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## **Ebola respons-ibility: moving from shared to multiple responsibilities**

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## **Ebola Respons-ibility: Moving from shared to multiple responsibilities**

### **Abstract**

Combating threats of infectious diseases has been increasingly framed as a global shared responsibility for a multi-actor framework, of states, international organisations and non-governmental actors. However, the outbreak of Ebola Virus Disease (EVD) has shown that this governance framework has not been able to limit the spread of this virus, despite the normative and legislative changes to global disease control. By unbundling the concept of responsibility, this article will assess how global shared responsibility may have failed due to the fact that accountability does not fall on any one state or stakeholder, highlighting an inherent weakness with the global disease governance regime. As such, this paper concludes that a move towards multiple responsibilities may prove a more effective mechanism for ensuring global health security.

Keywords: Ebola, responsibility, global disease governance, disease control, accountability

### **Introduction**

*“There is no one to take responsibility, absolutely no one, since the beginning of the [EVD] crisis”* claimed a Médecins Sans Frontières (MSF) advisor (New York Times: 3/9/2014) summarising the unprecedented scale of the West African outbreak. This paper seeks to question this assumption of responsibility for disease control. It suggests that the framing of a global shared responsibility for disease threats, which has developed in the post-SARS era, is inherently flawed if no one actor is able to be held accountable for any one part of it. This empirical study of EVD offers an alternative re-framing, as multiple accountabilities may prove more fruitful for understanding failures in this health crisis. This paper suggests three sets of actors that contributed to the chaotic response to the global health threat: the E3 states (Sierra Leone, Liberia and Guinea), the World Health Organisation (WHO) and Western states. As such, instead of relying on a global shared responsibility for disease control, the paper suggests global health should seek a new framework for governance of infectious disease, with more clearly defined responsibilities for individual actors, based on established accountability chains.

### **The EVD Outbreak**

EVD is a relatively rare disease, yet the 2014-5 crisis represents the largest and most complex outbreak on record, witnessing over 28,000 cases and over 11,000 deaths. This amounts to more cases than all previous outbreaks of EVD combined, since its ‘discovery’ in 1976<sup>1</sup>. These previous outbreaks were successfully controlled through rapid diagnosis; effective treatment of infected individuals; isolation of patients; contact tracing of all potential infections; safe burials and effective community mobilisation. As such, this EVD outbreak is paradoxical: from a public health perspective the pathogen is readily controllable and yet for much of 2014 it was out of control<sup>2</sup>. Consequently

the global health community has sought to understand what or who may be responsible for the unprecedented scale of this outbreak.

One plausible analysis by Piot suggests a series of delays and an uncoordinated response have created a 'perfect storm' for the outbreak to spread rapidly through the population<sup>3</sup>. One such delay was the time-lag between the episode emerging in rural Guinea in December 2013, and it being reported to the WHO on 22<sup>nd</sup> March 2014. Further factors contributing to Piot's perfect storm narrative include; the spread within a dense urban area; highly mobile populations; porous international borders; the pathogen's appearance in a previously uninfected location; the lack of health system capacity; and mistrust within West-African governments<sup>4</sup>. This paper works within this perfect storm narrative, and seeks to suggest a further contributing factor; the failure of global shared responsibility in global disease governance.

### **Global Shared Responsibility**

The framing of an issue is vital to understanding the ensuing response. The outbreaks of SARS (2003), H5N1 (2005), H1N1 (2009) and MERS (2012-2015) highlighted global mutual vulnerabilities to infectious disease, leading to disease being framed as a collective security threat<sup>5</sup>. This collective security suggests that the responsibility for the protection from the threat (of disease) is held collectively rather than by individual members of the community. Such an understanding can be seen through the favouring of a dynamic global disease governance arrangement championing global shared responsibility for disease control. The framework of global disease governance involves many actors, each maintaining an important position in a multi-actor mosaic. This includes states, international organisations (such as WHO, UN, World Bank etc.), NGOs (ranging from large NGOs such as MSF down to grassroots initiatives, such as those seen in the EVD crisis offering community awareness about the risks of the disease), the private sector, public-private partnerships and many more besides. Although this produces a series of complex interactions between the stakeholders, one point of convergence appears to be their mutual understanding of global shared responsibility.

International organisations have started to use the language of global shared responsibility for global health. The WHO website suggests that *"In the 21st century, health is a shared responsibility, involving ... collective defence against transnational threats"*. The UN have also used the language of shared responsibility for addressing major global threats, in particular in the Millennium Declaration which states there is a *'shared responsibility for managing ... threats to international peace and security'*<sup>6</sup>, and in titling a key report *A More Secure World: Our Shared Responsibility*, which explicitly

recognised that *“no state, no matter how powerful can by its own efforts alone make itself invulnerable to today’s threats... we all share responsibility for each other’s security”*<sup>7</sup>

Academic scholars have similarly used this framing of global shared responsibility for disease: Buse and Martin, in their analysis of the response to HIV/AIDS suggest *‘Shared responsibility represents a normative ideal to which both individual stakeholders and the global community must subscribe [if our collective vision of an AIDS-free world is to be realised]*<sup>8</sup>. Davies, Youde & Parker recognise this normative ideal through their work on *“Shared Responsibilities of Disease Surveillance”*<sup>9</sup>. Furthermore, Gostin et al. highlight in their analysis of global health that there is a *“shared responsibility for collective defence against transnational health threats”*<sup>10</sup>.

Moreover, global leaders have also used this rhetoric of shared responsibility for disease control. Margaret Chan, Director General of the WHO stated, *“When the world is collectively at risk, defence becomes a shared responsibility of all nations”*<sup>11</sup>. David Heymann, former Assistant Director General at the WHO, suggested that there is a *“shared responsibility for improving international public health security”*<sup>12</sup>. President Obama, during the EVD outbreak asked the global community to speed up the response, claiming, *“The world has a responsibility to act, to step up and do more”*<sup>13</sup>. This language echoes that of Hillary Clinton in relation to HIV/AIDS who declared *“America’s commitment to shared responsibility as we all work together towards... creating an AIDS-free generation”*<sup>14</sup> and Onyebuchi Chukwu, Nigeria’s Health Minister, saying *“African countries were on the right track by sharing the responsibility in health”*<sup>15</sup>.

However, this global shared responsibility is most clearly manifested through the revisions to the International Health Regulations (IHR) completed in 2005. These marked a conceptual shift for the responsibilities of states, non-state actors and the WHO<sup>16</sup>. The aim was to develop a regulatory framework for states and non-state actors to meet certain core public health competencies to limit the transnational spread of infectious disease, championing this new understanding of global shared responsibility. To paraphrase Bruen et al., frameworks such as the IHR rearrange responsibilities to mimic the transition from a world of governments to a world of governance<sup>17</sup>. Under the IHR, all states have a responsibility to develop, strengthen and maintain the capacity to detect, assess, notify and report (an outbreak) to the WHO<sup>18</sup>. Furthermore, they also have a responsibility beyond their own borders, firstly in maintaining a degree of vigilance over the health of others<sup>19</sup>, but to support other states in meeting their core capacities too: *State parties shall undertake to collaborate with each other in... the development, strengthening and maintenance of the public health capacities required under the regulations.*<sup>20</sup>

The involvement of a wider set of stakeholders beyond just states further reflects the normative shift to global disease governance and the framing of shared responsibility for disease control. For example, under the IHR, the WHO have a responsibility to help states meet the core capacity requirements; collaborate in surveillance, verification and response (Articles 5, 8 and 10) and even share information with other states if necessary for public health benefit (Article 10). Moreover, under Article 9, other actors (broadly defined) are able to notify the WHO of unusual health events, if member states fail to do so in a timely manner. This represented a normative change from previous iterations of the IHR, which only allowed for reporting between states and the WHO. Furthermore, Articles 14 and 44 suggest that states and the WHO should coordinate their activities in infectious disease control multilaterally with other states, through regional networks, international organisations and with other competent international bodies.<sup>21</sup>

On first viewing, such articles of the IHR may seem to show quite clearly defined responsibilities for individual actors. However, framed holistically as part of the wider discourse of shared responsibility, a tension has arisen with their enforceability. An inherent problem with a collective governance arrangement is that it is incapable of bearing shared responsibility for any particular outcome when no individual member of that community is individually accountable for their part<sup>22</sup>. As highlighted by Gostin and Friedman “the IHR do not allocate responsibility”<sup>23</sup>. There may be defined activities for each actor to carry out, but there are no means to ensure actors uphold their responsibilities. What underlies the power of any governance mechanism is enforceability, and even where broad norms are accepted in rhetoric (as with global shared responsibility) and even formalised in treaties (such as the IHR) their enforcement remains problematic<sup>24</sup>. This may be due to multilateral horizontal governance arrangements creating chains of accountability that are less clear and direct than within more vertical systems such as domestic politics<sup>25</sup>. This paper suggests that the outbreak of EVD highlights the framing of global shared responsibility offers an unclear allocation of responsibility, but where this allocation is present (under IHR) global shared responsibility lacks a clear chain of enforceability and accountability. Major failures of governance normally call for a review of the status quo, and to reconfigure the arrangements to ensure that such crisis does not reoccur. This paper suggests that to provide greater security from the threat of disease, global shared responsibility should be reframed in terms of multiple responsibilities of individual actors.

### **Multiple Responsibilities**

Accountability for one’s responsibilities can be understood as the condition of being answerable to someone for one’s activities or performance. It is often underpinned by principal agent logic, in that there is a lead actor (principal) to set responsibilities for agents to carry out, and judge whether they have fulfilled them<sup>26</sup>. However, global health does not always lend itself to readily identifiable

principals and agents, as this binary relationship does not reflect the multiple actors, relationships and power in a multi-actor governance framework such as global disease governance<sup>27</sup>. One suggestion might be that the rhetoric of global shared responsibility for disease infers the agents are the multiple actors involved in the framework. However, designating the principal of such a collective arrangement proves more difficult. If taking a globalist view, this principal might be the global population, who seek to benefit from the reduction in disease incidence and give multiple organizations the responsibility for delivering on that<sup>28</sup>. A statist approach might suggest that Western states are the principal, as they champion the global disease governance framework to ensure their own health security. However, whilst either of these principals would be able to judge whether the global health community has fulfilled their responsibilities, neither are able to truly hold the many actors to account for their failings. Ebrahim and Weisband identify this as a common analytical problem of accountability and responsibility as *“a rift between how it is imagined and how it actually operates . . . [for] definitions and framings of responsibility tend to be driven by normative agendas rather than by empirical realities”*<sup>29</sup>. As such, the normative agenda may call for a global shared responsibility, but the empirical reality – as we shall see through analysis of EVD - does not reflect this framing of responsibility, but rather suggests a myriad of differing principal – agent relationships, which need to be recognised and incorporated into global disease governance to improve its efficacy.

Many actors recognise disease as a security threat. However, the way in which they conceive of this security may vary. For example, some may understand the referent object of threat to be the state (national security threat); the population (human security threat); or economic interest (socio-economic threat)<sup>30</sup>. If there is no true common understanding of the ways in which disease constitutes a security threat, then it is probable that conceptions of global shared responsibility to combat the threat are not alike either. Therefore it may be that there is never a clear alignment of what this shared responsibility may entail, and other accountability chains may be prioritised. Accordingly, what might be seen is that fundamentally, collective responsibility cannot and does not take precedence over the individual interests of actors<sup>31</sup>. In the case of EVD, each actor made a rational calculation of their interests in and responsibility for disease control and to whom they feel accountable for this responsibility, such as their electorate, their international donors or economic interest groups rather than prioritising this notion of global shared responsibility.

Moving away from this notion of global shared responsibility, this paper seeks to show that in fact there were multiple responsibilities and accountability relationships present during the outbreak concurrently. This paper suggests that the actions of three key sets of actors can be shown to represent the failure of shared responsibility; E3 states (Sierra Leone, Liberia and Guinea), the WHO

and Western States. This is not an exhaustive list, and several other actors involved in the global disease governance network could equally be placed here. However, these three have been selected as three of the most prominent actors involved in the response, both financially and from a hands on perspective. Furthermore, these three sets of actors appeared during the outbreak to reject the norm of global shared responsibility either in favour of their own domestic priorities (the E3 and Western states), or due to structural and financial limitations (the WHO). It is important to understand why they were unable to uphold the normative ideal of global shared responsibility, and to reflect on their competing priorities and understandings of domestic and international accountability chains in an effort to strengthen the global disease governance framework ahead of future outbreaks.

### **E3 States**

Individual states (at least in democratic political systems) have a clear principal – agent accountability relationship between state functions/elected officials and the electorate. As part of the social contract, states have a responsibility to safeguard and protect the health of their populations, and to take the necessary steps to ensure the health security of their citizens<sup>32</sup>. This includes access to essential goods and services under the concept of right to health<sup>33</sup>. As such, it should have fallen to the E3 states to have sufficient resources to detect and respond to the outbreak in the first instance. The structural weakness of their health systems has been highlighted as a key factor in their failure to do so<sup>34</sup>. Liberia, Guinea and Sierra Leone rank amongst the lowest in the world on the Human Development Index (176, 179 and 183 respectively out of 187 countries<sup>35</sup>). As such, it is not surprising that they do not have a health system able to cope with the extra capacity required to handle a mass epidemic<sup>36</sup>. An outbreak of cholera in 2012 in Guinea and Sierra Leone demonstrated that the health systems in this region were incapable of handling any sort of health emergency, with the WHO reporting on their website soon after that several health care facilities did not even have running water or electricity.

Several functions of a health system which would be normally required to limit the spread of a communicable disease were not present; there was a severe dearth of qualified health care workers (for example Liberia has 0.1 physicians, 1.7 nurses and midwives and 8 hospital beds for every 10,000 people<sup>37</sup>); disease surveillance was rudimentary at best (it is estimated that it took 3 months for the Guinean Ministry of Health to become aware of the outbreak in the first instance); and there was little wherewithal for surge capacity resources to respond to such an outbreak. This lack of capacity was compounded by the governments of the affected countries initially being in denial over

the occurrence of the disease, and consequentially, relinquishing responsibility for the care of infected patients to overworked NGOs, whilst simultaneously issuing incoherent directives, such as the closures of markets and borders<sup>38</sup>. This highlights the fact that the E3 states had already failed in their responsibilities to offer health security to their citizens well before this outbreak emerged, quickly becoming overwhelmed when cases presented at hospitals. This suggests a first failure of responsibility; that of the elected organs of state failing to meet their safeguarding responsibilities to their citizens.

The E3 states are also accountable to international donors who have provided funding for their post-conflict reconstruction efforts, although not always in ways that delivered positive results. Kentekelenis et al. have shown that the International Monetary Fund loans with attached conditionalities have undermined government funding for the health systems in E3 states, and that these have contributed to the weak health systems which have proven wholeheartedly insufficient to cope with the outbreak<sup>39</sup>. This shows an interesting accountability prioritisation at play, in that these states have appeared to prioritise their relationships with western donors, and the responsibilities they feel to them to meet certain governance requirements, rather than the accountability they feel towards their citizens to limit the spread of disease.

Under the IHR, states are required to strengthen their disease control capacities, including in the areas of policy, surveillance, response, preparedness, human resources and lab capacity. However, an analysis in 2013 showed that none of the E3 states had met their IHR requirements. Nor, in fact, had any African nation<sup>40</sup>. Herein lies a key problem with the IHR as they stand. The IHR assume that states shall utilize their existing national structures and resources to meet their core capacity requirements. However, such requirements implicitly assume that states already have a relatively well functioning public health infrastructure to which these additional requirements can be attached<sup>41</sup>. The IHR, whilst offering best-practice disease control policies, include no financial allowance to help states attain the required infrastructure. More notably, there is little enforceability if states fail to meet the requirements. Based on normative understandings (such as shared responsibility), it was hoped that states would strive to meet these competencies, yet there are no sanctions for not attempting to do so. As such, E3 states did not have infrastructure in place to be able to detect, report and respond to the EVD outbreak. Yet, this may not suggest that the E3 states have not internalised the normative understandings of global shared responsibility and global disease governance, rather that they do not have the resources to implement any public health improvements.



Interestingly, a considerable amount of academic literature in global health since the IHR revisions has focused on the normative requirement of states to report an outbreak in a timely manner, irrespective of this capacity. It has been suggested that, despite a lack of strict enforceability, states would do so for fear of being named and shamed by the international community<sup>42</sup>. In this outbreak, the fact that Guinea didn't report an outbreak to the WHO under the IHR instrument for almost four months has not received the aforementioned 'naming and shaming' that was witnessed during SARS. This may be because other actors recognise the lack of capacity in this region to detect an outbreak either through state or non-state infrastructure, or it may represent the fact that the global disease governance agenda has recognised that there is little enforceability of such a norm in the real world. Nevertheless, E3 states have violated their responsibilities both to their citizens to offer freedom from the threat of disease, but also in their global shared responsibility under the IHR to meet certain competencies<sup>43</sup>.

## **WHO**

With the framing of disease as a security threat in recent decades, the WHO has continued in its "*central and historic responsibility for the control of the international spread of disease*"<sup>44</sup>, and has sought to take on the leadership duties enshrined within it. However, as the following discussion will show, throughout the EVD outbreak the WHO has fallen short of its leadership responsibilities for disease control, which they themselves have recognised through an open apology and an interim assessment panel highlighting its failures<sup>45</sup>. This is an interesting turn for understanding responsibility in global disease control, as their accountability relationship should (in strict principal-agent logic) be to their member states, and yet they recognise that they have also failed in their responsibilities to individuals affected by the outbreak<sup>46</sup>.

First and foremost, the WHO has been widely criticised for inactivity in the first months of the outbreak. Although the WHO were effective in their epidemiological analysis of the outbreak<sup>47</sup>, their initial approach failed to take into account the attributes of the location (in a densely populated area) with numerous travel routes across borders, suggesting the outbreak could have considerable reach. The New York Times reported (April 1<sup>st</sup> 2014) that the WHO dismissed the outbreak as '*it's quite difficult to transmit... you have to touch someone. Fortunately for the greater population, the risks are quite small*' and similarly the institution was quoted in Reuters (April 1<sup>st</sup> 2014) '*this is relatively small still... we need to be very careful about how we characterise something which is up until now an outbreak with sporadic cases*'. As such, in the initial months after notification of the outbreak, the WHO did little to elicit a response, relying on the regional AFRO office and the E3 WHO country offices to keep abreast of developments<sup>48</sup>.

Following on, the WHO sought to deflect any responsibility onto the overwhelmed governments of the E3 for not being able to manage such an outbreak on their own. Although they cannot be held accountable for the delay in reporting the outbreak by the E3 Ministries of Health, the WHO can be held to account for not understanding the gravity of the situation, in that it took them until August 8<sup>th</sup> 2014 to declare the outbreak a Public Health Emergency of International Concern (PHEIC), despite having received the initial report of the outbreak in March 2014, as well as a number of warnings from officials and NGOs in E3 states (New York Times: January 6<sup>th</sup> 2015). By this stage, a WHO online interim report suggested that the disease had already infected 1779 cases with 961 deaths. It could be suggested that the delay in declaring a PHEIC was as a result of both being preoccupied with MERS-CoV, H7N9, H5N1 and polio, but it may also have been a reaction to their over cautious response to the H1N1 pandemic in 2009. The WHO may have been cognisant of the criticism they faced overreacting to that outbreak, not wanting to cause undue global alarm, not to mention the organisation's concerns about the economic impact to West-Africa (The Guardian: March 20<sup>th</sup> 2015). However, such inactivity can suggest that the WHO failed in its responsibility to its member states to lead an effective response to the outbreak. More explicitly it failed in its prescribed role in the IHR to assist with verification and response to an outbreak (Articles 8 and 10) and in its responsibilities to cooperate, coordinate and collaborate with states and non-state actors in the ensuing response (Articles 14 & 44).

However, is it not much of surprise that the WHO has failed in its responsibility to its member states in the outbreak of EVD when roles and responsibilities are not clearly defined within the organisation. This may have led to different levels of the organisation (HQ, regional and country) passing the buck, as there wasn't a clear division of labour, nor accountability. Interestingly, a review process in 2014 showed that *"there were different understandings and interpretations by managers and even senior leaders on their respective roles and responsibilities"*<sup>49</sup> Furthermore, the WHO has suffered from substantial budget cuts in recent years. The budget for responding to outbreaks was reduced to \$228m in 2014-5 compared with \$469m in 2012-13<sup>50</sup>. Its budget is now a third of that of the United States' Center for Disease Control (US-CDC), which Gostin and Friedman have described as *"incommensurate with its responsibilities"*<sup>51</sup>. More alarmingly, there are no core funds reserved for emergency outbreaks, which does not allow for an appropriate base from which to start a response<sup>52</sup>. Even if the WHO had declared a PHEIC sooner, it was still missing the much needed financial resources required for managing the outbreak. The WHO subsequently had to put out a series of calls for increasing emergency funding<sup>53</sup>. Prior to this outbreak, Fidler questioned whether the consequences of WHO budget cuts would fall disproportionately on countries least able to manage dangerous disease events<sup>54</sup>, which appears to have been exactly what has happened in the

E3 states, as the organisation they were supposed to rely on to offer leadership in their global shared responsibility for global disease control failed to support them in their time of need. However, responsibility for this lack of finances available to handle an outbreak can also highlight the failings of the reverse the accountability relationship between WHO and states, as the latter have consistently failed to meet their committed donations each year, hampering their agent's ability to carry out the necessary activities.

### **Western States**

Western states have also been criticised for their response to the EVD outbreak. The United States, have committed over \$350 million, the UK £437m, France EUR20m and China \$120m to the response. To contextualise this, the USA spent a total of \$321 million between 2012-2014 on emergency response and pandemic preparedness<sup>55</sup>. The Western response has included deploying personnel from several governmental departments, building of EVD treatment units, providing diagnostic kits and laboratory facilities, training healthcare workers and provision of medical equipment<sup>56</sup>. However, these interventions have been heavily criticised due to the self-interested nature responses from Western states. Their involvement coincided with the first infections manifesting themselves in USA and Europe, many months after the start of the outbreak in West Africa. Yet, if taking the same principal-agent logic of accountability that was applied to E3 states, these governments understand their responsibility to their population in the same terms, in that they are responsible to their electorate for ensuring that the threat of EVD does not reach their shores, then this is not surprising. By extension, examining the response of Western states to the EVD outbreak, it could be that their involvement shows that their understanding of a global shared responsibility is more aligned to a global shared responsibility for (their own) national health security. There is no coincidence to this, perhaps the self-interested nature of their response further highlights the inadequacies of the shared responsibility discourse championed by the global disease governance regime<sup>57</sup>.

The Western community could further be held responsible for the onslaught of media hysteria surrounding the outbreak. In highlighting the threat of EVD, and framing it as a deadly plague, the media spawned public fear in several Western countries. As such, these states were then required to take what could be seen as placebo measures to reassure their citizens that they were not at risk of EVD, and that the government had a functioning preparedness plan, should it reach their shores. This included the USA, UK, France and Canada implementing heightened airport screening for potential EVD cases – a biosecurity measure which has been widely criticised by the public health community for its limited efficacy, due to the long incubation period of the pathogen where

travellers may not show any symptoms<sup>58</sup>. Ironically had the financing provided for airport screening been used to resource the on-going response in the E3 or to meet their WHO funding commitments, rather than within Western states, this could have had a considerably greater impact. A number of national airline carriers also suspended flights to E3 states in an effort to stop the international spread of the disease (including British Airways, Emirates, Air France), despite UN resolution 2177 asking for states to not impose such travel changes. Although this was at the discretion of each airline, rather than Western states, this action by Western carriers severely restricted the economies of these E3 states further through barriers to international travel and trade. This is in spite of the fact that such measures would do little to limit the spread: as projections suggest that only 2.8 people per month were likely to be infected with EVD and leave the E3 by air<sup>59</sup>. This highlights a further accountability relationship, the accountability that the Western community feels towards its business and economic interests.

The Committee on Social, Economic and Cultural Rights has declared that cooperation in health is not only an obligation of all states, but for all those in a position to assist others<sup>60</sup>. However, according to Gostin et al. in their review of national and global responsibilities in health, one of the least understood obligations is the responsibility of Western states to augment the capacity of low and middle-income states to ensure their populations' health<sup>61</sup>. In the case of the EVD outbreak, Western governments could be seen to be shirking their responsibilities in this area by failing to support the strengthening of the E3 health systems. The IHR, although not offering provision for financing to help states meet their core competencies, do *strongly encourage* states to provide each other with technical cooperation and logistical support to help develop the core competencies sought through the legislative framework. However, as aforementioned, the E3 states suffered from an exhausted and woefully under-resourced health infrastructure, which was barely able to handle endemic diseases in the region, let alone an outbreak of this scale. Although the ultimate responsibility for not developing a functioning disease control mechanism must fall on the E3 states themselves (and the flawed IHR funding and enforceability mechanisms), Western states should also bear some responsibility for their shortfalls in contributing to helping these states meet these requirements, as per the IHR articles 14 and 44. This argument has suggested that, had Western states invested in greater health system strengthening in the E3 countries prior to the outbreak rather than focusing on issues of Western biosecurity, this outbreak may not have become the humanitarian crisis that has been witnessed.

### **The end of shared responsibility**

*The [global] community must show the collective responsibility absent at the start of this outbreak to bring it to an end*<sup>62</sup>.

As set out in the preceding discussion, the EVD epidemic has exposed a fragmented disease control governance framework in which the institutions do not function as a coherent whole<sup>63</sup>. Moreover, it has highlighted that global health does not always offer readily identifiable principals and agents, as this does not reflect the multiple responsibility relationships that actors contend with<sup>64</sup>. It is a combination of multiple failures in individual responsibilities that led to the collective failure of the global health community to be able to limit the spread of the EVD outbreak in a reasonable time frame. The framing of responsibility as a shared concept muddied the waters of responsibility and had made it less clear what each actor's roles (and duties of such role) are at the global level and to whom each is accountable.

This paper does not wish to suggest that actors should go it alone, or that there should be an end to global cooperation for disease control and response. In the interconnected world in which we exist, such action would be unfeasible. With mass travel and transport, it is inevitable that diseases will cross borders, and that the mutual vulnerability to the threat of disease is ever present. As such, multiple actors will need to continue to work together to manage the threat. Gostin and Friedman have called for a new global health framework, one in which there were "*clearer roles and responsibilities for all stakeholders... Including effective legal methods to establish clear accountability (and shared responsibility to build core capacities)*"<sup>65</sup>. This paper actively supports such a position, but suggests that a core problem with the global health framework as it stands is the very concept of shared responsibility.

Interestingly, other areas of global health governance have clearer definitions of delineated responsibility. For example, the Framework Convention on Tobacco Control has a code on responsibility; the Global Health Workforce Alliance has defined membership responsibilities and as such there seems to be a precedent for the production of clearer divisions of labour, which should be embraced by the global disease governance community. Fundamentally, the global health architecture must find a way to be able to hold individual stakeholders accountable in order for global efforts in disease control to be effective<sup>66</sup>. There should be delineated roles and responsibilities, where each actor in the framework has a designated position within the global disease control matrix and understands what their responsibilities are for and to whom. It has been suggested that significant impetus or political shock must be present to change the status quo of any international law<sup>67</sup>. The crisis of the EVD outbreak and the evidenced failure of global shared responsibility may

hopefully provide such an impetus, in the same way that SARS acted as a catalyst to update the IHR in 2005.

As an interconnected globe, there is a need to work together to face the spread of infectious disease, and yet individual actors need more tangible individual responsibilities for which they can be held to account. Developing a more coherent responsibility and governance framework will be a difficult challenge. Although this paper cannot provide all of the answers, it seeks to offer three recommendations for consideration in any new approach.

#### Learning from other governance frameworks

One recommendation would be to reflect on other global governance arrangements. An assessment of global environmental governance showed that the most successful engagement between actors happens at a more devolved level of activity<sup>68</sup>. Furthermore, reflecting on the Sustainable Development Goals and the Millennium Development Goals, it can be seen that a goal setting approach with effective progress monitoring has raised public and policy support, as well as being a mechanism to channel funds to areas in urgent need<sup>69</sup>. As such, multiple devolved arrangements with clearer tangible goals between actors bilaterally or multilaterally could provide a more fruitful result than broader normative calls for global shared responsibility for improving global health security.

#### Offering greater financing mechanisms

A key factor in this EVD outbreak and around the IHR more generally has been a lack of financing to implement disease control measures<sup>70</sup>. Western states fundamentally will need to offer greater financing mechanisms to ensure health security. This could be done bilaterally between states or through increased contributions to the WHO, allowing for a strengthened role for the lead global organisation for health. In the case of EVD, it did not appear that the E3 states were fundamentally unwilling to internalise the normative understanding of responsibility for global health security or to improve their domestic disease control capacities, they simply lacked the resources to do so. Accordingly, one such devolved responsibility relationship could be, based on Articles 14 and 44 of the IHR, for Western states to help build disease control infrastructure in developing states. The EVD crisis has highlighted that improving disease control is very much in the interest of Western states that seek to protect their own populations and economies from the threat of disease, and therefore such a relationship may suit both parties.

Obviously there are a number of issues with such a recommendation that would need to be addressed, notably that it would reinforce unequal power relationships between states.

Furthermore, it would depend on the willingness of Western states to bear the costs accordingly. Moreover, if done bilaterally, it would not adequately account for the WHO's activities in global health, or necessarily offer them an empowered role as championed by Gostin and Friedman<sup>71</sup>. Who should decide on how these new multiple accountability relationships are formed or financed is a greater question, and would open its own Pandora's box. However, individual relationships have developed through previous outbreaks, as well as the former colonial links reemerging in the EVD crisis (which raises its own concerns), suggesting that actors could arrange themselves organically. Simply, this paper calls for greater financing mechanisms, whether from Western states or other Bretton Woods institutions<sup>72</sup>, to help developing states, such as the E3, build effective disease control infrastructure.

#### Addressing issues of enforcement

Enforcement is another issue, and one that deserves considerable thought to explore effective mechanisms for ensuring that each actor in the framework takes their responsibilities seriously and meets any designated goals, in whatever formation these may appear. Although this is a recurrent problem in international law, the IHR and normative goals of global disease governance have not proven strong enough to generate global action. One example might be to include independent monitoring of country compliance into the IHR, rather than the status quo of self-assessment<sup>73</sup>. An alternative approach could include withholding institutional privileges at the WHO, such as voting rights at the World Health Assembly, for those actors who fail to meet their individual requirements. Another option would be to move away from conceptualising enforcement, and to consider incentivising states to adhere to their global health responsibilities. This could include a new financing mechanism for disease outbreaks, an insurance scheme or other innovative approaches<sup>74</sup>.

#### **Conclusion**

The EVD outbreak proves an excellent case study to highlight a concern with the global disease governance landscape in that to imagine a governance framework in which every actor shares in the same collective security and collective responsibility to combat the threat is naïve. Although states and non-state actors have, for the most part, been complicit in constructing a discourse of global shared responsibility for disease control through the IHR and rhetorical changes to policy, each actor conceives of this threat and responsibility differently and has a multiple of different accountability relationships. These in part, may have contributed to the 'perfect storm' of the failed response to the EVD outbreak in West Africa. This paper has suggested that instead of working within a

framework where accountability is unable to fall onto any one actor, it is better to re-frame the responsibility for disease control as a series of differentiated responsibilities. Furthermore, the global health landscape should define clearer roles and responsibilities to each actor in the global health mosaic and understand how they can be held to account for them, rather than to continue by championing a global shared responsibility.

This paper does not seek to provide a definitive solution to the weaknesses of global shared responsibility. It has simply endeavoured to show that the framing of responsibility at a global level has itself become a factor in the inadequate response to the EVD outbreak, as there have not been clear lines of accountability between actors, who have thus been able to pass the buck to others for their failures to respond appropriately. As such, this paper has offered a potential new framing of responsibility; that of multiple responsibilities for global disease control, but as there are inherent flaws in these too, further development of notions of responsibility and governance for disease control must be sought in an effort to strengthen global health security.

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