour of their own national interests, a situation that gravely jeopardises collective security.[257] This has sparked discussion that calls for the development of a PHEIC declaration system that goes beyond its binary structure by

[255] Ibid.
[256] The Independent Panel for Pandemic Preparedness and Response. 2021. "COVID-19: Make It the Last Pandemic." Accessed September 10, 2022. https://theindependentpanel.org/wp-content/uploads/2021/05/COVID-19-Make-it-the-Last-Pandemic_final.pdf. 29.
[257] Ibid, 12.

implementing various stages that correspond to tiers of severity.[258] This modification to the existing method would shorten the period of inaction by Member States in the "wait and see" time frame.

Policy stream

The IPPPR recommended a pandemic Framework Convention in an effort to close the existing gaps in WHO's pandemic preparedness and response and rigidity of the IHR.[259] The framework convention would complement present mechanisms rather than replacing the IHR as it is now. Article 19 of the WHO Constitution is to facilitate the framework convention to involve the highest echelons of government and specialists from civil society and scientific disciplines.[260] The IPPPR advises Heads of State and Government to adopt political declarations during Special Sessions of the UN General Assembly.[261] As these actors appoint the national pandemic coordinators who are subsequently given the authority and mandate to lead whole-of-government coordination to conduct a pandemic preparation response, heads of state and government are targeted. Through these joint public pledges of commitment to

[258] World Health Organization. 2022. *Report of the Third Open Meeting of the Review Committee on the Functioning of the International Health Regulations (2005) During the COVID-19 Response.* Geneva: World Health Organization. 2.
[259] The Independent Panel for Pandemic Preparedness and Response. 2021. "COVID-19: Make It the Last Pandemic." Accessed September 10, 2022. https://theindependentpanel.org/wp-content/uploads/2021/05/COVID-19-Make-it-the-Last-Pandemic_final.pdf. 46-47.
[260] World Health Organization. 1989. *Constitution*. Geneva: World Health Organization. 7.
[261] The Independent Panel for Pandemic Preparedness and Response. 2021. "COVID-19: Make It the Last Pandemic." Accessed September 10, 2022. https://theindependentpanel.org/wp-content/uploads/2021/05/COVID-19-Make-it-the-Last-Pandemic_final.pdf. 47.

the initiative, it will be made sure that present pandemic preparation responses are converted for potential future outbreaks. At the 74th WHA, consensus was reached.[262]

The IHR should therefore carry out their duty as a first line of defence against the health threat, as described by Burci, albeit not fulfilling a purpose of completely resolving the pandemic. The concurrent COVID-19 and monkeypox epidemics have once again highlighted the impracticality of the IHR's binary alert system and raised the need for regulatory reform among various State and non-State entities. Since earlier outbreaks, it has been repeatedly advocated that there should be a tiered or graded system of intermediate degrees of alert since a health emergency could lead to pre-emptive guidance or solutions. The necessity for a tiered PHEIC system has been raised by several sources, including the IPPPR itself, due to the ambiguity that the all-or-nothing binary alarm system creates.[263] The WHO was also urged by the IHR EC to look into the idea of developing a level of warning that would fall between the current binary alert system and would not necessitate the IHR's resolution to go back to the negotiating table.[264]

At the request of Member States and in line with Article 50 of the IHR, the Review Committee on the functioning of the IHR during the COVID-19

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[262] World Health Organization. 2021. *Special Session of the World Health Assembly to Consider Developing a WHO Convention, Agreement or Other International Instrument on Pandemic Preparedness and Response.* Geneva: World Health Organization. 1.
[263] World Health Organization. 2022. *Report of the Third Open Meeting of the Review Committee on the Functioning of the International Health Regulations (2005) During the COVID-19 Response.* Geneva: World Health Organization. 3.
[264] Ibid.

response was convened by the WHO DG on 8 September 2020.[265] The Review Committee on the Functioning of the International Health Regulations during the COVID-19 response conducted work through four subgroups being, preparedness, alert, response, and governance.[266] A total of 40 recommendations in 10 areas were made to strengthen implementation of the IHR in April, 2021.[267] It was suggested that WHO monitor and record how well each country complies with IHR criteria for information sharing and verification requests in order to address issues of non-compliance. The WHO's yearly report for the WHA on the implementation of IHR is expected to include these findings.

To assess, report on, and improve compliance with IHR requirements, and to ensure accountability for the IHR obligations through a multisectoral and whole-of-government approach, WHO should collaborate with States Parties and pertinent stakeholders to develop and implement a universal periodic review mechanism.[268] Incentives for States to uphold duties in relation to WHO travel recommendations that were contentious among Member States required further investigation. They recognised the necessity to clearly explore the applicability of an intermediate level of alert to avoid a PHEIC, as well as

[265] World Health Organization. 2021. *WHO's Work in Health Emergencies. Strengthening Preparedness for Health Emergencies: Implementation of the International Health Regulations (2005*). Geneva: World Health Organization. 9.
[266] Ibid.
[267] Ibid, 7.
[268] Ibid, 16.

potential ways to implement it.[269] The PHEIC system reform suggestions made by various academics are listed in the table below.

Table 2. PHEIC reform recommendations.

Scholars	Level 1	Level 2	Level 3
Durrheim, Gostin and Moodley (2020)[270]	"Level 1 PHEIC alert should indicate a high-risk outbreak in a single country, with the potential for international spread requiring concerted public health efforts to contain and manage it locally."	"Level 2 PHEIC should imply that multiple countries have had importations and that limited spread has occurred in those countries."	"Level 3 PHEIC would indicate large clusters in multiple countries, with evidence of ongoing local transmission."

[269] World Health Organization. 2022. *Report of the Third Open Meeting of the Review Committee on the Functioning of the International Health Regulations (2005) During the COVID-19 Response.* Geneva: World Health Organization. 2.
[270] Durrheim, David N., Laurence O. Gostin, and Keymanthri Moodley. 2020. "When Does a Major Outbreak Become a Public Health Emergency of International Concern?" *The Lancet Infectious Diseases* 20 (8): 887-889. https://doi.org/10.1016/s1473-3099(20)30401-1. 888.

The emergency committee advised that a new World Alert and Response Notice (WARN) system should be developed to inform countries of the necessary actions to take in response to the event as soon as possible to prevent escalation into a global crisis in the cases where events do not meet the criteria for a PHEIC but require urgent escalation of a public health response.[271]

Politics stream

Due to endogenous and exogenous factors such as high levels of politicisation of decision-making procedures and an excessive devotion to national sovereignty, the actions of WHO under the scope of the IHR were profoundly impacted by the problems inherent to global governance.[272] The COVID-19 response was largely hampered due to global geopolitical and normative contexts. Conflicts of interest are inevitable during decision-making procedures, usually caused by exogenous factors and differences in ideologies, carrying high stake costs especially during time sensitive issues. However, the severity of the problem was heightened owing to the ongoing political conflict between the United States and China. This political rivalry and lack of cooperation played a significant role in the politicisation of policy responses,

[271] World Health Organization. 2021. *WHO's Work in Health Emergencies. Strengthening Preparedness for Health Emergencies: Implementation of the International Health Regulations (2005*). Geneva: World Health Organization. 14.
[272] Müller, Gustavo, Melanie Ruelens, and Jan Wouters. 2021. "The Role of the World Health Organization in the COVID-19 Pandemic." Accessed September 5, 2022. https://ghum.kuleuven.be/ggs/documents/final-metaforum-research-report-7-12-21.pdf. 6.

hindering WHO's leadership as well as causing delays to WHO led investigations in outbreak ridden regions.

The COVID-19 response was inevitably delayed due to Member States' focus on their own national interests, where WHO guidelines and actions were at risk of being used as a scapegoat for domestically focused Member States' shortcomings.[273] The greatest obstacle to any kind of success for rapid disease containment is Member States' repeated behaviour in non-adherence to the IHR obligations from one health crisis to another, which is greater than the limitations of geopolitics. Although the characteristics of the COVID-19 disease was unfavourable, ill-preparedness due to non-compliance to the IHR time and time again ultimately led to the failure of successful and rapid containment of COVID-19. This in turn increased the intensity at which State Parties diverged from WHO recommendations aimed at collective security to pursue one's own national interest.

The overt manifestation of one's national interest made it abundantly clear that, despite Member States' interests in working with WHO to jointly combat COVID-19, one's own state will always come first when it comes to ensuring national security, such as through equitable vaccine distribution or border closures. Member States desiring to withhold a certain level of control and sovereignty impairs WHO's ability to take functional action during an outbreak like COVID-19. The convergence and alignment of national interest to

[273] Ibid, 5.

secure collective security amongst Member States of WHO is declining as witnessed throughout the COVID-19 pandemic.

Successes and failures of COVID-19

Throughout the COVID-19 pandemic, a number of successes were achieved. The WHO's expertise in science and evidence-based research significantly benefited studies in vaccine development through collaboration with Member States external stakeholders. The WHA examined the possibility of pursuing a tiered approach to the current binary PHEIC alert system, which had been identified as a key vulnerability of WHO's pandemic response in the IHR. Member States have been observed aiding other Member States who are experiencing difficulty controlling disease through the provision of vaccines and personal protective equipment.

Despite WHO having made considerable advancements over the years, the organisation's competence in some areas is still threatened due to the ever-expanding global health issues. The organisation faces new difficulties from emerging risks in which present measures are revealing blind spots and gaps that require improvement to effectively prepare for the next global health emergency, with the areas of concern frequently resurfacing. COVID-19 may serve as another wake-up call for the WHO by acknowledging several reform prospects that necessitate additional time for discussion and execution. Many of the endogenous and exogenous issues that hindered containment of the

COVID-19 disease may be addressed and remedied through sincere reform initiatives and strong international commitment.

Inevitably, problems explicated by the Garbage Can Model and exogenous factors like bureaucratic red tape, non-compliance, and lack of preparedness will affect WHO's ability to determine policy priorities and make decisions, protracting a global health emergency.[274] Political considerations and the unfavourable qualities of the disease such as high transmissibility and pre-symptomatic and asymptomatic transmission also contributed to the COVID-19 pandemic's difficulties.[275] However, given its knowledge of such recurrent behaviour, WHO should take appropriate action to address these issues, putting particular emphasis on the long-term consequences. Reform initiatives should concentrate on strengthening WHO's authority rather than expanding the already crowded global governance environment with new organisations and protocols. Lessons learned can aid in improving public health landscape and preventing a global catastrophe like the one that COVID-19 has caused.

The COVID-19 pandemic cannot be used to fairly assess the effectiveness of the management of the pandemic due to the different timeframes in which containment was achieved with the smallpox epidemic. However, the degree to

[274] World Health Organization. 2021. *WHO's Work in Health Emergencies. Strengthening Preparedness for Health Emergencies: Implementation of the International Health Regulations (2005*). Geneva: World Health Organization. 10.
[275] Wilder-Smith, A., Chiew, C., & Lee, V. 2020. "Can We Contain the COVID-19 Outbreak with the Same Measures as for SARS?" *The Lancet Infectious Diseases* 20 (5): E102-E107. https://doi.org/10.1016/S1473-3099(20)30129-8. E102.

which COVID-19 has escalated is unacceptable given the numerous public health challenges that WHO has dealt with and the several reform resolutions that have been encountered. In other words, due to exogenous variables that are primarily outside WHO's control, the management of COVID-19 was predestined to fail.

Chapter VI: Conclusion

Over the years, WHO has dealt with a variety of public health emergencies, experiencing both many successes and failures. As John Stuart Mill once said, *"if two or more instances of the phenomenon under investigation have only one circumstance in common, the circumstance in which alone all the instances agree is the cause (or effect) of the given phenomenon."*[276] Upon analysing the smallpox, SARS, and COVID-19 case studies, the three public health crises all reveal an underlying correlating factor that had a substantial impact on the success or failure of policy implementation and eventual containment and eradication of the diseases. These underlying factors which have been reoccurring are the endogenous and exogenous factors that have been reiterated throughout this study.

The independence of the organisation has been severely hampered by endogenous issues, including but not limited to WHO's inadequate finance, which has prevented WHO from fully operating autonomously. Due to its dependence on external funding, WHO is severely constrained in its ability to pursue projects since it runs the risk of having its policy priorities influenced politically in exchange for financial support. Despite being legally binding, Member States consistently fail to follow WHO guidelines. Many have argued that this is because WHO lacks the hard power to enforce its rules through

[276] Mill, John Stuart. 1873. *A System of Logic, Ratiocinative and Inductive, Being a Connected View of the Principles of Evidence, and the Methods of Scientific Investigation*. Third edition. Vol. 1. 2 vols. London: Parker Publishing Company. 454.

sanctions. In essence, this reduces the impact of WHO recommendations and guidelines. Many WHO policies are also thought to be overly broad and general, which causes confusion when conditions are disease specific. Due to fragmented governance and bureaucratic red tape, reform initiatives to strengthen these areas frequently move too slowly and lag behind and unsuitable for the current public health landscape.

Exogenous factors were the main obstacles to the WHO's policies' efficacy and ultimate success in disease containment and eradication. Failure to comply with WHO regulations by Member States seriously undermines WHO's authority and the effectiveness of any policy implementation. Failure to comply resulted from a state's drive to advance its own national interests at the expense of collective security. If Member States felt that WHO regulations were not optimal, they frequently turned to their own solutions to address public health risks. This resulted in issues with late reporting and slowed down WHO's capacity to respond quickly to public health threats. Bureaucratic red tapes once again slowed down efficient and rapid implementation of WHO's policies at the national level. Political interferences such as pandemic politics greatly impinged on the possibility of national interest alignment, derailing WHO from its course. Lack of cooperation and diverging national interests led to several failures, as witnessed with the first SEP and the ongoing COVID-19 pandemic.

The table below represents the convergence and divergence of national interest during the public health crises. When national interests collectively aligned, a convergence would occur, cooperation aiding appropriate policy

implementation and overall success of the WHO programme. When national interests were conflicting, a divergence would occur, leading to difficulties with the WHO programme and preventing its success.

Table 3. Convergence and divergence of national interest.

	Convergence	**Divergence**
Smallpox	X	
SARS	X	
COVID-19		X

Considering other variables, an equitable comparative analysis of the three case studies cannot be made. For example, the smallpox and COVID-19 health crises cannot be equally assessed as the timeframes of both crises significantly vary. The characteristics of the diseases differ, where COVID-19 (SARS-Cov-2) saw much faster transmissibility rates as opposed to the SARS virus. Additionally, the COVID-19 pandemic is still unfolding, making the drawn conclusions inconclusive. The general conclusion is that no matter how many reforms the WHO makes, they can never fully achieve their goals unless Member States cooperate to advance collective security.

WHO continues to remain pivotal as today's global health leader within the public health landscape. However, issues challenging the effectiveness and

success of WHO programmes have been recurring as demonstrated by the three case studies. Exogenous issues such as Member States divergence from the collective fight against health threats to pursue national interest was the greatest hindrance to WHO programmes and attaining collective security. As WHO's legally binding regulations are not met with full compliance from Member States, collective security cannot be attained to pursue the common goal.

As Member States political interests will repeat the cycle of non-compliance, there is a need for an introduction of harsher consequences to penalise Member States for non-compliance. However, the success of WHO programmes are not attained purely by collective interest alone. Current WHO pandemic preparedness responses need to be revised to strengthen the weaknesses revealed by the COVID-19 pandemic such as the PHEIC alert system to increase clarity for Member States. Reformed policies coupled with the convergence national interest will create a synergy that will best prepare WHO for the next public health crisis management and response.

Further study should continue to follow-up with up-to-date COVID-19 resources to help draw an equitable conclusion.

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국문 초록

본 논문은 천연두, 사스, COVID-19 보건 위기에 걸친 세계보건기구(이하 WHO)의 정책 의제 설정 및 의사 결정 과정을 분석하는 질적 비교 사례 연구입니다. 이 연구는 내생적 요인과 외생적 요인이 WHO 의 정책과 선택에 미치는 영향을 이해하기 위해 The Garbage Can Model of Organization Choice 와 The Multiple Streams Framework 를 사용했습니다. 이러한 발견은 WHO 가 주도하는 프로그램의 성과에 기여하거나 저해하는 요인을 결정하기 위해 개혁 이니셔티브와 결합되었습니다. 세 가지 사례 연구의 결과는 회원국들이 법적 구속력이 있는 WHO 규정을 준수하지 않는 것이 수많은 WHO 프로그램의 실패를 초래한 반복적인 외생적 문제였음을 보여줍니다. 이것은 회원국들이 규정을 준수하지 않은 것에 대해 직접적인 처벌을 받지 않기 때문에 건강 위기 전반에 걸쳐 반복되는 패턴입니다. 미준수의 이유는 WHO 와 회원국의 이해관계가 달랐고, 국익을 추구하기 위해 집단 안보를 포기하기로 한 결정은 사회경제적, 정치적 요인에 의해 동기 부여되었습니다. 성공적인 질병 퇴치는 국익이 수렴되고 개혁된 프로그램 정책에 의해 지원될 때 달성되었습니다.

주제어: 세계보건기구, 정책 의제 설정, 의사 결정, 천연두, 사스, COVID-19

학생 번호: 2020-21170

Acknowledgments

I would like to sincerely express my utmost gratitude to my advisor Professor Sheen Seong-Ho. Your patience, generosity, and caring demeanour throughout my time at Seoul National University has helped me immensely. To my thesis committee Chair, Professor Koo Min Gyo of GSPA. I thank you for all your helpful feedback and guidance. Your hardworking ethic coupled with your uplifting demeanour has considerably inspired me. To my Vice Chair, Professor Erik Mobrand. I thank you for your helpful feedback despite being in another time zone. Your teachings helped me understand my roots, and I carry that knowledge with me for the rest of my life.

To my colleagues Kevin and Mathew. I want to express my gratitude to you both for your endless support, thoughtfulness, and words of support whenever I have needed them. I appreciate your generosity more than either of you could ever know.

To my parents. Your unwavering support and confidence in me have shaped who I am today. You most likely have no idea what I covered in this thesis, but your encouragement allowed me to persevere all the way to the end.

Ha Eun (Helen) Lee