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WHO's to blame? The World Health Organization and the 2014 Ebola outbreak in West Africa

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ABSTRACT

Since 2001 the World Health Organization (WHO) has been actively promoting its credentials for managing 'global health security'. However, the organisation's initial response to the 2014 Ebola outbreak in West Africa has attracted significant criticism, even prompting calls for its dissolution and the creation of a new global health agency. Drawing on principal–agent theory and insights from previous disease outbreaks, this article examines what went wrong, the extent to which the organisation can be held to account, and what this means for the WHO's global health security mandate.

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Introduction

Since May 2001 the secretariat of the World Health Organization (WHO) has promoted its ability to manage global health security, which it subsequently defined as 'the activities required, both proactive and reactive, to minimize vulnerability to acute public health events that endanger the collective health of populations living across geographical regions and international boundaries'.¹ Yet, whereas the organisation's response to the 2003 Severe Acute Respiratory Syndrome (SARS) outbreak was seen as efficient, competent and effective, the WHO's management of the 2009 H1N1 pandemic and of the 2014 outbreak of Ebola Virus Disease (EVD) in West Africa has been perceived as inept, dysfunctional, even shambolic. Indeed, so poorly has the organisation's handling of these global health crises been viewed that each public health emergency of international concern (PHEIC) has spurred several independent external reviews of the organisation's performance. Every review has subsequently concluded that there is an urgent need to reform the organisation.

These events are understandably disconcerting, and on the surface would suggest that the WHO has been shirking its delegated responsibilities, exhibiting a type of dysfunctional behaviour often attributed to international organisations (IOs).² But has it? This article interrogates the WHO's management of the 2014 EVD outbreak from March to September 2014 in an attempt to evaluate whether the IO's initial response to the crisis was appropriate and reasonable, and whether the criticisms that have emerged are justified. To accomplish this

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task the article explores, first, the WHO's constitutional obligations and customary practice in managing global health security before, second, comparing the organisation's handling of the 2014 EVD epidemic with its handling of previous outbreaks. What this analysis reveals is that, while mistakes were clearly made, criticisms that the secretariat was remiss in its initial response are somewhat misguided when taking account of previous outbreaks and of the IO's customary practice. Moreover, the investigation reveals that there are far more fundamental issues at stake which – if left unaddressed – will continue to impede the WHO's ability to fulfil its delegated responsibilities. The article then concludes by considering what this event signifies for the future of the WHO and global health security.

WHO's evolving authority to control and eradicate disease outbreaks

The WHO was created in 1948 with the overall objective of improving the health of all populations worldwide. Within this, the containment and eradication of infectious diseases was considered to be the IO's primary task, and the organisation was imbued with considerable authority and autonomy to pursue this goal.³ The priority attached to this specific function reflected the postwar world-view, which regarded good health as a precondition for international peace and security.⁴ Health was essential for security; and as infectious diseases were recognised to adversely affect not only the health of populations but also the global economy, by disrupting international trade, great weight was attached to preventing their spread. The WHO, which had been established to serve as the 'directing and coordinating authority' in all international health matters,⁵ was thus tasked with seeking to eliminate infectious diseases wherever they arose.

To give effect to this mandate, and in a classic example of principal–agent (PA) delegation,⁶ several specific powers were conferred upon the organisation. These notably included the authority to: (1) adopt regulations pertaining to sanitary and quarantine measures that – if two-thirds of member states agree – are automatically binding on all governments; (2) designate disease and public health-related nomenclatures; and (3) pass emergency powers that, once enacted, allow the director-general to use every available resource at the organisation's disposal to respond to any event requiring 'immediate action.'⁷ The WHO's member states also ensured that the organisation soon exercised this new found authority, adopting the International Sanitary Regulations in 1951 and launching the first global eradication programme targeting malaria in 1958.

Over time and based on a number of eradication initiatives the organisation developed a standard approach to managing disease outbreaks, one characterised by collating epidemic intelligence and issuing policy advice. Importantly, however, following the prominent failure of the malaria eradication programme, the secretariat fastidiously refrained from even the appearance of instructing governments on the precise measures they should take to eradicate or control diseases. Instead the WHO secretariat consistently demurred, proffering advice derived from expert consensus and coordinating efforts only where it had been explicitly invited to do so. This standard, or classical, approach to disease eradication typified the WHO secretariat's efforts throughout the remainder of the 20th century, and demonstrated that the IO had developed a customary practice towards fulfilling its obligations.⁸

Perhaps more significantly member states were broadly content with the WHO's classical approach, and robustly resisted any perceived IO autonomy or mission creep. This was most clearly exemplified by the WHO director-general Marcolino Candau's decision in 1970 to

report an outbreak of cholera underway in Guinea, despite the fact that the Guinean government had not officially notified the secretariat of the event. Although the director-general maintained that he took this action 'in order to fulfil the Organization's obligations under Article 2 of the WHO Constitution',⁹ member states reacted swiftly in condemning his breach of the now renamed and updated 1969 International Health (formerly Sanitary) Regulations (IHR), which required government notification before publicly disseminating any alert.¹⁰ This one incident had a notable impact on the secretariat – including on the publicly chastised director-general – for it revealed very clearly that governments would not tolerate infringement of their sovereignty.

In 2003 the emergence of a novel pathogen in the form of SARS aided the WHO secretariat in establishing a new approach to global health security. By the end of the 20th century, confronted by the emergence of new diseases like HIV/AIDS, the resurgence of new and resistant forms of disease such as multi-drug-resistant tuberculosis and the threat of biological weapons, governments increasingly appreciated that the WHO's former methods of coordinating disease outbreaks were no longer fit for purpose. The IHR, which formed an integral part of the IO's delegation contract with member states, were identified to be in urgent need of reform. Even so, several delays were encountered,¹¹ and before the IHR revisions could be completed the SARS-associated coronavirus spread internationally to cause over 700 deaths and economic damage of over US\$30 billion.¹² Among governments the SARS experience became widely regarded as a timely 'wake-up call'; thus the WHO secretariat was encouraged to redouble its efforts to finalise the IHR revisions.

The updated IHR framework was adopted by the 58th World Health Assembly (WHA) in 2005, and officially entered into force in June 2007. Under the terms of the IHR 2005 member states tasked themselves with developing national disease surveillance and response capacities to prevent the international spread of disease, while instructing the WHO to provide technical support to those countries struggling to meet these requirements. In addition, new powers were conferred upon the secretariat to utilise non-government sources of information to detect disease outbreaks, and to 'name and shame' countries that refused assistance or attempted to cover up public health risks.

At the same time, however, member states also ensured new checks and balances were placed on the WHO to prevent a repeat of what some viewed as unmitigated autonomy by the secretariat throughout the SARS epidemic, particularly with regard to issuing travel advisories that might cause economic damage. These new measures included, among others, the explicit requirement for the director-general to convene an emergency committee for expert advice before declaring a PHEIC or recommending measures (such as travel advisories). While the director-general may select specific individuals to serve on an emergency committee, s/he may only choose from a roster of experts nominated by member states. This conceivably opens the committee to political interference; and although the director-general is only obligated to consider the committee's advice, it is nevertheless difficult to envisage a situation in which the director-general would dismiss such advice without having his or her own legitimacy publicly questioned. Thus, while in many respects the WHO secretariat's authority to eradicate diseases was refreshed for the conditions of a highly interconnected, globalised world, the organisation's principals also guaranteed that there were limits to the secretariat's autonomy that prevented their agent from becoming too independent or powerful.

In 2009 the revised IHR 2005 framework was put to its inaugural test with the emergence of a novel strain of influenza A(H1N1), which achieved effective human-to-human transmission, sparking the first pandemic of the 21st century. This event also proved to be a critical test of the WHO secretariat, one that many commentators subsequently concluded it failed. Indeed, the organisation's handling of the crisis sparked considerable controversy, resulting in at least three independent investigations. Although all three reviews had ultimately concluded by 2011 that the organisation's integrity had not been compromised, they nevertheless each recommended a series of measures designed to strengthen both member states' and the WHO secretariat's capacities for managing the next PHEIC more effectively. Regrettably, by 2014 when the West African EVD outbreak was identified, only limited progress had been made in implementing the measures and many of the recommendations remained unaddressed.

WHO responds to the 2014 EVD outbreak in West Africa

An outbreak of EVD was officially declared to be underway in Guinea on 23 March 2014.¹³ By this time, however, the virus had already been circulating undetected for some three months and, as a result, had spread across border regions into neighbouring Liberia and Sierra Leone. Initially suspected to be Lassa Fever, within hours of confirming that the etiological agent was Ebola, the WHO secretariat in Geneva mobilised a response team via the Global Outbreak Alert and Response Network (GOARN) to deploy to Guinea to assist local health authorities. The secretariat also alerted Liberian and Sierra Leonean health officials to commence surveillance. On 27 March 2014 both Liberia and Sierra Leone confirmed that they had identified a small number of suspected EVD cases;¹⁴ and within 72 hours laboratory testing verified that cases had indeed appeared in Liberia.¹⁵ The GOARN team, which had arrived in Guinea on 28 March 2014, immediately began an assessment of local conditions and then presented these findings at a press conference in Geneva on 8 April 2014. At the briefing it was noted by WHO officials that the outbreak underway in Guinea was 'one of the most challenging Ebola outbreaks that we have ever faced'.¹⁶ Yet, even as the weeks progressed and additional suspected cases were reported in Liberia, Sierra Leone and Mali,¹⁷ significant concerns were not raised by the secretariat in Geneva until late June 2014.

Having said this, it would be erroneous to suggest – as some have – that the WHO secretariat did nothing. Throughout April 2014, for instance, the organisation continued to mobilise technical support and resources to assist the affected countries. As a result, by 7 May 2014 some 113 technical experts had been deployed to assist the health authorities in Guinea (88), Liberia (23), Sierra Leone (1) and the WHO African regional office (AFRO).¹⁸ Moreover, the expertise deployed represented a wide array of skill sets, including coordination, surveillance and epidemiology, infection prevention and control, clinical case management, anthropology, logistics, laboratory services, risk communication, social mobilisation, finance, health informatics, and resource mobilisation. These were drawn from partner organisations and recruited via the WHO's surge capacity mechanisms. Thus, while the WHO's response was extensively criticised by Médecins Sans Frontières (MSF) for its perceived lack of action throughout this period,¹⁹ given that the number of suspected cases and deaths were consistent with the size of previous EVD outbreaks in other parts of Africa,²⁰ it would be improper to suggest that the WHO secretariat had been negligent.

Indeed, it seems only reasonable that, when evaluating the WHO secretariat's initial reaction to the 2014 EVD outbreak, the IO's actions are also compared against previous outbreaks. In this regard it is important to note that in the immediate decade preceding the 2014 epidemic, the WHO had received reports of a total of nine EVD outbreaks – four in the Democratic Republic of Congo (DRC), four in Uganda and one outbreak of Ebola Reston Virus in the Philippines.²¹ Critically, however, with the exception of the 2007 DRC outbreak, which even necessitated deployment of UN peacekeepers to provide logistical support as a result of the size of the outbreak,²² the WHO secretariat had previously sent very limited numbers of personnel to countries affected by Ebola. In fact, from all the available evidence it appears that the WHO secretariat has, on average, only ever dispatched between two and five technical experts for each EVD outbreak over the previous 10 years.²³

That the WHO secretariat has only ever deployed very modest numbers of technical experts is understandable when recalling that the IO was never intended to be a 'first responder' agency, but rather the 'directing and coordinating authority' in international health. Its primary task has always been to coordinate, only assisting governments upon request. In this respect the IO's 'arm's length' approach to fulfilling its delegated functions is not a modern phenomenon, as Frank Gutteridge's observations in 1963 demonstrate: 'Although it possesses...wider scope and powers than its predecessors, the World Health Organization remains without any direct authority over its Members. Thus it may advise, assist, co-ordinate and recommend, but it is not enabled to legislate or execute.'²⁴ Even after SARS acutely demonstrated the need for a new approach, governments have consistently resisted attempts to expand the IO's staffing levels to one that might enable the secretariat to adopt a more operational role. As a result, since its failed malaria eradication programme the WHO has never retained large numbers of staff that can be deployed in emergencies.²⁵ Consistent with the organisation's customary practice, the WHO secretariat's response to previous EVD outbreaks has thus been to draw on networks such as GOARN to gather the requisite expertise to assist national health authorities to lead any operational response.

Given, therefore, that in previous EVD outbreaks the number of personnel mobilised by the WHO has consistently been between two and five persons, the fact that the secretariat had deployed 113 experts to West Africa within six weeks of the outbreak being confirmed suggests that the IO's initial response was at least reasonable and arguably defensible. However, confusion over the outbreak was then further compounded in mid-May 2014, when all epidemiological indicators suggested that the EVD outbreak, which was primarily still concentrated in Guinea,²⁶ might be nearing its end. This perception was reinforced at the 67th WHA in May 2014 when the Guinean Minister for Health reported that the outbreak in his country was 'yielding very encouraging results' and was now essentially under control.²⁷ In these circumstances it can be appreciated that the secretariat in Geneva believed it had acted appropriately and proportionately to the Ebola crisis. Of course, in hindsight it is now clear that the sense of security was misplaced, for immediately after the 67th WHA Sierra Leone notified the WHO of 16 either suspected or confirmed EVD cases that proved to be the first of thousands.²⁸

By mid-June 2014 a very different epidemiological picture was emerging, and it was at this juncture the flaws in the WHO secretariat's management of the crisis especially materialised. Between 28 May and 10 June 2014, for instance, Guinea and Sierra Leone recorded some 150 new infections, bringing the cumulative total to 440 suspected or confirmed EVD cases. The rise in cases so alarmed some officials in AFRO that they contacted the secretariat

in Geneva recommending a PHEIC be declared, but the response they received discouraged invoking the IHR 2005, suggesting a declaration of that nature would only damage relations with the affected countries.²⁹ By 17 June the cumulative number of cases throughout the region had risen again, to 528 suspected or confirmed cases, with Liberia reporting nine new suspected cases and five deaths – the first since April earlier that year.³⁰ Reacting to this news the AFRO convened a high-level meeting on 23 June 2014 in Conakry with the Guinean president, the US ambassador to Guinea, WHO officials, and representatives from the Centers for Disease Control and Prevention (CDC), while in Geneva the GOARN steering committee met to review the situation.³¹ The conclusion these meetings drew was that the WHO needed to take greater control of the response. Thus on 27 June 2014 the WHO director-general was sent a report that outlined the case for more ‘forceful leadership’.³²

By late July 2014, however, beyond a series of additional meetings little further effort had been expended. The director-general, who purportedly assumed personal responsibility for managing the crisis in late June, convened yet another high-level meeting of officials in early July in Ghana, where additional commitments were made from partners that included airlines, mining companies and the African Development Bank to support the outbreak response. Yet, in terms of practical measures, no further steps were taken. This was despite the fact that across the region EVD infections had effectively doubled to almost 1000 suspected or confirmed cases.³³ Somewhat inevitably, therefore, at the same time as a conference was being held in the third week of July to identify the technical and human resources required to contain the virus’s spread, a Liberian man who had contracted EVD boarded a plane for Nigeria, where he subsequently initiated a local outbreak.³⁴ This event understandably alarmed health authorities around the world, prompting the director-general, finally, to invoke the IHR and assemble an emergency committee to review the epidemiological situation and determine whether the conditions for a PHEIC had been reached.

The IHR emergency committee met for the first time via teleconference over two days on 7–8 August 2014 and conveyed to the director-general their assessment that the declaration of a PHEIC was justified. Yet, again, despite the fact that a PHEIC was declared that same day,³⁵ and almost 1800 EVD cases had now been reported,³⁶ few additional measures were implemented to assist those countries affected. On 27 August 2014 the WHO secretariat in Geneva released its ‘Ebola Roadmap’, which outlined various strategies and targets to contain the virus.³⁷ But by this stage public criticisms of the organisation’s response, combined with anxiety about the risk of the virus spreading internationally, had grown to such an extent that plans had already been drawn up to elevate the crisis to the peak UN body – the UN Security Council – while advance teams of foreign military personnel arrived in Liberia and Sierra Leone to begin assessing how international civil–military cooperation might support such efforts.³⁸

At the beginning of September 2014 several organisations, including MSF and the WHO, as well as representatives from the countries worst affected by the outbreak, were invited to New York to brief the UN and world leaders on the Ebola crisis. In an explicit attempt to highlight the severity of the emergency MSF issued an unprecedented call for urgent military intervention, declaring the response to date ‘lethally inadequate’;³⁹ while Liberia’s defence minister opined that the virus was ‘spreading like wild fire and devouring everything in its path’.⁴⁰ In response, the UN Security Council was convened on 15 September 2014 and passed resolution UNSC 2176 authorising the extension of the UN mission to Liberia (UNMIL) by an initial three months (with provision for further extensions) to provide additional support in

containing the virus.⁴¹ This announcement was followed the next day by US President Barack Obama declaring his country's commitment to deploy 3000 military personnel to support affected countries; just two days later on 18 September the UN Security Council passed resolution UNSC 2177 that declared the outbreak a 'threat to international peace and security'.⁴² On the basis of these resolutions Secretary-General Ban Ki-Moon obtained authorisation from the UN General Assembly the following day to create the UN's first-ever public health mission – the United Nations Mission for Ebola Emergency Response (UNMEER) – and tasked the entity with coordinating the international humanitarian response in West Africa.⁴³

So what went wrong and why?

The official launch of UNMEER has been interpreted by many as a stunning admission of the WHO's failure to respond adequately to the EVD crisis.⁴⁴ In October 2014 this perception was reinforced when the unauthorised release of a draft internal review of the WHO's handling of the Ebola outbreak confirmed what many had already suspected: that 'A perfect storm' had been 'brewing, ready to burst open in full force' but that the WHO secretariat had 'failed to see some fairly plain writing on the wall'.⁴⁵ Subsequent international media reports exposed the fact that, despite dire warnings of a growing humanitarian crisis and responder agencies being overwhelmed, senior officials within WHO had resisted calls to invoke the IHR 2005, suggesting such steps would not only be unhelpful but potentially viewed as a 'hostile act'.⁴⁶ As time has progressed, a series of scholarly analyses has added to the litany of critiques calling for the WHO to undergo significant reforms in the wake of the EVD outbreak. World leaders called for the establishment of entirely new global health institutions to prevent a repeat of similar crises in the future and an independent panel established by the WHO director-general released an interim report noting that the IO's response was 'surprising' and that it was 'still unclear... why early warnings, approximately from May through to July 2014, did not result in an effective and adequate response'.⁴⁷

In light of such assessments, elements of the WHO secretariat, including the director-general, periodically attempted to defend the organisation. As early as 3 September 2014, for example, Assistant Director-General for Health Security, Keiji Fukuda, emphasised to international media that WHO did not have 'enough health workers, doctors, nurses, drivers, and contact tracers' to manage the high numbers of EVD cases.⁴⁸ The following day the director-general emphasised in an interview with a *New York Times* reporter that: 'First and foremost people need to understand WHO. WHO is the UN specialized agency for health. And we are not the first responder. You know, the government has first priority to take care of their people and provide health care'.⁴⁹ Ensuing reports produced by the secretariat have also noted the large number of other humanitarian crises that preceded or were concurrent with the EVD outbreak, pointing to their limited capacity to respond to all emergencies with equal attention.⁵⁰

Even so, the WHO secretariat has acknowledged on several occasions that mistakes were made. For instance, on 4 October 2014 Richard Brennan, director of the IO's emergency risk management department, admitted: 'In retrospect, we could have responded faster. Some of the criticism is appropriate'.⁵¹ This was followed on 25 January 2015 by the special session of the Executive Board to review the Ebola response, where the director-general agreed that the organisation had been 'too slow to see what was unfolding before us', and that the response had revealed several administrative, managerial and technical infrastructure shortcomings.⁵²

At the 68th WHA in May 2015 the director-general went on to outline a series of reforms to address identified failings, including merging departments to create a single programme for responding to health emergencies, helping establish a global emergency health workforce and a \$100 million contingency fund, and expanding the organisation's existing capabilities in emergency management and response.⁵³

Importantly, however, while the majority of attention to date has focused on fixing certain aspects of the WHO secretariat, there are several far more fundamental structural factors that contributed to the IO's inadequate EVD response that are being overlooked. These notably include various financial, cultural, political and design constraints which, in virtually every instance, can be directly traced to the IO's principal-agent relationship with its member states. For instance, in the immediate 12-month period before the EVD outbreak in one department central to the WHO's emergency response capacity the number of staff had been reduced from 90 to 36 persons.⁵⁴ These staffing reductions were admittedly instituted by the secretariat, but they were executed in response to a 51% spending cut by member states in 2013 to the WHO's 'outbreak and crisis response' budget for 2014–15.⁵⁵ In making these staffing reductions the secretariat in Geneva had anticipated that the IO's regional offices, which possess far more autonomy over their finances, would mitigate some of these reductions by increasing their own capacity but, as one senior WHO official observed, 'this didn't happen'.⁵⁶ Faced with such reductions it is likely that any organisation would struggle, but the EVD outbreak placed demands on the organisation that, according to the director-general, were 'more than 10 times greater than ever experienced in the almost 70-year history'.⁵⁷ Worse still, the EVD crisis occurred at a time when the IO was responding to at least three other significant humanitarian emergencies in Syria, South Sudan and the Central African Republic.⁵⁸ The collective decision by member states to reduce the IO's crisis response budget was thus not only ill-timed, but it directly compromised the secretariat's ability to respond to the EVD outbreak.

That said, from the narrative above it is apparent that the internal culture of the WHO secretariat also contributed to shortcomings in the organisation's response. Yet, even here, much of this can be attributed to former conduct of the IO's principals. As mentioned earlier, between March and June 2014 the governments of Liberia, Sierra Leone and Guinea repeatedly downplayed the extent of their respective outbreaks. As early as March 2014, for instance, rumours emerged of large numbers of deaths suspected to be EVD-related occurring in Monrovia,⁵⁹ yet by the end of April the government – whether through negligence or obfuscation – had only ever reported one suspected case within the entire county of Montserrado.⁶⁰ Further, as noted above, the Guinean Minister for Health emphasised at the 67th WHA that his country was seeing tremendous progress in containing the outbreak, with five out of the six foci areas of the epidemic effectively now controlled.⁶¹ This attempt at obfuscation reportedly even persisted to the extent that, when Liberia's president, Ellen Johnson-Sirleaf, later did call for international assistance, the leaders of neighbouring Guinea and Sierra Leone criticised her for doing so.⁶² When the AFRO and specifically its regional director also failed to counter these views,⁶³ it can perhaps be appreciated why the secretariat in Geneva did not adopt an emergency mind-set.

Nevertheless, the WHO secretariat's unwillingness to challenge or gainsay official reports emerging from the affected countries is arguably one of the most damning indictments of the IO's performance. The secretariat's error is made particularly acute when considering the historical record of governments' attempts to conceal disease-related events as a result of

concerns that these may lead to trade and travel sanctions – a practice that, ironically, member states had hoped would be addressed when they commissioned the IHR to be revised. It is thus perplexing that the organisation failed to contest the affected countries' official reports when the poor state of their healthcare systems, and, in particular, the absence of any comprehensive disease surveillance, were well known.

At the same time, whenever the WHO secretariat has publicly challenged governments' official positions or pushed hard to intervene in an event, member states have often responded negatively. It is a pattern of behaviour witnessed many times over, extending from events such as the 1970 cholera outbreak in Guinea that resulted in diplomatic rebukes, to the 2003 SARS outbreak, which culminated in the imposition of new control mechanisms to limit the IO's autonomy. Throughout the IHR negotiations, for example, while many governments initially welcomed the secretariat's rebuke of the Chinese for attempting to cover up the true nature of their SARS outbreak, they subsequently rejected draft proposals to allow the WHO equivalent autonomy to intervene in public health emergencies, emphasising instead the need to protect state sovereignty.⁶⁴ Similarly, in 2009 when the WHO secretariat publicly questioned Russia's decision to ban pork imports over alleged concerns about influenza transmission, Russian bureaucrats reacted by stating: 'Health officials should stick to their own business and not promote the world pork trade.'⁶⁵ These events underscore the precarious position in which the WHO secretariat frequently finds itself. For member states, as the IO's principals, preserve various means to reprimand the secretariat, ranging from immediately ceasing voluntary contributions (which make up the majority of the WHO's budget – see below) to more substantive measures such as altering the IO's design, function and autonomy – a fact the IO remains acutely aware of.

This same dynamic also underlines the broader political challenge confronting the WHO. It must be recalled, for instance, that the 2014 EVD outbreak occurred in an environment in which the secretariat had been extensively accused of 'crying wolf' over its response to the 2009 H1N1 influenza pandemic.⁶⁶ These criticisms essentially revolved around the perception that the pandemic did not turn out to be as severe as first predicted. In this context, when it is recalled how member states reacted in the wake of SARS, the multiple investigations into the WHO's handling of H1N1, and that the organisation's normative reputation remains one of the IO's most powerful tools,⁶⁷ it can be appreciated why the secretariat might have approached the EVD outbreak cautiously, only escalating its discourse and activities when it was apparent that the virus's spread remained uncontrolled. Of course, in hindsight it is also easy to criticise the WHO secretariat for the fact that it judged the situation poorly. Yet, given the above set of circumstances, the difficult line the IO must constantly tread between its principals' sovereignty, public health and significant economic interests when facing crises characterised by pervasive uncertainty, mistruths and obfuscation can at least be understood.

Lastly, in reviewing the WHO's actions it is clear that structural factors related to the IO's design additionally contributed – and arguably exacerbated – its ineffectual response. This was most clearly exemplified in the first months of the response by the disjointed approach taken by the secretariat in Geneva and its regional office, AFRO. As revealed in a leaked internal memo dated 25 March 2014, the AFRO had convened an emergency teleconference the previous day, where the high number of suspected cases and deaths in Guinea and the 'high possibility of cross-border transmission' were noted with concern.⁶⁸ In response, the AFRO secretariat advocated that the regional director declare an 'internal WHO Grade

2 emergency' and establish a *regional* emergency support team to coordinate technical and operational support. This action plan was approved the same day.⁶⁹ Yet by 5 May 2014, whereas the WHO secretariat in Geneva had deployed almost 90 staff to Guinea, only 20 were sent to Liberia, one was dispatched to Sierra Leone and four were sent to the regional office.⁷⁰ This suggests that information and decisions taken at the regional level were not sufficiently communicated to the central office or, if they were, were not acted upon. Sending the bulk of personnel to Guinea also suggests that the Geneva-based secretariat lacked sufficient insight into how the outbreak might unfold and spread to affect neighbouring states, which is rather odd given that the outbreak was known to have started in a region close to international borders and that the poor surveillance capacity of all three countries was well documented. At the same time the AFRO ignored its own standard operating procedures (SOPs) for disease outbreaks which, astonishingly, were released in the very same month the outbreak was detected and which advocated the mobilisation and deployment of expertise within 72 hours of official notification.⁷¹

These events underscore yet again the disjointed nature of the WHO's division into seven organisations (six regional offices and central headquarters) that have long been identified as impeding its effectiveness. Importantly, however, the regional offices, which are separate and largely autonomous from the central headquarters in Geneva, are a result of disagreement over the incorporation of the Pan American Sanitary (later Health) Bureau that dates back to 1946.⁷² Yet, while the regional structure has consistently been identified as a problem in multiple reviews of the IO's functioning for perpetuating a raft of inefficiencies, duplication of services, poor health outcomes and unhelpful infighting,⁷³ governments have resisted calls to significantly reform this element of the WHO's design. Accordingly, it raises the question: are the reforms now being proposed going to address the various structural issues that inhibited the WHO's response to Ebola?

So what happens now?

As revealed at the 68th WHA in May 2015, the WHO director-general is proceeding with a series of proposed reforms designed to prevent a repeat of the organisation's EVD mistakes and strengthen the IO's global health security and emergency response capacities. Among the recommended changes are establishing a global emergency health workforce and a \$100 million replenishable contingency fund that the WHO secretariat can immediately draw upon whenever a PHEIC arises to mobilise resources and personnel. These measures, combined with internal restructuring efforts to streamline and augment the WHO secretariat's emergency response capacity, will arguably go some way to enhancing the IO's overall ability to respond to health emergencies when they arise. In the longer term, however, it remains doubtful that the international community will see any substantive change in the way the organisation responds to future health crises; ultimately, the responsibility for this rests with the IO's principals.

In January 2015, for instance, the WHO director-general observed at the special session of the Executive Board on Ebola that the IHR 2005 clearly needed 'more teeth' if the world was ever to 'reach true health security'.⁷⁴ Yet, although the independent expert panel established in the aftermath of the 2009 H1N1 pandemic also identified this precise issue, viewing it as fundamental to several of the recommendations it produced,⁷⁵ practical proposals for how the IHR 2005 framework might be further strengthened have been few or politically

naive.⁷⁶ In fact, in many respects the exact opposite has now occurred, with member states agreeing to extend the deadline for those countries yet to develop the core capacities to 2019 – seven years beyond the original target date.⁷⁷ Given that the deadline has now been extended once, political pressure on non-compliant governments has been lifted, raising the prospect that these core capacities will never be achieved.

Even more disconcerting is the fact that on two distinct occasions now countries have ignored WHO recommendations and imposed various trade and travel sanctions that contravene the spirit and purpose of the IHR 2005. Throughout the 2009 H1N1 influenza pandemic and again in the 2014 EVD outbreak roughly 40 governments implemented policies and measures that the IO explicitly advised against, purportedly on the basis of wanting to protect themselves from the risk the diseases would spread to their respective territories.⁷⁸ Disappointingly, in both contexts the WHO secretariat under Margaret Chan's leadership selected not to exercise its ability to 'name and shame' these governments; given that no other provision exists within the IHR 2005 to penalise countries that contravene the framework, these governments have eluded reprimand. Crucially, however, preventing such behaviour was one of the fundamental reasons why the IHR revision process was instigated in the first place. These developments thus signal a disturbing trend whereby governments can act with impunity, without fear of retribution, while simultaneously undermining a framework intended to strengthen global health security.

Further, and as noted above, the budgetary restrictions and efficiency savings imposed on the WHO directly contributed to the organisation's poor EVD response. It had been hoped at the beginning of the 68th WHA that member states would reconsider their long-held opposition to increasing their assessed contributions, which have remained unchanged since the 1980s,⁷⁹ thereby allowing the IO greater flexibility and autonomy to reallocate funds to respond to health emergencies. To that end the director-general had put forward a suggestion ahead of the meeting to increase member states' assessed contributions by 5%, which would in turn raise the organisation's overall operational budget by 8%.⁸⁰ Even before the meeting commenced, however, Chan was forced to drop the proposed 5% increase in order to secure broader consensus on raising the overall budget ceiling.⁸¹ By the time the WHA concluded, a budget increase had been approved but with any additional funds to be donated on a voluntarily basis only.⁸² Such a concession does not augur well for the WHO, however, as it fails to provide any surety of financial sustainability and evades entirely the need for the organisation to have greater autonomy around its finances to redeploy them, as the founders intended, for events demanding 'immediate action'.

Alongside the financial circumstances, the second major structural issue that has remained unaddressed in the wake of the EVD crisis is the WHO's division into seven effectively distinct entities. As noted above, the disjuncture between the AFRO and the WHO secretariat in Geneva contributed to delays in how the IO responded throughout the first six months of the EVD outbreak. Yet, while the regional director, Dr Luis Gomes Sambo, was replaced in January 2015,⁸³ the wider structural arrangements have been left untouched. In fact, rather than member states taking up the challenge to reform this system, the director-general has been left to try and integrate services designed to streamline the organisation into 'one WHO'.⁸⁴ Previous attempts by directors general at such realignment have conspicuously failed, however.⁸⁵ Until member states are prepared to collectively intervene and reshape the IO's organisational design the international community is unlikely to see any significant progress in this area.

In the meantime, addressing the cultural factors and the broader political environment in which the WHO secretariat operates entails a far more complex set of problems which, regrettably, are intimately tied to member state behaviour. To see lasting change here, governments would – collectively – have to regulate themselves and be prepared not only to sacrifice a degree of state sovereignty to facilitate a more interventionist role by the IO when PHEICs arise, but also to accept a greater level of uncertainty and avoid knee-jerk reactions when events do not play out as anticipated. Put another way, it would require the IO's principals to collectively agree to relinquish some of their control over their agent, allowing it greater scope and autonomy to act in the interests of global health security. Unfortunately, the prospects of such a fundamental transformation in the PA relationship between the WHO and its member states are currently very remote.

Conclusion

It would be easy, as a number of media commentators and scholars have already done, to blame the WHO for its perceived failure in responding to the Ebola outbreak. Yet, as is often the case in international relations, the picture is rarely, if ever, so clear-cut. As this article has sought to highlight, there are several examples of where the WHO's dysfunction can be clearly and directly attributed to the organisation's customary practices and internal culture. It can be expected that in the coming months, as the various independent investigations, including the UN high-level panel, hand down their findings, much more attention will be paid to the WHO's overall response and, while the above factors are not the only examples of where the IO failed in its delegated duty, they arguably represent some of the most serious, given the IO's global health security mandate.

Equally, however, any reasonable evaluation of the WHO's actions must also take into account the various structural constraints upon the secretariat that contributed to the IO's slow response. The budget cuts and efficiency savings instituted by governments as part of the WHO reform process are part of this, but some culpability must also be accepted by member states for their past opposition to the IO assuming a more proactive, interventionist role. The fact that governments have now finally acted on a four-year-old proposal to establish a \$100 million contingency fund, as well as instructing the director-general to form and coordinate a global emergency health workforce, will arguably serve to strengthen global health security capacities to some extent. But for the people of West Africa, these reforms come too little too late to save the thousands of lives that have been lost as a result of EVD. It also remains decidedly unclear how willing governments are to address some of the wider, more important reforms such as the organisation's design and financial arrangements.

Within this mix the governments of West Africa must also accept some responsibility for not calling for assistance earlier. Indeed, the fact that Liberia's president attracted criticism from the leaders of Guinea and Sierra Leone even after it had become apparent that the virus was wreaking widespread havoc is a damning critique of the political leadership throughout this crisis. Attempts at subterfuge are not uncommon in disease outbreaks. But the EVD crisis once again highlights the desperate need for governments to develop sufficient capacity to detect and verify disease outbreaks, to be open and willing to share that information and, if necessary, call for assistance, whenever a public health crisis with international transmission potential arises. Disappointingly the 2014 EVD outbreak has shown that this lesson is yet

to be learned, which raises the question of what it will take and how many lives will be lost before it is.

Intergovernmental organisations are, by design, answerable to their member states and, as much as it is tempting to single out agencies for their perceived and actual failings, it must also be appreciated that they are ultimately the creations of governments. These governments are also organisations' principals, and possess the ultimate authority over how their agents execute their duties. Accordingly, governments also bear the bulk of responsibility for when IOs – such as the WHO in the context of the Ebola outbreak – fail. It is also the case that, if these organisations are to ever improve, governments must take the lead in reforming them. Time and again, however, it seems such political leadership is intentionally absent.

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Notes

1. WHO, *The World Health Report 2007*, ix.
2. Barnett and Finnemore, *Rules for the World*; and Hawkins et al., "Delegation under Anarchy," 3–38.
3. Kamradt-Scott, *Managing Global Health Security*.
4. Shimkin, "The World Health Organization," 281–283.
5. WHO, "Constitution," Article 2.
6. Kassim and Menon, "The Principal–Agent Approach," 121–139.
7. WHO, "Constitution," Articles 21, 28.
8. Kamradt-Scott, *Managing Global Health Security*, 45–78.
9. WHO, "Cholera," 377.
10. Weir and Mykhalovskiy, *Global Public Health Vigilance*, 75; and Fidler, *SARS, Governance and the Globalization of Disease*, 64–65.

11. Davies et al., *Disease Diplomacy*.
12. WHO, *The World Health Report 2007*, 40.
13. WHO, "Ebola Virus Disease in Guinea, 23 March 2014."
14. WHO, "Ebola Virus Disease in Guinea – Update, 27 March 2014."
15. WHO, "Ebola Virus Disease in Guinea – Update, 30 March 2014"; and WHO, "Ebola Virus Disease in Liberia, 30 March 2014."
16. WHO, "Key Events."
17. AFRO, "Ebola Virus Disease, West Africa (Situation as of 7 April 2014)."
18. AFRO, "Ebola Virus Disease, West Africa (Situation as of 7 May 2014)."
19. Hussain, "Ebola Response of MSF."
20. As of May 7, 2014 the number of confirmed EVD cases in Guinea was 235, including 157 deaths. These numbers were consistent with former outbreaks in locations like Uganda. See CDC, "Ebola Outbreaks 2000–2014."
21. WHO, "Ebola Virus Disease: Disease Outbreak News"; and CDC, "Outbreaks Chronology."
22. WHO, "Ebola Haemorrhagic Fever."
23. This number is derived from systematically reviewing photographic evidence and secretariat reports from WHO teams deployed to EVD outbreaks between 2005 and 2012. However, this excludes the 2007 outbreak in the DRC, which entailed WHO deploying country teams, the African Regional Office and staff from headquarters. See WHO, "Ebola Virus Disease: Disease Outbreak News"
24. Gutteridge, "The World Health Organization," 6–7.
25. Kamradt-Scott, *Managing Global Health Security*, 46–54.
26. By May 15, 2014 only 12 EVD cases and 11 deaths had been recorded. WHO, "Ebola Virus Disease, West Africa – Update, 12 May 2014."
27. WHO, "Key Events."
28. WHO, "Ebola Virus Disease, West Africa – Update, 28 May 2014."
29. "Bungling Ebola."
30. AFRO, "Ebola Virus Disease, West Africa (Situation as of 17 June 2014)."
31. WHO, "Key Events."
32. Ibid.
33. WHO, "Ebola Virus Disease, West Africa – Update, 15 July 2014."
34. WHO, "Ebola Virus Disease, West Africa – Update, 27 July 2014"; and WHO, "Ebola Virus Disease, West Africa – Update, 8 August 2014."
35. WHO, "8 August 2014 Press Briefing."
36. AFRO, "Ebola Virus Disease, West Africa (Situation as of 8 August 2014)."
37. WHO, *Ebola Response Roadmap*.
38. Interview with US military official, Monrovia, Liberia, March 25, 2015.
39. MSF, "Press Release."
40. Nichols, "Ebola seriously threatens Liberia's National Existence."
41. UN Security Council, S/RES/2176.
42. UN Security Council, S/RES/2177.
43. UN General Assembly, *Resolution 69/1*.
44. Sengupta, "Effort on Ebola hurt WHO Chief"
45. Cheng, "UN: We botched Response."
46. WHO, "BRIEFING NOTE"; and "Bungling Ebola."
47. WHO, "2014 Ebola Virus Disease Outbreak." A68/25, 3–4.
48. WHO, "Key Events."
49. Fink, "WHO Leader describes the Agency's Ebola Operations."
50. WHO, "WHO Response."
51. Sun et al., "Out of Control."
52. Chan, "Report by the Director-General."
53. WHO, "Address by Dr. Margaret Chan."
54. Interview with senior WHO official, Geneva, May 27, 2015.
55. Butler, "Agency gets a Grip on Budget," 18–19.

56. Interview with senior WHO official, Geneva, May 27, 2015.
57. WHO, "Address by Dr. Margaret Chan."
58. WHO, "WHO Response," 1.
59. Sengupta, "Effort on Ebola hurt WHO Chief"
60. WHO, "Ebola Virus Disease, West Africa – Update, 14 April 2014"; and WHO, "Ebola Virus Disease, West Africa – Update, 25 April 2014."
61. WHO, "Key Events."
62. Interview with UN official, Monrovia, March 25, 2015.
63. The AFRO regional director did not visit all three affected countries until July 21, 2014. AFRO, "Ebola Virus Disease, West Africa – Update 23 July 2014."
64. Kamradt-Scott, *Managing Global Health Security*, 134–135.
65. Budrys, "Russia says extends Pork Import Ban"; and Davies et al., *Disease Diplomacy*, 108.
66. Dumiak, "Push needed for Pandemic Planning," 800–801; and Carney and Bennett, "Framing Pandemic Management," 136–147.
67. Burci and Vignes, *World Health Organization*.
68. Cheng and Satter, "Emails."
69. AFRO, "AFRO-MEMORANDUM."
70. AFRO, "Ebola Virus Disease, West Africa (Situation as of 5 May 2014)."
71. AFRO, *Standard Operating Procedures*.
72. WHO, *The First Ten Years*; and Lee, *The World Health Organization*.
73. Godlee, "The World Health Organization," 1424–1428; WHO, "Looking Ahead"; and Burci and Vignes, *World Health Organization*, 121.
74. Chan, "Report by the Director-General," 4.
75. WHO, "Implementation of the International Health Regulations (2005): Report of the Review Committee."
76. Moon et al., "Will Ebola change the game?," 2204–2221.
77. WHO, "Decisions and List of Resolutions."
78. Davies et al., *Disease Diplomacy*; and WHO, "Implementation of the International Health Regulations (2005): Responding to Public Health Emergencies," 3.
79. Legge, "Future of WHO hangs in the Balance," e6877.
80. Lei Ravelo, "To accommodate Reforms."
81. Interview with senior WHO official, Geneva, May 20, 2015.
82. Garrett, "The Ebola Review."
83. AFRO, "WHO Executive Board appoints Dr. Matshidiso Moeti."
84. Chan, "Report by the Director-General," 4.
85. Notably the reforms attempted by Dr. Gro H. Brundtland between 1998 and 2003. See Yamey, "Have the latest Reforms reversed WHO's Decline?," 1107–1112; and Lerer and Matzopoulos, "The Worst of Both Worlds," 415–438.

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