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The pandemic disease caused by the novel coronavirus (COVID-19) is a political problem as much as it is a public health tragedy. Politics has been at the core of how governments have prepared for and responded to this crisis.<sup>1</sup> Political decisions have beleaguered or improved outbreak management, sometimes irrespective of the strength of a health system, clearly demonstrating the political determinants of public health.<sup>2</sup> However, more often than not, politics is presented as an ignoble irritant in contrast to the public health domain: ‘The IO’ [International Organization] professional staff of medical and public health advocates{1} sought to do what was necessary to stem the epidemics of infectious disease, not to follow the political dictates of its{2} principals [states].’<sup>3</sup> Yet, as is clear from the different government responses to the outbreak itself, technical decisions require political decisions about who should be consulted, who should provide advice, which models should be used, what policies should be implemented, how such policies should be enforced, and who should be trusted in the international arena. Put simply: politics is deciding how COVID-19 is spreading and whether people are living or dying.

Political tensions are not limited to the domestic arena. International organizations such as the World Health Organization (WHO) are operating in an increasingly combative and divisive political realm, with proxy battles being waged within these institutions between

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<sup>1</sup> Swee Kheng Khor, ‘The politics of the coronavirus outbreak’, *Think Global Health*, 24 Jan. 2020, <https://www.thinkglobalhealth.org/article/politics-coronavirus-outbreak>. (Unless otherwise noted at point of citation, all URLs cited in this article were accessible on 24 July 2020.)

<sup>2</sup> Hans Kluge, Jose Maria Martín-Moreno, Nedret Emiroglu, Guenael Rodier, Edward Kelley, Melitta Vujnovic and Govin Permanand, ‘Strengthening global health security by embedding the International Health Regulations requirements into national health systems’, *BMJ Global Health* 3: suppl.1, 2018, [https://gh.bmj.com/content/3/Suppl\\_1/e000656#xref-ref-28-1](https://gh.bmj.com/content/3/Suppl_1/e000656#xref-ref-28-1).

<sup>3</sup> Andrew P. Cortell and Susan Peterson, ‘Dutiful agents, rogue actors, or both? Staffing, voting rules, and slack in the WHO and WTO’, in Darren G. Hawkins, ed., *Delegation and agency in international organizations* (Cambridge: Cambridge University Press, 2006), pp. 255–80 at p. 271.

member states, for example China and the United States. The WHO is considered to be either too political——‘in bed with China’<sup>4</sup>——or not political enough.<sup>5</sup> The politics of orchestrating the multiple demands and expectations of states within one international organization is vital to effective management of COVID-19.

From the outset of COVID-19, we (the authors) have been regularly asked to explain to the media the international relations behind the outbreak response: that is, why states are reporting, testing or responding differently; whether they are heeding the WHO advice or charting their own path; what they are thinking regarding the political, travel and trade ramifications; and how they see themselves compared to their neighbours’ capacity within their respective regional environments. It has struck us, however, that we are rarely asked these questions by WHO or domestic public (health) officials seeking to refine their response efforts. {3}

A publication from 2018 seems to explain why. This was a piece written by a group of leading global health specialists lamenting the lack of research published on the topic of health security and how to strengthen state capacity to meet the International Health Regulations (IHR).<sup>6</sup> Despite the vast volume of research by International Relations (IR) scholars on preparedness, prevention and communication of outbreak events,<sup>7</sup> the IHR and

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<sup>4</sup> Hinnerk Feldwisch-Drentrup, ‘How WHO became China’s coronavirus accomplice’, *Foreign Policy*, 2 April 2020, <https://foreignpolicy.com/2020/04/02/china-coronavirus-who-health-soft-power/>; Christian Kreuder-Sonnen, ‘China vs the WHO: a behavioural norm conflict in the SARS crisis’, *International Affairs* 95: 3, May 2019, pp. 535–52.

<sup>5</sup> David P. Fidler, ‘The World Health Organization and pandemic politics’, *Think Global Health*, 10 April 2020, <https://www.thinkglobalhealth.org/article/world-health-organization-and-pandemic-politics>.

<sup>6</sup> Kluge et al., ‘Strengthening global health security’.

<sup>7</sup> Sara E. Davies, Adam Kamradt-Scott and Simon Rushton, *Disease diplomacy: international norms and global health security* (Baltimore: Johns Hopkins University Press, 2015); Adam Kamradt-Scott and Simon Rushton, ‘The revised International Health Regulations: socialization, compliance and changing norms of global health security’, *Global Change, Peace and Security* 24: 1, 2012, pp. 57–70; Catherine Z. Worsnop, ‘Domestic politics and the WHO’s International Health Regulations: explaining the use of trade and travel barriers during disease outbreaks’, *Review of International Organizations* 12: 3, 2017,

health security more broadly, it appears that social science research is not being read by those in health institutions, and that the public health and global health security communities remain in separate silos.

The WHO Director-General has continued to reiterate that global political cooperation, not isolationism, will be required to halt the spread of COVID-19. We agree. The WHO Director-General has recently stated that “COVID-19 politics should be quarantined...Politics and partisanship has made things worse. What is important is science solutions and solidarity”.<sup>8</sup> We respectfully disagree. Political solutions will also be required to achieve international cooperation and solidarity. This article seeks to reach out across the divide between the public health and IR communities to establish what contribution IR scholarship can make to real-time decision-making both during such outbreaks and in the post hoc analysis of emergencies. We argue that there has not been enough recognition of the normative value of diplomacy in preparations for health emergencies, either by the WHO or by states. This deficiency is now having real-world effects on the chances of infection, and indeed survival, for individuals living under a range of different administrations around the world. We need to understand the role of diplomacy, competing political priorities, and find a way in which public health officials can learn to work within these global political constructions.

We argue that there are important diplomatic entry points, from which disease diplomacy and cooperation could be advanced, that are not being captured owing to the exclusion of IR knowledge from technical health responses, and indeed policy, both within the WHO and within national governments.<sup>9</sup> The article will develop this argument in two stages. First, we examine how the WHO currently ‘orchestrates’ its authority as an international

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pp. 365–95; Jeremy Youde, *Biopolitical surveillance and public health in international politics* (New York: Palgrave, 2010); Sara E. Davies and Jeremy Youde, ‘The IHR (2005), disease surveillance, and the individual in global health politics’, *International Journal of Human Rights* 17: 1, 2013, pp. 133–51; Stefan Elbe, *Security and global health* (Cambridge: Polity, 2010).

<sup>8</sup> Tedros Adhanom Ghebreyesus, ‘WHO Chief Slams Pompeo Over 'Unacceptable' Allegations on Chinese Influence’, Bloomberg QuickTake News, 23 July 2020. <https://www.youtube.com/watch?v=QwsBrOak9FU>

<sup>9</sup> In fact, we would argue that foreign policy and diplomatic expertise needs to be embraced by the WHO across all health programmes: we thank one of reviewers for this suggestion.

organization.<sup>10</sup> In a political environment of anarchy, where the WHO has no direct authority over member states, the organization seeks to claim authority on the basis of performative leadership, normative public health expertise, and technical guidance. Within the WHO these soft tools are guarded by public health experts and often deployed as a defensive shield to avoid political attention, while the organization itself remains an entirely political structure. The attempt to avoid politics compromises the work of the WHO. We suggest that the WHO needs to embrace the political alongside the technical, specifically engage foreign policy and diplomatic expertise. This may assist with implementation at the ‘hard’ end of international cooperation concerning specific health system responses. Perhaps at a time when it has a former foreign affairs minister, Dr Tedros, at the helm, the WHO can build upon this expertise and use it as a pertinent point of departure for systemic WHO reform.

Second, we present practical examples of points at which IR could inform public health decision-making and technical policy coordination. We do not claim to have more insight into a political context than the affected governments or communities themselves; but this is precisely our point. It is important to ask more about the political context in which an outbreak is occurring, as well as about the local, regional and global landscape in which cooperation and coordination will be sought.<sup>11</sup> Failure is not always zero-sum and diplomatic engagement is always possible, even in the direst of circumstances.<sup>12</sup> Amid the COVID-19 pandemic we can identify diverse narratives about what is going to be the silver bullet to get us out of the crisis; how serious a concern it is; and whose authority we should be following to mitigate the risks posed. We argue that through IR it is possible to identify diplomatic entry points: economic, geopolitical and political opportunities for the cooperation, coordination and even resistance before, during and after health emergencies. At the end of this section we provide examples of how IR knowledge can directly engage with and support health diplomacy in managing the COVID-19 crisis.

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<sup>10</sup> Kenneth W. Abbott, Philipp Genschel, Duncan Snidal and Bernhard Zangl, *International organizations as orchestrators* (Cambridge: Cambridge University Press, 2015).

<sup>11</sup> We acknowledge that the Global Health Security Index did try to capture political landscapes; but, basing its work on quantifiable data and/or the simple existence or non-existence of a policy {?}, it missed the nuances that IR analysis can offer.

<sup>12</sup> Graham T. Allison and Philip Zelikow, *Essence of decision* (New York: Longman, 1999).

At this point we wish to enter one caveat: we acknowledge that many may disagree with our characterization of IR and our advocacy of purposive policy engagement.<sup>13</sup> We consider ourselves as IR academics who produce policy-relevant research, grounded in the discipline's theory, empirical research and practice. While our work is rooted in constructivist and feminist approaches to international relations, we recognize that theoretical work in IR can seem impenetrable to public health practitioners. We do not wish to lose the broader message. This article is one contribution to what should be a broader and deeper conversation about the potential subdisciplinary, theoretical and policy-specific approaches across political science, comparative politics, IR, and public and/or global health.

### **The COVID-19 pandemic in brief**

From the very beginning, key tenets of international relations have dominated this outbreak, and cooperation between states and WHO has dominated the narrative. In January 2020, Dr Tedros was at pains to stress that China was cooperating, and that the WHO did not support the restrictive trade and travel measures being adopted against China by other states and their corporations. No doubt this emphasis was fuelled by a desire to ensure that China continued to engage in a transparent reporting relationship with the WHO so that it would get much-needed data from China about the scale of the outbreak and successful prevention or treatment options. The politics of this diplomatic relationship remains hotly contested even six months later: how does the WHO walk the tightrope of preserving a working relationship with China while not condoning delayed outbreak reports and lockdown procedures that may amount to human rights abuses? This question may be asked of many member states with whom WHO must maintain a technical and diplomatic relationship.

On 22 January, the IHR Emergency Committee convened its first meeting to consider the outbreak. The vote was split on whether it had at that point acquired the status of a public health emergency of international concern (PHEIC).<sup>14</sup> Some western states sided with China

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<sup>13</sup> See David A. Lake, 'Theory is dead, long live theory: the end of the great debates and the rise of eclecticism in International Relations', *European Journal of International Relations* 19: 3, 2013, pp. 567–87; Joseph M. Grieco, 'The schools of thought problem in International Relations', *International Studies Review* 21: 3, 2019, pp. 424–46.

<sup>14</sup> Mark Eccleston-Turner, 'COVID-19 symposium: the declaration of Public Health Emergency of International Concern', *OpinioJuris*, 31 March 2020,

at this meeting in taking the view that the novel coronavirus did not yet meet the conditions for a PHEIC.<sup>15</sup> These meetings are strongly political; in the IHR legislation, the decision to declare a PHEIC remains with the Director-General, upon the advice of the Emergency Committee. It is not based on a vote, and member states are not represented on the committee, whose members sit by virtue of their public health expertise, rather than as state diplomats. A week later, a PHEIC was declared, albeit still in markedly political terms, with Dr Tedros stating that the decision was not linked to the risks posed in China, but in view of the risks posed to low- and middle-income countries with weak health systems unprepared to manage the demands of a major epidemic.<sup>16</sup>

By March the WHO was coming under increasingly strong criticism for ‘appeasing’ China’s actions, which included Chinese police threatening medical staff with arrest for any online communication about the outbreak; forced quarantine and lockdown on cities (despite this later becoming the norm globally); and the failure to recognize and address the human and civil rights implications of such interventions.<sup>17</sup> Others challenged the restrictive travel and trade measures adopted by countries such as the United States, Australia and New Zealand. The Canadian prime minister, Justin Trudeau, said:

<ext>We recognize there are countries that make different decisions. The decisions we make are based on the best recommendations of the World Health Organization (WHO) and the

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<http://opiniojuris.org/2020/03/31/covid-19-symposium-the-declaration-of-a-public-health-emergency-of-international-concern-in-international-law/>.

<sup>15</sup> Julian Borger, ‘Caught in a superpower struggle: the inside story of the WHO’s response to coronavirus’, *Guardian*, 18 April 2020,

<https://www.theguardian.com/world/2020/apr/18/caught-in-a-superpower-struggle-the-inside-story-of-the-whos-response-to-coronavirus>.

<sup>16</sup> World Health Organization (WHO), ‘WHO Director-General’s statement on IHR Emergency Committee on Novel Coronavirus (2019-nCoV)’, Geneva, 30 Jan. 2020, [https://www.who.int/dg/speeches/detail/who-director-general-s-statement-on-ihr-emergency-committee-on-novel-coronavirus-\(2019-ncov\)](https://www.who.int/dg/speeches/detail/who-director-general-s-statement-on-ihr-emergency-committee-on-novel-coronavirus-(2019-ncov)).

<sup>17</sup> Kai Kupferschmidt, ‘Mission impossible? WHO director fights to prevent a pandemic without offending China’, *Science*, 10 Feb. 2020, <https://www.sciencemag.org/news/2020/02/mission-impossible-who-director-fights-prevent-pandemic-without-offending-china>.

tremendous health experts who work within Canada and around the world . . . There is a lot of misinformation out there, there is a lot of knee-jerk reaction that isn't keeping people safe. That is having real, challenging impacts on communities, on community safety.<sup>18</sup><extend>

Yet to date the WHO Director-General has not called out any individual state for failure to heed WHO advice—although it used sterner language in the face of the UK's approach to seeking 'herd immunity' and not rolling out community testing to manage the outbreak as recommended by the WHO.<sup>19</sup> Even when the United States sought to terminate its relationship with the WHO in June 2020, Dr Tedros sought continued collaboration with Washington.<sup>20</sup>

The trust of states in the WHO, as the best delegated authority to steer the international community through COVID-19, is again being tested,<sup>21</sup> as it was during the Ebola outbreak in 2014–15 and the Zika outbreak in 2016.<sup>22</sup> For example, very few states adhered to the

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<sup>18</sup> Kathleen Harris, 'Trudeau says "knee-jerk reactions" won't stop spread of COVID-19', CBC, 5 March 2020, <https://www.cbc.ca/news/politics/covid19-trudeau-coronavirus-travel-1.5486799>.

<sup>19</sup> 'WHO Director-General's opening remarks at the media briefing on COVID-19—13 March 2020', 13 March 2020, <https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-mission-briefing-on-covid-19---13-march-2020>; Jane Warton, 'World Health Organisation questions UK's "herd immunity" approach to coronavirus', *Metro*, 14 March 2020, <https://metro.co.uk/2020/03/14/world-health-organisation-questions-uk-coronavirus-approach-12397312/>.

<sup>20</sup> Pien Huang, 'WHO's measured reaction to Trump's pledge to cut US ties to the agency', NPR *Goats and Soda*, 1 June 2020, <https://www.npr.org/sections/goatsandsoda/2020/05/29/865816855/whos-muted-reaction-to-trumps-pledge-to-withdraw-u-s-from-the-u-n-agency>.

<sup>21</sup> Ilona Kickbusch and Gabriel Leung, 'We need new forms of governance to better manage our response to pandemics', *BMJ Opinion*, 3 Feb. 2020, <https://blogs.bmj.com/bmj/2020/02/03/we-need-new-forms-of-governance-to-better-manage-our-response-to-pandemics/>.

<sup>22</sup> Colin McInnes, 'WHO's next? Changing authority in global health governance after Ebola', *International Affairs* 91: 6, Nov. 2015, pp. 1299–1316.

WHO's trade and travel advice, issued under the IHR.<sup>23</sup> Nor are all states following the procedures recommended by the WHO to 'test, trace, isolate' to limit disease transmission.<sup>24</sup> This lack of recognition of the WHO's authority to WHO to manage COVID-19 is most starkly demonstrated by President Trump's decision on 14 April 2020 to halt funding to the organization, on the grounds of its the apparent failure 'to adequately obtain, vet and share information [on COVID-19] in a timely and transparent fashion' {4}.<sup>25</sup> While this claim has been widely refuted, the very fact that it was made demonstrates that trust between actors in the global health arena is not easily established or maintained. Therefore, it was auspicious that the World Health Assembly agreed, in May 2020, that the WHO should initiate an independent evaluation of the 'lessons learned' from the international health response to COVID-19. In July 2020, the former New Zealand prime minister Helen Clark and former Liberian president Ellen Johnson Sirleaf were announced as the co-chairs of the Independent Panel for Pandemic Preparedness and Response (IPPR). However, as Dr Tedros said on announcing the creation of the IPPR, whatever lessons are identified, the greatest threat remains the 'lack of leadership and solidarity at the global and national levels'.<sup>26</sup> Six months on from the beginning of the outbreak, many domestic responses to COVID-19 are severely lacking, case numbers are soaring and governments are failing to protect their citizens, while

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<sup>23</sup> Samantha Kiernan and Madeleine Devita, 'Travel restrictions on China due to COVID-19', *Think Global Health*, 6 April 2020, <https://www.thinkglobalhealth.org/article/travel-restrictions-china-due-covid-19>.

<sup>24</sup> Anthony Costello, 'The UK's COVID-19 strategy dangerously leaves too many questions unanswered', *Guardian*, 16 Mar. 2020, <https://www.theguardian.com/commentisfree/2020/mar/15/uk-covid-19-strategy-questions-unanswered-coronavirus-outbreak>.

<sup>25</sup> David Smith, 'Trump halts World Health Organization funding over coronavirus "failure"', *Guardian*, 15 April 2020, <https://www.theguardian.com/world/2020/apr/14/coronavirus-trump-halts-funding-to-world-health-organization>.

<sup>26</sup> 'WHO Director-General opening remarks at the member state briefing on the COVID-19 pandemic evaluation', 9 July 2020, <https://www.who.int/dg/speeches/detail/who-director-general-opening-remarks-at-the-member-state-briefing-on-the-covid-19-pandemic-evaluation---9-july-2020>.



the global political focus remains—erroneously, in the view of many—on China and the WHO’s alleged failures in the early stages.

Richard Horton, editor of the *Lancet*, described the current situation as a struggle for the soul of global health:

<ext>Global health is typically agnostic about the kind of political system a country chooses to adopt. Global health and its institutions see health systems as separate—technically, socially, economically—from the political ideologies of nations. This view is not sustainable. We cannot say that the terms of political engagement within a country are irrelevant to our hopes for health.<sup>27</sup><extend>

As IR scholars, we know that global health institutions can never rightly be viewed as separate from politics and political ideology. There are volumes of research detailing the intricate and elaborate politicization of institutions such as the WHO, UNAIDS, GAVI (the Vaccine Alliance), the World Bank, and initiatives such as PEPFAR (the President’s Emergency Plan for AIDS Relief), UNMEER (the UN Mission for Ebola Emergency Response) and Health for All.<sup>28</sup> The conviction that health could ever be apolitical, in spite of the abundant evidence to the contrary, highlights how little health disciplines have engaged with IR research, despite our collective efforts to seriously engage with theirs. Now is the time for us to support the outbreak response effort and demonstrate how political analysis can enhance global disease control efforts.

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<sup>27</sup> Richard Horton, ‘Offline: facts are not enough’, *Lancet* 395: 10224, 22 Feb. 2020, [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(20\)30405-0/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30405-0/fulltext).

<sup>28</sup> See, among others, Stefan Elbe, *Virus alert: security, governmentality, and the AIDS pandemic* (New York: Columbia University Press, 2009); Nitsan Chorev, *The World Health Organization between North and South* (Ithaca, NY: Cornell University Press, 2012); Joseph Harris, *Achieving access: professional movements and the politics of health universalism* (Ithaca, NY: Cornell University Press, 2017); Sharifah Sekalala, *Soft law and global health problems: lessons from responses to HIV/AIDS, malaria and tuberculosis* (Cambridge: Cambridge University Press, 2017); Kim Yi Dionne, *Doomed interventions: the failure of global responses to AIDS in Africa* (Cambridge: Cambridge University Press, 2018).

Politics cannot be wished away. Even the most democratic country can stumble over political ideologies and nationalism when facing the strength and pace of a virus outbreak.<sup>29</sup> The contemporary debate about the wearing of face masks demonstrates this in abundance.<sup>30</sup> Political forces will dramatically affect the fortunes of public health bodies, the efficacy of technical advice, and faith in the normative value of international health diplomacy.

How to ‘orchestrate’ the multiple competing approaches of states (and indeed non-state actors within the global health governance landscape) is the task now facing public health experts and, especially, the WHO.<sup>31</sup> As IR scholars, we have some understanding of the structure, agency and preferences most likely to mobilize states and organizations to act cooperatively rather than as random individual agents in the way that has plagued the COVID-19 response.

### **The authority of the WHO**

As feminist IR scholars, we understand that the decision on who has a seat at the table is a powerful, conscious and political one.<sup>32</sup> Within emergencies, invitations to the table often come down to personal, professional and strategic networks: who is known to the key team, who is respected or feared. We argue that the absence of IR knowledge and expertise is problematic for pandemic response as it means that the political contents of representation, power and inclusion may be overlooked as secondary to the normative value of technical

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<sup>29</sup> ‘Coronavirus: English local elections postponed for a year’, BBC News, 13 March 2020, <https://www.bbc.co.uk/news/uk-politics-51876269>; Nick Corasaniti and Stephanie Saul, ‘16 states have postponed primaries during the pandemic’, *New York Times*, 27 May 2020, <https://www.nytimes.com/article/2020-campaign-primary-calendar-coronavirus.html>.

<sup>30</sup> Lauren Aratani, ‘How did face masks become a political issue in America?’, *Guardian*, 29 June 2020, <https://www.theguardian.com/world/2020/jun/29/face-masks-us-politics-coronavirus>.

<sup>31</sup> Abbott et al., *International organizations as orchestrators*.

<sup>32</sup> Adam William Chalmers, ‘Getting a seat at the table: capital, capture and expert groups in the European Union’, *West European Politics* 37: 5, 2014, pp. 976–92; Sam Cook, ‘Marking failure, making space: feminist interventions in Security Council policy’, *International Affairs* 95: 6, nov. 2019, pp. 1289–1306.

epidemiological advice. This form of knowledge triage has implications across multiple policy areas.

Leadership and governance have been identified by public health scholars {5} as two areas where work could be done to improve state capacity to respond to outbreaks, along with transparency and accountability.<sup>33</sup> Performance in these areas is often measured in terms of the presence of national laws or regulatory frameworks, transparent decision-making structures for federal or centralized systems, evidence-based risk communication channels, and some national-level collaboration system that includes a ‘whole of society’ approach.<sup>34</sup> However, while transparent and coordinated leadership and governance will assist during any emergency response domestically, a leadership or governance checklist will not always tell us how a state will ‘play’ with others in the global system, perhaps especially at time of crisis—as shown by the Global Health Security Index, which placed the United States in the lead for outbreak preparedness.<sup>35</sup> States do not exist in a timeless governance vacuums. A state may stay the same but its government may change; nor do governments exercise their responsibilities to health governance exclusively through health ministries and membership of the WHO. States belong to regional communities that may provide more security in this instance.<sup>36</sup> There are competing transnational forces at work, such as economic stability, even (perhaps especially) during a once-in-a-century health crisis that pulls at the loyalties, interests and trust relationships of the international community. It may not be possible to predict how cultural, gender, racial and economic dynamics will affect how states view

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<sup>33</sup> Kluge et al., ‘Strengthening global health security’.

<sup>34</sup> Kluge et al., ‘Strengthening global health security’; Nuclear Threat Initiative and John Hopkins Center for Health Security, ‘Global Health Security Index’, 2019, <https://www.ghsindex.org>: see indicators for prevent, detection and respond.

<sup>35</sup> Sarah L. Dalglish, ‘COVID-19 gives the lie to global health expertise’, *Lancet* 395: 10231, 11 April 2020, p. 1189.

<sup>36</sup> Emmanuel Adler and Michael Barnett, ‘Security communities in theoretical perspective’, in Emmanuel Adler and Michael Barnett, eds, *Security communities* (Cambridge: Cambridge University Press, 2000), p. 4.

themselves, their neighbours and their place in the world during a pandemic, but it is important to recognize, document and analyse these political effects.<sup>37</sup>

What is missing in current global health discussions about the coordinated global response to the current outbreak is an assessment of the international relations environment in which collective action is more likely to overcome domestic conditions of resistance: in brief, an assessment of how to play the two-level game of diplomacy and domestic politics.<sup>38</sup> This is the game currently being played out between China and the United States through the medium of WHO adherence and interactions. Understanding the relationship between these two key states is vital if we are to understand how best to navigate these discussions and ensure that persistent Cold War-like tensions do not determine the potential success of global COVID-19 interventions.<sup>39</sup>

There should be, at the core of the public health advice being issued at the international level, an IR-informed understanding of why states *would* delegate to the WHO their agency to coordinate public health responses and public health action. As the COVID-19 outbreak progresses, domestic governments are proceeding alone, sometimes independent of the advice offered by the WHO. These actions put multilateral cooperation at risk, at a time when global supply chains, global trade routes and broader international diplomacy will be vital to secure populations and health systems until—if it is ever created—there is a vaccine. And even when (if) there is, coordination of the manufacture, distribution and supply of that vaccine will require more coordinated health diplomacy among very different political regimes and health systems.

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<sup>37</sup> Dheepa Rajan, Kira Koch, Katja Rohrer, Csongor Bajnoczki, Anna Socha, Maike Voss, Marjolaine Nicod, Valery Ridde and Justin Koonin, ‘Governance of the COVID-19 response: a call for more inclusive and transparent decision-making’, *BMJ Global Health* 5: 5, 2020, <https://gh.bmj.com/content/5/5/e002655>.

<sup>38</sup> Robert D. Putnam, ‘Diplomacy and domestic politics: the logic of two-level games’, *International Organization* 42: 3, 1988, pp. 427–60.

<sup>39</sup> Andrew B. Kennedy and Darren J. Lim, ‘The innovation imperative: technology and US–China rivalry in the twenty-first century’, *International Affairs* 94: 3, May 2018, pp. 553–72; Xiangfeng Yang, ‘The great Chinese surprise: the rupture with the United States is real and is happening’, *International Affairs* 96: 2, 2020, pp. 419–38.

There is an abundant literature on the WHO, global governance, and the management of states' collective and individual expectations within the pathologies of international organizations, non-governmental organizations and issue-specific networks.<sup>40</sup> The core message across these studies is that while states always seek to maintain their sovereign independence, it is important to study *when* states choose to delegate authority to separate organizations to build institutional capacity, encourage moral persuasion or develop enforcement mechanisms. In other words, when do states—irrespective of their political complexion and powers—choose to respond to problems with collective action (shared among states) rather than 'going it alone'? And, indeed, as states diverge from WHO advice during COVID-19, what can the WHO do to encourage a return to health diplomacy despite these differences? When is expertise required by a 'third' actor to 'orchestrate' cohesion over the differences between states and the limitations of their relationship {6}?<sup>41</sup> The degree to which states materially, normatively and strategically adhere to international laws, norms, rules and practices is at the core of what we study in IR.

We need here to consider briefly the WHO's pre-COVID record of coordinating or orchestrating state cooperation in response to health emergencies. Since the adoption in 2005 of the revised IHR, the primary international instrument and governance mechanism that guides collective behaviour in the event of a disease outbreak, many publications have flagged gaps in implementation. Attached to the IHR are eight core capacity criteria that states are expected to meet through legislation, finance, training, laboratory preparedness etc. Since 2010, the WHO has received State Parties' Self-Assessment Annual Reports (SPAR), which review progress in building IHR core capacities and measure performance against 13

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<sup>40</sup> Michael Barnett and Martha Finnemore, *Rules for the world: international organizations in global politics* (Ithaca, NY: Cornell University Press, 2004); Darren G. Hawkins, David A Lake, Daniel L Nielson and Michael J Tierney et al. {?}, *Delegation and agency in international organization* (Cambridge: Cambridge University Press, 2006); Deborah D. Avant, Martha Finnemore and Susan K. Sell, *Who governs the globe?* (Cambridge: Cambridge University Press, 2012); Abbott et al., *International organizations as orchestrators*; Sarah S. Stroup and Wendy H. Wong, 'Leading authority as hierarchy among INGOs', in Ayşe Zarakol, ed., *Hierarchies in world politics* (Cambridge: Cambridge University Press, 2017).

<sup>41</sup> Abbott et al., *International organizations as orchestrators*, p. 11.

criteria and 24 indicators.<sup>42</sup> In addition, since 2016 the WHO has coordinated nearly 100 (96) joint evaluation exercises (JEE) in which, upon state invitation, an external committee is sent in to evaluate how the state is meeting its IHR obligations.<sup>43</sup> It is in these focused areas that issue-specific agents such as the WHO are attractive to state principals because ‘they [WHO] offer consistent governance schemes that lower transaction costs involved in establishing collaborative ties’.<sup>44</sup> The question is whether the WHO has been able to capitalize on the consent previously won from its state principals—advising on health emergencies—for a situation such as current COVID-19 crisis{7}.

Attempts to manage differing contexts have been considered by WHO, but the JEE process has primarily focused on structural questions such as size of country, federated systems and overseas territories, rather than considering a more holistic contemporary political picture, with analysis of governance capacity and human rights in relation to operationalizing the IHR.<sup>45</sup> The vast majority of the knowledge gathered through the IHR eSPAR website, the

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<sup>42</sup> International Health Regulations (2005) *Guidance document for State Party Self-Assessment Annual Reporting tool* (Geneva: WHO, 2018), p. 7.

<sup>43</sup> WHO, ‘Joint External Evaluation (JEE) mission reports’, n.d., <https://www.who.int/ihr/procedures/mission-reports/en/>; Emily McPhee, Gigi K. Gronvall and Tara Kirk Sell, ‘Analysis of sectoral participation in the development of Joint External Evaluations’, *BMC Public Health* 19: 631, 2019; Georgetown University Medical Center, Center for Global Health Science and Security, *IHR costing tool*, 2017, <https://ghscosting.org/#background>; Feng-Jen Tsai and Rebecca Katz, ‘Measuring global health security: comparison of self- and external evaluations for IHR core capacity’, *Health Security* 16: 5, 2018, pp. 304-310{?}.

<sup>44</sup> Tine Hanrieder, ‘WHO orchestrates? Coping with competitors in global health’, in Abbott et al., *International organizations as orchestrators*, p. 192.

<sup>45</sup> Sara E. Davies, *Containing contagion: the politics of disease outbreaks in southeast Asia* (Baltimore: Johns Hopkins University Press, 2019), ch. 6; Feng-Jen Tsai and Battsetseg Turbat, ‘Is countries’ transparency associated with gaps between countries’ self and external evaluations for IHR core capacity?’, *Global Health* 16: 10, 2020, pp. 1-8 (on pdf, no detail in reference Tsai, F., Turbat, B. Is countries’ transparency associated with gaps between countries’ self and external evaluations for IHR core capacity?. *Global Health* **16**, 10 (2020). <https://doi.org/10.1186/s12992-020-0541-3>}; Amy Patterson and Mary Clark, ‘COVID-19 and

SPAR guidance documents and the JEE guidance documents concerns states' legislation, epidemiological training, and technical proficiency. It is in these terms that the capacity to meet the IHR is assessed{8}.<sup>46</sup> Put another way, a state's capacity to meet the IHR has been separated from its political, economic, diplomatic and human rights positionality. As the COVID-19 outbreak clearly shows, the WHO's attempt to ascertain state capacity primarily through public health indicators neglects the range of historic, economic, political, and social institutions that support state implementation of the IHR (and indeed any international legal instrument).<sup>47</sup>

Obviously, in a highly charged environment such as a health emergency, understanding the political and socio-economic conditions within a country, as well as its economic and diplomatic interests in relation to neighbouring states—what may constrain or enable cooperation and coordination—becomes essential.<sup>48</sup> In an international crisis such as this, a 'we feeling' might create a dynamic process of mutual sympathy, consideration, loyalty, trust and responsiveness in decision-making which could facilitate a global response to COVID-19; equally, individual state-centric concern for pandemic security also has the potential to become a barrier to such cooperation.<sup>49</sup>

Historically, the WHO has faced few organizational competitors for its pre-eminent role as lead actor in international health governance orchestration, especially in health emergencies.<sup>50</sup> The WHO is uniquely positioned—owing to its history as the conductor of

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power in global health', *International Journal of Health Policy and Management*, forthcoming 2020, doi:10.34172/ijhpm.2020.72.

<sup>46</sup> See WHO Electronic State Parties Self-Assessment Annual Reporting Tool, 2020, <https://extranet.who.int/e-spar/#submission-details>.

<sup>47</sup> Kheng Khor, 'The politics of the coronavirus outbreak'; Sawyer Crosby et al. 'All Bets Are Off for Measuring Pandemic Preparedness' *Think Global Health*, 30 June 2020.

<https://www.thinkglobalhealth.org/article/all-bets-are-measuring-pandemic-preparedness>

<sup>48</sup> Heather Marquette, On Covid-19 Social Science can save lives: where do we start? *From Poverty to Power*, 22 April 2020. <https://oxfamblogs.org/fp2p/on-covid-19-social-science-can-save-lives-where-do-we-start/>

<sup>49</sup> Laurie Nathan, 'Domestic instability and security communities', *European Journal of International Relations* 12: 2, 2006, pp. 275–99.

<sup>50</sup> Hanrieder, 'WHO orchestrates?', p. 212.

international health for over 60 years—to disseminate advice that can serve to enable cooperation.<sup>51</sup> Ultimately, health issues transcend borders, and the WHO has done a brilliant job in understanding the importance of claiming international technical authority; it has done less well, however, in appreciating and understanding the political or problem-solving skills required to understand contemporary sovereign behaviour. The WHO’s failure to grasp the political priorities of its member states, and realize that health is not a first, second or third priority for many of its members, has left the organization struggling in recent years with how to manage and delegate its authority, as evidenced by the intense contestation about its actions in response to H1N1, MERS, Ebola, Zika and now COVID-19.<sup>52</sup>

We suggest that the WHO (along with other actors in the broader global health governance landscape) needs to pay serious attention to whether it has taken advantage of all knowledge tools in addressing the politics of pandemic response and coordination. It is helpful to conceptualize the WHO’s authority as a conductor because it is important to note that despite the fractious political circumstances in which it is embroiled, as an organization and an institution it is in a rarefied position to ‘conduct’ expertise in response to the COVID-19 outbreak. Orchestration by an international organization requires specific knowledge, factored into planning, and the technical advice given must be aware of the political environment in which the organization exists, informed by knowledge of the competing diplomatic priorities of states. IR scholarship is well placed to assist the WHO with this understanding, advising on states’ geopolitical and diplomatic relationships beyond a technical health focus.<sup>53</sup> Such IR knowledge inputs (and methods), we suggest, should become core business for the WHO and other technical agencies that are seeking to establish optimal diplomatic conditions for coordinated responses to public health challenges. We call for such IR assessments to become a component part of JEE reviews (though probably not the eSPAR, given the method of state self-reporting), and of the IHR Emergency Committee decision-making process, in order to ensure that the political determinants of health are

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<sup>51</sup> Adam Kamradt-Scott, ‘WHO’s to blame? The World Health Organization and the 2014 Ebola outbreak in West Africa’, *Third World Quarterly* 37: 3, 2016, pp. 401–18.

<sup>52</sup> McInnes, ‘WHO’s next?’; Clare Wenham and Deborah B. L. Farias, ‘Securitizing Zika: the case of Brazil’, *Security Dialogue* 50: 5, 2019, pp. 398–415.

<sup>53</sup> Asha Herten-Crabb and Sara E. Davies, ‘Why WHO needs a feminist economic agenda’, *Lancet* 395: 10229, 2020, pp. 1018–20.



understood, and that subsequent domestic and foreign policies and politics do not have spillover effects on global infectious disease control.

### **Entry points for IR in health emergency planning and response**

IR deals with the interrelationship between domestic and international politics. In any kind of emergency, including a health emergency, it is important first to have an understanding of the contemporary political environment—not to assume that such knowledge is ‘common sense’ or can easily be aligned with ‘past experiences’.<sup>54</sup> Politics changes domestically and internationally on a daily basis as governments and non-governmental actors react to new events. Every outbreak situation deserves recognition as unique. Every state has dynamic priorities, agendas and conditions that may affect its response to a new emergency, and the invitation to international cooperation may be received very differently from one year to the next. Keeping track of the diplomatic conditions that may enable, or constrain, states’ cooperation during an emergency is of paramount importance to a successful health emergency response.

IR can offer ‘entry points’ for understanding cooperation and coordination between states, and where barriers may arise. One option may be to create a Politics in Health Emergencies provision, similar to the Social Science in Humanitarian Action service, established as a result of the Ebola outbreak in West-Africa by anthropologists at Institute of Development Studies, London School of Hygiene and Tropical Medicine and Anthropologica {10}: a great example of how one social science—anthropology—facilitated communication{11} within the WHO and beyond to understand what was missing from interactions between international organizations, states and academics.<sup>55</sup> Already, during Covid-19, we are seeing the creation of advisory groups, such as the post-crisis recovery specialists’ groups in Germany (including jurists and philosophers) and the Australian University’s Group of 8 Roadmap to Recovery Task Force, which includes subgroups on international relations, human rights and vulnerable populations. Within the WHO, it is time to revisit the Secretariat’s normative preference for health professionals and seriously engage with the contribution of political science expertise. For example, just as anthropologists are now

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<sup>54</sup> Séverine Autesserre, *Peaceland: conflict resolution and the everyday politics of international intervention* (Cambridge: Cambridge University Press, 2014).

<sup>55</sup> See <https://www.socialscienceinaction.org/about/>.

routinely engaged by IHR committees, why not also permit decisions concerning a PHEIC declaration to be informed by human rights, diplomatic and political implications? An independent analysis of a country's diplomatic capacity to report and verify outbreak events appears to be especially vital when deciding if an outbreak could escalate.<sup>56</sup> Clearly, the best surveillance system in the world is futile if governments are not willing to share their data internally or globally, and if regions do not trust the reports; and the WHO can be placed in a politically precarious position of defending a 'Potemkin village'.

We describe below five tangible 'entry points' through which IR can contribute to international organizations and state governments in health emergencies, and the real-world consequences of what has happened in the absence of such inputs.

*Comparative analysis—because politics is not the same everywhere*

IR offers analysis of the formal and informal political and governance landscape, and the impact this will have on disease transmission. Every state is unique, with its own political structures and nuances. In each case, the executive, legislative and judicial branches of government will look different, and decision-making power is diffused differently among actors. Trust between institutions may also affect the timing and engagement strategies of health diplomacy. Area-specific political scientists and comparative analysts, working alongside conflict and humanitarian analysts and global health governance experts, can support the global health community in navigating these institutional differences and the associated tensions. Knowing the 'sweet spot' for interacting with a particular state is vital to mitigating the risks posed by health emergencies.

Different structural and historical developments will further affect which ministries have authority to make decisions, which have effective mandates for implementing outbreak responses, and their respective operational capabilities.<sup>57</sup> The political history of a country,

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<sup>56</sup> Daniel Hurst, 'Australia hails global support for independent coronavirus investigation', *Guardian*, 18 May 2020, <https://www.theguardian.com/world/2020/may/18/australia-wins-international-support-for-independent-coronavirus-inquiry>.

<sup>57</sup> Emma Ross, Gita Honwana Welch and Philip Angelides, *Sierra Leone's response to the Ebola outbreak* (London: Chatham House, March 2017), <https://www.chathamhouse.org/sites/default/files/publications/research/2017-03-31-sierra->

including its legacies in respect of colonialism or patronage politics, is also vital to understanding the health landscape within a particular location, and who may be influencing decision-makers behind the scenes. Working with political scientists who know the landscape of the health and political sectors in a given location at the start of the outbreak can ensure that conversations are had with the relevant parties, in the relevant order, and facilitate a global outlook towards the response.

The failure to think about governance concerns can have significant real-world implications. During the Ebola outbreak in West Africa, a lack of governance knowledge on the ground (and indeed globally) exacerbated the apparent haphazardness of WHO Headquarters' response through both international actors and domestic political actors, leading to the unprecedented deployment of international militaries and the creation of a new UN institutional response, UNMEER.<sup>58</sup> Political analysis within the WHO prior to these actions might have recognized the existing role of the UN Mission in Liberia (UNMIL) and the UN Office for Coordination of Humanitarian Affairs (UNOCHA) and the potential of these bodies in informing, supporting and directing the WHO's response to this humanitarian emergency. Efforts could have been made sooner to engage with the strong and growing civil society movements within West African states, bodies that already had an established presence and the trust of local and diplomatic communities.<sup>59</sup> IR guidance at this early stage could have identified alternative hybrid governance mechanisms that could have responded more quickly to the outbreak.

Political expertise, then, can be highly pertinent in disease outbreaks, allowing the WHO quickly to understand the landscape of a particular location, including the different agendas

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leone-ebola-ross-welch-angelides-final.pdf; Freya Louise Jephcott, 'Holding back Ebola', *British Medical Journal*, 16 July 2019; Wenham and Farias, 'Securitizing Zika'.

<sup>58</sup> Sophie Harman and Clare Wenham, 'Governing Ebola: between global health and medical humanitarianism', *Globalizations* 15: 3, 2018, pp. 362–76.

<sup>59</sup> Sara E. Davies and Simon Rushton, 'Public health emergencies: a new peacekeeping mission? Insights from Unmil's role in the Liberia Ebola outbreak', *Third World Quarterly* 37: 3, 2016, pp. 419–35; Harman and Wenham, 'Governing Ebola'; Amaya M. Gillespie et al., 'Social mobilization and community engagement central to the Ebola response in West Africa: lessons for future public health emergencies', *Global Health: Science and Practice* 4: 4, 2016, pp. 626–46.

and competing interest groups operating there. At moments of crisis, this type of knowledge can be invaluable to avoid wasting precious time in a race against an epidemic. One important ‘added value’ of IR expertise over that of government officials, is that we can also advise on the informal governance structures that are relevant in an outbreak. Local authority may lie with particular social movements, tribal groups, religious denominations or dominant popular voices. Governments aren’t going to tell you, public health officials may know but can’t say, and scientists may find the political scene an endless irritant or a threat to their independence. In outbreaks reliant on social messaging and risk communication, knowing the formal and informal mechanisms of statecraft can make all the difference.

*Governance: the international politics of disease outbreaks*

Disease outbreaks reveal strains on collective governance. IR can provide public health officials with an understanding of the pre-existing transnational networks established before the crisis, and which are most likely to feel its impacts.<sup>60</sup> For example, global governance analysis explains how the WHO works and how it interacts with sovereign member states and other actors in the global health regime. Previous research has considered the shifting power and agency of the organization both in ‘peace time’ and in times of health emergencies.<sup>61</sup> The study of global governance conceptualizes the WHO within a larger international ecosystem, considering what has worked, what has been challenged by member states, what has brought states together and divided them, and how to embed any lessons learned to enhance authority when needed. In-depth analysis of the WHO and its position within the broader global health

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<sup>60</sup> Sophie Harman, *Global health governance* (Abingdon: Routledge, 2012); Jeremy Youde, *Global health governance* (Cambridge: Polity, 2012). **YES SAME TITLE FOR BOTH**

<sup>61</sup> Tine Hanrieder and Christian Kreuder-Sonnen, ‘WHO decides on the exception? Securitization and emergency governance in global health’, *Security Dialogue* 45: 4, 2014, pp. 331–48; Adam Kamradt-Scott, ‘The evolving WHO: implications for global health security’, *Global Public Health* 6: 8, 2011, pp. 801–13; Adam Kamradt-Scott, ‘The WHO Secretariat, norm entrepreneurship, and global disease outbreak control’, *Journal of International Organizations Studies* 1: 1, 2010, pp. 72–89; Adam Kamradt-Scott, ‘WHO’s to Blame?’; Colin McInnes and Anne Roemer-Mahler, ‘From security to risk: reframing global health threats’, *International Affairs* 93: 6, Nov. 2017, pp. 1313–37.

landscape is vital for building a typology of which political manoeuvres work (and which don't) during crises.

IR scholars have been studying WHO's role as an international political actor for some time, and providing insight on the ramifications of its failure to grasp its political role. During the 2009 H1N1 and the 2014 West African Ebola outbreaks, a mismatch arose between what the WHO is mandated to do in its constitution, as the 'directing and coordinating authority in global health',<sup>62</sup> and what the world expected it to do. During H1N1 the world expected less from the WHO; and then in 2014, the world wanted an operational team ready to respond to outbreaks with personnel on the ground.<sup>63</sup> IR provides nuance to the international politics of outbreaks. It is our 'business' to understand how states may choose to interact with one another and the WHO during health emergencies.

Global health security is predicated on norms of reciprocity, solidarity and sovereignty within the international community. These are embedded within competing global regulatory and legal frameworks which govern global disease control; IR can explain departures from these frameworks. For example, prior to 2006, governments were normatively expected to share virus samples of new pathogens with the WHO, so that the WHO could harness the power of the global health community to undertake research into vaccine or treatment options. In 2007, Indonesia challenged this normative understanding and status quo when{12} it refused to share a viral sample of H5N1 with the WHO, citing the Convention on Biological Diversity and ownership of biological samples within a sovereign state, leading to considerable diplomatic tension.<sup>64</sup> Their fear was of reciprocity of a different kind: they feared that vaccines developed from their virus samples would be unaffordable or unavailable to them, in view of prevalent geopolitical economic structures and power relations. An understanding of politics between states, and of Indonesia's own world-view, would have allowed for nuanced negotiations from the start to mitigate such fears. The issue of equitable vaccine distribution is not resolved and is likely to rear its head again if a vaccine is ever developed for COVID-19, despite the hard work undertaken by a range of actors to secure equitable

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<sup>62</sup> *Constitution of the World Health Organization*, 2006, [https://www.who.int/governance/eb/who\\_constitution\\_en.pdf](https://www.who.int/governance/eb/who_constitution_en.pdf).

<sup>63</sup> McInnes, 'WHO's next?'

<sup>64</sup> Stefan Elbe, 'Haggling over viruses: the downside risks of securitizing infectious disease', *Health Policy and Planning* 25: 6, 2010, pp. 476–85.

distribution of associated treatments and vaccines. The WHO, through the Pandemic Influenza Preparedness Framework and the Coalition for Epidemic Preparedness Innovations (CEPI),<sup>65</sup> attempts to construct scientific and legal solutions, which ignore politics at their peril.

IR scholarship has also studied state compliance in reporting disease outbreaks to the WHO (and other states), and the conditions under which states willingly share such data.<sup>66</sup> Understanding how and when states comply with global disease transparency is vital to the management of any outbreak response. This issue was first identified by scholars following Chinese activities during the SARS outbreak, when the Beijing government's delay in reporting, and its concealment of cases, led to a fundamental revision to global disease governance through the revisions to the IHR.<sup>67</sup> Over the past two decades, IR scholars have sought to understand how and when governments report. During the H5N1 outbreak, it appeared that states did willingly share epidemiological data with neighbouring states and the WHO.<sup>68</sup> Yet this is not always the case, with significant rumours that Tanzania concealed the spread of Ebola in the neighbouring Democratic Republic of Congo (DRC) in 2019, and Turkmenistan insisting in July 2020 that it has zero cases of COVID-19.<sup>69</sup> IR scholars seek to understand these differences on the basis of contextual factors relating to the states involved

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<sup>65</sup> Michelle F. Rourke, 'Access by design, benefits if convenient: a closer look at the Pandemic Influenza Preparedness framework's standard material transfer agreements', *Milbank Quarterly* 97: 1, 2019, pp. 91–112.

<sup>66</sup> Andrew T. Price-Smith, *The health of nations* (Cambridge, MA: MIT Press, 2001); Davies, *Containing contagion*; Davies et al., *Disease diplomacy*.

<sup>67</sup> David P. Fidler, 'SARS: political pathology of the first post-Westphalian pathogen', *Journal of Law, Medicine and Ethics* 31: 4, 2003, pp. 485–505.

<sup>68</sup> Sara E. Davies, 'The international politics of disease reporting: towards post-Westphalianism?', *International Politics* 49: 5, 2012, pp. 591–613.

<sup>69</sup> 'Tanzania denies hiding information on suspected Ebola cases', Reuters, 3 Oct. 2019, <https://www.reuters.com/article/us-health-ebola-tanzania/tanzania-denies-hiding-information-on-suspected-ebola-cases-idUSKBN1W11Z5>; Anne Gulland, 'Reclusive Turkmenistan continues to insist it is COVID-free despite reports of pneumonia', *Daily Telegraph*, 15 July 2020, <https://www.telegraph.co.uk/global-health/science-and-disease/reclusive-turkmenistan-continues-insist-covid-free-despite-reports/>.

and the particular risks posed to reporting, whether economic, political and/or social. Public health officials know states are not the same; IR studies *why* states are not the same. In doing so, it moves beyond the legal structures such as the IHR to understand when departure from regulations occurs and when their diffusion is successful. We study what public health officials want to know—the political levers and pulleys that mobilize serious health commitments.

*Political economy: money and power*

IR examines when states work alongside multilateral or regional institutions and when they do not—and, crucially, where the money goes within these commitments. Outside health emergencies, where the WHO's voice remains strong, the organization is being led rather than leading. The increased contribution to WHO's voluntary budget over its core budget means there are powerful funding actors who increasingly decide on the focus and direction of WHO's programmes,<sup>70</sup> and its total income is a fraction of the major bilateral assistance programmes run from the United States and China.<sup>71</sup> The WHO does not necessarily get the first phone call or the first injection of funds. The precarious financing mechanisms within the WHO, with underfunded assessed contributions and voluntary programme funds linked to external actors' domestic or personal objectives, mean that the organization does not control 80 per cent of its own budget.<sup>72</sup> The legislative power granted to the WHO (by Article 43 of the 2005 IHR) to implement additional health measures is constrained by the lack of a sustained funding mechanism (suggested in article 44) through which countries can cooperatively support each other to build core competencies for disease surveillance and response. The WHO will never have the financial or political support it needs to implement all the activities it might wish to undertake to improve public health. States and the institution must know this. Moreover, with the recent cessation of funds from the Trump administration, this precariousness is ever more apparent. But the argument for change and more money is

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<sup>70</sup> Srikanth Reddy, Sumaira Mazhar, and Raphael Lencucha. '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: 1, 2018, pp.NA.

<sup>71</sup> Olivia J. Killeen, Alissa Davis, Joseph D. Tucker and Benjamin Mason Meier, 'Chinese global health diplomacy in Africa: opportunities and challenges', *Global Health Governance* 12: 2, 2018, pp. 4–29.

<sup>72</sup> Charles Clift, *What's the World Health Organization for?* (London: Chatham House, 2014); Sara Davies, *Global politics of health* (Cambridge: Polity, 2010), p. 34.

getting tired. No UN agency is getting more money. What can the WHO do about the inevitable reality?

In an ever more constrained financial environment, it is vital to identify the instances where states seek the cooperation of the WHO to assist with external health diplomacy. This may take the form of novel health governance arrangements, such as the Asia–Pacific Strategy for Emerging Diseases (APSED), adopted by the WHO’s western Pacific and south-east Asia regional offices after SARS and H5N1. Deliberate entreaties to regional institutions such as ASEAN and ASEAN+3 created a politically inclusive network, and the new body was attractive to donors because it had a clear, shared regional purpose tailored to political needs and realities. There is a diplomatic balancing act in such arrangements that requires the WHO to play to both its normative and its technical strengths—in this case, creating an epistemic community of politically diverse experts and bureaucrats from two regions through dense learning and sharing networks.<sup>73</sup> In the post-COVID-19 era, the WHO will need to embrace these new forms of collective power and hybrid governance engagements to establish its epistemic authority and attract donor interest. IR can provide the knowledge inputs to identify opportunity for {14} regional and sub-regional diplomatic engagement, cooperation and planning, being well versed in the creation of security communities.

#### *Human rights: trust and information*

Within both the formal and informal governance of outbreaks, trust is of paramount importance.<sup>74</sup> Broader IR scholarship has contributed to understanding the theme of trust,<sup>75</sup> and these insights have applicability to outbreak response. Communities need to trust in the public health advice they are given, and respond to the authority of domestic and international institutions providing such advice. Recent outbreaks have shown that different

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<sup>73</sup> Davies, *Containing contagion*.

<sup>74</sup> Sonja Kristine Kittelsen and Vincent Charles Keating, ‘Rational trust in resilient health systems’, *Health Policy and Planning* 34: 7, 2019, pp. 553–7; Peter O’Malley, John Rainford and Alison Thompson, ‘Transparency during public health emergencies: from rhetoric to reality’, *Bulletin of the World Health Organization*, no. 87, 2009.

<sup>75</sup> Nicholas J. Wheeler, ‘Trust-building in international relations’, *Peace Prints: South Asian Journal of Peacebuilding* 4: 2, 2012, pp. 1–13.



sources of information are accorded different degrees of legitimacy in moments of crisis,<sup>76</sup> as has been apparent in the debate over the use of face masks during the COVID-19 pandemic.

Lack of trust in actors with supposed authority in health emergencies, differing sources of ‘legitimate’ information and ‘infodemics’ can all have substantial effects on health security. The health-care workers killed in Guinea during the Ebola outbreak in 2014 were perceived to be spreading the disease, rather than trying to quell it.<sup>77</sup> Similarly, we can predict the likelihood of tensions and risk communication failure when government public health campaigns are introduced in locations where governments do not have authority or trust among populations at risk, as was apparent in variable vaccination coverage for polio (another PHEIC) in Syria;<sup>78</sup> arson attacks on Ebola treatment units and health-care facilities in eastern DRC;<sup>79</sup> and vector-control strategies targeted at women in gang-controlled favelas in Brazil.<sup>80</sup> Although the context varies, the importance of understanding informal political control of information and access to communities is everywhere vital for reaching the front line of outbreaks and those most marginalized within health crises.

The WHO has shown little recognition of the relationship between human rights, state capacity and outbreak response since the introduction of the IHR.<sup>81</sup> In the technical spaces of infectious disease surveillance and response we must be attentive to the civil and political rights space in which health-care workers, scientists, NGOs and the media work. Freedom to

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<sup>76</sup> John M. Carey, Victoria Chi, D. J. Flynn, Brendan Nyhan and Thomas Zeitzoff, ‘The effects of corrective information about disease epidemics and outbreaks: evidence from Zika and yellow fever in Brazil’, *Science Advances* 6: 5, 2020, doi: 10.1126/sciadv.aaw7449.

<sup>77</sup> ‘Ebola outbreak: Guinea health team killed’, BBC News, 19 Sept. 2014, <https://www.bbc.com/news/world-africa-29256443>.

<sup>78</sup> Jonathan Kennedy and Domna Michailidou, ‘Civil war, contested sovereignty and the limits of global health partnerships: a case study of the Syrian polio outbreak in 2013’, *Health Policy and Planning* 32: 5, 2017, pp. 690–98.

<sup>79</sup> Vinh-Kim Nguyen, ‘An epidemic of suspicion: Ebola and violence in the DRC’, *New England Journal of Medicine* Apr 4;380(14):1298-1299: 0{?}.

<sup>80</sup> Clare Wenham, *Clean your house and don’t get pregnant: a feminist critique of global health security* (Oxford: Oxford University Press, forthcoming 2021){?}.

<sup>81</sup> Sara E. Davies, ‘Infectious disease outbreak response: mind the rights gap’, *Medical Law Review* 25: 2, 2017, pp. 270–92.

report, freedom to share information without fear of reprisals and freedom to seek health care without fear all affect collective capacity to conduct disease outbreak surveillance and reporting. We only have to consider the implications faced by the Chinese doctors who first alerted the world to COVID-19 in 2019,<sup>82</sup> or similar whistle-blowers during MERS, to see the challenges that this freedom to report poses within political systems.<sup>83</sup>

Human rights is the long neglected core capacity of the IHR that we—academics, states, and regional and international organizations—must collectively discuss.<sup>84</sup> The WHO has neglected to carry out a systematic and sustained review of states' practices concerning human rights obligations under the IHR. This must change, during and after COVID-19, as we see a range of human rights concerns arise. For example, considerations of immunity passports offer widespread concerns for human rights abuses if people are treated differently on the basis of their immunological status.<sup>85</sup> Self-isolation creates human rights challenges when particular communities are locked down for long periods, and immediate danger in highly militarized states when security forces are brought into manage the system of lockdown. These need to be considered by those with experience in human rights analysis, not just public health officials.

### *Gender inclusion*

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<sup>82</sup> Nikhil 'Sunny' A. Patel and Ankita Rao, 'Doctors have been whistleblowers throughout history. They've also been silenced', *Guardian*, 8 April 2020, <https://www.theguardian.com/education/2020/apr/08/coronavirus-doctors-whistleblowers-history-silenced>.

<sup>83</sup> Ian Sample, 'Mers coronavirus: is this the next pandemic?', *Guardian*, 16 March 2013, <https://www.theguardian.com/science/2013/mar/15/coronavirus-next-global-pandemic>.

<sup>84</sup> Davies, 'Infectious disease outbreak response'.

<sup>85</sup> Alexandra Phelan, 'COVID-19 immunity passports and vaccination certificates: scientific, equitable, and legal challenges', *Lancet* 395: 1595, 2020, [https://doi.org/10.1016/S0140-6736\(20\)31034-5](https://doi.org/10.1016/S0140-6736(20)31034-5) [https://doi.org/10.1016/S0140-6736\(20\)31034-5](https://doi.org/10.1016/S0140-6736(20)31034-5)

Feminist IR theory asks ‘Where are the women?’<sup>86</sup> In the analysis of global health emergencies, consideration of women and non-binary gender identities is often missing.<sup>87</sup> In 2020, the primary sex and gender effects of COVID-19 are hard to examine owing to a lack of real-time sex-disaggregated data available during the course of the outbreak, as was the case with H1N1 in 2009 and Ebola in 2014–15, so decision-makers may not appreciate the sex-related distribution of disease. Moreover, policies created to respond to outbreaks fail to appreciate the differential secondary effects of health emergencies on men and women affected or at risk of the disease.<sup>88</sup> Women’s social reproduction (the informal care they perform in the home, caring duties for children or the sick, and increasing role as volunteer community health workers) is undervalued within global health.<sup>89</sup> The combined formal and informal care role that women perform in health emergencies has become even more apparent during COVID-19. As Harman writes, moreover, women are ‘conspicuously invisible’ within the policy space; although they were in positions of apparent power in governance mechanisms for the Ebola outbreak in West Africa, these were not where decisions were made.<sup>90</sup> The failure to include women is replicated across the policy landscape.<sup>91</sup> Women were notably absent from the processes that led to the International

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<sup>86</sup> Cynthia Enloe, *Bananas, beaches and bases: making feminist sense of international politics* (Berkeley, CA: University of California Press, 2014).

<sup>87</sup> Sara E. Davies and Belinda Bennett, ‘A gendered human rights analysis of Ebola and Zika: locating gender in global health emergencies’, *International Affairs* 92: 5, Sept. 2016, pp. 1041–60; Julia Smith, ‘Overcoming the “tyranny of the urgent”: integrating gender into disease outbreak preparedness and response’, *Gender and Development* 27: 2, 2019, pp. 355–69.

<sup>88</sup> Clare Wenham, Julia Smith and Rosemary Morgan on behalf of Gender & COVID 19 working group, ‘COVID-19: the gendered impacts of the outbreak’, *Lancet* 395: 10227, 2020, pp. 846–8.

<sup>89</sup> Sophie Harman, ‘The dual feminisation of HIV/AIDS’, *Globalizations* 8: 2, 2011, pp. 213–28.

<sup>90</sup> Sophie Harman, ‘Ebola, gender and conspicuously invisible women in global health governance’, *Third World Quarterly* 37: 3, 2016, pp. 524–41.

<sup>91</sup> Clare Wenham, Julia Smith, Sara E. Davies, Huiyun Feng, Karen Grepin, Sophie Harman, Asha Herten-Crabb and Rosemary Morgan, ‘Women are most affected by pandemics: lessons from past outbreaks’, *Nature* 583: 7815, 2020, pp. 194–8.

Health Regulations (2005), the Biological Weapons Convention, the Pandemic Emergency Financing Facility, the JEE, the Global Health Security Agenda and the WHO Blueprint on R&D for Health Emergencies.

Beyond the direct impacts of failure to engage with gender during an outbreak, there are several indirect effects. The Ebola outbreak in West Africa demonstrated the effects on health systems. More women died of obstetric and post-natal complications than of the virus itself during the crisis period as health facilities were diverted to solely care for Ebola patients, and some women, fearing Ebola infection in clinical settings, refrained from visiting.<sup>92</sup> The same pattern was evident in a reduction of routine immunization schedules,<sup>93</sup> the consequence of which is likely to be gendered, given norms of (female) social reproduction and the additional care work this might require. The quarantine measures implemented in Liberia during the Ebola outbreak led to a spate of domestic and sexual violence in homes, linked to a surge of teenage pregnancies, a devastating downstream effect equally evident in the COVID-19 episode.<sup>94</sup> Moreover, outbreaks can cause longer-term gender inequalities, with many women losing their small enterprises as a consequence of outbreaks: for example, in the West African Ebola outbreak, the economic security of the predominantly female market traders was

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<sup>92</sup> Laura Sochas, Andrew Amos Channon and Sara Nam, 'Counting indirect crisis-related deaths in the context of a low-resilience health system: the case of maternal and neonatal health during the Ebola epidemic in Sierra Leone', *Health Policy and Planning* 32: suppl. 3, 2017, pp. iii32–iii39.

<sup>93</sup> C. S. Wesseh, R. Najjemba, J. K. Edwards, P. Owiti, H. Tweya and P. Bhat, 'Did the Ebola outbreak disrupt immunisation services? A case study from Liberia', *Public Health Action* 7: suppl. 1, 2017, pp. 82–7.

<sup>94</sup> Seema Yemin, 'The Ebola rape epidemic no one's talking about', *Foreign Policy*, 2 Feb. 2016, <https://foreignpolicy.com/2016/02/02/the-ebola-rape-epidemic-west-africa-teenage-pregnancy/>; Amber Peterman, Alina Potts, Megan O'Donnell, Kelly Thompson, Niyati Shah, Sabine Oertelt-Prigione and Nicole van Gelder, *Pandemics and violence against women and children*, working paper no. 528 (Washington DC: Center for Global Development, April 2020), <https://www.cgdev.org/publication/pandemics-and-violence-against-women-and-children>.

jeopardized for considerably longer than that of men.<sup>95</sup> These trends are all resurfacing during COVID-19, and IR scholarship could anticipate and mitigate such downstream effects of disease intervention strategies. IR questions the impact of emergency response policies that fail to recognize the differential position of men and women within health systems. No humanitarian response or health system is gender neutral or impartial. IR offers important insights to programme and policy design that can help ensure that the effects do not have create disproportionate impacts or burdens on women or other marginalized groups.<sup>96</sup>

### **The current context: diplomatic entry points for COVID-19**

Even a cursory look at the impact of COVID-19 reveals the core potential role of IR in understanding the international response to this outbreak. Tom Frieden has requoted the familiar saying ‘diseases don’t care about governments, ideologies or borders’.<sup>97</sup> Viruses might not care about politics, but the political system in which they operate will have a direct impact on the success of a virus in multiplying and spreading through a community. National

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<sup>95</sup> Oriana Bandiera, Niklas Buehren, Markus Goldstein, Imran Rasul and Andrea Smurra, *The economic lives of young women in the time of Ebola: lessons from an empowerment programme*, working paper no. F-39301-SLE-2 (London: International Growth Centre, Dec. 2018), [https://www.theigc.org/wp-content/uploads/2018/06/Bandiera-et-al-2018-Working-Paper\\_rev-Dec-2018.pdf](https://www.theigc.org/wp-content/uploads/2018/06/Bandiera-et-al-2018-Working-Paper_rev-Dec-2018.pdf).

<sup>96</sup> Smith, ‘Overcoming the “tyranny of the urgent”’.

<sup>97</sup> Thomas R. Frieden, ‘Dr Tom Frieden on the politics of epidemics’, *Think Global Health*, 31 Jan. 2020.

governments,<sup>98</sup> interstate relations,<sup>99</sup> the political economy of states,<sup>100</sup> the challenge to civil liberties,<sup>101</sup> different socio-economic conditions,<sup>102</sup> geopolitical differences in response:<sup>103</sup> all these factors directly affect disease transmission and the success of any intervention measures. We repeat: politics drives epidemics. Failing to engage with politics and international relations means not using the arsenal of potential knowledge available to public health policy-makers and practitioners.

So, what can we as IR scholars offer those making decisions for the current COVID-19 outbreak? Using the five entry points introduced above, we propose the following initial inputs.

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<sup>98</sup> Emma Graham-Harrison, ‘Help or hindrance? How Chinese politics affected coronavirus response’, *Guardian*, 31 Jan. 2020, <https://www.theguardian.com/world/2020/jan/31/help-or-hindrance-how-chinese-politics-affected-coronavirus-response>.

<sup>99</sup> David Nakamura and Anna Fifield, ‘Spread of coronavirus threatens to strain US–China relations along with global health system’, *Washington Post*, 3 Feb. 2020, [https://www.washingtonpost.com/politics/spread-of-coronavirus-threatens-to-strain-us-china-relations-along-with-global-health-system/2020/02/03/14d52fea-469c-11ea-bc78-8a18f7afcee7\\_story.html](https://www.washingtonpost.com/politics/spread-of-coronavirus-threatens-to-strain-us-china-relations-along-with-global-health-system/2020/02/03/14d52fea-469c-11ea-bc78-8a18f7afcee7_story.html).

<sup>100</sup> Frederick Kempe, ‘The coronavirus is just starting to have an impact on the globe’s economy and politics’, CNBC, 1 Feb. 2020, <https://www.cnbc.com/2020/01/31/coronavirus-just-starting-to-have-an-impact-on-global-economy-geopolitics.html>.

<sup>101</sup> Frances Eve, ‘China’s reaction to the coronavirus outbreak violates human rights’, *Guardian*, 2 Feb. 2020, <https://www.theguardian.com/world/2020/feb/02/chinas-reaction-to-the-coronavirus-outbreak-violates-human-rights>.

<sup>102</sup> Felipe Betim, ‘No Brasil informal com coronavírus, domésticas dependem de altruísmo de patrões para evitar contágio’ “For Coronavirus and the informal sector in Brazil, domestic workers depend on the good-will of bosses to avoid infection” [{}], *El País*, 17 March 2020, <https://brasil.elpais.com/sociedade/2020-03-17/no-brasil-informal-com-coronavirus-domesticas-dependem-de-altruismo-de-patroes-para-evitar-contagio.html>.

<sup>103</sup> Tom Phillips, ‘Brazilians stranded in Wuhan issue plea to Bolsonaro for rescue’, *Guardian*, 3 Feb. 2020, <https://www.theguardian.com/world/2020/feb/02/brazilians-wuhan-plea-to-bolsonaro-coronavirus>.

First, comparative analysis. There must be an independent review of states' responses during COVID-19. Confronted with the same pathogen, states' different responses are evident: some heeded WHO advice, others charted their own courses. We need to understand why states make these decisions before we criticize. Different governance approaches are likely to lead to different outcomes, as we are already witnessing. The IHR is not a medicine to be consumed in the same dosage for each state. Domestic politics will have an impact on how this outbreak is governed, and this needs to be fully understood for effective pandemic management.

For example, the Indonesian president admitted he delayed public risk communication for fear of the economic cost that would come with public panic and public restrictions.<sup>104</sup> We need to understand why and how this happened—without bias or causal assumptions—in order to assist the next executive faced with competing demands. Indonesia's case is very different from that of Iran, where secrecy certainly contributed to the mortality rate soaring very quickly. High public distrust in the state's reporting system and its response capacity, fuelled by neighbouring states, has contributed to sustained economic sanctions during the crisis. Assistance to Iran for future implementation of the IHR will look very different from that offered to Indonesia. Understanding the competing interests and political landscape of each country is vital to ensure that policies are developed by the WHO (or other global actors) which can be integrated into the new political reality after COVID-19.

Second, we need to understand constructively when and why states might not comply with the travel and trade recommendations set out in article 43 of the IHR (2005).<sup>105</sup> Despite the WHO not suggesting travel or trade limitations, several countries almost immediately halted travel to and/or from China in January 2020, subsequently extending this prohibition to other high-risk locations. Similarly, governments evacuated and quarantined citizens returning from hot-spots almost as a piece of political theatre to ensure that the population felt that the authorities had the situation under control, even though community transmission was already

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<sup>104</sup> Dyaning Pangestika, “‘We don’t want people to panic’: Jokowi says on lack of transparency about COVID cases”, *Jakarta Post*, 14 March 2020, <https://www.thejakartapost.com/news/2020/03/13/we-dont-want-people-to-panic-jokowi-says-on-lack-of-transparency-about-covid-cases.html>.

<sup>105</sup> Worsnop, ‘Domestic politics and the WHO’s International Health Regulations’.

occurring. Many governments are convinced that the right to decide their trade and travel bans belongs with them alone and not the WHO, despite the IHR (2005). The WHO needs to establish the pattern linking global and national responses, decisions around travel restrictions and the epidemic curve. Then it needs to establish the political conditions under which a state would comply with the IHR recommendations or otherwise, to rebuild trust and incorporate this into the IHR process. Just as not all states are the same, so there will be different models and agendas for potential engagement with member states. The WHO needs to audit member states' interests and their diplomatic red flags. Member states will need different things from the organization at different times; dynamism (which the WHO has previously demonstrated) is pivotal to the organization's future. We argue that each state needs the WHO in some form, so the WHO needs to commit to a systematic framework that analyses and reviews, on an annual basis, what these needs are.

We call, furthermore, for a review of state and interstate activity in global health emergencies. The WHO must seek guidance and support from actors outside the health arena, breaking down silo divisions to bring much-needed expertise to managing the cautious careful diplomatic activity required for a truly global response. Breaking out of the compartmentalization that limits its power and reach, the WHO could approach the UN High Commissioner for Human Rights for consideration of joint reviews; UN Women for gender expertise; UNICEF for on-the-ground concerns; and so on.

Third, we need to understand the money required for, and involved in, the COVID-19 response. Who is paying, and why does this matter? States have increasingly stepped back from providing the WHO with the necessary resources it needs to deliver its core activities (25 per cent of its total budget). The WHO Health Emergency Programme is currently only 74 per cent funded;<sup>106</sup> the WHO has struggled to secure sufficient money for its strategic fund<sup>{15}</sup> for COVID-19 response and, as of 14 July 2020, had received only \$848m, 49 per cent of what it requested.<sup>107</sup> The failure of the WHO's fund-raising attempts <sup>{16}</sup> during this crisis demonstrates that states prefer other mechanisms of resource distribution. The donor

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<sup>106</sup> WHO, 'Key figures', 2017, <http://open.who.int/2016-17/our-work/category/12/about/key-figures>.

<sup>107</sup> WHO, 'Coronavirus disease (COVID-19) donors & partners: WHO says thank you!', n.d., <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/donors-and-partners/funding>.



landscape has moved on, while the WHO has not. The WHO had to create the coronavirus solidarity fund and to appeal for voluntary contributions from individuals, philanthropists and the private sector globally to support the outbreak response through global music events and champions such as Lady Gaga.<sup>108</sup> This is unprecedented; but the global reduction in GDP that will follow the pandemic will only mean a greater need for innovative financing in the future.

Financing shortfalls also raise the question of what the money will be used for. The WHO is a technical organization, and has only modest operational capacity to respond to disease outbreaks through the Health Emergency Programme. Is this out of date? The focus of spending in the coming months is likely to be on vaccine production and distribution, which falls beyond the WHO to GAVI and CEPI. The WHO needs to consider these stark realities in its request for money—what is the ‘added value’ of the institution? We suggest two ways in which the WHO can establish its relevance: through the collection of surveillance data and through reporting under the IHR. The world needs the WHO to be able to detect and share information about new pathogens as early as possible—this part of the IHR seems to be holding up in the COVID-19 outbreak and should be recognized as vital by member states. A suggestion has recently been made that the G20 create a new global viral surveillance organization; this would only replicate existing WHO activity and take further power from the international organization.<sup>109</sup> This is a large part of the organization’s *raison d’être* and it should not be belittled.

Fourth, COVID-19 has shown us the capacity for an outbreak to go ‘viral’ in more ways than one,<sup>110</sup> with the substantial increase in online visits to news provider sites showing that populations are desperate for information. However, this thirst for knowledge can be capitalized on by those wishing to challenge formal debates and scientific evidence, whether

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<sup>108</sup> WHO, ‘COVID-19 Solidarity Response Fund’, n.d., <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/donate>.

<sup>109</sup> David Cameron, ‘We need a new international body to sound the alarm earlier’, *The Times*, 24 June, <https://www.thetimes.co.uk/article/david-cameron-we-need-a-new-international-body-to-sound-the-alarm-earlier-2wwxkc3ml>.

<sup>110</sup> Clare Wenham, Stephen L. Roberts and Elias Mossialos, ‘Is reporting on the coronavirus producing viral panic?’, *BMJ Opinion*, 31 Jan. 2020, <https://blogs.bmj.com/bmj/2020/01/31/is-reporting-of-the-coronavirus-producing-viral-panic/>.

Russian bots, populist presidents or Joe Bloggs with an anecdotal story about his aunt's neighbour's daughter being infected and this giving him legitimate scientific expertise. The study of digital politics {17} has already demonstrated the impact that social media can have in other areas of governance.<sup>111</sup> Expertise on digital politics and methods {18} can advise on ways of navigating the Twittersphere and media storms with the aim of ensuring authority and legitimacy.<sup>112</sup> During COVID-19, the WHO has teamed up with Google, Instagram and Twitter to promote WHO websites, posts and tweets with the aim of encouraging people to have recourse to these sources rather than potentially misleading or hyperbolic information from elsewhere.<sup>113</sup> In the UK, the Department of Health and Social Care has entered a similar arrangement with Twitter.<sup>114</sup> Such relationships may potentially create tensions for future working relationships and control of information, particularly given the concerns over data

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<sup>111</sup> Melanie Freeze, Mary Baumgartner, Peter Bruno, Jacob R. Gunderson, Joshua Olin, Morgan Quinn Ross and Justine Szafran, 'Fake claims of fake news: political misinformation, warnings, and the tainted truth effect', *Political Behavior*, publ. online Feb. 2020, <https://doi.org/10.1007/s11109-020-09597-3>; Philip N. Howard, Aiden Duffy, Deen Freelon Muzammil M Hussain, Will Mari and Marwa Maziad{?}, *Opening closed regimes: what was the role of social media during the Arab Spring?*, Project on Information Technology and Political Islam (PIPTI){?} working paper 2011.1 (**University of Washington**: 2011), available at SSRN 2595096; Yarimar Bonilla and Jonathan Rosa, '#Ferguson: digital protest, hashtag ethnography, and the racial politics of social media in the United States', *American Ethnologist* 42: 1, 2015, pp. 4-17{?}; Tim Highfield, *Social media and everyday politics* (Hoboken, NJ: Wiley, 2017).

<sup>112</sup> Ryan Browne, 'Facebook to remove misinformation about coronavirus', CNBC, 31 Jan. 2020, <https://www.cnbc.com/2020/01/31/facebook-to-remove-misinformation-about-the-coronavirus.html>.

<sup>113</sup> 'UN health agency works with Google to combat coronavirus misinformation', ITV News, 3 Feb. 2020, <https://www.itv.com/news/2020-02-03/un-health-agency-works-with-google-to-combat-coronavirus-misinformation/>.

<sup>114</sup> Andrew Griffin, 'Coronavirus: Twitter directs users searching for information about deadly virus to official websites amid lies and rumours', *Independent*, 30 Jan. 2020, <https://www.independent.co.uk/life-style/gadgets-and-tech/news/coronavirus-twitter-search-china-official-advice-health-latest-a9310106.html>.

mining on health matters.<sup>115</sup> To ensure impartiality, buttress its leadership and reassert its position as the normative leader in global health, the WHO must consider the impact of these decisions.

Fifth and finally, we need to ask: where are the women in this outbreak? COVID-19 is already having a disproportionate impact upon women, regardless of context. While considerable attention has been given to the mortality burden, which appears to weigh more heavily on men, we have yet to see comprehensive sex-disaggregated data on incidence, owing to differential testing policies, which in many countries have limited testing to health-care workers. Given that women comprise 70 per cent of the global health workforce, it is important to know whether this role is putting them more at risk of infection than the general population; and for this we need accurate data. Second, we need to analyse the secondary impacts on women—both on their health and within society. COVID-19 is already leading to disruption to supply chains, and barriers to accessing contraception,<sup>116</sup> which is likely to lead to rising numbers of unwanted pregnancies, including in contexts where abortion may also be restricted.<sup>117</sup> Women, too, perform the burden of care work, both formally, as health-care workers, cleaners and teachers, and informally in the home. Women face greater risk of contracting the disease if they are caring for those infected, and will experience the impact of additional burdens of care as a consequence of public health interventions to combat disease transmission; the closure of schools and care homes, for example. We need to consider the threats to which women may be subject in their homes if they are required to self-isolate with their families when they may be at risk of domestic violence, and the long-term impact of the outbreak on women's economic empowerment if they are forced out of work to care for children or for other reasons. This problem is particularly acute in low- and middle-income

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<sup>115</sup> Carleen Hawn, 'Take two aspirin and tweet me in the morning: how Twitter, Facebook, and other social media are reshaping health care', *Health Affairs* 28: 2, 2009, pp. 361–8.

<sup>116</sup> Christopher Purdy, 'The coronavirus will affect global access to contraceptives', LinkedIn, 7 March 2020, <https://www.linkedin.com/content-guest/article/coronavirus-affect-global-access-contraceptives-christopher-purdy/>.

<sup>117</sup> [Jessica](#) Glenza, States use coronavirus to ban abortions, leaving women desperate: you cant pause a pregnancy, The Guardian, Thursday 30<sup>th</sup> April <https://www.theguardian.com/world/2020/apr/30/us-states-ban-abortions-coronavirus-leave-women-desperate>

countries where lockdowns could create generational gaps for gender equality in areas including access to schooling, income and civic participation.<sup>118</sup>

### **Conclusion: who are we talking to?**

Why does attention to IR matter for the response to this and other disease outbreaks? The WHO is the international magnet that brings states together to discuss and collaborate on all matters of health science. The WHO has relied on science to persuade its member states and often to override their instinctual preferences. But scientific argument is not always enough to sway political forces. Political knowledge, political methods and policy implementation expertise are also needed to inform the problem-solving skills required to understand contemporary sovereign behaviour. The WHO's failure to grasp the political priorities of its member states, and realize that ministries of health do not figure highly among them in many cases, has left the organization struggling to manage and delegate its authority in recent years—as is apparent if we look at the intense contestation about its actions in response to H1N1, MERS, Ebola, Zika and now COVID-19. Everyone needs to be in the room, not just the white coats.

Therefore, we suggest, the WHO (and the broader global health governance landscape) needs to pay serious analytical attention to the competing diplomatic priorities of states. IR scholarship is well placed to assist the WHO with orchestrating states' geopolitical and diplomatic relationships in all their breadth and depth. The knowledge entry points we have identified in this article should therefore, we suggest, become core business for the WHO and other technical agencies that are seeking to advance optimal diplomatic conditions for coordinated responses to the increased technical challenges to come. In this time of COVID-19, where political decisions are having direct impacts on who lives and who dies, meaningful engagement between public health and IR is vital. Let us end the disciplinary quarantine.

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<sup>118</sup> Ginette Azcona, Antra Bhatt, Sara Davies, Sophie Harman, Julia Smith and Clare Wenham, *Spotlight on gender, COVID-19 and the SDGs: Will the pandemic derail hard won progress on gender equality?* (New York: UNWomen, 2020), <https://www.unwomen.org/en/digital-library/publications/2020/07/spotlight-on-gender-covid-19-and-the-sdgs>.