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Global Governance of Pandemics: an assesment on the role of the WHO before and after Covid-19

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To L.

Your strength is light to my darkness

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Introduction

Covid 19 has been a true shock for mankind. Each person on Earth has experienced, be it directly or indirectly, the impact of such an unprecedented and unexpected virus which has completely reshaped the habits and lifestyles of all the human population. Born during the age of high speed globalization, this threat had the possibility of developing itself rapidly and spreading to almost every nation on the globe, managing to reach the critical status of pandemic. It is sufficient to quote here the official numbers reported by the World Health Organization website to acknowledge to what extent this virus has hit the global population and what damages has brought to the health systems of the world. In particular, at the time of writing, the 12th of September 2021, the Organization reports a total of 223.022.538 cases and 4.602.882 deaths.[1] Impressive numbers which are particularly telling of the amount of people touched directly by the virus and the strain that it has posed on the health protection systems of almost every country in the world, from the richest to the poorest. However, what is most striking about Covid 19 is that it did not only have a profound impact on the theme of health but on almost every aspect of human life. From social activities to working habits to the realm of economics as a whole this virus had an unprecedented impact leading to the use of particularly severe measures such as different limitations on personal freedoms in order to try to curb its massive contagion. Such limitations, together with the massive strain imposed on national budgets to find ways to control and manage the problem, has created a global economic crisis and an unprecedented rise in public debt which will last, most probably, for many years to come. No country on the global scene has been spared by this wave of debt and recession and each one had to find its own way in order to try to overcome the impasse at the national level but also at the international one. In this sense it is sufficient to quote here the Next Generation EU plan, a completely unprecedented manoeuvre on part of the European Union to relaunch its economy and the well-being of its member states with a total budget of

[1] World Health Organization, (12 September 2021), WHO Coronavirus (COVID-19) Dashboard. Taken from World Health Organization Official Site: https://covid19.who.int/.

more than 800 billion euros to be spent on several different areas of national policy: from the development of the health preparedness systems to the environment protection and the green transition towards a more sustainable economy.

As it has been the case for the European Union many other international organizations have been touched by the effects of this new threat with one of them at the top of the list: the World Health Organization. As it is easily understandable, indeed, this Organization has been caught in the very centre of the storm and its structure, its legal instruments and its whole general purposes have been strongly questioned by the public opinion of the whole world. Covid 19 has exposed the fragility and all the weak spots of an organization which, built in the wake of WWII and at the very beginning of the Cold War, had to face geopolitical and legal constraints that the mindset of the time had imposed on it. And despite the number of debates and attempts to reformulate its mandate and scope of action through the years, the World Health Organization and its main legal instrument, the International Health Regulations, have persisted on an antiquated model not properly evolving at the same pace of human society. A missed opportunity which, even if the emergence of a possible global biological threat was foreseen by scientists many years before, resulted in the near sightedness of the Organization and the impossibility to properly perform the main task that its creators had given to it: the protection of global health. Creators which, it has to be specified, share a huge portion if not the whole responsibility of not having developed and shaped the structure of their own creation in order to properly fulfil such a task. International geopolitical mistakes and errors which, together with a tendency to put national interests first, have resulted in fatal mistakes in the early stages of the pandemic, namely those stages in which a threat should be rapidly eliminated before getting out of control.

The strong importance of an actor such as the World Health Organization in the field of global health protection and the critical relevance it should have had in curbing the expansion of Covid 19 represent the main framework and focal point

of the current thesis. Indeed, moving from this assumption, this work tries to give an assessment of the global health protection system with a particular focus over its main actor, the WHO, and attempts at analysing how and to what extent the intrinsic flaws of the Organization have contributed to the uncontrolled spreading of a threat such as Covid 19. Moreover, it also tries to develop an analysis of what responsibilities are attributable to the Organization per se and what can be ascribed to its masters and main crafters, namely its own member states. In this respect, the pandemic of Covid 19 is considered as a powerful catalyser, one that has the unprecedented power of exposing all the deepest flaws of the global health protection structure and of generating a strong international debate that will most probably result in various reforming attempts and in a reshaping of its general architecture.

In trying to analyse this set of crucial elements for the future of international cooperation, the current thesis is developed over 5 different chapters moving from a more general description of the actors involved in global health protection to the G-20 Rome Declaration and the possible future path to be followed by the international community. In particular, Chapter I titled *Global Health Governance: a brief recollection of its main pre-Covid features* represents a starting point of the whole analysis and lays the foundations to properly understand the rest of the debate. It contains, indeed, a recollection of what are the main types of disease outbreaks and how the international community is structured in order to control them. It also enlisted all the principal actors of the field from the top level of the World Health Organization as an international conductor of technical expertise to the many NGOs which practically contribute to the protection of global health on the ground. The chapter contains also an evaluation of all the different improvements that, as a consequence of disease outbreaks effectively controlled, contributed to the progress of the system and to its development. In this respect, particularly in Chapter II, a major focus is posed on the family of Coronaviruses, namely the one to which both the 2003 SARS and Covid 19 belong. The chapter, titled *The Coronaviruses as drivers of change: an analysis of the 2005 IHR Revisions in the light of the 2003 SARS epidemic*, presents indeed a description of the evolution of the 2003 SARS

outbreak and how it was effectively controlled by the international community. It has the aim of putting on the same line the two viruses belonging to the same family of Coronaviruses and highlight how they represented a major driver of change for the international system of health protection. In this respect, moreover, the chapter includes a description of the main evolutions that the fight to SARS brought to the International Health Regulations, revised in 2005 precisely as a consequence of the fight against that respiratory syndrome. The purpose of the chapter is that of underlying the evident fact that SARS-CoV-2 too will represent a major driver of change for the whole international community and highlighting how the measures taken with the 2005 Revision of the IHR revealed themselves unfit to the purpose of reinforcing the international health system.

Following this very line of acknowledgment of the role of SARS and the missed opportunity represented by the inappropriate reforms of 2005, Chapter III of the thesis represents, on the contrary, a more detailed analysis of the history of the early stages of Covid 19 and what went wrong compared to its predecessor. Indeed, titled quite tellingly *What went wrong with Covid 19: early timeline, member state's responsibilities and WHO's main flaws*, the chapter moves from the brief recollection of the early steps of the pandemic to the recognition of all the mistakes that led to its uncontrolled spread. In particular it analyses several crucial contributions of important authors of the field in order to highlight to what extent the responsibility of such failures can be ascribed to the WHO or to its member states. A chapter, this last one, which enlists all the main contributions on the theme and which lays the foundation for the following one on the possible reforming paths in order to overcome the difficulties exposed by Covid 19.

Titled *Reforming the World Health Organization in the light of Covid 19; main ideas and proposals*, Chapter IV of the thesis represents the ideal consequence of the preceding one and tries to analyse some of the most important contributions on the theme of how the Organization should be reformed. Bearing in mind all the elements exposed in the preceding chapter, it tries to anticipate what the possible choices made by the international community could be in order to reinforce the existing institutions or to completely replace them with newer and more efficient

ones. A chapter which cannot be separated by its ideal conclusion, Chapter V, which is titled *Health and environmental protection: the Berlin Principles and the G-20 Rome Declaration as guidelines to the post-Covid 19 world* and which represents an attempt to clarify the huge amount of different proposals presented in the previous one by trying to describe the line that will most probably be followed by the international community. In this respect, the chapter moves from the assessment of the multi-level and all-encompassing nature of Covid 19 and tries to insert it into the wider framework of super wicked problems. Giving a brief description of the most recognizable features of such highly impellent and deeply global problems, the chapter puts on the same line the issues of health and environmental protection. It establishes a connection between these two distinct but highly linked elements and clarifies the urgency on part of the international community to find ways to respond collectively to both the problems. Moreover, bearing in mind such a profound connection, the chapter manages to describe which will most probably be the future steps in the reforming process thus clarifying the complex issues anticipated in Chapter IV. In particular the focal points of this assessment are represented by *The Berlin Principles on One Health* and the G-20 *Rome Declaration,* with the former to be considered as a sort of pre-Covid antecedent of the principles and ideas stated as fundamental by the most developed nations in the world. A final chapter which, thanks to the crucial contribution represented by the Declaration, manages to describe the future development paths that the international community will try to follow or, at least, those to whom it is strongly and publicly committed. Political and diplomatic moves which are strongly needed by the whole global community in order to fully learn the bitter lessons imposed by Covid 19 and to properly adapt to a new global reality very much different from the post-World War in which the foundations of the whole health protection system have been laid.

I - Global Health Governance: a Brief Recollection of its Main Pre-Covid Features

I . 1 – Preliminary Considerations

One of the best way to analyse the role of the World Health Organization and, more generally, of the very notion of Global Governance in the containment of pandemics is to start by looking at the history of all those outbreaks which preceded Covid-19 and which have shaped the responses of the global community to this kind of issues. In this sense it is crucial to quote an illuminating chapter written by Mark W. Zacher and Tania J. Keefe titled *Disease Containment: Surveillance Systems, Emergency Responses, and Transborder Regulations* contained in their book of 2008 titled quite interestingly *The Politics of Global Health Governance*.[2] This study is of crucial importance in the present analysis for two different reasons. First of all it contains a detailed recollection of the history of the main outbreaks and of the responses they triggered from the global community. In this sense the chapter shows, as will be presented later on, the main reforms of the global health governance system and the process through which they were obtained. It underlines the critical dates that worked as turning points in the history of the WHO and shows how such reforms were obtained only after critical improvements in the technological and communication fields or after important and problematic outbreaks. Moreover, the chapter is very useful in underlying the main actors that are involved during the management of an epidemiological crisis both at the national and international levels. In this sense it is crucial in the purpose of the current analysis given the fact that it allows to better understand the complex network of relationships between the WHO and all the other institutions and bodies working on the same field of health protection An intricate network that partially explains why the WHO sometimes lack the effective power to take the measures it should and to impose its decisions

[2] Zacher, M. W., & Keefe, T. J. (2008), *Disease Containment: Surveillance Systems, Emergency Responses and Transborder Regulations* in *The Politics of Global Health Governance*, New York, Palgrave Macmillan.

to the other parties involved.

Another critical reason why the chapter in analysis is of great relevance is the fact that, even if published in 2008, long before the current health crisis the world is facing, it already foresaw the risk of such an unprecedented outbreak. In this sense it is very interesting in underlying how the current Covid 19 pandemic did not come out of the blue but, on the contrary, was something that the main experts of the field and the academic literature were aware of, at least in its general terms.

The first element of the picture that was known to the scientific community was the constant emergence of new different diseases, never experienced by humans, in the period from 1940 to the present days. This unprecedented rise was reported in a study conducted by a team of authors from different authoritative institutions on the field and published in the magazine Nature in 2008, the same year as the publication of the chapter mentioned before.[3] Through their analysis they reported the emergence of 335 infectious diseases between 1940 and 2004. They also went further in adding that "the incidence of EID [Emerging Infectious Disease] events has increased since 1940, reaching a maximum in the 1980s.".[4] However what matters the most in the purpose of this chapter is another statement present in the article. Indeed the authors, through a strict analysis based on a scientific methodological approach and the recourse to biological, spatial and temporal data over more than forty years, managed to reach the conclusion that "[…] disease emergence is largely a product of anthropogenic and demographic changes, and is a hidden 'cost' of human economic development.".[5] A statement which is perfectly in line with two other important quotations from the book by Zacher and Keefe and which clarify how a pandemic such as that of Covid 19 was foreseen by the scientific community and how it was perceived, already at the time, the critical relevance of the human being responsibility in the occurrence of these phenomena. In particular there should be mentioned here a statement from the Institute of Medicine reported in the chapter *The Politics of Global Health Governance* which

[3] Jones, K. E., Nikkita, P. G., Levy, M. A., Storeygard, A., Deborah, B., Gittleman, J. L., & Daszak, P. (2008, February 21). *Global Trends in Emerging Infectious Diseases*. Nature, 451, pp. 990-994.
[4] (Jones, et al., 2008), p. 990.
[5] Ibid., p. 991.

says that “we will inevitably see more emerging infections in the future as the factors that lead to emergence become more prevalent and converge with increased frequency”.[6] Moreover, the same authors of the book in question add that “When combined with other nonmedical factors such as advances in transportation technology, it becomes even more apparent that outbreaks can impact people around the globe, wherever they occur.”[7]

Just by reporting these few quotations it is quite clear how the problem of emerging diseases was perceived as a pressing one by the scientific community long before the emergence of Covid 19 and how the experts tried to stress the importance of a renewed approach towards the notion of Global Health Governance and the need to a reformed system. It is, indeed, of critical relevance the fact that the human being represents both one of the reasons behind the increased emergence of infectious diseases, both the only one who can find ways to reduce the incidence of these events and prevent them from happening.

I . 2 – Main Disease Categories

Once clarified the relevance of the matter under the perspective of the human society as a whole and the fact that Covid 19 was at least in its general terms predictable and foreseen, it is useful to get back to the historical recollection of the main outbreaks and actors involved in order to better understand the crucial role of the WHO. The first step that has to be done in order to properly analyse the issue is that of clarifying from the beginning the different types of diseases to which humanity is exposed. Indeed there is not a single and unifying definition for each type of infection and each one shows its one peculiar threats and characteristics. However we can assimilate them, as suggested by Zacher and Keefe, into three different macro-areas: New Diseases, Re-emerging diseases and Bioterrorism. The former category includes all those illnesses that have been discovered for the first

[6] (Zacher & Keefe, 2008), p. 44. The factors to which the Institute of Medicine refers to are precisely those that have been analysed in the *Nature* article, namely an increased movement of people and goods worldwide and the actions of humankind over the equilibrium of the ecosystem.
[7] Ibid., p. 45.

time and which the global community has never had the occasion to face before. One of the best examples of this typology is the virus Ebola, first discovered in 1976 with a mortality rate of 90%.[8] It is precisely about these kinds of illnesses that the authors of the article *Global Trends in Emerging Infectious Diseases* were referring to while underlying the unprecedented rise of new diseases from 1940 onwards. The second typology of infection, the re-emerging one, includes all the illnesses that were brought under control by medicine but managed to return to a state of threat after having undergone some kind of change. In this sense the most common reason for such a re-emergence is the antimicrobial resistance, that is the rise in the resistance of viruses and bacteria to the therapeutic drugs used to combat them. One of the best examples for this phenomenon is Tuberculosis (TB) which has undergone a process of strong antimicrobial resistance giving birth to its XDR TB variant, resistant to almost every known drug and therefore virtually untreatable. Another key virus belonging to this category, one especially relevant if considered under the point of view of a discussion on Covid 19, is the Influenza microbe. This one has the ability to mutate every 12 months therefore giving a lot of trouble to the experts who face the task of trying to contain it.

Finally, the last challenge to disease containment is characterized by the category of Bioterrorism. As can be easily understood this last one is the typology with more human interference and refers to all the "deliberate release of viruses, bacteria, or other germs used to cause illness or death in people […] to advance the political, social, or religious aims of the [terrorist] group.".[9] This last category is probably the one with a series of characteristics that differentiate it from the other two. Indeed, it involves the active and willing presence of a group of human beings acting in the pursuit of a specific interest, be it religious, political or of any other kind. As can be easily understood this peculiarity entails typology-specific means to counteract this threat to global health, namely an improved system of intelligence at the international and national levels and specific ways to reverse the process of radicalization typical among the components of a terrorist group. However, despite

[8] Ibid. p. 43.
[9] Ibid. p. 44.

this specific peculiarity, it should be noted how all of the three categories mentioned above entail also a set of common counter measures of the highest relevance. In particular, they have been underlined by the authors of *The Politics of Global Health Governance* at the very beginning of the chapter at the heart of the discussion. Indeed, they listed a set of three critical elements necessary to prevent and to control a potentially harmful outbreak which are: a surveillance system, efficient emergency response programs and the presence of effective transborder regulations.[10] These three different elements are crucial to an effective response by the global community and a lack in one of the three may seriously contribute to the emergence and the uncontrolled spread of an harmful microbiological element with consequences even worse than the one we experienced with Covid 19. As can be easily understood, however, an efficient coexistence of these elements entails the necessity of both an active preparedness and coordination at the national and regional levels and of the higher control and supervision of a supranational entity such as, for example, the WHO and other institutions. And it is precisely these kinds of interactions and linkages between the national level and the international one that may generate misunderstandings and problems over the effective control of decisional power as it will be shown through the rest of the present chapter and the whole thesis.

I . 3 – Control Elements: surveillance system

I . 3 . 1 - Main features and Developments

Avoiding to taking into consideration in detail, at least for now, the problem of coordination and cooperation between states and international organizations the focus should be on the first element of the three mentioned above, namely the surveillance system. This one is not only the first stage of whatever mechanism of disease control and prevention but it is also the part which has undergone the biggest

[10] Ibid. p. 43.

and most relevant improvements from the early 1990s onwards.[11] Indeed after this crucial moment the surveillance system started to benefit from some important advances in communication technology, namely Internet and e-mail, that contributed to a series of unexpected and extremely relevant changes. As a matter of fact, looking at the condition of the global surveillance system before that fundamental decade, it is possible to notice how the whole structure was based on the compulsory reporting to the WHO under the IHR[12] of just three diseases (plague, cholera and yellow fever). This situation translated into the impossibility to effectively control the rest of the threats that belonged to different kinds of microbiological elements. It also resulted in the inability for certain underdeveloped countries to effectively control the situation into their own states given the lack of preparedness and the absence of communication with more skilled external agents. Moreover, to make matters worse, there was also the extremely dangerous situation in which certain states, in order to avoid travel and economic restrictions on people and goods, deliberately decided not to report any kind of threat, even if included in the compulsory three. This situation, which now and then repeats itself even after the reforms of the 1990s and the advances in communication technologies, was especially frequent at the time given the impossibility for a supervising body to monitor the correct flow of information.

On the opposite side, the turning point of the '90s entailed a new system of almost open communications and allowed the WHO to "receive information on dozens, if not hundreds, of diseases. Moreover, "for the first time state governments did not have complete control over the flow of health information leaving their countries.".[13] An improvement of the highest relevance which was made possible,

[11] Ibid. p. 46.

[12] The IHR, International Health Regulations, are a legally binding instrument of international law firstly adopted by the World Health Assembly in 1969 and last revised in 2005. They represent the only international legal treaty with the possibility to empower the WHO with its mandate of main global surveillance supervisor. They will not be discussed in detail in this part of the thesis given the crucial role they will have in the next parts of the analysis. In particular, as it will be underlined in the following chapters, they represent one of the crucial elements to be improved by the global community in order to properly reform the WHO and to make it more effective in contrasting the future outbreaks.

[13] (Zacher & Keefe, 2008), p. 46.

in practical terms, for the major part by advances in the system concerning the nongovernmental actors but also, on a lower but still important level, by fundamental alterations to the WHO itself. In particular, one of the most notable changes involved the Weekly Epidemiological Record (WER) created as early as 1926 but reporting only those diseases that were specifically noted in the IHR until the 1990s. After this turning point the WER started to include reports based on a larger spectrum of diseases and microbiological agents. Moreover, another key initiative concerning the field of surveillance which benefited from the opening of the systems of communication was the Global Influenza Surveillance Network, one of the oldest and best established bodies of the global health protection system. It is easily understood how such an organ, with 117 National Influenza Centres in 88 different countries, was particularly assisted in its task of recommending to states the best vaccine against circulating influenza by the improvement in the information technologies.

These two WHO related bodies were, moreover, particularly assisted in their general task of surveillance by the creation of two other crucial initiatives, namely the Program for Monitoring Emerging Diseases (ProMED) and the Global Public Health Intelligence Network (GPHIN). The former was established in 1993 by a group of medical experts and was particularly linked to the advances brought by the invention of the Internet. Together with the parallel initiative ProMED-Mail it consisted in a global network of electronically linked health experts and it is now counting more than 30,000 subscribers in 150 countries with the assistance of many private funds such as the Rockefeller Foundation and the Oracle Corporation.[14] GPHIN, on the contrary, was created in 1997 by a collaboration between the WHO and the Canadian government and represents a system dedicated to monitoring all the possible media sources from around the globe searching information on disease outbreaks, bioterrorism and food contamination issues. It is important to note regarding this initiative how, as far as 2008, it proved to be the source of information on 40 percent of the approximately 250 outbreaks investigated by the WHO every

[14] Ibid. p. 48.

year.[15] Finally, a particular mention for its importance in the global monitoring system should be given to the role of the military and of the NGOs. In particular it should be noted how, through the creation of the Global Emerging Infections Surveillance and Response System (GEIS), the US military basically expanded its duties and contributed to the creation of a network of domestic and overseas research units supporting surveillance and training in collaboration with five other armies and laboratories.[16]

I . 3 . 2 – Main Problems and Issues

From the general picture provided until now of a renewed and improved system of global monitoring since the information revolution of the 1990s the general impression may be one of complete positivity. However, as it will be underlined in the next chapter and as it was made evident by the experience of the Covid 19 pandemic, the whole system had some problems that persisted despite the general improvements and that contributed to the failures and mistakes that led to the tragic event of 2019. Shortcomings which were already underlined in 2008 by the almost prophetic authors of *The Politics of Global Health Governance*. Indeed, as they envisioned the emergence of a pandemic and its spreading all over the world, they also listed some of the crucial issues concerning the whole system of global health surveillance. In particular, they started by signalling one of the most evident and notable problems to the complete protection of the health of the global population, namely the unbalance between developed and developing countries. Something that represented and still represents a weak spot in the global network given the general unpreparedness and the lack of expertise which they usually have to face. A condition which is partially improved by the aid of several different NGOs like Médecins sans Frontiers and Emergency but that still poses a major threat to the global surveillance system given the impossibility for the NGOs themselves to

[15] Ibid. p. 49.
[16] Ibidem. These collaborations include 5 navy laboratories respectively located in Egypt, Kenya, Indonesia, Peru and Thailand. An initiative that monitors the infectious diseases that may concern the host countries and, consequently, the military overseas.

collect and evaluate a massive quantity of epidemiological data on entire countries. Another weak spot underlined by the chapter at the heart of the present analysis is what could be summarized by the words of Dr. Juan Lubroth, former chief of the emergency prevention system for infectious animal disease at the Food and Agriculture Organization (FAO). He underlined another key issue in terms of surveillance systems, one that will be crucial also in the following pages on Covid 19, that is the deliberate hiding of crucial data for the controlling bodies on part of states. He resumed quite effectively the issue by saying that "any benefits of hiding data are short-lived" especially in the field of zoonotic diseases, namely the ones that can spread from animals to the human being, given the fact that "the World Animal Health Organization cannot accept information on wildlife diseases in a country unless that information has been submitted officially by a national agricultural authority […].".[17] Whatever the reason, be it the fear of the economic consequences or the willingness to avoid limitations over their citizens, the choice of deliberately not reporting the crucial data is a huge threat for the whole system of surveillance and is not a solution to the problem. Once an outbreak is already in motion the choice that should always be followed is to properly communicate the relevant data to the rest of the world in order to successfully pass to the other pillar of global health protection, namely the so-called emergency response. Moreover, all the benefits that the hiding may entail, as Dr. Lubroth stated, are short-lived given the fact that the consequences avoided in the immediate may transform into more severe and complicated problems, both in the social and in the economic sphere, involving an entire geographic area and thus making normality more difficult to be restored in the long run.

Finally, returning back to the issue of the so-called zoonotic diseases mentioned above, it should be noted here another crucial problem underlined by Mark Zacher and Tania Keefe already in 2008. Indeed the two authors stated the essential immobility in the field of animal diseases surveillance. According to them, for this peculiar kind of threat, the situation remained almost the same as it had been until

[17] Ibid. p. 50.

the 1990s, not following the evolution which characterized the surveillance of human outbreaks. They also reported an important statistic which highlighted how "more than 60 percent of the 1,415 infectious diseases currently [2008] known to modern medicine are capable of infecting both animals and humans.". [18] An assessment which led them to the conclusion that very likely, if not probably, a pandemic would have begun in animals before affecting humans. Something that, read with the hindsight of the pandemic we are currently facing, seems almost prophetic and quite disappointing for the lack of attention which was posed to the problem until 2019. It is sufficient to quote the WHO - Situation Report 94 of April 2020 to better understand the connection between the problem of a scarce animal diseases control, the authors' statement over the possible future pandemics and the Covid 19 outbreak. Indeed, it is precisely in this report where the World Health Organization officially stated that " All available evidence for Covid-19 suggests that SARS – CoV – 2 has a zoonotic source. Since there is usually limited close contact between humans and bats, it is more likely that transmission of the virus to humans happened through another animal species, one that is more likely to be handled by humans.".[19] Even though there is still much debate open over the actual origin of the Covid 19 infection and many more studies will be conducted in the future, such an information is particularly impressive and quite telling of the many measures that could have been taken in time to prevent such an outbreak to happen, or at least to prevent its dire consequences.

I . 4 – Control Elements: the Emergency Response

I . 4 . 1 – Main Actors

Once the main issues concerning the notion of surveillance system are clarified, it is worth passing to the second crucial element in a regime of global health protection, namely the emergency response. This kind of pillar can be considered

[18] Ibidem.
[19] World Health Organization, *Coronavirus Disease 2019 (COVID-19) Situation Report – 94*, 23 April 2020.

as a consequence of the failed functioning of the first one. Indeed, it is precisely when the surveillance system fails that a quick response has to be taken in order to counteract from the outset the emerging outbreak in the hope of reducing its impact and controlling its diffusion. Many actors are involved in this crucial phase and have to work in cooperation and strict coordination in order to efficiently reach their goal of ending the disease. Among them the WHO represents probably the most important player at least for its coordinating role of all the other actors dealing with the issues: research laboratories, medical NGOs, Ministries of Health of each country involved and other United Nations bodies. In particular, the institution might be considered as a sort of facilitator, a sort of first point of reference to which all the others look at during the outbreak. Indeed it has the capacity, knowledge and the proper legitimacy to mobilize the right people in assistance to the disease containment. Moreover it is composed of several different Regional Offices which may facilitate the whole management of the situation and which, sometimes, act also as mediators of the information that is shared to the media. More generally, wanting to resume the main tasks of the institution, it could be said that they consist, especially in the context of an outbreak containment, in the standardization of all the procedures for the alert and verification process, the facilitation and coordination of communications between the actors, the management of the research and the information sharing with the media and the organizing of the most effective emergency response.[20] Especially for this last point, it should also be noted how, in recent years, only one percent of the cases examined by the WHO among the 250 average annual outbreaks have entailed a direct role by the institution in containing the outbreak.[21] This confirms the understanding of the World Health Organization as an institution with the coordinating and facilitating roles at the top of its priorities but also underlines the crucial role it plays in those, fortunately rare, situations in which the surveillance system fails and more powerful and rapid measures have to be taken.

Once clarified the position of the WHO, some words have to be spent on the crucial

[20] (Zacher & Keefe, 2008), p. 52.
[21] Ibid. p. 51.

role of the national research laboratories in a situation of emergency. Indeed they possess the key technical knowledge about the new disease through their work of deep research in the field. This knowledge, in turn, represents the most important tool at the disposal of the experts on the ground to better proceed and determine a powerful containment strategy. That is the reason why such research laboratories are fundamental in any kind of outbreak scenario and it is also why most of them are affiliated with the WHO as Collaborating Centres. Indeed they allow the institution to cover most of the global reach without having to directly invest in owned laboratories but through the means of collaboration partnerships. Up to date, according to the official data available on the website of the WHO, there are over 800 Collaborating Centres in more than 80 member states supporting the institution in its effort to protect global health.[22] Among such crucial actors for the emergency response system it should be quoted the Centre for Disease Control (CDC) a US federal agency based in Atlanta, Georgia and known as the world leader in outbreak investigations.[23] Other laboratories, moreover, should be mentioned here for their relevance on the global scene and they are: the global network of Pasteur Institutes with its headquarters in Paris, the British Porton Down Institute, the National Institute of Virology in South Africa and the National Institute for Infectious Diseases INMI 'L. Spallanzani' in Italy. A key element, then, must be considered in order to assess the relevance of such partnerships between the WHO and these national research laboratories worldwide. Indeed, they do not only offer an extension to the actual monitoring capacity of the institution, as mentioned earlier. They also offer to the laboratories themselves the possibility of operating in foreign countries during a situation of emergency with the political acceptability at the government level of these countries which only being under the WHO umbrella can give. This crucial element allows the laboratories to conduct their research, at least in most of the cases, in a more peaceful environment without the threat of possible

[22] World Health Organization, (12 July 2021), *About WHO – Collaborating Centres.* Taken from World Health Organization Official Site: https://www.who.int/about/partnerships/collaborating-centres.
[23] (Zacher & Keefe, 2008), p. 52.

tensions with the local governments and the population itself.[24]

Then, another important role in the emergency response is taken by the most organized and technically skilled NGOs in the medical field. They are not many, given the quantity of experience and training needed to reach that status but offer a valid aid especially in practical medical terms. Indeed, they might prove very powerful in giving direct medical assistance to the population in the most different territories and thus helping in the crucial role of distributing drugs, vaccines and all the other medical items needed. Among these high-skilled and well organized NGOs could be included Médecins sans Frontières (MSF), the International Committee of the Red Cross (ICRC) with all the various Red Cross Groups and Merlin, an humanitarian health organization founded in 1993 and based in the United Kingdom which has conducted several emergency and long-term operations in countries like Rwanda, Afghanistan, Kenya and Sudan.

Another important actor that should be mentioned in the field of the emergency response is represented by the Ministries of Health of the countries involved in the outbreak. First of all, indeed, they usually provide the trained medical staff that will work with the experts team and all the rest of material goods such as hospital supplies and equipment that will be needed. Moreover they also have a crucial role at the very beginning of an outbreak, namely in the moment in which the disease could still be stopped with proper intervention. Indeed, such Ministries are quite often the first institution, together with their respective governments, to know about the disease and its spreading through the population. For this very reason they possess the fundamental power of deciding whether to report it or not to the WHO and to officially ask the international community for assistance. A crucial moment which, as it has been said and it will be explained later on, has the power to thwart the disease or let its expansion run freely since the very beginning. Moreover this reporting role on the Ministries part is even more crucial if it is considered how, in the words of Zacher and Keefe, "a call or invitation [to the WHO] is still considered necessary by custom and convention, and indeed it is a legal requirement of the IHR

[24] Ibidem.

before the WHO can organize a foreign team to assist in the health emergency.”.[25] A quotation that helps introducing an element of crucial relevance to the discussion and which will be clarified in the following chapters as one of the factors that took place in the expansion of the pandemic of Covid 19 and in the complex set of international relations that involved China, the WHO and the rest of the world.
Finally, as a conclusion to this summary of the most important actors in the field of emergency response should be mentioned the role of the other UN bodies beside the WHO. Among them there should be quoted here the United Nations Children's Fund (UNICEF) and the Food and Agriculture Organization of the United Nations (FAO) among the others. The former often has an already established presence in developing countries thus providing valuable material assistance in the occasion of an outbreak. The latter, on the contrary, has to be mentioned here given its vast experience in the field of animal health protection through its specialized veterinarians and biologists. It is precisely for this reason that FAO is a particularly important asset in the evaluation and prevention of zoonotic diseases. Namely those animal originated diseases, such as Covid 19 among the others, which spread to humans after being originally circumscribed to a restricted group of animals.

I . 4 . 2 – The Global Outbreak Alert and Response Network (GOARN)

The different actors enlisted above, thanks to the improvements in the communication technologies, started to increase their working together and developed a network of improved response procedures which proved themselves very effective, at least until the arrival of the turning point which is represented by Covid 19. This network was formalized in April 2000 under a WHO-led initiative called Global Outbreak Alert and Response Network (GOARN). It consists of a group of more than 120 governments, NGOs and other multi-partner health initiatives gathered together by the recognition of a simple but also crucial fact, one that will be analysed in more detail in the last chapter of the dissertation. Quoted with the same words through which it is reported in the 2008 book by Zacher and

[25] (Zacher & Keefe, 2008), p. 53.

Keefe this basic fact consists in the awareness that "no single institution or country has all the capacities to respond to international public health emergencies caused by epidemics and by the new emerging infectious disease.".[26] An understanding of a basic but also highly complex notion which led to the creation of GOARN in order to properly manage and verify each different outbreak within 24 hours of notification. An initiative that can be considered as the consolidation of all the collaborative efforts that started with the turning point of the 1990s and which were guided by the awareness of the importance of the notions of cooperation and coordination in order to effectively support global health. Something that reinforces the prominent position of the WHO as a leader in terms of coordination and facilitation of global health protection and that underlines the necessity of an increase in its legal prerogatives to reach a complete and effective access to all the information it requires. An improvement that, in a way, took already place through the years with its apex in the reform to the IHR in 2005 but which was not enough if are taken into consideration all the errors and complexities that led to the unexpected spread of the Covid 19 pandemic, as it will be clarified in the following chapters.

I . 5 – Recent Disease Outbreaks: a Brief Recollection

After having analysed the three major types of diseases, the necessities of a properly managed containment strategy and the main actors that are involved in the system, the present chapter should be concluded with a brief but complete recollection of the most important outbreaks, the ones that mostly affected the structure of the global health protection as a whole. In this sense, it is once again a precious resource Chapter 3 of *The Politics of Global Health Governance* which contains a detailed analysis of such outbreaks and of their principal consequences, with a special attention towards the most recent years. The first disease that has to be quoted in this respect is cholera, a very well-known infection that has been constantly reduced

[26] (Zacher & Keefe, 2008), p. 54.

through the years reaching a mortality rate as low as 1% in the cases in which it is treated early and properly.[27] Despite all the advances in the treatment and the reduction of its mortality rate the bacterium is still dangerous especially in the less developed areas of the world with poor access to uncontaminated sources of water. In particular, it is worth recalling here the outbreak which started in Peru in 1991 and then spread through the rest of Americas. The most notable fact regarding this outbreak in relation to the present research is the foreign reactions it caused and their dramatic consequences. Indeed, as reported by Zacher and Keefe, "Bolivia, Chile and Ecuador banned imports of perishable foods from Peru; Argentina banned fish imports, the EC banned all fish and goods from Peru; the United States required tests of all food coming from Peru.".[28] As can be easily understood, the economic and social impact of such measures were of the highest relevance for Peru and generated a profound crisis which worsened the already terrible situation generated by the epidemic. In this sense it helps in explaining why, under the threat of certain foreign limitations and their consequences on the prosperity of the nation, some states may decide to willingly avoid reporting the spread of an infection on their territory. As it has been said before, such a choice does not represent a solution to the problem and has the dangerous effect of amplifying the whole outbreak diffusion. However, it is also important to bear in mind the reasons why certain decisions might be taken notwithstanding their moral and practical hazard toward the rest of the global population. Reasons that, already at the time, entailed the creation by the WHO of the Global Task Force on Cholera Control with the two critical goals of: reducing the morbidity and mortality rates of the infection and alleviating its socioeconomic effects.[29] A decision that basically upheld the idea of the necessity of both an improvement in the overall control system but also of the sharing of the socioeconomic burdens connected with the signalling of an outbreak. The second important disease that should be definitely mentioned here is Ebola, the highly known haemorrhagic fever widespread especially in the African continent.

[27] World Health Organization, (5 February 2021), Fact Sheets – Detail - Cholera. Taken from World Health Organization Official Site: https://www.who.int/news-room/fact-sheets/detail/cholera.
[28] (Zacher & Keefe, 2008), p. 55.
[29] (Zacher & Keefe, 2008), p. 55

This one is a zoonotic virus spread from wild animals and then transmitted among the population through human to human contact which has a mortality rate on average of 50%, with an oscillation which varied from 25% to 90% in the last outbreaks.[30] Regarding this virus in particular, one of the most notable cases in the purpose of the present thesis was the outbreak in Zaire (now the Democratic Republic of the Congo) in 1995. According to the official sources it numbered 316 cases and 245 deaths in a period of several months and requested the intervention of the WHO in coordinating the important number of foreign medical aid coming to the country.[31] In particular, the small team that coordinated the effort had a huge success considering the scarcity of staff, equipment and financial resources it had to face in dealing with many health workers from several different countries. And it is precisely for this success that this outbreak is particularly relevant for the purposes of the chapter. Indeed it helps in highlighting the importance of two fundamental points. The former is the high relevance of the WHO as a coordinator and facilitator which has been described earlier and which will be crucial later on. The latter is the recognition, as reported in the book by Zacher and Keefe, of the fact that "nearly all Europeans, who took part in Kikwit [an important city of the Democratic Republic of the Congo] did so under the aegis of the American CDC, *Médecins sans Frontièrs*, or WHO – not under their own country's sponsorship.".[32] An assessment that is very much useful in reaffirming the international nature of the global health protection effort, a theme which will be crucial in the next chapters of the current analysis.

Finally, in order to conclude this recollection of the most notable and impacting outbreaks of recent times it is worth quoting the threat posed by the whole different forms of Influenza virus. Indeed, as stated by Zacher and Keefe, "in talking to health professional about their fears of future disease pandemics, they usually mention the likelihood of an influenza outbreak along the lines of the 1918-1919 Spanish Flu,

[30] World Health Organization, (23 February 2021), Fact Sheets – Detail – Ebola virus disease. Taken from World Health Organization Official Site: https://www.who.int/news-room/fact-sheets/detail/ebola-virus-disease.
[31] (Zacher & Keefe, 2008), p. 57.
[32] (Zacher & Keefe, 2008), p. 57.

or the smaller but still deadly influenza pandemics of 1957 and 1968.".[33] In particular if it is considered the mortality of the Spanish flu it is striking to see how it killed approximately 50 million people, especially considering the potentiality that a much interconnected and easy to travel world might give to the death rate of such a virus. The most notable one, at least until the epidemic of SARS between 2002 and 2003 and the infamous pandemic of SARS-CoV-2, has been the so-called Avian Influenza, the H5N1. One of the crucial elements regarding this influenza virus is that it was recognized for centuries as a common affliction for a variety of bird species but, unfortunately, only in the recent decades managed to afflict the human species too. In particular the first noted case of so-called *jumping* from birds to humans occurred in Hong Kong in 1997 with 18 people who contracted it and 6 deaths.[34] Fortunately the virus was not so easily communicable between humans and for this reason did not succeed in its transmission and in becoming an effective pandemic. However, and this is the reason why it is particularly important to mention it here, it caused the experts of the field to call for a dramatic response given the high mortality rate and the its dreadful similarities with the Spanish Flu. In particular, it prompted an important initiative on part of the WHO which developed the Influenza Pandemic Preparedness Plan in 1999, a document laying out the steps that have to be done in order to be prepared to properly respond to an outbreak of that kind. Moreover it also prompted the mobilization of GOARN and of many other WHO affiliated laboratories to respond to each outbreak of H5N1 properly and to try to contain its diffusion in the best way possible. Unfortunately, however, despite all the measures taken by the WHO and the main related actors in order to stop the spreading of the Avian Influenza another one took its place as a harmful threat in the priorities of the global health protection system: the SARS virus. As a matter of fact, the high mutability of this kind of viruses proved itself stronger than the measures that the international community of the time was willing to implement in order to contain them. It is for this reason that the new threat of SARS virus emerged and became the focal point of the international attention on

[33] Ibid., p. 58.
[34] Ibidem.

the topic of pandemics, paving the way for several major changes in the whole system of the IHR and of global health protection. Reforms that, as it will be clarified in the following chapter, would have constituted a sort of turning point coinciding with the 2005 IHR Reform and would have given to the Coronaviruses family the attribute of main drivers of change of the WHO and of the whole system of global health protection.

II – The Coronaviruses as Drivers of Change: an Analysis of the 2005 IHR Revisions in the Light of the 2003 SARS Epidemic

II . 1 – Introduction: the crucial relevance of SARS

After having analysed the most important features of the global health governance system, its major actors and the way it has been shaped during the years as a consequence of the outbreaks it faced, it is worth taking into consideration a crucial turning point in its development: the outbreak of SARS disease in 2002-2003. The emergence of this virus, as will be clarified in the following pages, has a peculiar relevance in the purpose of the current thesis for several different reasons. First of all for its strong connection with the Covid 19 virus, namely one of the focal points together with the WHO of the whole discussion, given the belonging of both of them to the same bigger family of the so-called human Coronaviruses. This linkage between the two diseases is crucial in determining a sort of standard of comparison between the different responses they triggered. It is also helpful in delimiting one of the families of viruses which, as will be clarified later on, represents a sort of driver of change of the whole system of global health protection. Indeed, while SARS represented the apex of a long debate over the necessity of reforming the whole system and in particular the International Health Regulations which culminated in the Revision of 2005, Covid 19, on the contrary, is probably the most important outbreak of contemporary history and will surely represent a major turning point in the history of the global community as a whole triggering, as it already did, a long series of multi-level and multi-actor reforms in all the political fields.

Another important reason to analyse more in detail the history of the SAARS 2002-2003 outbreak is to properly describe the way it developed itself, the social and economic consequences it had, how it was counteracted and to what extent the response which was taken by the global community proved itself effective. Indeed, the virus not only triggered a strong response on part of the WHO to immediately stop its diffusion but also implied the already mentioned deepening of the debate

over a reform of the International Health Regulations leading to their new edition in 2005. A series of major changes that will be analysed more in detail in the chapter given the extent to which they changed the whole system of global health protection and the relevance they should have had in the defence of mankind from a threat such as Covid 19.

In this sense, indeed, it is worth noting how already in 2008, the authors of *The Politics of Global Health Governance*, the precious resource that has been quoted several times in the previous chapter, could describe the end of the SARS outbreak as "one of the great success stories in global public health efforts on infectious diseases.".[35] A statement which, if analysed under the perspective of what happened just a decade later, urges the necessity of a deeper analysis of the whole matter in order to properly understand what measures proved themselves so efficient with SARS and what went wrong with Covid 19 instead.

II . 2 – The Family of Human Coronaviruses

Once mentioned the crucial relationship between the two viruses which mostly affected the history of global health protection in recent years, it comes immediately to the front the necessity to better understand the whole Coronaviruses family. A correct understanding of the topic represents, indeed, a crucial step that has to be taken even before that of coming to the heart of the matter and analysing the SARS virus itself more closely. In this respect, in particular, it is very helpful to start by quoting here an article written by Jeffrey Kahn and Kenneth McIntosh and published on *The Paediatric Infectious Disease Journal* in November 2005, precisely the year in which the IHR were reformed as a consequence of the SARS outbreak. This article, even if very specifical and deeply concentrated in the paediatric field, contains an interesting resume of the history of the disease and helps in highlighting some crucial elements. First of all, it helps in tracing back the history of Coronaviruses to 1965 when they were firstly discovered by Tyrell and

[35] (Zacher & Keefe, 2008), p. 60.

Bynoe under the name of B814.[36] The research that came after this first discovery resulted in a considerable amount of information and data over the epidemiology and the effects of such viruses. Indeed, it was found that these medium-size RNA viruses "[…]are responsible for a substantial proportion of upper respiratory tract infections […]" and that "[…] in temperate climates, respiratory coronavirus infections occur more often in the winter and spring than in the summer and fall. Data revealed that coronavirus infections contribute as much as 35% of the total respiratory viral activity during epidemics.".[37] Moreover, it should be noted how such Coronaviruses are more than just the SARS disease and Covid 19. They included, at least up to 2003 according to the article, five different diseases among which "the severe acute respiratory syndrome coronavirus [namely SAARS], which caused significant morbidity and mortality.". They also included "NL63, representing a group of newly identified Group I Coronaviruses that includes NL and the New Heaven Coronavirus.", all of them associated with both upper and lower respiratory tract diseases. [38] More recently to this list has also been added the newly discovered Covid 19 and the count has reached the number of seven different diseases belonging to the family. They are enlisted in many different sources, in particular according to the official site of the Centres for Disease Control and Prevention, the already mentioned US research institution, they are divided into two groups. The first one is the Common Human Coronaviruses including 229E, NL63, OC43 and HKU1, namely the more frequent and less dangerous diseases for the human being. The second group is the so-called Other Human Coronaviruses which includes the more dangerous and unfortunately more famous MERS-CoV, SARS-CoV and SARS-CoV-2.[39] Besides this categorization and subdivision of the viruses in groups, the article in the CDC Official Website contains also a crucial statement over the origin of the second group. Quoting it directly it says that "sometimes coronaviruses that infect animals can evolve and make people sick and become a

[36] Kahn, J. S., & McIntosh, K. (2005, November), History and Recent Advances in Coronavirus Discovery. *The Paediatric Infectious Disease Journal*, Volume 24, Issue 11.
[37] Ibidem.
[38] Ibidem.
[39] Centres for Disease Control and Prevention, (15 February 2020), Human Coronaviruses Types. Taken from CDC Official Site: https://www.cdc.gov/coronavirus/types.html.

new human coronavirus. Three recent examples of this are 2019-nCoV, SARS-CoV, and MERS-CoV.".[40] An acknowledgment which was already present in the article of 2005 quoted in the previous pages and which reinforced a key element in the purpose of the whole thesis: the importance and the hazard of the zoonotic element in the field of global health protection. In particular, the authors of *History and Recent Advances in Coronavirus Discovery* stated that "while research was proceeding to explore the pathogenicity and epidemiology of the human coronaviruses, the number and importance of animal coronaviruses were growing rapidly.".[41] They also went even further in adding, as much as it has been underlined in Chapter I, that "given the enormous variety of animal coronaviruses, it was not surprising when the cause of a very new, severe acute respiratory syndrome, called SARS, emerged in 2002-2003 as a coronavirus from southern China and spread throughout the world with quantifiable speed.".[42] A statement which contributes in reaffirming how such viruses were not only known by many years but were also understood as a potential threat, especially if connected to the animal field and to the issue of zoonosis.

II . 3 – The 2003 SARS Outbreak

II . 3 . 1 – Main Characteristics and Brief History

After having briefly contextualized the larger family of the Coronaviruses, it is now worth returning to the heart of the matter and analysing more in detail the actual focus of the present chapter: the SARS disease. It is indeed this virus which behaved as a sort of anticipation of what would have come after in the form of Covid 19 and which triggered the 2005 IHR Revisions that will be taken into consideration in the following pages.

As it has been already seen in the previous resources and as it is stated in the Overview Page of the virus on the WHO Official Website, SAARS "[…] was firstly

[40] (Centers for Disease Control and Prevention, 2020).
[41] (Kahn & Kenneth, 2005).
[42] Ibidem.

identified at the end of February 2003 during an outbreak that emerged in China".[43] Connected to the family of the Coronaviruses and belonging to their most dangerous sub-family it was one of the most important outbreaks up to those years and had severe health, financial and political impacts. In this respect, it can be very useful to quote here once again the precious book written by W. Zacher and T. Keefe in which it is contained a brief overview of its main features.[44] In particular, the first element which is underlined as crucial is its subtle spreading through humans. Indeed, as reported by the WHO official data, this virus has an incubation period of 2 to 7 days with the possibility of an extension of the period to even 10 days. [45] This characteristic makes it quite difficult to be successfully traced since it can spread easily among humans before showing effective signs of illness in the bearer. The second relevant element mentioned by the authors is its capacity of progressing very quickly into severe pneumonia and respiratory collapse, with the possible death of the infected occurring in a matter of weeks. The two peculiarities, which are also quite similar to the behaviour of the more recent and dangerous Covid 19 virus, led to the expansion of the virus to 8,098 people worldwide with 774 deaths, according to the official data by the WHO reported in the CDC website.[46] A statistic which is luckily moderate for what concerns the effective number of people who were infected but that show also a mortality rate of 9.55% helpful in explaining the global impact the virus had despite the contained amount of infections. Indeed, not only China suffered from the spread of the disease with its 83% share of the global outbreak but also other countries such as Taiwan with the 8% and Canada and Singapore with the 3% were affected by the virus. In this sense, it has to be taken into consideration another crucial element concerning the outbreak, that is its economical dimension. This last one is what affected these countries the most even

[43] World Health Organization, (2021), Health Topics – Severe Acute Respiratory Syndrome (SARS) - Overview. Taken from World Health Organization Official Site: https://www.who.int/health-topics/severe-acute-respiratory-syndrome#tab=tab_1.
[44] (Zacher & Keefe, 2008).
[45] (World Health Organization, 2021).
[46] Centres for Disease Control and Prevention, (6 December 2017), Severe Acute Respiratory Syndrome (SARS) – Basic Fact Sheet. Taken from CDC Official Website: https://www.cdc.gov/sars/about/fs-sars.html#outbreak.

in a situation in which the contagions were not so widespread as they have been in the peak phases of the Covid 19 pandemic. In particular, quoting again the data provided by Zacher and Keefe, "SARS cost Asian countries alone between 11$ and 18$ billion in lost trade and income. [Moreover] estimate as to the global losses owing to SARS ranges between $40 and $80 billion.".[47] An important decrease in the global economy which can be explained with the general stop to the movement of both people and goods imposed by the health authorities in order to reduce the spread of the virus. Something that helps explain the already mentioned resistances on part of certain states in releasing official data on the number of contagions and the diffusion of the virus inside their borders which is crucial in determining an uncontrollable expansion of any disease. A reticence which will be one of the most interesting elements in explaining the worldwide expansion of Covid 19 but which is also fundamental in the history of the SARS pandemic itself.

As a matter of fact, taking into consideration the timeline of the outbreak's diffusion it is immediately evident the connection between its spreading and the reticence by national governments, at least in the initial phase. According to the official reconstruction mentioned in *The Politics of Global Health Governance*, the first case known of SARS originated in Guangdong, a China's province, in November 2002.[48] The earliest information about the virus were gathered and presented by the two reporting networks which have been described in the previous chapter, namely GPHIN and ProMED. However, despite their rapidity in spotting a potential threat, something that reinforces their importance on the overall system of global health protection, they were not able to precisely identify the character of the menace. The virus, after being originated in the Chinese province, then managed to spread to Honk Kong and, from there, to reach different countries like Singapore and Vietnam but also Canada and the United States. Even if for several months the Chinese authorities labelled the disease as a case of unique pneumonia, quite underestimating it and lessening its effective potential, both the WHO and the CDC sent a team of experts to China in order to directly verify the situation. It is precisely

[47] (Zacher & Keefe, 2008), p.60.
[48] (Zacher & Keefe, 2008), p. 61.

at this point, then, that comes to the front the theme of reticence on part of sovereign states to disclose crucial data for the fear of social and economic repercussions. Indeed, the Chinese authorities did not allow the foreign experts to enter the country and only in February 2003 a representative of the WHO in Vietnam, not in China anyway, could identify the features of the disease. This not only led to the launch of the global alert by the WHO on the 12th of March but also to the issuance of the now famous Travel Advisories on the 15th of the same month.[49] These first advisories consisted in a call on travellers and health professionals to adopt certain practices in order to curb the spread of the disease. A kind of response to which, after the Covid 19 crisis, almost every country of the world is accustomed to but which, in 2002, was perceived as a very strong and violent response. Moreover, the Advisories did not stop at this first one but went on to other two calls respectively on the 27th of March and on the 2nd of April. In the former the WHO called on airport authorities to screen passengers from infected areas while in the latter there was the recommendation to every individual to postpone all the nonessential travels to areas in which infected residents had been identified.[50]

II . 3 . 2 – The Crucial Role of the WHO

The Travel Advisories, as it has been said earlier, were quite uncommon at the time of the SARS outbreak and became immediately the most famous response among all the other actions that the WHO promoted in order to curb the virus. However, it is impossible not to mention also two other fundamental elements which had been crucial in the efficacy of the response and which helped in stopping the virus. The former had been the role of the recommendations. Indeed, in the months of the outbreak, more than 20 sets of guidelines and recommendations were issued regarding the control of SARS.[51] They were not a legally binding instrument but proved themselves very important both for states and NGOs in their effort against

[49] Ibidem.
[50] (Zacher & Keefe, 2008), p. 61.
[51] Ibidem, p. 62.

the virus, providing them with crucial information on the epidemiology and the peculiarities of the virus. They emanated thanks to three main sources to which it has to be added also the mobilization of 115 experts from 26 institutions in 17 countries by the GOARN, the Global Outbreak Alert and Response Network.

The first one consisted in the linkages between researches from 13 laboratories in 10 countries that devoted their attention to the identification of the aetiology of SARS thus contributing to the overall understanding of the virus in itself and of the whole family of coronaviruses it belonged to. The second source consisted in the network of 50 clinicians in 14 countries created by the WHO in order to develop definitions and control guidelines against the virus. Finally, the third element to be quoted here, was the union of 32 epidemiologists from 11 countries, promoted again by the WHO, who were responsible for the data collection process and a general study on the characteristics of the disease.

Together with the role of the guidelines and recommendations mentioned above, the latter element which was at the core of the successful response to the outbreak of SARS was the overall rapidity and strength with which it was counteracted. In this sense, it is quite interesting to look at a Review by Astrid Stuckelberger and Manuel Urbina published in the Journal *Acta Biomed.* The two authors reviewed the IHR Regulations and put them into contrast with the uncertainty that characterised the initial phases of the Covid 19 outbreak. In doing so they also offered a critical view of how the SARS epidemic had been defeated with some insights that are very useful in the purposes of the current chapter. Indeed, they mentioned as one of the key decisions taken by the World Health Organization precisely its strength and its major interference in contrasting the predecessor of Covid. They quoted, for example, the fact that SARS "became the first public health emergency of international concern (PHEIC) of our newly webwide globalized Century.".[52] They also went even further in reporting the strong role which was taken through all the management of the epidemic by the then WHO Director General, Dr. Gro Harlem Brundtland. She was considered as the most important

[52] Stuckelberger, A., Urbina, M. (2020). WHO International Health Regulations (IHR) vs Covid-19 Uncertainty. *Acta Biomed*, Volume 91, Number 2, p. 114.

figure, the one who "took the lead in coordinating this global health emergency by immediately releasing transparent communication about the knowns and unknowns, claiming full disclosure of data after late notification from China, and firmly recommending travel restrictions and preventive actions from every country.".[53] A statement by the authors of the Review which is very important in reaffirming what it has been said up to this point and also in adding one other fundamental point valid for the analysis of SARS and for the future analysis of Covid 19. Indeed, they basically resumed in one statement the importance of the Travel Advisories issued by the WHO, the role of the information gathering process at the core of the networks of experts and clinician and the strong role acted by Dr. Brundtland in leading the whole global response. However, they also underlined the behaviour that the international organization took vis à vis a country that, at least in the initial phases, showed reticence in disclosing full information to the authorities, namely China. In this sense, it can be said that the WHO followed, even in this delicate field of international diplomatic relations, the very same policy it had for all the other issues concerning SARS. A policy which is perfectly described by the already known authors of *Politics of Global Health Governance*. In particular, they claimed that the then Director General "recommended certain dramatic policy changes for states and travellers" and that her role "was not a mediatory one between states [as it was the rule until SARS]; it was an international executive's recommending remedial policies both for states and individuals to reduce the incidence of infection and deaths.".[54]

It is exactly on the line of this more proactive and executive role that the WHO took a series of strong decisions with respect to China and its voluntary hiding of crucial data in the first stages of the epidemic. In this sense, it could again be interesting to quote the opinion of Zacher and Keefe who resumed the whole change in the relations between the WHO and China as an important landmark in the promotion of states compliance to the international organisation's recommendations and

[53] Ibidem.
[54] (Zacher & Keefe, 2008), p. 66.

directives.[55] In particular, in the pursuit of a more detailed analysis of what happened between the institution and the Asian state, some crucial dates have to be quoted here. First of all on the 15th of March, following the travel advisory calling on states to report possible outbreaks, the WHO specifically directed its attention toward China asking to provide information. However it was only on the 4th of April that China started to send electronic reports about the disease for two different reasons: the insistence of the WHO and also the fact that some data were already leaving the country thanks to the work of some NGOs both inside and outside China. A little increase in the flowing of data which was still not perceived as complete and which led, on the 16th of April, to the expression from the WHO of strong concern over an inadequate reporting. A concern which, as noted by an author such David Fidler and reported in *Politics of Global Health Governance*, represented a completely new behaviour from the WHO. Indeed, quoting him literally, " WHO's public criticism of the Chinese government presented a radical break with the traditional diplomacy that characterizes relations between the Organization and member states.".[56] And it is precisely following these public and unexpected statements of concern that, on the 20th of April, the Chinese Premier took the decision of firing both the Health Minister and the Mayor of Beijing in order to mute external criticism. A political and diplomatic clash which went even further when the deputy Minister of Health argued on May 30 that China had never concealed the truth. A statement which led to the announcement from the WHO of removing all staff from the country whether the deputy Minister did not recant. Something that happened within a couple of days "revealing a remarkable amount of effective political pressure by WHO officials.".[57] An unprecedented shift in the diplomatic behaviour of the World Health Organisation which was perceived at the time as a real landmark in the history of the Organisation as a whole. An element which, combined with the other crucial measures outlined in the previous pages, led to the declaration on the 4th of July of the definitive containment of the SARS

[55] Ibid., p.63
[56] (Zacher & Keefe, 2008), p. 63.
[57] Ibid., p. 64.

outbreak. A moment which was perceived as an enormous victory for the international organization seen by the whole world as "[…] a much stronger and more important organization than had ever been in the past.".[58] Something that did not only imply a renewed role for the WHO in the scheme of global health protection but which entailed a whole new understanding of the very notion of disease containment under the perspective of a multilateral approach.

II . 4 – The International Health Regulations: from 1969 to 2005

II . 4 . 1 – History and Main Characteristics

With the hindsight of what would have happened less than two decades later with Covid 19, it is almost impossible to look at those events as a full victory of the multilateral approach and of the WHO. It is indeed clear how certain lessons that could have been derived from the SARS outbreak were not fully learnt by the global community and that the alert which such an unprecedented disease triggered should have led to more stringent and important measures at both the international and the national levels. However, the end of the SARS epidemic and the way through which it was obtained still represents a crucial moment in the history of global health protection and must be analysed, as it has been done in the previous pages, in order to fully understand the Covid 19 pandemic. As a matter of fact, precisely as a consequence of the 2002-2003 pandemic, one of the main instruments at the disposal of the WHO to preserve global health, the already mentioned IHR, started to be questioned up to the point of a complete revision in 2005. A crucial moment if it is taken into consideration the fact that the version of the IHR which emerged from that reforming process was, with the exception of some minor changes applied through the years, one of the most important tools at the disposal of the World Health Assembly to face the 2019 Covid outbreak. So, precisely for this reason it is important to devote some attention to this issue and to describe the IHR as a whole with a narrower focus on the major changes they underwent after the 2003 SARS

[58] Ibidem.

outbreak before taking into consideration the actual elements which led to the Covid 19 pandemic the world is currently facing.

In order to properly describe the International Health Regulations in the context of the present analysis, it is worth spending some time in resuming their history and the reasons why they were first created. In doing so it is very helpful to look at the words of Stuckelberger and Urbina who described the birth of the Regulations in their already mentioned Focus in the Acta Biomed magazine. They reported that the IHR were adopted for the first time in 1969 as a consequence of the increase in travel and trade brought by the technological and industrial improvements of the post-WWII global situation. They were a sort of consequence of the growing concern about transborder contagion which was dominating the health debate at the time.[59] In particular they can be seen as something emanating directly from two of the most important articles of the World Health Organization Constitution, the founding document of the whole Organization signed in July 1946 by representatives of 61 different states and entered into force on the 7th of April 1948. The portions of the Constitution into question are more precisely Article 2 and Article 21(a). The former is located at the very beginning of the document and enlists all the crucial functions that the organization has been given by the member states. In the context of this analysis, it is sufficient to resume these elements with the point (a) of the Article, that is the necessity of the organization "to act as the directing body and coordinating authority on international health work".[60] In order to perform such tasks it has to collaborate with the United Nations and its specialized agencies, assist Governments, furnish appropriate technical assistance and to promote health in each of its different declinations. The latter, on the other hand, is Article 21(a) which is a very specific portion of the Constitution stating the authority of the World Health Assembly to adopt regulations concerning "sanitary and quarantine requirements and other procedures designed to prevent the international spread of disease."[61]. An article which is particularly useful, moreover,

[59] (Stuckelberger & Manuel, 2020), p.113.
[60] (Constitution of The World Health Organization, 1946), p.2.
[61] Ibidem, p. 7.

in explaining a crucial characteristic of the IHR, the one that distinguishes them from the rest of the treaties emanated by the World Health Assembly. Indeed, precisely in order to guarantee the prevention of the international spread of disease, the International Health Regulations are the only legally binding treaty approved by the WHA between 1958 and 2000.[62] Something that not only differentiates them from the other treaties of the WHA but also from most of the other UN bodies and agencies which possess in the majority of the cases a simple recommendatory role. To be honest, it has to be added, as clearly noted by Zacher and Keefe in their precious chapter, how such binding nature of the IHR had always been underestimated by the international community in the field of global health politics and law. Indeed, the authors affirmed how "throughout most of the twentieth century the character of WHO institutions was similar to that of other UN bodies.".[63] They could basically adopt recommendations on a variety of matters by simple or two-thirds vote majority but "[…] states did not comply with the rules in many circumstances, and [moreover] there was little effort to expand the scope of the IHR beyond the three diseases of cholera, plague and yellow fever."[64].

Bearing in mind the unique position of the International Health Regulations as one of the only binding treaties in global health protection and, more generally, in the UN system as a whole is crucial in approaching the issue of the reforms they went through. In the context of the current analysis the most important revision moment has surely taken place in 2005 at the 58th World Health Assembly emanating from the lesson that had been learnt after SARS in 2003. Anyway the Regulations had already been revised and amended several other times in the course of their history. It has already been mentioned in the notes at the bottom of the page the Amendment of 1981 with the reduction in the number of the diseases to be monitored from six

[62] (Zacher & Keefe, 2008), p.66.
[63] Ibidem.
[64] (Zacher & Keefe, 2008) p. 66-67. In order to clarify the content of the quotation, it has to be noted here how, when they were firstly adopted, the IHR contained six *quarantinable disease* (cholera, plague, yellow fever, smallpox, relapsing fever and typhus) while, following an amendment of 1981 the closely monitorable disease were reduced to the three mentioned in the text. A reduction in scope and fields of interest that is quite telling of the general underestimation of the Regulations by the rest of the international community over most of the XX Century.

to three. Anyway it is important to mention here another moment of change in the IHR development: the draft of 1998. In that year there was a particularly interesting attempt to overcome the reduction in the number of the diseases to be monitored through a change in the whole approaching system. Indeed it was proposed a so-called *syndromic approach* in which the focus of the monitoring system should have passed from the three epidemic-prone diseases (cholera, plague and yellow fever) to six categories of syndromes. Among them there were: acute haemorrhagic fever, acute respiratory, acute diarrheal, acute jaundice, acute neurological, and other notifiable diseases. [65] An expansion attempt which clearly represented the willingness to enlarge the amount of monitored illnesses but which was constrained by the limits of many countries in funding the expensive evaluation processes that were needed. Moreover, the whole revision process and the syndromic approach it proposed, even if accompanied by considerable optimism at the time, did not manage to obtain enough political attention in order to be approved. In particular it attracted considerable opposition to the 1998 draft which, in turn, led to the end of the reforming momentum and to the drop of the approach itself in 1999.

II . 4 . 2 – 2003 as a Turning Point

Despite the premature end of the revision process it has to be noted how, among the whole international community, especially within the WHO, a change of thinking over the issue of disease control was taking place. An intellectual work sustained by several different proposals and critical essays that would have led to the Interim Draft of the IHR in January 2004 first, to the November of 2004 international evaluating conference and to the subsequent May 2005 Conference which would have approved the crucial 2005 International Health Regulations Revisions.[66] In this sense, among all of the fundamental publications by experts and WHO officials, there must be quoted at least three: the one appeared in the journal *Emerging Infectious Diseases* in early 2000, *Global Crises – Global Solutions* and, more

[65] Ibidem, p. 65.
[66] (Zacher & Keefe, 2008), p. 65.

generally, the whole set of publications that focused on the lesson to be learnt after the SARS outbreak in 2003. The former of these essays was co-authored by nine WHO officials and it has to be mentioned here because it already envisaged a more proactive role for the Organization vis à vis states both in the field of outbreak verification through the dispatch of verification teams, both in the field of surveillance capabilities building. The other publications mentioned above, on the other hand, were included in the Interim Draft of January 2004 and had particular resonance in the reform process as a whole. The crucial element that has to be underlined here, before moving to the actual analysis of the changes applied to the IHR at the end of the process, is the fact that they were following the end of the SARS outbreak and thus were deeply affected by the new behaviour that the WHO showed in fighting that disease. A new attitude which was testified, as it has already been mentioned in the previous pages, by the creation of GOARN in 2000 with the aim of legitimizing a broader range of interventionist strategies and by the subsequent application of such strategies by the then Director General of the WHO, Dr. Gro Harlem Brundtland.

II . 4 . 3 – The 2005 Revisions: main innovative elements

It was only through the union of this intellectual and political ferment at the international level, the emergence of a potentially very harmful threat such as SARS and the positive results brought by the new more proactive WHO strategy that it was possible to reach all the major changes applied to the IHR in the 2005 Revisions. The most important revision steps and all the debate which led to the adoption of the final text at the 58th World Health Assembly have already been described in the previous pages. For this reason it is now the proper time to come to the heart of the matter and to examine the main changes that were applied to the original text and what they entailed for the global health protection system as a whole.

The first element that should be mentioned here is one of the most important institutional changes brought by the Revision, namely the introduction of several new bodies operating under the WHA. In this sense it is crucial to quote at least

three of them: two involving the surveillance and monitoring system and the other concerning a sort of internal revision mechanism. The first category is represented by the Expert Roster and the Emergency Committee, with the former as a permanent body composed of one technical representative for each member state and the latter as a team appointed directly by the Director General and composed by members of the Expert Roster and other bodies. As can be easily understood, both of them had the target of enhancing the monitoring power of the WHO and helping the Organization and its member states in the analysis of possible new emergencies of international concern. The second category, on the opposite hand, is represented by the Review Committee whose membership is taken again by the Expert Roster and other technical groups and whose main objective is to propose "[…] amendments for the IHR as well as *standing recommendations* pertaining to long-term health problems."[67]. A body which can be seen as the controller of the IHR in the long run with a particular eye on the amendments necessary to improve the international health protection system in accordance with the newly emerging diseases and their related risk for the global community.

In this very context of description of the main institutional changes, it has to be underlined here also the fact that, despite the presence in the 2005 IHR of a variety of approaches to dispute settlement inside the Organization, there was no body, neither among the older ones neither among the newly established, with the capacity of imposing a legally binding judgment. A peculiarity that went in line, in a way, with the more general option guaranteed to states to reject the agreement or to make reservations concerning particular provisions within 18 months of the IHR acceptance by the WHA. Two different elements that, if considered together, help in testifying a willingness on part of states to retain some control over the Organization and over the system of global health protection which is, as it will be clarified in the following chapters, one of the main weak spot in terms of effectiveness for the UN International system as a whole.

[67] (Zacher & Keefe, 2008), p. 66.

Coming back to the main changes that were included in the 2005 IHR Revision it must be added here an expansive trend, in line with Dr. Brundtland strong response to SARS, which covered both the core values of the Regulations themselves and the sources of information that could be legally used by the WHO in performing its tasks. In particular, the former expansion in values can be described as the inclusion of the notions of human rights promotion, environment protection and security to the original two goals of limiting the spread of infectious disease and reducing the interference with the flow of international commerce. An enlargement of the political goals of the Regulations which was labelled by David Fidler, an authoritative author in this field, as *Integrated Governance* [68]and which testified the improvements in the understanding by the global community of two fundamental elements. The former, emanating directly from the preamble of the 1948 WHO Constitution, consisted in reaffirming the importance of the enjoyment of the highest possible standard of health as " basic to the happiness, harmonious relations and security of all peoples", and as a fundamental principle "without distinction of race, religion, and political belief, economic or social conditions.".[69] The latter, on the opposite hand, involved a better understanding of the direct link between the themes of health, economics, environment and even politics that the newly interconnected global world was establishing and the increasing necessity, on part of states, of a more coordinated and international approach to solve the problems connected to such global issues. A theme which will be analysed more in detail in the following chapters but which is already crucial to mention here given the relevance it had in shaping the 2005 IHR and the even greater importance it acquired as a consequence of the Covid 19 pandemic.

The other expansive trend mentioned above concerned the sources of information at the disposal of the WHO for its purpose of surveillance and monitoring of emerging threats. In this sense, it has to be underlined how, during the whole twentieth century, there had been a long-standing clause that the Organization could only publicize information coming from the official governments of an affected

[68] (Zacher & Keefe, 2008), p. 67.
[69] (Constitution of The World Health Organization, 1946).

state. This was one of the main reasons why many outbreaks, SARS included, could spread unnoticed at least in their initial phases given the willingness of states to avoid expensive trade embargoes and quarantines and thus limiting the amount of crucial information shared. A trend which, as it has been described in the previous chapter, started to change with the advances in the information system and the creation of monitoring bodies such as GOARN (informally established in 1997) or the recourse to other sources such as other UN agencies or specialized NGOs but which was formally approved only in the 2005 IHR. In particular, according to Article 9 of the revised document "WHO may take into account reports from sources other than notifications or consultations and shall assess the reports according to established epidemiological principles and then communicate information on the event to the State Party in whose territory the event is allegedly occurring.".[70] So, according to the article in question, the WHO was given the right to use also information coming from other non-state sources with the only requisite, contained in the very same article, of consulting with and attempting "to obtain verification from the State Party in whose territory the event is allegedly occurring in accordance with the procedure set forth in Article 10.".[71] And it is particularly interesting to quote here precisely the fourth paragraph of this Article 10 containing the procedures of Verification. Indeed, it clearly states that "if the State Party does not accept the offer of collaboration, WHO may, when justified by the magnitude of the public health risk, share with other State Parties the information available to it, whilst encouraging the State Party to accept the offer of collaboration by WHO, taking into account the views of the State Party concerned.".[72] A series of provisions that, as can be easily understood, enhanced the position of the Organization vis à vis its member states over the control of information and which entailed the importance of collaboration between the parties in order to fulfil their respective obligations. However, this new focus on states information sharing implied also the need for strengthening the technical capacities to monitor health which many states

[70] World Health Organization (2016), *International Health Regulations (2005) – Third Edition*, Part II, Article 9.1, Geneva, p.12.
[71] Ibidem.
[72] (World Health Organization, 2016), Article 10, Paragraph 4, p. 13.

lacked at the time of the Revision. In particular, during the negotiations, it was underlined how sometimes states chose not to report simply because they were unaware of what was occurring in their country. For this reason it was included to the text the Annex I Part A which, as clearly stated in its title *Core Capacity Requirements for Surveillance and Response*, consisted in a recollection of all the duties of each member state in connection to the surveillance system. And it is particularly interesting to notice how, from the very beginning of Article 1, it is stated that "Stats Parties shall utilize existing national structures and resources to meet their core capacity requirements under these Regulations" with a particular focus on two field mentioned respectively in paragraph (a) and (b) of the article: activities concerning surveillance, reporting and notification and activities concerning ports, airports and ground crossings.[73]

The 2005 International Health Regulations did not limit to reiterating the necessity of improved surveillance and improved communication between member states and the World Health Organization. They also went further in stating how to enhance such communication and, thus, how to improve the surveillance capacities of both states and WHO. This element was particularly clarified in Part I, Article 4 of the 2005 IHR, namely the article concerning the responsible authorities in terms of monitoring system. Indeed, in Paragraph 1 of the article it is stated that "each State Party shall designate or establish a National IHR Focal Point and the authorities responsible within its respective jurisdiction for the implementation of health measures under these Regulations.".[74] On its part, on the other hand, the WHO committed itself to the designation of IHR Contact Points "which shall be accessible at all times for communications with National IHR Focal Points" in Paragraph 3 of the very same article.[75] Finally, besides the creation of these contact points between member states and the Organization, there was also another crucial provision contained in the Revision and regarding the access to resources in order

[73] Ibidem, ANNEX I, Article 1, p. 40.
[74] (World Health Organization, 2016), Part I, Article 4, Paragraph 1, p. 11.
[75] Ibidem, Paragraph 3.

to improve the surveillance capabilities. It was contained in Article 46 of Part VIII and clearly stated that "states parties shall, subject to national law and taking into account relevant international guidelines, facilitates the transport, entry, exit, processing and disposal of biological substances and diagnostic specimens, reagents and other diagnostic materials for verification and public health response purposes under these Regulations.".[76] As noted by Zacher and Keefe, this provision was a very important one in that it established the possibility both for other non-involved state parties and the WHO to request particular biological substances be sent to them in order to be analysed and it also entailed an obligation for the recipient to comply to the request.[77] A provision which was, thus, of critical relevance for the expansion of the sources of information at the disposal of both states and Organization and which expanded the surveillance capacity system as a whole thanks to an improved connection between all the actors at stake. However it has also to be underlined how, notwithstanding the positive impact it had, as noted again by the authors of *Politics of Global Health Governance*, the WHO found difficult on occasion to enforce compliance to such rule and states managed to avoid its requirements or at least managed to stall the situation as it will be described with Covid 19 in the next chapters.

II . 4 .4 – Annex II: guidelines to the issuance of a Public Health Emergency of International Concern

Finally, the last provision that has to be quoted here and probably one of the most important for the whole structure of global health protection emerging from the 2005 IHR Revisions is the one contained in Article 6 and Annex II of the document. As a matter of fact in Paragraph 1 of the article it is stated that "each State Party shall assess events occurring within its territory by using the decision instrument in Annex 2.".[78] The Annex, titled *Decision Instrument for the Assessment and Notification of Events that may Constitute a Public Health emergency of*

[76] Ibidem, Part VIII, Article 46, p. 31.
[77] (Zacher & Keefe, 2008), p. 70.
[78] (World Health Organization, 2016), Part II, Article 6, Paragraph 1, p. 12.

International Concern, is composed by a flow chart representing the questions that must be asked in order to properly classify a disease outbreak. It also includes a series of tables with four general questions and for each of them a series of other more specific ones to which each state has to answer in order to understand the gravity of the threat. The general questions are divided as follows:

I – Is the public health impact of the event serious?
II – Is the event unusual or unexpected?
III – Is there a significant risk of international spread?
IV – Is there a significant risk of international travel or trade restrictions?

As a conclusion to these questions and to the other they imply it is stated at the end of Annex II that "State Parties that answer *yes* to the question whether the event meets any two of the four criteria (I-IV) above, shall notify WHO under Article 6 of the International Health Regulations.".[79] Such classification facilitated the way in which states could verify a threat and posed a whole set of shared criteria common to all the international community. In order to be more specific it is useful, moreover, to add briefly here the resume made by the authors Zacher and Keefe who identified in their book three ways to classify the diseases according to the IHR method.[80] The first classification regards the diseases which are always deemed as a public health emergency of international concern and which, according to the rule in Annex II, must always be reported under Article 6. Among them are included smallpox, poliomyelitis, human influenza caused by a new subtype and SARS. It is particularly interesting to notice the presence in this list of the last two elements, namely new influenza subtypes and SARS. They should have been a major reason to include SARS-CoV-2 into the list of dangerous threats way before it spread as a pandemic to the whole world, a topic of crucial importance which will be clarified in the following chapter. The second classification, on the other hand, includes a group of diseases that sometimes pose a public health emergency. Among them the

[79] Ibidem, Annex II, p.46.
[80] (Zacher & Keefe, 2008), p.69.

authors recognized cholera, pneumonic plague, yellow fever, viral haemorrhagic fevers (Ebola, Lassa and Marburg), West Nile fever and all the other diseases of special national or regional concern. For these kinds of diseases the examination follows the four questions above mentioned and, as it has been noted, they are considered PHEIC when triggering a *yes* answer for two questions out of four. A methodology which reveals itself useful even in the context of the last category, namely the one of emerging and re-emerging diseases. A category that once again could have triggered a stronger response at the very first signals of an outbreak such as the one of Covid 19.

II . 5 – Final Considerations

Finally, in order to end the current chapter and to pass to the Covid 19 outbreak and what has gone wrong in its containment despite the measures that were taken as a consequence of SARS, it is worth resuming here in brief all the crucial elements of the 2005 IHR Revision analysed up to this point. In doing so it is again an helpful source of information Chapter 3 of *Politics of Global Health Governance*. Indeed, the two authors enlisted all the key changes that were applied in reforming the IHR and which have been described in the paragraphs above and listed them into five different elements. The first one, which is strictly connected to what has been said in the last paragraph, is the crucial broadening of the coverage of diseases from just 3 to more than 15 with a door open to include even more thanks to the classification methods proposed in Annex II. The second crucial change is what has been analysed as the expansion of the sources of information at the disposal of the WHO and consequently the permission for the Organization to accept data coming from nongovernmental sources. Third, and very much connected to the second point, is the commitment on part of states to improve their capabilities in terms of disease detection and to distribute all the information on a potentially harmful outbreak in order to curb its potential since the very beginning. In this sense, and included by the authors as the fourth relevant point to be mentioned, is crucial the fact that states were also given greater latitude in adopting more stringent measures vis à vis the

past. Something perfectly in line with the emergency response which was taken by the then Director-General of the World Health Organization Dr. Brundtland in order to cope with SARS and which triggered measures completely new for the time in which they took place. Finally, the fifth and last point to be mentioned is the fact that the WHO was given three new decision making bodies, namely the Expert Roster, the Emergency Committee and the Review Committee, in order to improve its efficiency in the creation of rules and guidelines to be followed in emergency outbreaks and over long-run health problems.

All of the measures described above, and analysed more in detail in the course of the whole chapter, were seen as crucial in the development of a new understanding of the notion of global health protection. A new way of approaching the issue which was caused by the dangers faced with the unexpected rise of SARS and the unprecedented response taken by the WHO of the time. Something that led the authors of *Politics of Global Health Governance* to conclude their chapter on disease containment strategies with such a statement: "Nowadays, the deeper understanding of the self-interested benefits of disease containment has made it easier to argue that a strong global surveillance and containment system is not just desirable for humanitarian reasons but necessary for survival reasons.".[81] Words that, with the understanding of what would have happened just a decade later, cannot but trigger a reaction of discomfort in their reader about all the lessons that should have been learnt with an outbreak like SARS and all the opportunities that the global community missed in the field of health protection. The only hope left is that, at least as a consequence of the Covid 19 pandemic, such lessons will be applied in new and more efficient ways and that a Coronavirus, precisely as it was the case with SARS, will once again be the driver of major changes for the whole global community.

[81] (Zacher & Keefe, 2008), p. 75.

III – What Went Wrong with Covid 19: Early Timeline, Member States' Responsibilities and WHO's Main Flaws.

III . 1 - Introduction

Up to this point two major elements have been analysed. The former is represented by the overall composition of the global health protection system while the latter is a more practical example of how the system managed to defeat a dangerous outbreak such SARS in 2003. In particular the end of that virus, which as it has been seen in the previous pages shares some important ties with Covid 19, represented for the global community a fundamental turning point. Indeed, not only the World Health Organization managed to obtain even more prestige and importance on the global scenario but many attempts of reforming the International Health Regulations came to the front of the public debate. In this sense, both the Organization and its main binding instrument should have been strongly improved by the Revision process taking place in 2005 and should have reached a higher level of effectiveness and a better possibility of responding to the threats following SARS. An assertion which is, however, profoundly contradicted by what would have happened just a decade after with another virus belonging to the very same family of Coronaviruses. It is clear now, with the awareness of what happened since the virus was first discovered in the city of Wuhan and all the unprecedented effects it had on the world as a whole, how the general optimism coming out from the 2005 Revision process was at least a bit exaggerated. Indeed, despite the victory over SARS and a better understanding by the global public opinion of the absolute importance of the theme of global health, it is evident how with SARS-CoV-2 something went wrong vis à vis its predecessor. It will be precisely the objective of the current chapter, then, that of analysing the main reasons which contributed to a late recognition of the threat and thus to the impossibility of curbing it before it reached the level of a global pandemic as it did. And in doing so the World Health Organization, its structure and its internal weak spots will be in the spotlight of the analysis with an eye on how it tried to contain the geopolitical clashes that Covid

19 brought with it and how the theme of health and that of politics are strictly and, almost indivisibly, intertwined.

III . 2 – Account of the Early Stages of the Pandemic

One of the best ways to start a discussion over what has gone wrong with Covid is to look at its history and in particular at the timeline of its beginnings, namely how and where it was firstly discovered and what had been its first steps before reaching a global diffusion. This type of approach proves itself very useful not only in determining the initial spread of the virus but also in analysing more closely the response of the global community to the emerging threat and the problems in the reporting system it had to face. In this respect, a very helpful resource is represented by the editorial written by Theodore M. Brown and Susan Ladwig titled *Covid 19, China, the World Health Organization, and the Limits of International Health Diplomacy* and published in August 2020 in the American Journal of Public Health. An editorial which is very useful given the fact it reports and comments the official chronology posted on the WHO website of the early stages of the Covid 19 pandemic, associating each stage to the subsequent response it triggered in the global community.[82]

The very first step of the timeline which has to be quoted here is represented by the 31st of December 2019 in which a cluster of cases of pneumonia was reported in the now famous city of Wuhan, in the Hubei Province of China. A passage which is strictly connected to the ones that immediately followed on the 5th of January 2020 in which the *Disease Outbreak News* of the WHO announced for the first time 44 reported patients in the city. According to the official sources they were mainly vendors at the Huan Seafood Market and among them 11 were severely ill with a pneumonia whose aetiology was unknown at the time. It has to be added here how, at that point, according to the Chinese investigators on the field no evidence of human-to-human transmission could have been reported despite the homogeneity

[82] Brown, T. M., Ladwig, S. (2020). Covid 19, China, the World Health Organization, and the Limits of International Diplomacy. *American Journal of Public Health*, Volume 110, Number 8, p. 1150.

of the patients coming from the same area and even the same working place.

The third passage, following the above mentioned ones by a week, is of crucial importance and entails a first moment of reflection over the responsibility of states, in particular of the People's Republic of China, as it will be noted by the authors of the editorial too. In particular the passage into question refers to the 12th of January in which the second *Disease Outbreak News* by the WHO revealed that one death had occurred as a consequence of this new disease and that among the remaining 41 confirmed patients most of the cases were of workers or frequent visitors to the Huan market. It also reported how the contact tracing of 763 close contacts of the afflicted ones, including health care workers of those hospitalized, occurred with no additional cases of infection identified. Something in line with the reiterated reporting, on part of the Chinese authorities, of the absence of a clear evidence of easy person to person transmission but which will be then contradicted by the WHO note in a press briefing on the 14th of January stating that limited human-to-human transmission could have been possible and that there was a risk of a wider outbreak.[83] However, this is not the most controversial and debated part of this stage in the early chronology of Covid 19. Indeed, the element triggering the first questions in the minds of Brown and Ladwig and in those of their readers too was the fact that on that same 12th of January the Chinese authorities shared the genetic sequence of the newly discovered coronavirus and announced that they had isolated it already on the 7th of January. Quoting directly the words of the authors of the editorial the immediate question that can be raised is if "the new coronavirus was isolated by Chinese scientists by January 7, so why did China not report this to the WHO until January 12?"[84]. A sort of question which is even more interesting bearing in mind the highest importance applied to the theme of surveillance and reporting in the 2005 Revision of the IHR analysed in the previous chapter. Something that, already at this stage, contributes in highlighting one of the reasons why it became almost impossible to totally curb the spread of the disease and which

[83] (Brown & Ladwig, 2020), p.1150. It is also interesting to note here how the acknowledgment of the possibility of a major diffusion of the virus was immediately preceded, on the 13th of January by the reporting of a confirmed case in Thailand: a traveller coming precisely from the city of Wuhan.
[84] Ibidem, p. 1149.

underlines the crucial importance of the behaviour of states in the delicate and fundamental phases of surveillance.

It is only 10 days after the announcement of the newly discovered genetic sequence of the Coronavirus, on the 20th - 22nd of January, that a team of WHO officials from its Western Pacific Regional Office in Manila, Philippines and its Country Office in Beijing made a brief field visit to Wuhan. Despite the quite long timespan between the two moments what is most striking about this event is the fact that the technical experts of the Organization issued a statement of evidence of human-to-human transmission thus contradicting what had been said by the Chinese authorities until then. Moreover, the situation report issued as a consequence of the visit noted 32 new cases in a single day, something that prompted the high infectivity of the threat, and the addition of seven different provinces and two municipalities reporting new cases in China. The immediately following stage is even more interesting for the purpose of the current analysis given the fact that the situation report also noted how the Chinese national authorities, despite their denial of human-to-human transmission, had installed already on the 14th of January "35 infrared thermometers in airports, railway stations, long-distance bus stations and ferry terminals.".[85] An evidence that raised an almost immediate question in the minds of the two authors of the editorial who asked themselves "[…] why was no confirmatory evidence [of human-to-human transmission] reported by China until January 23, just after a small WHO team was allowed to visit Wuhan for the first time and more than a week after the Chinese had installed thermometers at airports, rain stations, and long-range bus stations?"[86].

As a consequence of this situation of extreme uncertainty and bad cooperation between states and the Organization, the WHO Director General Dr. Tedros Adhanom Ghebreyesus decided to try obtaining a mandate to declare the issue a public health emergency of international concern (PHEIC). Indeed, he convened an Emergency Committee (EC) under the IHR in order to assess the relevance of the outbreak which, however, deadlocked between January 22 and 23 with its 15

[85] (Brown & Ladwig, 2020), p. 1150.
[86] Ibidem, p. 1149.

members split down and failing to reach a consensus. Five days later, still moved by the compelling evidence of the relevance of the threat, he managed to organize a senior delegation to Beijing where he met with Chinese leaders, including President XI Jinping. It was only at this point that the Chinese authorities agreed with the Organization over the necessity of an international team of experts to definitively curb the virus. And just two days after this acknowledgment, on the 30th of January, Covid 19 was finally declared a PHEIC by the Emergency Committee when there were already 7818 confirmed cases, with a vast majority in China but also 82 additional ones in 18 other different countries.[87] The Situation Report emerging from the EC with a detailed account of its deliberation contained a warm praise for China and welcomed "the leadership and political commitment of the very highest levels of Chinese government, their commitment to transparency, and the efforts made to investigate the current outbreak."[88]. Something that clashes a bit with what has been said up to this point about the omission of timely information on part of China in the early stages of the outbreak. However, it also led to the creation of a WHO-China Joint Mission from the 16th to the 24th of February. It included 25 experts from Canada, Germany, Japan, Nigeria, Republic of Korea, Russia, Singapore and the US who spent time both in Beijing and Wuhan and found that a cumulative total of 75,456 cases were reported in China by February 20. Numbers extremely bigger vis à vis the ones reported in declaring the PHEIC just two weeks before, which confirmed the high infectivity of the virus which, in turn, partially explains how it managed to spread so fast, as it did, from a single circumscribed region of China to the whole world.

III . 3 – Errors, Responsibilities and Accusations

After having analysed in brief the chronology of the first two months of the outbreak what emerges as most striking and interesting is, without any doubts, the amount of time that passed since the first discovery of the first cluster of cases of pneumonia

[87] (Brown & Ladwig, 2020), p. 1149.
[88] Ibidem, p. 1150.

to the declaration of a PHEIC and from that moment to the first Joint Mission to China. Among any of the steps which have been listed above there are time spans that should have been shorter in order to properly fight the virus since its beginnings. In this sense, in order to better acknowledge the gravity of such delays in sharing of information in the context of the pandemic it is sufficient to quote an article written by Lawrence O. Gostin and published in the Journal of American Medical Association in which it is described what he calls literally the *Early Failure of the Global Health System.* He reported that "SARS-CoV-2 is a highly transmissible pathogen, fuelled by asymptomatic spread. Rapid detection of and response at the Wuhan wet market may not have prevented the pandemic, but it was the world's only opportunity."[89]. He went even further in reporting how, already in early December, Wuhan hospitals were witnessing cases of unexplained pneumonias but only on December 31 China's National Health Commission finally announced an outbreak of viral pneumonia unrelated to SARS. In his opinion the fact that "China did not report the novel viral clusters to the WHO, even though the IHR requires notification within 24 hours" and that it "did not confirm [the unofficial sources of information] until January 3" had been crucial in the uncontrolled spread of the pandemic. In particular he noted how "due to the lack of accurate and full reporting, the WHO continued to publish inaccurate information regarding human-to-human transmission", thus compromising the situation even more.[90] A very dangerous situation if taken into consideration also those criticisms levelled not at the Chinese government for its delays but at the World Health Organization for its management of the early phase of the pandemic. In particular, it is sufficient to quote here the very beginning of an essay which will be analysed more in detail in the following pages written by Eyal Benvenisti. It is titled *The WHO – Destined to Fail? Political Cooperation and the Covid 19 Pandemic* and starts with a brief recollection of the accusations levelled at the Organization. Accusations not shared by the author, whose purpose was completely different as it will be clarified later on, but which

[89] Gostin, Lawrence O. (March, 2021). The Coronavirus Pandemic 1 Year On – What Went Wrong? *Journal of the American Medical Association*, Volume 325, Number 12, p. 1132.
[90] Ibidem.

are particularly useful in the present context. In particular, it is reported how "admittedly, the organization reacted slowly to information about an outbreak of Coronavirus in China, and offered imprudent advice – exhorting states to avoid travel bans, even after China had imposed a lockdown in Wuhan."[91].

In such a condition of errors and accusations on both the sides involved in the management of the early stages of the pandemic it is easy to understand the reason why, as reported by Brown and Ladwig, almost every media in the world tried to find a responsible for the uncontrolled spread of the virus. In particular, they quoted two different points of view, both coming from the US newspapers, which are useful in explaining two of the most common positions against each one of the two sides. Concerning the voices more critical toward the Chinese government, they quoted the conservative newspaper *Washington Examiner* which, in their own words, "claimed that China lied about the virus' capacity for human-to-human transmission" and that "was relatively easy on the World Health Organization which […] China had manipulated by refusing to let it see early data.".[92] On the opposite side, among the voices critical towards the Organization's management of the outbreak, the authors quoted the American libertarian magazine *Reason* which on the 15th of April 2020 "asserted that the WHO whitewashed the Chinese government's early handling of the crisis and did this because of its overly deferential stance towards China, which is its second-biggest financial contributor."[93].

It is precisely after these critical premises that Brown and Ladwig continued their editorial with the above mentioned chronology of the early timeline of the Covid 19 pandemic. They considered it a very useful tool in order to assess the truth about the WHO's response to the coronavirus crisis and also about the errors and responsibilities of the Chinese government in the issue. And it has to be

[91] Benvenisti, Eyal (June 30, 2020) The WHO – Destined to Fail?: Political Cooperation and the COVID-19 Pandemic. Research Paper No. 24/2020, University of Cambridge Faculty of Law, p. 588.

[92] (Brown & Ladwig, 2020), p. 1149.

[93] Ibidem. It is interesting to note here a first mention of the theme of financial contributions to the international Organization which is very helpful in understanding part of its difficulties and contradictions and that will be analysed in the following pages.

acknowledged that this very same analysis has been quoted also in the context of the current chapter precisely for its usefulness in framing the issue and in giving a good starting point to the assessment of what are the main flaws of the WHO and how they influenced the poor response to Covid 19. An investigation which, at this point, has to move forward toward another crucial element to be underlined in order to ascertain the real responsibilities of the World Health Organization.

The element into question is represented by a fundamental document quoted by Clare Wenham, assistant professor of global health policy at the London School of Economics, in her editorial for the British Medical Journal published on the 4th of February 2021 under the title *What Went Wrong in the Global Governance of Covid – 19?*. In particular, it is the Independent Panel for Pandemic Preparedness and Response launched by the WHO in order to "provide an evidence-based path for the future, grounded in lessons of the present and the past to ensure countries and global institutions, including specifically WHO, effectively address health threats."[94]. According to the author, the elements that mostly affected the global governance of Covid started to emerge through the Panel's second progress report. Indeed, she recollected them at the very beginning of her editorial and enlisted them stating that "unsurprisingly, the report touches several key problems in the global governance of Covid 19: WHO's position, structure, and lack of financing; excessive focus on metrics to the detriment of political analysis; a lack of coordinated and sufficient financing for pandemic preparedness and response; global vaccines inequities; and the role of the broader global health architecture.".[95] She also went further in reporting how the Panel identified 12 previous commissions and other panels that had made similar recommendations in the past, and how this second progress report just repeated much of what had been said. In particular she stated that "the overwhelming subtext to the independent panel's report is that the system we have established for global health security cannot respond adequately to a health emergency.". In her opinion, the real problem was

[94] Wenham, Claire, (February 04, 2021) What Went Wrong in the Global Governance of Covid 19? *The British Medical Journal – BMJ*, London, p. 1.
[95] Ibidem.

the absence of a standardized response on which the whole global community could agree on. A problem specifically connected to the role of the WHO, whose authority should be improved in order to obtain complete agreement and adherence from states on health issues and on how to solve the challenges they pose to the global community.[96]

III . 4 – WHO: an assessment of the flaws exposed by the pandemic

After having ascertained how the WHO is perceived as one of the main actors responsible for a good management of global health protection and how its structural problems are enlisted at the top of the flaws in the Independent Panel for Pandemic Preparedness and Response, it comes almost as a consequence the idea of focusing on its weak spots in more details to effectively understand what went wrong in the management of Covid 19. A topic which is precisely the centre of the present chapter and which will lead the discussion to the other crucial analysis of the reforms that have been proposed in order to strengthen the Organization and, as a consequence, global health protection itself.

III . 4 . 1 – José Alvarez: the structural flaws of the UN-modelled institutions

One of the best resources in the recollection of the imperfections and structural problems that mostly affected the WHO and which compromised its effectiveness in managing the response to the emerging Covid threat is represented by an essay published in July 2020 and written by José E. Alvarez. The title of the paper is *The WHO in the Age of the Coronavirus* and through it the author, a jurist at the NYU School of Law, analysed the Organization under a broader and very interesting perspective which took into consideration the UN system as a whole. In particular, at the very beginning of the document, he said that "the responses of states and the WHO to the Covid 19 pandemic reveal the considerable weaknesses of international organizations" and he added, quite interestingly, how "the WHO's responses to the

[96] Ibidem.

current crisis demonstrate that it shares five disorders common to other UN system expert-driven organizations […].".[97] He then went on listing these five common disorders at the heart of each UN technical agency which will be analysed in more detail in the following pages. However, before moving to that crucial part, it is worth nothing how the whole topic of the essay emerged from the willingness to connect, in the author's own words, "the frustrations generated by the global health regime's response to the current pandemic to the broader criticism of interstate organizations (IOs).".[98] In this sense the author started from what he considered a *misdiagnosis* of the ills of the WHO contained in the *Wall Street Journal*, whose editorial board "[…] opined that absent radical reform, the WHO needs to be replaced by a new, leaner organization, comparable to Interpol, which would efficiently coordinate effective pandemic response.".[99] Besides considering it a "deeply ahistorical misdiagnosis of the WHO and a fundamental misreading of the lessons of the pandemic" he went further in noting how "the *Journal*'s view found a receptive ear in the White House.". Indeed he mentioned how, despite having praised the organization at the beginning of the crisis, the then President of the United States Donald Trump announced plans both to cease funding and to withdraw from the Organization. A decision which would have been immediately retracted with the instalment of the new President Joe Biden at the White House and his promises to restore the American ties with an Organization he views "as an ally – not an adversary.".[100] However, despite its short duration, this move was considered as completely unprecedented and had been caused by the claims made by Trump of a WHO too much deferential towards China misinformation and too critical of the US travel ban on passengers arriving from China. Sufficient is to quote here, in order to highlight the importance of that geopolitical move by the

[97] Alvarez, José E., (July 13, 2020). The WHO in the Age of the Coronavirus. Public Law Research Paper No. 20-30, NYU School of Law. Published in the *American Journal of International Law*, (October, 2020) Volume 114, Issue 4 p. 578.
[98] Ibidem.
[99] (Alvarez, 2020), p. 580.
[100] Morales, Christina (January 20, 2020). Biden restores ties with the World Health Organization that were cut by Trump, published in *The New York Times*, URL: https://www.nytimes.com/2021/01/20/world/biden-restores-who-ties.html

President of the US in the context of this chapter, a brief article by Artagan, Cook and Lin. It was published as an introduction to a series of articles on the theme of Covid 19 and global health management under the title of *Covid 19 and WHO: Global Institutions in the Context of Shifting Multilateral and Regional Dynamics.* Among the preliminary considerations made by the three authors there was a particularly interesting one, which is very helpful in clarifying what has been recently analysed. In particular, the authors stated that "while not the first time the WHO has been caught in the crossfire between discordant member states, it is unprecedented that an influential member state should leave the organization in the midst of a global health crisis or disease outbreak. The resulting scrutiny and fierce debate extends beyond the role or mandate of WHO, its response to Covid 19 or its capabilities for fulfilling its functions: it is more fundamentally about the role of politics in global health crises, against a background of geopolitical shifts, the changing nature of multilateralism and the rise of nationalist or populist politics within countries.".[101] So they were basically reasserting the crucial role of states, politics and geopolitical clashes into the well-functioning of an Organization such as the WHO and of the whole system of global health protection as a consequence. Something that, in a certain sense, is perfectly in line with the aspirations and the aims of the Organization which was precisely established in order to "ground pandemic response in the more holistic approach to health that such crises demand" and which, after SARS, "restructured its IHR to require improvements in states' internal health systems, facilitate greater interstate cooperation with respect to improving primary health care, and enable surveillance to track and contain public health threats from whatever source.".[102] An aspiration which is deemed to be strongly constrained by any kind of possible clash between those states which were intended to cooperate precisely under the umbrella of the WHO. Something which, if not already clear before, has been particularly highlighted by Covid 19 in which "[…] no state can expect to go alone when it comes to pandemics. Even states that

[101] Agartan, Tuba I, & Cook, Sarah, & Lin, Vivian (2020). Introduction: Covid 19 and WHO: Global Institutions in the Context of Shifting Multilateral and Regional Dynamics, published in *Global Social Policy*, Volume 20, p. 368.
[102] (Alvarez, 2020), p. 580.

have been relatively successful to date with respect to Covid 19, like New Zealand, continue to depend on other states' success. No state can expect to protect its population solely on the basis of measures at the border conducted with assistance of an Interpol-styled organization".[103]

It was precisely this recognition of a WHO which is not ailed by "its prescient vision of the multifaceted right to health, its recognition of the complexity of the global health threats, or its fact-backed approach to pandemic response" but by the fact that "its members have fallen short of fulfilling that ambitious vision" which led Alvarez's analysis to the first weak spot intrinsic to the UN system of Organizations. In particular, the element into question here is what the author defined as the WHO's *Inability to Overcome its State-Centred Roots*.[104] In practical terms, this weak spot common to many other UN modelled agencies can be resumed by the fact that, despite being no longer dependent only on member states' contributions, the Organization still continues to accord them unique benefits and privileges including that of voting. A situation which contributes in creating very strong tensions inside the WHO's identity which, in the words of Agartan, Cook and Lin, is caught between "its roles as an organization of Member States and as the world's leading public health agency." Something that raises a fundamental question: "does [the WHO] serve the interests of [some of] its members or does it prioritize global public goods and advocate for the world's public health needs?".[105]
Moreover, this kind of tension between member states and organizational goals reflects itself also in the impossibility for the WHO to go beyond states in getting independent information and advice. Something that turns into the constraints the organization has to face in involving other non-state actors, like airlines, which could be crucial in helping the Organization in the fulfilment of its public health

[103] Ibid., p. 581. That kind of organization which had been proposed by the authors of the *Wall Street Journal* as a possible substitution of the WHO in the new global health protection scheme, as it has been said above. A point of view which had caught the ear of the then President of the United States Donald Trump but which was not sustainable given the importance of a broader cooperation between states which only an organization such as the WHO can guarantee.
[104] (Alvarez, 2020), p. 582.
[105] (Agartan, Cook, & Lin, 2020), p.368.

mandate. And what is particularly important to note is the fact that, even after the improvements that the 2005 Revision should have brought to the information gathering process of the Organization, the system is still stalling for these very same structural characteristics. Indeed, in the words of Alvarez, "WHO officials, appointed by states and accountable to them, are reluctant to resort to the non-state sources of information that the revised IHR allow them to use, much less use that information to challenge what states report to the organization.".[106] A consideration which is very useful in partially clarifying what happened between China and the WHO in what have been underlined at the beginning of the chapter as crucial delays in reporting information about the beginning of the pandemic. In this sense, the Organization did not have enough political and financial power to force the Asian state to disclose the information it possessed and had to play a soft diplomatic game to obtain at least partial results from its interlocutor. In the words of Brown and Ladwig, "what alternative does the WHO [had] but to use delicate diplomacy to ensure the transmission of data and the cooperation of [a] member state?".[107] An inadequate authority which is even more amplified by an element not particularly underlined by Alvarez but of the highest importance and very much connected to the state-centred roots of the organization: its financing. Indeed, even if not only dependent on states' contributions but also on other revenues coming from independent philanthropic funds such as the Bill & Melinda Gates Foundation, the annual budget of the Organization is a little more than 2 billion dollars per annum.[108] Numbers which seem high in absolute terms but which reveal their real nature when confronted to other important health institutions. In this sense the annual budget of the WHO, an international organization that should supersede the whole system of global health protection, is "about one third of the Centre for Disease Control and Prevention's annual budget and less than the annual budgets of many hospitals in Western Europe and the United States.".[109] A consideration which is very helpful in highlighting why and to what extent the WHO is profoundly constrained by its

[106] (Alvarez, 2020), p. 582.
[107] (Brown & Ladwig, 2020), p. 1150.
[108] Ibid., p. 1149.
[109] Ibidem.

limited financial capacity and, as a consequence, by its too close links with its member states. An element that is also interesting in partially explaining the mistakes and problems that have been underlined in the context of the early management of the Covid 19 pandemic.

The second crucial element exposed by Alvarez as a weak spot of the UN modelled organizations is their *overreliance on soft law techniques*. This characteristic creates a similarity between the World Health Organization and other technocratic specialized agencies under the UN such as the International Civil Aviation (ICAO), for example. Both of them share non formally binding edicts which accompany, as a *welter of guidance measures*, the formally binding IHR or the ICAO's Standards and Recommended Practices (SARPs) very much resembling to the formers both in their potentially binding nature and in their ambiguity in terms of legal effects.[110] A similarity which, it has to be specified, is fitting but which can also be misleading if taken into consideration the considerable quantity of market incentives that drive the national aviation authorities to comply with the SARPs in opposition to the IHR which, as it has been already noted, remain sometimes uncompiled for economic and social considerations on part of states. This characteristic, united with the absence of a proper institutionalized mechanism for accountability inside the global health regime, creates a situation of impossibility to control the effective adherence of states to the binding measures imposed by the IHR. Moreover, the absence of even basic "name and shame" techniques, namely the fact that non complying states are generally not accused and exposed to the public opinion by the other members of the global community, increases the number of states that decide to "ignore or openly defy their legal obligations under the IHR" thus creating a "problem that needs fixing.".[111] In this sense, many types of reform have been proposed to correct this problem of accountability and they will be analysed more in detail in the course of the next chapter. It is sufficient to quote briefly here the proposal made by knowledgeable global experts such as the former WHO General Counsel Gian Luca

[110] (Alvarez, 2020), p. 582.
[111] Ibid., p. 583.

Burci and reported by Alvarez in his essay. Among them the author enlisted the creation of an ombudsperson comparable to the mechanism adopted on some UN Security Council *smart sanctions*, expert committees such as the ones at the ILO or the practice of influential, even non if non authoritative, opinions issued by the WHO's lawyers.[112]

The third problematic element of the UN modelled organizations is the so called *inflexibility of the Emergency Declarations*. In particular Alvarez noted how the emergency proclamations issued by any type of international organization have always inspired critical literature. Something that is particularly relevant for decisions such as those emanating from the WHO Emergency Committees or the UN Security Council under Chapter VII given their generally non-representative nature, the vague criteria applied and their largely secret operating methods.[113] The author also noted how, even if the recommendations pursuant to a PHEIC are not comparable to the powers of the UN Security Council under Chapter VII, their economic and social consequences on states may be as grave and politically divisive. Taking in consideration the example of Covid 19 it is clear how the declaration of a PHEIC for this threat was strongly criticized as coming too late. Anyway, through the history of the Organization, many other cases of emergency declarations were considered as too premature or as unjustified by the rest of the global community. In many cases, as reported by Alvarez, "PHEIC have also drawn complaints for lack of transparency and the harsh consequences that befall states on the receiving end of such actions.".[114] It goes without saying that these kind of considerations are very helpful in understanding why member states may be tempted in certain cases to avoid detailed and accurate reporting to the WHO. They are very helpful, moreover, in clarifying the types of reforms briefly proposed by the author and resumable under two types of measures: the former consisting in a traffic light system for counteracting diseases in a more gradual way, the latter in procedural changes aimed at increasing transparency and participation to the decision process.

[112] Ibidem.
[113] (Alvarez, 2020), p. 583.
[114] Ibid., p. 584.

The fourth problem intrinsic to the UN modelled organizations reported by Alvarez in his *The WHO in the Age of Coronavirus* is what he defined as *absence of cross-regime institutionalized mechanism for collaboration*. In particular, he mentioned the questions raised by global health threats over the prioritization and harmonization of distinct parts of international law: is the individual or collective *fundamental* right to health higher in terms of priority vis à vis other human rights, given its linkages with the notion of *right to life*? This kind of question, along with many others on different security, financial and legal issues, is understandable in the light of the problem of *fragmentation* of the international law on cross-boundary regime issues. And despite the many attempts that have been made through the years in order to elevate the alleged principle of *systemic integration*, Alvarez mentioned in this regard the Article 31(3)(c) of the Vienna Convention on the Law of Treaties, "black letter international legal doctrine is woefully underdeveloped" over these kind of issues and the best way to handle them remains a "legal black-hole".[115] In this respect, the almost immediate consideration that could be made is the necessity to devise newer and more developed mechanisms of inter-regime consultation which could be translated, in the case of the World Health Organization, into prior consultations between director generals of different IOs before the declaration of a PHEIC or the issuance of leaner temporary recommendations.

Finally, the fifth element mentioned by the author, consisted in what he defined as the *hazards of expertise*, a peculiar type of criticism which has been largely escaped by the WHO and which consists, as noted by a growing body of literature, in the blind spots developed by the organizations when experts become bureaucrats. In particular, regarding the World Health Organization this kind of problem is framed by Alvarez in the understanding that " although the WHO's Constitution affirms the multidisciplinarity of the right to health, in practice the organization had been run by public health professionals resistant to, among others, lawyers. That resistance has been reflected in the organization's rarely deployed powers to promulgate

[115] (Alvarez, 2020), p. 584.

binding rules (the IHR as revised are the rare exception), engage in treaty-making […], or resort to the International Court of Justice or other forms of adjudication.".[116] Moreover, beside this fundamental problem of absence of much needed legal expertise inside the Organization, Alvarez also mentioned the critical connection between a regime of global health and issues like trade and human rights. Concerning the former of the two, it has already been described the link between the measures applied to curb an outbreak and their dire economic consequences. For the latter it is important to underline how "the multiple dimensions of Covid 19 are clearly prompting the organization to reach outside its comfort zone" and how, as a consequence, a more human right centred approach could be very useful if not desirable. [117] In this sense, it is very interesting to notice how in its very Constitution the WHO upheld the formal right to health as a human right while it never had anything to say about what was the actual relationship of that right vis à vis the rest of the human rights. Moreover, according to Alvarez, both the IHR and the WHO as a whole failed in taking seriously into considerations the states' positive obligations to respect and ensure the right to health they imply. A problem which is created both by the failure of the leading members to push for them and by what Alvarez defined as Weberian pathologies endemic to all bureaucracies. In this sense, it has been already mentioned the risk of an Organization led only by experts of a narrow sector and highly bureaucratized, but it is also important to mention other "[…] dysfunctional behaviours: such as capture, agency slack, bounded rationality, the flattening of diversity, along with path dependence and other forms of ritualized behaviour.". [118] The result of this whole process of bureaucratization of the Organization and of its technical members creates a situation of *paralyzed status quo* in which important decisions may be avoided by experts for the fear of losing their credibility or, even worse, for the fear of taking sides. A situation that is totally detrimental not only to the Organization itself, but

[116] Ibid., p.585. It is also interesting to note how, as mentioned in the previous pages, the IHR represent a formally binding instrument for the World Health Organization which is very often underestimated and not applied by the member states.
[117] (Alvarez, 2020), p. 586.
[118] Ibidem.

also to the health of the global population it should protect in the first place.

III . 4 . 2 – Eyal Benvenisti: the problem of political cooperation

The most important hope regarding the situation of paralysation created by the Weberian bureaucratization of the World Health Organization is that, operating under the impulse of the current crisis, decision makers will drive the institution toward a new and more efficient path. However, besides the flaws of the UN modelled technical agencies, there is also another crucial theme exposed by the Covid 19 outbreak which deserves being carefully analysed in the context of the present chapter. It has been exposed by Eyal Benvenisti in his already mentioned essay *The WHO – Destined to Fail? Political Cooperation and the Covid 19 Pandemic* and, as can be understood from the title, regards the crucial absence of political cooperation among the main involved actors. The starting point of his analysis involved the recognition of the fact that the WHO was created by its founding fathers as a body that had to focus on the coordination of the experts by taking a science-based approach which transcended politics. However, the author also underlined how the current Covid 19 pandemic has shown that "the underlying challenge of improving global health is not one of poor coordination among scientists, nor even one of lack of scientific cooperation but a lack of *political cooperation*.".[119] In this sense, in order to clarify his statement, he mentioned the difference of vulnerabilities among the many states involved in the process and the fact that several competing economic, political and social demands may render "coordination difficult and cooperation impossible.". He also made the crucial example of another global scale issue such as climate change affirming that "as in other global-scale cooperation problems […], even if everybody knows what needs to be done, at least some have the incentive to *cheat*.".[120] He then moved on to a more detailed analysis of the above mentioned problems of political cooperation that led him to the conclusion that the failures of the WHO were a consequence of

[119] (Benvenisti, 2020), p. 589.
[120] Ibidem.

the errors of the member states who designed it. In particular, such discrepancy between Organization's goals and effective tools at its disposal was built "into the original (1948) concept and [was] later compounded in the adoption of the IHR (2005).". Something that could suggest the designers' toleration, in the very moment of creation of such a tool to protect global health, of the "likelihood that it would fall short of its stated objective.".[121]

Given the amount of time that passed from the creation of the WHO and the number of complex and dramatic events it had to face it is almost impossible to know whether its creators expected or not a certain type of outcome. It is interesting, however, to look at the different problems raised by Benvenisti in his essay and to understand how he reached such a strong conclusion. The very first element of analysis brought to the attention of the reader is a crucial distinction between the two different topics of *coordination* and *cooperation*. In particular, the former refers to the necessity of agreeing on certain common rules such as the use of particular metrics, standard of procedures and a common language to speak. They entail problems less difficult to solve given the fact that they are connected to the effective content of certain rules and do not entail the necessity of monitoring their enforcement after the adoption. The latter, on the contrary, refers to the fact that, even with a set of standard rules shared by each actor at stake and with a series of common goals, certain states may find it more strategically advantageous to cheat.[122]It is precisely for this reason that the issues arising from coordination need mechanisms to ensure compliance to the common rules and to monitor and verify the possible transgressions. In this sense, the management of global health is precisely one that poses not only issues of coordination about rules and procedures to follow but also interstate cooperation problems arising from the different capabilities and vulnerabilities of each state on the global scene.

The second element analysed by Benvenisti in the context of political cooperation is specifically linked to the context of global health and regards the peculiar factors that function as an incentive to cooperate. Among them the most famous and

[121] Ibid., p. 597.
[122] (Benvenisti, 2020), p. 590.

analysed by the available literature are the number of participants (bilateral or multiparty), the expectations over the duration of their engagement and the quality of the information they possess about the other partners' performances. Besides these three general elements the author went further in adding other three more specific factors which, according to him, are very useful in predicting a successful cooperation. The first element is the *scope* of the issue and, in particular, the fact that cooperation over a well-defined and single problem is way easier to obtain vis à vis the one over multifaceted issues like economic development, human rights and so on. It is almost immediate to see, in this context, how the issue of global health protection is among the widest and most faceted ones and, for this reason, implies more constraints to a lean political cooperation. The second element is represented by the *frequency* of iteration of exchanges among the parties. The author, in this respect, made a very clear example quoting the 1916 trench warfare in which cooperation among soldiers was spontaneously enhanced by the context of extreme closeness in which they were living. On the opposite side of the spectrum, as can be easily understood, there are all those situations in which signalling a stable commitment to the cause is made more difficult by intermittency and infrequency of the iterations. Finally, the third element underlined by Benvenisti is what he called *relative vulnerability*. This last element is particularly interesting in the context of the current analysis given the fact it refers to the situations in which different actors have different vulnerabilities at stake and do not share the same kind of perfect reciprocity. A situation which can be seen, according to the author, in the context of environment protection and climate change where a condition of unequal vulnerability among the states involved increases the difficulties of cooperation. In this sense, global health protection too poses a lot of different extremely difficult issues precisely for its nature of complex, multifaceted and highly differentiated issues among the players involved. It is very interesting, at this point, to quote Benvenisti when, concluding the first part of his analysis over the issue of cooperation, he stated that "the more multifaceted, infrequent and reflective of unequal vulnerabilities the issue is, the more challenging cooperation becomes. Global health management offers one of the more challenging cooperation

problems along all these axes.".[123]

The analysis of the author, then, moved on to problems more specifically connected to the World Health Organization itself with the strong conviction that, given all the constraining factors listed above, each international organization should possess "the tools to overcome the most complex cooperation problem among mutually distrustful sovereigns" and that "the WHO was never designed to have these resources.".[124] In particular, he made an interesting analysis over the flaws of the 2005 Revised IHR which has to be mentioned here given the importance they had in shaping the response to Covid 19. The crucial point in this respect is the fact that, despite acknowledging the important improvements which were brought to the Regulations thanks to the Revision process[125], he also noted some unresolved problems of the text which are a strong weak spot in the whole architecture of global health protection. The basic assumption is that the outcome of the Revision process reflected the inability to overcome the fundamental conflict between developed and developing states over the access to information. In particular, the former wanted the WHO to have more access to non-state based information while the latter insisted on a WHO remaining dependent on information they would only provide, demanding also more accountability from states blocking trade. The outcome of this debate, which can be considered under the above mentioned framework of diverging relative vulnerabilities, was what the author defined as "[…] an agreement to *reify member states* sovereignty.". [126] In particular, among the elements implied by Benvenisti to corroborate his thesis, is important to mention here the fact that the WHO was strongly limited in its "authority to offer a swift and resolute response to outbreaks.". Indeed, it had not only to "consult with a source state before exercising its powers" but its whole power to obtain independent information from sources other than the affected state government was "severely

[123] (Benvenisti, 2020), p. 592.
[124] Ibidem.
[125] Improvements which have been analysed in greater detail in Chapter II in the context of the revision process occurred as a consequence of the 2003 SARS outbreak.
[126] (Benvenisti, 2020), p. 595.

limited.".[127] Indeed, according to the revised document, the WHO has the duty to reveal to the source state any independent sources of information, something that highly limits not only the total amount of information gatherable but also the potential positive effects of the so-called whistle-blowers, now severely discouraged from reporting.

A second, very interesting, problematic element reported by Benvenisti is the fact that the newly adopted IHR also limited the authority of the WHO to issue travel advisories. It is sufficient to quote here Article 43 of the document to clarify what is the hearth of the matter. Indeed, it affirms that state parties have the right to "implement[…] health measures in accordance with their relevant national law and obligations under international law" which "(a) achieve the same *or greater* level of health protection than WHO recommendations; or are otherwise prohibited under [specific IHR provisions], provided such measures are otherwise consistent with these Regulations.".[128] This element, combined with the need to rely on Emergency Committees in response to outbreaks is, according to Benvenisti, "an invitation for political and economic interests to intervene in expert decision making.".[129] Indeed, Article 43 leaves enough room for manoeuvre in the hands of states and the WHO itself has no weight with which to sanction states taking, or not taking, certain types of measures. Once again in the word of Benvenisti its only authority is "[…] to request that the State Party concerned reconsider the application of the measures if and when it complies with the duty to report such measures.".[130] Something that, as can be easily understood, strongly limits the effective power in the hands of the Organization while reaffirming, on the contrary, the importance of sovereign states' autonomous decisions.

III . 4 . 3 – Davies and Wenham: the highly political environment surrounding the WHO

In the light of all the previous considerations and all the flaws of the WHO listed

[127] Ibidem.
[128] (World Health Organization, 2016), Part VIII, Article 43, p. 28.
[129] (Benvenisti, 2020), p. 596.
[130] Ibidem.

up to this point, both considering it as an independent Organization both as a part of the bigger framework of UN modelled agencies, one of the fundamental elements emerging is the still crucial importance of sovereign states in the whole picture. They are, indeed, the ones with the major capabilities of influencing, modelling and crafting the global health protection system in its entirety. Through their actions, they can basically decide whether to enhance the work of the WHO or to constrain it up to the point of not being able to effectively control the spreading of an outbreak for the lack of proper and tempestive information or for the lack of practical resources and enough funding. In this sense, bearing in mind the crucial relevance of states, it is impossible not to acknowledge the fact that " a *politics-free WHO*, while frequently evoked as an ideal, has never existed in reality, and that global health and politics are inextricably intertwined.".[131] And precisely for this reason, notwithstanding the involvement of more and more group of actors through the years[132], the crucial fact that should be recognized and restated in order to properly understand the WHO in all its potentiality and flaws is the fact that the Organization operates in a highly political environment with all the rules and behaviours that characterize the game of politics. A precious contribution to clarify this last consideration of the current chapter, one that will lead the argument to its next stage of analysing the most important proposal of reforms to improve the WHO, is an article by Sara E. Davies and Claire Wenham titled *Why the Covid 19 response needs International Relations*. The paper, published in September 2020 in the magazine *International Affairs*, contained a detailed analysis of the strong relationship between politics and health which has been mentioned above. It went even further in stating the fact that the political realm in which the WHO is operating, besides its intrinsic difficulties, is getting "increasingly combative and divisive […], with proxy battles being waged within this institution between

[131] (Agartan, Cook, & Lin, 2020), p. 369.
[132] Among these actors, quoted by Agartan, Cook and Lin in their Introduction to Volume 20(3) of *Global Social Policy*, there should be mentioned here: long standing international NGOs such as Médecins sans Frontiers, public-private partnerships such as GAVI and the Global Fund, private philanthropic organizations and Regional organizations such as the EU, Mercosur, ASEAN and so on.

member states, for example China and the United States.".[133] In this respect, the authors showed another crucial flaw of the World Health Organization, one that has to be mentioned in the context of this chapter. Indeed, strongly disagreeing with the words of the WHO Director General who stated that "politics and partisanship has made things worse […] what is important is science solutions and solidarity", they added that "political solutions will also be required to achieve international cooperation and solidarity.".[134] Their basic assumption, the one that underlined the last WHO problem that has to be analysed here, was that "there has not been enough recognition of the normative value of diplomacy in preparation for health emergencies, either by the WHO or by states.".[135] The two fundamental elements of diplomacy and the recognition of diverging and sometimes even competitive priorities between the actors involved has been almost forgotten both by national and international decision makers. This has created a situation in which, in the global debate over how to effectively coordinate a response to the current outbreak, it is missing the key element of " […] an assessment of the international relations environment in which collective action is more likely to overcome conditions of resistance: in brief, an assessment of how to play the two level game of diplomacy and domestic politics.".[136]

In this respect, the crucial element noted by Davies and Wenham is that, despite the brilliant job made by the World Health Organization in understanding the importance of claiming the leadership in technical authority, it had done less well in "appreciating and understanding the political or problem-solving skills required to understand contemporary sovereign behaviour.".[137] A failure in grasping the political priorities of its member states which is very much interesting if taken into consideration the unique position of the WHO in the global health protection architecture as a *powerful conductor* which, "[…] despite the fractious political circumstances in which it is embroiled, as an organization and an institution it is in

[133] Davies, Sara E., & Wenham, Clare, (September 2020).Why the Covid 19 response needs International Relations, published in *International Affairs*, Volume 96, Issue 5, p. 1227.
[134] Ibid., p. 1228.
[135] Ibidem.
[136] (Davies & Wenham, 2020), p. 1234.
[137] Ibid., p. 1237.

a rarefied position to *conduct* expertise in response to the Covid 19 outbreak.".[138] An element which surely has to be taken in consideration by the designers of the Organization if they are willing, as a consequence of the deep problems exposed by Covid 19, to improve the work of the institution and, thus, to improve the protection of the health of the global population as a whole. In this respect, it will be exactly the aim of the following chapter that of analysing how and through what kind of reforms the World Health Organization may come out renewed from the unprecedented pandemic the world is facing with a reinvigorated power to effectively control the upcoming global health threats.

[138] Ibidem.

IV – Reforming the World Health Organization in the Light of Covid 19: Main Ideas and Proposals.

IV . 1 – Introduction

In the previous chapter the major flaws at the heart of the World Health Organization and, more generally, of the whole global health protection system have been analysed in order to highlight what has gone wrong in the context of the Covid 19 outbreak vis à vis its predecessors. The delays in the transmission of relevant data over the newly discovered disease on part of the People's Republic of China, together with the structural problems at the heart of the Organization constraining the process of data gathering and verification in its early and most important phases have resulted as some of the main factors in this sense. At the end of the chapter, moreover, after having analysed the constitutional and legal flaws of the institution, it has also emerged another of its weak spots: its detachment from the political and geopolitical context in which the whole issue of health protection takes place. An essay by Sara Davies and Clare Wenham titled *Why the Covid 19 response needs International Relations* has been analysed in order to clarify the issue and to assess to what extent an excessive focus over technical expertise has undermined the effective capacity of the WHO to operate in the highly political context it has to face. It has been noted how the two authors came to the conclusion that the Organization represents a powerful and perfectly positioned *conductor* of expertise which could only benefit from a renewed approach to the issues of politics and diplomacy. However, it has only been anticipated and now it is time to analyse more in detail the fact that they also mentioned a list of crucial entry points which international relations could offer to the WHO "[…] for understanding cooperation between states, and where barriers may arise.".[139] Something that, together with the advisory groups which have been forming already during the pandemic, triggered in the opinion of the authors the necessity for the Organization to "[…] revisit the Secretariat's normative preference for health professionals and seriously engage

[139] (Davies & Wenham, 2020), p. 1238.

with the contribution of political science expertise.".[140] Given the focus of the current chapter on a more detailed analysis of the main reforming ideas that have been proposed by the literature in order to improve the Organization after the Covid 19 tragic experience, it is interesting to start precisely here with such proposals by Davies and Wenham and their approach modelled on a new role for international relations inside the global health protection system.

IV . 2 – Davies and Wenham: reforming the WHO through International Relations

IV . 2 . 1 – International Relations' Entry Points

The elements considered by the two authors as tangible entry points through which international relations can contribute to international organizations and state governments in times of health emergencies are five and are described together with the real-word consequences of their absence. The former of such points is what has been named in the essay as *comparative analysis*. This element starts from the basic assumption that "every state is unique, with its own political structures and nuances" and that "in each case, the executive, legislative and judicial branches of government will look different, and decision making power is diffused among actors.".[141] In this sense international relations experts, together with political scientists and comparative analysts could prove fundamental in "support[ing] the global health community in navigating these institutional differences and the associated tensions.".[142] Indeed, according to Davies and Wenham, knowing the political landscape of a given location, namely the one in which a new outbreak would take place, has to be considered as a critical tool in order to ensure good communication with the right decision makers involved thus guaranteeing effective counteraction to the threat since its early stages. In particular, as an example of a failure in this aspect, the authors mentioned the Ebola outbreak in West Africa

[140] Ibidem.
[141] (Davies & Wenham, 2020), p. 1238.
[142] Ibid., p. 1239.

which triggered an "unprecedented deployment of international militaries and the creation of a new UN institutional response, UNMEER.". In their opinion, the role of political analysis within the WHO prior to such strong measures would have underlined the presence and the existing role of other UN missions such as the one in Liberia (UNMIL) or the UN Office for Coordination of Humanitarian Affairs (UNOCHA) thus reducing the amount of time needed to effectively respond to Ebola. They also mentioned the crucial role that an improved relationship with the growing civil society movements in west African states or the identification of alternative hybrid governance mechanisms could have had.[143] The crucial theme that has to be underlined in this sense is the fact that not always power lies in the hands of official governments, especially in certain areas of the world such as Africa. In this sense, knowing from the very beginning the social movements, tribal groups or religious dominant popular voices at the core of the local authority could be fundamental in counteracting a newly discovered threat and limiting its negative effects on the population. An issue which can be resumed very well with the own words of Davies and Wenham who stated that " in outbreaks reliant [as they are] on social messaging and risk communication, knowing the formal and informal mechanism of statecraft can make all the difference.".[144]

The second entry point analysed by the authors is what they named as *Governance: the international politics of disease outbreaks.* Under this label they evaluated the critical impact that could be brought by an improved and more detailed "[…] analysis of the WHO and its position within the broader global health landscape [which] is vital for building a typology of which political manoeuvres work (and which don't) during crises.".[145] In this respect, they mentioned the importance of studies of global governance which conceptualize the WHO within a larger international ecosystem and which consider what has worked, what has been challenged by the member states and what has divided or brought them together among the actions of the Organization. Among the examples of cases in which this

[143] (Davies & Wenham, 2020), p. 1239.
[144] Ibid. , p.1240.
[145] Ibidem.

understanding of the WHO position has failed leading to critiques and misunderstandings they mentioned the 2009 H1N1 and once again the 2014 West African Ebola outbreaks. In those cases they noted a crucial mismatch between what the WHO was mandated to do in its Constitution and what the world actually expected from it. In particular, in the first case the global expectation was of a less strong intervention on part of the Organization while, in the latter, it was criticized by the global community precisely for the lack of strength in its response and for the absence of an operational team ready to respond on the ground from the beginning. Moreover, this very same entry point of governance understanding also included another crucial type of awareness vital for the improvement of the WHO, namely the recognition of state compliance. In this sense, the authors mentioned the fact that "over the past two decades, [International Relations] scholars have sought to understand how and when government reports". In doing so, they have tried to understand the differences they noted "[…] on the basis of contextual factors relating to the states involved and the particular risks posed to reporting, whether economic, political and/or social.". [146] It is quite intuitive to notice how such an understanding of the history and the reasons at the heart of the behaviours of each member state could be crucial for the World Health Organization in the early steps of its strategic planning. In particular, it could help the institution in properly designing the best possible response and in deciding how to start the discussions with the states involved long before having to issue a PHEIC.

Coming to the third entry point which Davies and Wenham mentioned among the IR contributions to an improvement of the WHO there is what they called *political economy*. In this respect they noticed a critical problem of the Organization which is represented by its almost always insufficient budget. In particular they highlighted the crucial fact that the total income of the WHO is just a fraction of the major bilateral assistance programmes run from the United States and China.[147] They also reported how, precisely for this reasons, the voluntary contributions to

[146] (Davies & Wenham, 2020), p. 1241-1242.

[147] Ibidem. A problem of inadequate financing which has already been analysed in the context of the previous chapter as one of the major flaws of the whole Organization.

the WHO have reached an unprecedented share of the annual budget of the Organization thus creating a situation in which "[…] powerful funding actors […] increasingly decide on the focus and direction of the organisation's programmes […]".[148] As an example related to this issue, the authors mentioned how "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.".[149] In this respect, especially considering that many other UN specialized agencies suffer from the same problem and none of them is getting an improved budget, the authors underlined how international relations can "[…] provide knowledge inputs to identify opportunities for regional and subregional diplomatic engagement, cooperation and planning, being well versed in the creation of security communities.". [150] New forms of collective power and hybrid governance engagement, with a financing more tailored to specific regional purposes and thus more attractive to donors, which, in the opinion of Davies and Wenham will be of crucial importance in the WHO money gathering of the post Covid 19 era.

The fourth entry point outlined by the authors is what they titled *human rights: trust and information.* The former element among the two referrers to what they defined as the paramount importance of the notion of trust in both formal and informal governance of outbreaks. Indeed, they highlighted how the communities, in every geographical and cultural position, "need to trust the public health advice they are given, and respond to the authority of domestic and international institutions providing such advice.".[151] In this respect, as examples of the relevance of trust and of the different degrees of legitimacy accorded to different sources of information,

[148] Ibidem.

[149] (Davies & Wenham, 2020), p. 1,242. The Article into question is the one of the Revised IHR concerning the additional health measures that can be implemented by member states which has already been analysed in the previous chapter as a weak spot of the WHO, in the opinion of Benvenisti. In this case, opposed to the view of the mentioned author, Davies and Wenham saw the Article as an improvement in the legislative power of the WHO but noticed also the constraints that it has to face in terms of related supporting budget.

[150] Ibid., p. 1243.

[151] Ibidem.

Davies and Wenham briefly mentioned the debate over the use of face masks during the very first moments of the Covid 19 pandemic. It is interesting to notice how something that is currently perceived as mandatory and of common sense had undergone a moment of discussion and questioning precisely when it would have been more needed. Moreover, the two authors also quoted the case of the health-care workers killed in Guinea during Ebola in 2014 who were perceived "[…] to be spreading the disease rather than trying to quell it.".[152] A consideration which is also very interesting in the cases of big public health campaigns introduced by governments in territories where the authority lies in the hands of different major actors. An understanding of the theme of trust on part of the population which, for this very specific case, is very much comparable to the crucial theme of formal and informal authority which has been discussed earlier. Anyway, the key assumption, as literally stated by Davies and Wenham is that "although the context varies, the importance of understanding informal political control and access to communities is vital for reaching the front lines of outbreaks and those most marginalized within health crises.".[153] A quotation which is particularly interesting given the fact that, associated with the theme of trust, appears also the other one of *information* as entry point of international relations to the global health protection system. In particular, concerning such theme, the two authors underlined a crucial connection between an effective outbreak management and the existence of mechanisms protecting the freedom of reporting and of communication. It is precisely in this respect which they mentioned a particularly interesting example of the relevance of the issue for the contemporary global health debate. Indeed, they invited the reader to consider "[…] the implications faced by the Chinese doctors who first alerted the world to Covid 19 in 2019, or similar whistle-blowers during MERS, to see the challenges that this freedom to report poses within the political systems.".[154] A theme which is in general particularly interesting since it underlines the strong relationship between global health and human rights protection which, as it has already emerged in the

[152] Ibidem.
[153] (Davies & Wenham, 2020), p. 1244.
[154] Ibidem.

previous pages and as it will be restated in the following ones, is crucial for a renewed and stronger international health regime.

Finally, the fifth and last entry point for international relations in the theme of global health protection considered by Davies and Wenham is what they defined as *gender inclusion*. This last point, which is particularly connected to the overall discussion regarding the more general issue of human rights protection, is interesting given the fact that it helps in recognizing how "women were notably absent from the processes that led to the International Health Regulations […]" and several others conventions on the field. According to the authors, the role of women in the field of social reproduction, that is the informal care they perform in home, caring duties for children and sick people, and their increasing volunteering as community health workers, is profoundly undervalued within global health and should be relaunched. In this respect, they noted how the theme of international relations, together with more a developed mechanism of human rights protection, could be very helpful in producing outbreak responses more equal and without "[…] disproportionate impacts and burdens on women and other marginalized groups.".[155]

IV . 2 . 2 – Main Applications to the WHO Reform

After having analysed the five entry points and having briefly recalled what they meant in the critical position of Davies and Wenham, it is useful to outline what such entry points meant in terms of reforming proposal for the WHO. In this respect, after having restated their understanding of the global political environment as one of the main drivers for the spread of epidemics, they went further in expressing the lesson that should be learnt after Covid 19. The first element that in their opinion should be implemented in order to strengthen the World Health Organization's role is the adoption of comparative analysis. Indeed, precisely as stated in the very first entry point, Davies and Wenham reaffirmed the necessity, on part of the Organization, to improve the evaluation of the response to Covid of each single member state. In this respect, bearing in mind the fact that to each state generally

[155] (Davies & Wenham, 2020), p. 1246.

corresponds a different governance approach and, as a consequence, a different outcome in terms of response to the virus, the authors underlined the importance of such an improved awareness to produce future health policies more in line and thus more easily "[…] integrated into the new political reality after Covid 19.".[156]

The second suggestion by the two authors for an improved WHO concerned the issue of travel bans and it basically consisted in the need for a constructive understanding of the fact that, as it has been proved in the past, states might not want to comply with travel and trade recommendations. In this sense, Davies and Wenham underlined how "many governments are convinced that the right to decide their trade and travel bans belong to them alone and not the WHO, despite the IHR (2005).".[157] It is precisely for this reason that they suggested the necessity for the WHO of auditing each different member state in order to assess their interests and diplomatic red flags before issuing mandatory travel bans. Of course this proposal is not perfectly in line with the necessity of a rapid and strong response to an outbreak which does not consider diplomatic issues. However, it is important to understand the stringent necessity, especially during times free from the urgencies of a pandemic, of increasing the diplomatic interchange between the Organization and its member states in order to foster their relationships and, as a consequence, the global health protection system as a whole.

Another key suggestion proposed by the authors, in line with the critiques regarding a too bureaucratized WHO which have been analysed in the previous chapter, is the search for "[…] guidance and support from actors outside the health arena, breaking down silo division to bring much-needed expertise to managing the careful diplomatic activity required for a truly global response.".[158] A management of global health protection which, together with expertise from various areas of research, has to face also the issue underlined in entry point number three of a proper funding. In this respect Davies and Wenham clearly stated how "the WHO Health Emergency Programme is currently only 74 per cent funded" and how it has

[156] Ibid., p. 1247.
[157] (Davies & Wenham, 2020), p. 1247.
[158] Ibid., p. 1248.

"[…] struggled to secure sufficient money for its strategic fund for Covid 19 response and, as of 14 July 2020, had received only $848 million, 49 per cent of what it requested.". [159] A situation that translated itself in the impossibility for the Organization to properly execute all of its functions and which, in the opinion of the authors, will be furtherly penalised by the decrease in global GDP which will follow the pandemic. In this respect, their suggestions concerned the critical question of what could be considered as the *added value* of the Organization and how to reassess its relevance on the global scene. Two were the elements that Davies and Wenham considered as the pillars on which the WHO should insist on in order to increase its accession to a better funding: the collection of surveillance data and the reporting under the IHR. In their opinion "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.".[160] It goes without saying that, precisely insisting on this crucial ability, the WHO could convince its membership to increase the amount of dedicated financing and to acquire new and much needed resources from other regional or non-state actors. Finally, deriving from the fifth and last of their entry points, the authors included among their proposals also the necessity of finding a solution for the gender issue. Indeed, in their own words, "given that women comprise 70 per cent of the global health workforce, it is important to know whether this role is putting them at greater risk of infection than the general population.".[161] An assessment which, together with a wider focus on the theme of human rights, is useful in providing the necessity for the WHO of considering with more attention those minority groups which, especially in low/middle income countries, face increased inequalities as a consequence of the outbreaks.

[159] Ibidem.
[160] (Davies & Wenham, 2020), p. 1248.
[161] Ibid., p. 1250.

IV . 3 – Lawrence Gostin and Sarah Wetter: liberating the WHO from geopolitics

After having considered the position of authors like Davies and Wenham which clearly stated in their essay the importance of geopolitics and international relations in the theme of global health protection, it is interesting to look at a position which moved from completely different premises. The document in question is an opinion by Lawrence O. Gostin and Sarah Wetter published in *The Milbank Quarterly* in May 2020. Its title, *Using Covid 19 to Strengthen the WHO: Promoting Health and Science Above Politics,* is already quite significative in stating the difference of starting assumptions between the two couple of authors. Indeed, even if starting from the same assumption of considering the Covid 19 pandemic as a turning point for the architecture of global health protection, Gosting and Wetter clearly stated the importance of a WHO free from the geopolitical world in which it is heavily involved. They claimed, as Davies and Wenham also did, that "[…] Covid 19 has become so politicized and divisive" and that the reform emanating from the pandemic "[…] should address the structural problems that put the WHO in the crossfires of geopolitical disputes and force it to appeal to countries' political interests instead of the best scientific evidence.".[162] A statement which clearly underlines the differences of approach to the reforming process between the current paper and the one analysed in the previous pages. The latter, indeed, insisted on the necessity for the WHO to enlarge its overall position and to take in consideration the political and diplomatic realms too. The Opinion by Gostin and Wetter, on the contrary, strongly asserted the superior importance of science and considered all the reforming proposals under a broader framework of "[…] empower[ing] WHO to protect the world – following no political agenda, while advocating for science and equity.".[163]

Under the perspective of empowering the World Health Organization above the

[162] Gostin, Lawrence O., Wetter Sarah (6 May 2020), Using Covid 19 to strengthen the WHO: Promoting Health and Science Above Politics, *Milbank Quarterly Opinion.*
[163] Ibidem.

level of politics, the first reform proposed by the authors is over an emboldened and stronger Director General. Indeed, even in the absence of more structural reforms, they considered as crucial for the Organization a role of Director General acted boldly and without fears about the opinion of member states. A figure that, in their opinion, should "[…] always speak truth to power, standing up even to the most powerful member states" in order to assess and clarify the reputation of the Organization as a global leader on health issues, backed by its highly scientific standards. Precisely in this respect, moreover, it is very interesting to quote a reflection by Gostin on the behaviour of the Director General of the WHO during the first steps of the Covid 19 timeline already analysed in Chapter III. The author, knowing Dr. Tedros Adhanom Ghebreyesus personally, hypothesised that his early decisions against the delay in reporting and sharing of information on part of China were due to the willingness of "[…] using diplomacy to coax China into deeper international cooperation.". In this sense he acknowledged, given the absence of major reforms and of a globally recognized stronger position for the Director General of the Organization, the importance of balancing science against politics in order to obtain full collaboration by the member states.[164]

The second point among the reforms proposed by Gosting and Wetter regards the theme of the funding of the Organization which, as it has been already clarified, is perceived as inadequate by the vast majority of the critics. In this sense the two authors do not represent an exception and clearly stated the importance of renewing and amplifying the funding mechanism at the disposal of the WHO. It is also very interesting in this context to quote here another article by Gostin published in the *Journal of the American Medical Association* on the 16th of June 2020. In this paper, titled *Covid 19 Reveals Urgent Need to Strengthen the World Health Organization*, the author restated the necessity of reforming the WHO as a consequence of the pandemic and gave some interesting data in terms of its funding. Indeed it reported how "[…] its biennial 2020-2021 budget is $4.8 billion – similar to a large US hospital, and about $2 billion less than the US Centre for Disease Control and

[164] (Gostin & Wetter, Using Covid 19 to Strenghten the WHO: Promoting Health and Science Above Politics, 2020).

Prevention's annual budget.". [165] It is sufficient to consider these figures to understand why Gosting, both in the article with Sarah Wetter both in his subsequent article in the *JAMA*, claimed the strong importance of reviewing the funding of the Organization. In doing so he claimed the international community to "[…] fund WHO on a scale commensurate with its global mandate, enabling WHO to set norms, publish guidance, and offer technical assistance on a wide array of health issues.". Moreover, the authors claimed the importance of a sustainable funding which, in their opinion, should come from mandatory assessments and not from voluntary contributions in order to liberate the Organization from the unrequested intromission of both member states, other external actors and private organizations.[166] A statement which anticipated what Gostin would have added in his subsequent article for the *JAMA* in which he claimed the necessity for the WHO of undertaking a "[…] transparent planning process to estimate realistic budgets needed to achieve tangible health benefits.".[167]

The third reforming issue presented by Gostin and Wetter concerned another crucial theme which, together with the one of funding, has been analysed by most of the literature: the use of unofficial data sources. In this respect, the position of the two authors was that of strongly amplifying the World Health Organization's recourse to that instrument. Indeed, they underlined how the delays in key data sharing during Covid 19 highlighted the need for urgent restructuring of the IHR even if they had been already revised on the topic in 2005. They claimed that, given the necessity of collaborating with member states before taking action and before resorting to unofficial sources, the WHO is severely limited in its access to epidemiological data. In this respect, the authors asked for the Director General to "[…] assemble an on-call independent expert group, like the IHR roster of experts, to independently assess official and unofficial data. If the expert consensus supports

[165] Gostin, Lawrence O. (16 June 2020), Covid 19 Reveals Urgent Need to Strengthen the World Health Organization, published in *The Journal of the American Medical Association* Volume 323, Number 23, p. 2361-2362.
[166] (Gostin & Wetter, Using Covid 19 to Strenghten the WHO: Promoting Health and Science Above Politics, 2020).
[167] (Gostin, Covid 19 Reveals Urgent Need to Strenghten the World Health Organization, 2020), p. 2362.

the reliability of unofficial data sources, it should have the power to recommend sharing those data with other states and the public.".[168] A proposal of enlarging the availability of data at the disposal of the Organization which takes into consideration also the important aspects of the verification and validation of the information, crucial in the line of respecting the scientific standards of the WHO. Moreover, Gostin and Wetter did not limit their analysis to the theme of the sources per se. They also went further in including to this reforming proposal another crucial element linked both to the issue of data collection and to that of human rights protection. Indeed, they mentioned the urgent necessity on part of the WHO to protect all the unofficial data sources from possible repercussions on part of their home governments. In this respect they stated how "failure to safeguard privacy could chill whistle blowers, fearful of being sanctioned by government", something that happened in the case of Covid 19 to Li Wenliang, the Chinese physician who tried to alert the world at the very beginning of the threat but was heavily censored by his government.[169]

Finally, the last topic among the reforms needed by the World Health Organization and reported by Gostin and Wetter is what they defined as the inclusion of *compliance-enhancing incentives* for member states. Among them they included public call outs from the Director General of the offending member states, namely those acting against the mandatory requirements of the IHR, shadow reports provided by the civil society on the adherence of states to their obligations and, as a sort of last resort, the withdrawal of voting rights for members chronically non complying. In particular, concerning this very last solution, Gostin underlined as a legal framework in his analysis for the *Journal of the American Medical Association* Article 7 of the WHO Constitution. According to the text, indeed, "if a Member fails to meet its financial obligations to the Organization or in other exceptional circumstances, the Health Assembly may, on such conditions as it thinks proper, suspend the voting privileges and services to which a Member is entitled.".[170] An

[168] (Gostin & Wetter, Using Covid 19 to Strenghten the WHO: Promoting Health and Science Above Politics, 2020).
[169] Ibidem.
[170] (Constitution of The World Health Organization, 1946), Chapter III, Article 7, p. 4.

extensive use of the Article into question which may involve some political risks but which could strongly promote adherence of states to their obligations under the IHR for the fear of major repercussions.

Finally, in order to conclude this brief analysis of the main proposals of WHO reforming by Lawrence Gostin, it is also interesting to mention other two relevant points absent in the article written in collaboration with Sarah Wetter but included in the one for the *JAMA*. The former is a more practical and broader understanding of the WHO's relations with the other international organizations present on the global scene and regards the collaboration between these and the Organization itself. In this respect the author mentioned, as an example, the incorporation from the International Monetary Fund of national health preparedness into its macroeconomic assessments or the recourse to the World Trade Organization for issues arising from economic and trade restrictions. The latter, on the contrary, is a more ideological and philosophical proposal and involved the possibility of moving the headquarters of the WHO from Geneva, Switzerland to sub-Saharan Africa[171]. Despite its almost impossible realization for several different economic and geopolitical reasons such a proposal has to be mentioned for its capacity of underlying the necessity of the Organization to draw closer attention on less developed states and to show increased commitment to the poorest and most affected areas of the world.

IV . 4 – The Principle of Solidarity: applications to the WHO reforming process

IV . 4 . 1 – *Solidarity in the Wake of Covid-19*: main ideas and proposals

This very last proposal made by Lawrence Gostin shows another interesting aspect despite its intrinsic difficulties. Indeed, it highlighted a crucial principle which lies at the hearth of several other reforming ideas by authors with completely different backgrounds and areas of expertise. The principle in question is that of *solidarity*

[171] (Gostin, Covid 19 Reveals Urgent Need to Strenghten the World Health Organization, 2020), p. 2362.

intended both as a form of collaboration and support among the different actors on the global scene both as the precious assistance that should be given by the more developed states to the less developed and thus most affected ones. A vision of health in its nature of common good which will be the focus of the last and concluding chapter of the current dissertation but which is already interesting to mention here given the amount of influence it had on other WHO reforming proposals. In particular, among them it is important to start here by quoting a Comment published on *The Lancet* on the 11th of July 2020 and signed by a team of different scholars from several important universities worldwide (among them there was also the already widely quoted Lawrence Gosting). The article in question was titled *Solidarity in the wake of Covid 19: reimagining the International Health Regulations* and presented a new and different view of the IHR under the perspective of the flaws emerged during the pandemic. In this respect the view of the authors was that of the IHR "[…] as an instrument that will compel global solidarity and national action against threat of emerging and re-emerging pathogens" with a call on state parties to "reform the IHR to improve supervision, international assistance, dispute resolution and overall textual clarity.".[172] The first request the team of authors made in the light of these reimagined IHR was over the progressive inclusion of information coming from non-state actors without being subject to verification. A request which, in line with all the others coming from different authors and analysed up to this point, perfectly highlights one of the deepest flaws of the 2005 revised IHR, namely the retaining of control on part of states over the information gathering of the World Health Organization.

A second point made by the authors, one which is very much connected to the issue of information collection and power retained by member states, was the request of an improved national accountability which "[…] should be strengthened by mandating independent experts to conduct missions to states so that they can review potential outbreaks situations.".[173] A sort of provision which, as noted by the

[172] Taylor et al. (19 June 2020), Solidarity in the wake of Covid 19: reimagining the International Health Regulations, published in *The Lancet*, Volume 396, pp. 82-83.
[173] (Taylor, et al., 2020), p.82.

authors themselves, is already taking place in other international issues such as the arms control treaties, the strongest example in this sense, and the international drug control regime, very close to the theme of global health.

Another aspect suggested by the team writing for *The Lancet* concerned another highly debated theme among the literature of the field: the issuance of Public Health Emergencies of International Concern. In relation to this issue the authors suggested first of all the necessity of deeply increasing the transparency underpinning the whole process of PHEIC deliberation. In this sense they envisaged the possibility of publishing the transcript of records of each discussion leading to such a declaration in order to make them available to the whole population and, as a consequence, improving the accountability of the IHR process as a whole. Moreover, they also went further in proposing a sort of incremental system to replace the rigid binary dynamic of the PHEIC architecture. In this respect what they intended was the creation of intermediate stages of increasing alert and guidance leading to the PHEIC as the most important and grave status, dedicated only to the real emergencies. A change which, in their opinion "[…] would enable greater flexibility and global coordination in responding to disease outbreaks as they unfold.".[174]

Another interesting proposal, in the line of a more interconnected and cooperative health protection system, consisted in the integration of an effective reporting system to monitor implementation of the obligations under the IHR. Following the idea of a progressive system such as the one proposed for the issuance of PHEICs, the team of scholars who signed the article proposed "periodic reporting procedures [which could] assist states in identifying and alleviating obstacles they face when implementing commitments, without criticising their performance.".[175] A set of proposals which, as it has been said before, has the crucial target of creating a more cooperative and integrated system into which both the WHO and member states accountabilities are publicly stated and the commitment to the project is constantly monitored on both sides. An idea which is in line with the theme of global solidarity

[174] (Taylor, et al., 2020), p. 82.
[175] Ibidem.

and international support perceived, as literally stated by the authors, as crucial elements in the fight against what they defined as "[…] our shared vulnerability to pathogens.".[176] Finally, in this very same line of improved cooperation among the most relevant actors, it should be quoted here the very last proposal made by the experts on *The Lancet.* Indeed, as a conclusion, they mentioned the importance of improving and giving legal value to a series of "multilateral dispute resolution processes, including consultation forums among concerned states and an active good offices role by the WHO Director General […]" which are already included in the IHR but have never been publicly used.[177]

IV . 4 . 2 – Thana C. de Campos: improvements to the PG/SHG model

The above mentioned application of the theme of solidarity to the pressing problem of reforming the IHR as a consequence of the Covid 19 pandemic brought the authors of the article on *The Lancet* to some interesting pragmatic proposals. The main goal at the core of their ideal reforms was to eliminate any possible kind of *zone of ambiguity* on the legal obligations of states which highly penalized the IHR as they came out of the 2005 revision process. However, they were not the only authors developing reforming proposals under the perspective of the notion of solidarity and improved cooperation among the parts. Indeed, under this very same perspective but with a more theoretical approach, it is also interesting to mention here an article by Thana C. de Campos published in *The American Journal of Bioethics*. In this paper of July 2020 titled *Guiding Principles of Global Health Governance in Times of Pandemics: Solidarity, Subsidiarity, and Stewardship in Covid 19*, the author provides an extension of the Provincial Globalism and Shared Health Governance (PG/SHG) model by Prah Ruger. Such a model, as described by de Campos "[…] argues for shared global responsibilities and resources" which, in the context of the Covid 19 pandemic, would signify non only the sharing of relevant scientific information but also that of scarce medical care resources such

[176] Ibidem.
[177] Ibidem.

as pharmaceuticals, diagnostic tests and vaccines".[178] What is very much relevant of such a model and of the implementations added by de Campos are the crucial implications they brought to the understanding of health as a common good with common responsibilities and shared burdens. An understanding which, in the line with the article published on *The Lancet*, is based on the theme of global solidarity and requires, precisely as the proposal mentioned above, an improved cooperation between the actors at stake in order to, this time in the words of de Campos, "[…] ensuring that shared responsibilities are communicated in a truthful, evidence-based, consistent and timely manner to ensure accountable coordination.".[179] An idea which, according to the author, would improve the status of the WHO which "[…] would be a better leader if instead of trying to expand its power, resources and control over other global health stakeholders […] would do only one thing and do it well in the hopes of reclaiming public trust.".[180]

After having clarified the reasons why this article by Thana de Campos is mentioned in this context and how it is strictly connected to the vision of reforms proposed by the authors of *The Lancet,* it is important to analyse more in detail here the implementation which the author applied to the Ruger's PG/SHG Model. In particular they were developed on three crucial principles, each one produced as the subsequent complementation of the other, which are the principle of solidarity, the principle of subsidiarity and that of stewardship. The first element is necessary in the opinion of de Campos as a strong starting point to justify the pressing demands of shared responsibilities and resources made by Ruger's Model. Indeed, "as a principle of justice, solidarity has the purpose of protecting the human dignity of each and every human life […]"[181] and for these reasons it entails the protection of the common good, namely the good of each and every person. In this sense, under the perspective of global health, the principle of solidarity entails what the author defined as "[…] a shared commitment, among all global stakeholders and

[178] De Campos, Thana C. (27 July 2020), Guiding Principles of Global Health Governance in Times of Pandemics: Solidarity, Subsidiarity and Stewardship in Covid-19, published in *The American Journal of Bioethics,* Volume 20, Number 7, p. 212.
[179] Ibid., p. 214.
[180] Ibidem.
[181] (de Campos, 2020), p. 213.

institutions, to uphold the good and the flourishing of each individual in every community.".[182] An understanding of the implications of solidarity which is common to both Ruger and de Campos' positions and which, as stated by the author of the PG/SHG Model, "[…] allocates specific responsibilities to individuals, communities and international institutions based on their abilities".[183] And it is precisely at this point that the above mentioned model, in the opinion of de Campos, required the inclusion of another principle, that of subsidiarity, in order to give an answer to how such responsibilities should be distributed among the actors at stake. In particular, according to this type of principle, the allocation of proper decisional authority among the multiplicity of stakeholders should be given according to a bottom-up approach. Indeed, as opposed to the top-down approach implied by Ruger in which national governments possessed primary responsibilities, de Campos proposed a system based on the allocation of duties firstly to local communities. Only in the case of a request of help and assistance this duty should be moved up to the higher levels of government in an environment in which, as can be clearly understood, the role of improved communication and cooperation between the stakeholders should be deemed as fundamental to the well-functioning of the whole system. It is precisely in this kind of perspective that the WHO, at the top of the ladder in terms of duties and responsibilities, would be highly recognized as the most important facilitator and conductor of global coordination on the issue of health. And it is exactly this kind of task performed by the World Health Organization that led Thana de Campos to include the third and final principle of stewardship to the model. This last one is "[…] a regulatory principle that determines when intervening and assisting are reasonable and legitimate acts and when not, further complementing and specifying the principles of solidarity and subsidiarity.".[184] In this respect, the key elements at the heart of such a principle are the figure of a steward, a sort of regulator and leader of the whole system and the presence of a "[…] truthful and accountable communication between the steward

[182] Ibidem.
[183] Ibidem.
[184] (de Campos, 2020), p 213.

and those under their leadership.".[185] An element this last one which, as underlined in the previous chapter on the main flaws of the WHO and by both Ruger and de Campos among their reforming ideas, was particularly absent during the Covid 19 crisis when "the lack of truthful and accountable communication has eroded WHO's public trust.".[186]

It is precisely for the objective of relaunching the Organization as the steward *par excellence* of the global health protection system that, as previously noted, de Campos proposed the idea of reforming its mandate toward much more limited but better performed tasks. In this sense her reforming proposal, emanating from the very same principle of solidarity of the authors of *The Lancet*, took a different path, not giving importance to the expansion of both WHO's functions and funding but to a reshaping of its main role. A proposal which can be clearly summarized by directly quoting the author when she stated that "[…] the WHO would do well to delegate more global health functions to other stakeholders more capable and best situated to realize them.".[187]

IV . 5 – Tine Hanrieder: management strategies applied to the WHO

The proposal by Thana de Campos of restructuring the WHO in order to reduce its overstretching priorities towards a role of coordinator and facilitator of the whole system of global health protection is very useful in analysing a different possible path vis à vis the other reform ideas analysed up to this point. Moreover, it does not represent an isolated case among the number of different reviews and reforming ideas triggered by the Covid 19 crisis. Indeed, even if starting from a totally different and more theoretical approach, it shares certain similarities to the opinions expressed by Tine Hanrieder in her article *Priorities, Partners, Politics – The WHO's Mandate beyond the Crisis* published in the journal *Global Governance*. In particular, starting from the debate over the mandate of the WHO and its being

[185] Ibidem.
[186] Ibidem.
[187] Ibid., p. 214.

described as an "[…] Organization that has lost its way", the author tried to give an assessment over the increasing number of contributions on how to reform and improve the WHO's position.[188] Proposals which, in her opinion, are generally borrowed from the consultancy world and which "[…] can help to only a limited extent, given the underlying normative controversies and lack of political commitment.".[189] In the pursuit of trying to give a better assessment of these kind of reforming ideas and to motivate their advantages and disadvantages, the author framed her analysis according to three different proposals: focus on pandemics, maintenance of a broad conception of health but setting priorities, finding the right niche.

The former of the three elements consists in an idea which, in the mind of the author, can be understood as a reflection of the spirit of the day and the sense of urgency caused by the Covid 19 pandemic, namely the narrowing of the WHO's mandate to the sole fighting of pandemics. This last goal can be easily understood as one of the most important goals of the Organization, one in which it possesses some relative well established formal authority but in which, as it has been noted in the previous chapter, it has also flaws in verifying the independent sources of information and in obtaining a real power under the IHR. Moreover, according to Hanrieder, a more intrusive and controlling role for the WHO towards its member states will be very hard to achieve. The reason, as it has already been said in the previous pages, can be ascribed to the fact that "many states, not only China, will hardly allow the WHO to gather its own disease intelligence.".[190] Indeed, according to Hanrieder too, outbreak reports and the travel warnings that emanate from them profoundly harm national economies, thus creating serious constraints on the effective possibility for the WHO to retain effective control over the process. Given this reticence on part of member states in delegating core powers and the increasing desire to perform sovereign control, the author came to the conclusion that the goal of focusing exclusively on pandemics is not well suited for the WHO. She also went further in

[188] Hanrieder, Tine (2020), Priorities, Partners, Politics – The WHO's Mandate beyond the Crisis, published in *Global Governance*, Volume 26, p. 534.
[189] Ibidem.
[190] Ibid., p. 535.

adding that it would "dramatically truncate the WHO's mandate in global public health" as a whole.[191] Indeed, she underlined how "[…] ill health is not only caused by pandemics, but to a significant extent produced by causes other than infectious diseases (e.g. cancer, heart disease)" which are again conditioned by many other crucial determinants such as food security, education and global economy too.[192] It is precisely for this reason that the WHO's mandate and portfolio were conceived as wide and not only limited to pandemics from its very foundation. And it is again for this reason that the author herself underlined the impossibility for the WHO of performing the goal of focusing on pandemics while highlighting, at the same time, the necessity to take the second path, namely the priority setting one.

The idea of improving the Organization by implementing a more detailed and well-functioning priority setting system would be crucial, according to Hanrieder, in escaping from the so-called *project spiral*. In this respect, she underlined how the current funding of the World Health Organization is "[…] strongly project oriented, often ad hoc, and generally demand driven.".[193] A situation which makes it hard for the Organization to sustain its activities and resource them in a proper way and which imply the short-term nature of its staff. In this respect she also noted how, starting from the already mentioned figure of Gro Harlem Brundtland (Director General from 1998 to 2003) and her overhaul of the Organization, the element of priorities had figured prominently in speeches, programs of work and reform proposals by experts. Contributions which, however, hardly ever became concrete enough to be implemented and which underlined a strong political challenge behind the difficult task of defining what are the right core areas of the Organization. Indeed, such a goal implies the necessity of finding a collective agreement between all the actors involved on what the WHO should be asked to do. Something that appears quite difficult, especially in the light of all the considerations made up to this point, if the general attitude of such donors is "[…] to retain control of the activities they fund and to claim credit for visible activities such as, for example,

[191] (Hanrieder, 2020), p. 536.
[192] Ibidem.
[193] Ibidem.

the polio eradication.". A situation which is even worsened by their general willingness to "[…] reign in or punish the WHO when it ventures into terrains that touch on national industries or interests.".[194] The author also went further in exposing a very interesting example over the ability on part of states of circumventing the unwanted provisions of the WHO. A peculiar situation which has not been described up to this point but which is very interesting in further clarifying the focus of the current analysis. Indeed, she mentioned the efforts made by the WHO in 1994 to conclude an Agreement on Trade-Related aspects of Intellectual Property (TRIPS) which was opposed by several manufacturers and countries. Such an agreement, related as it was to the field of trade and economics, created a lot of opposition which in turn translated into the proliferation of legal ways of circumventing it. As in the words of Hanrieder "many states later simply bypassed it and concluded bilateral trade agreements with other states, so called TRIPS-plus agreements, whose provisions prioritize intellectual property protection on the detriment of public health concerns.".[195]

Taking into consideration these tight linkages between the WHO and its stakeholders, whose contribution is crucial in determining the success or failure of the Organization's priorities, there is another important evaluation made by the author. Indeed, she underlined how, in such a condition and with the presence on the global scene of other major public private partnerships, multilateral organizations and NGOs, the WHO has to face a lot of competition in the field of global health protection. It is precisely in this context that she then presented the third point of the reforming proposals at the core of her essay, namely the one she described as finding the right niche. This last proposal, another one in line with what Hanrieder defined as the *public management speak*, considers the WHO as a simple provider of health services in a global market which, as noted earlier, is very much crowded with competitors. In this respect, then, the Organization has the crucial task of finding its competitive advantage, that is demonstrating its relevance in comparison to the other providers on the scene. Something that, in the words of

[194] (Hanrieder, 2020), p. 537.
[195] Ibid., p. 538.

the author, translates itself into the WHO leaders acting as salesmen and saleswomen and trying to market their product to the interested investors. [196] However she also noted the intrinsic difficulty of such an operation given the fact that, first of all, the WHO is not an easy sell and that, secondly, "its constitutional mandate to act as the UN's *coordinating* agency for global health, does not fit well with the niche imagery.".[197] Indeed, the existence of a niche dedicated to guiding the others and connecting their expertise and data is probably too stretched if not impossible at all. Moreover, as underlined by the author, "the WHO often is dependent on the contributions of other health organizations: the research and training provided by its more than 800 collaborating centres, the data gathered by national or private laboratories, the expertise of specialists from the private sectors, the logistics of public and private organizations, and lately the donations made to its newly established WHO Foundations.".[198] It is precisely for this reason that the Organization is constantly struggling to find its own independence vis à vis the other partners in the pursuit of expressing its renewed authority too. Something that is too difficult to be considered as a real niche of the WHO and which has also posed the Organization in a difficult position for several times. Indeed, "its close engagement with the private sector, or with individual experts closely entangled with for-profit organizations, had repeatedly caused problems.".[199] In this respect the author mentioned the cases of the initiative with the Interpol and major pharmaceutical associations in order to fight trademark violations or the hastened recommendations of pharmaceuticals against swine flu which, in her opinion, are just two of the many cases in which the credibility of the Organization as a whole suffered from suspected undue private influence. In this sense, in order to overcome this problem and to continue developing linkages with other organizations and with the private sector, the WHO should concentrate its efforts towards the development and the implementation of clear conflict of interest policies. An effort that, as shown by Hanrieder, the Organization has already undergone since the turn of the

[196] (Hanrieder, 2020), p. 539.
[197] Ibidem.
[198] Ibidem.
[199] Ibidem.

millennium but which has been severely constrained by opposition from member states with the sole exception of a New Framework for Engagement with Non-State Actors (FENSA) developed in 2016. It has to be noted, however, how for this framework there have been many debates and controversies during the negotiation period. Something that had led to a general lack of clarity and leadership on how to work with an instrument which, among the others, "[…] leaves important grey zones such as the work with consultancy firms, which is technically a *procurement*, and therefore not covered by FENSA.".[200]

Given all the difficulties in developing a very much needed policy for conflict of interest within the Organization and the important lack of a completely developed framework for cooperation with non-state actors, it is almost impossible to consider the WHO as an Organization which has found its own niche in the crowded environment of global health protection. In this sense, as noted by Hanrieder herself, Covid 19 has also shown the limits of the WHO in the field of leadership, precisely the one which was underlined by the author as the real niche of the Organization. She mentioned for example the theme of the COVAX initiative, the project to pool procurement and achieving economies of scale for equitable vaccine distribution, which "[…] remains contested given that potential barriers imposed by patents are not addressed, contracts with manufacturers are not transparent, and civil society has little voice in it.".[201] Something that in the opinion of the authors shows how the WHO, in this respect, represents only a part of the whole architecture and not its coordinator as it should be. An assessment of the actual role of the Organization which led the author to the conclusion that even this third reforming proposal developed in the framework of a managerial approach, the one of finding a niche, does still not represent an adequate one for the World Health Organization. In this sense, it is very interesting to report here the words of Hanrieder in the very conclusion of her essay given the importance of the consideration she made. Indeed, she highlighted the fact that "the WHO […] struggles to find a definition of its normative work that resonates with the language of markets. This struggle reflects

[200] (Hanrieder, 2020), p. 540.
[201] Ibid., p. 541.

the rise of public-private arrangements, and the celebration of "partnerships" by the WHO's big stakeholders. Such marketing is time consuming and probably inevitable, as long as the WHO is precariously funded.".[202] However, besides this lack of proper funding which has already been mentioned as a critical weak spot in the WHO structure, Hanrieder noted also another crucial element connected to the impossibility of business-modelled reforming proposals. Indeed, she underlined the fact that "[…] managerial cleverness is not a remedy for political vulnerability.".[203] The only hope, one that is shared by many others experts of the field, is that thanks to the many issues underlined by the Covid 19 pandemic the shareholders of the WHO will try to find a new reform momentum in order to develop a renovated and improved social contract for public interest policy-making.

IV . 6 – Kelley Lee and Julianne Piper: IT metaphors applied to the WHO

The very same consideration of Covid 19 as an important opportunity to renew and relaunch the World Health Organization in its entirety is shared by another article published in the same issue of Global Governance as the one by Hanrieder. This article, written by Kelley Lee and Julianne Piper and titled *The WHO and the Covid-19 Pandemic – Less Reform, More Innovation* started from the assumption of the pandemic as a rare opportunity to "[…] find a way of moving beyond the months of mudslinging and divisive political posturing toward a shared vision of collective action.". [204] Moving from an assumption that is very much assimilable to the conclusions reached by Hanrieder at the end of her article, Lee and Piper decided to propose in their article an analysis of how to move forward in the architecture of the WHO. In doing so they presented the opportunities at the disposal of the global community through an interesting metaphor which linked the World Health Organization to an aging computer. In this respect, they reported how "what one does with such a computer depends on available resources, current needs and

[202] (Hanrieder, 2020), p. 541.
[203] Ibidem.
[204] Lee, Kelley, Piper, Julianne (2020), The WHO and the Covid-19 Pandemic – Less Reform, More Innovation, published in Global Governance, Volume 26, p. 526.

available technology.".[205] Using this analogy they came to four different practical approaches to reform the WHO and they presented it as: *Time for Retirement, Refreshing with Add-Ons, Network Coordinator* and *Innovation in Global Health Governance*.

As can be easily understood from its very title the first proposal analysed by Lee and Piper was based on the acknowledgment of the WHO as an old and uneasy post-war compromise between two worldviews. In this respect the two authors attributed to the Organizations the same illnesses that had been analysed in the previous chapter thanks to the contribution of José Alvarez in his *The WHO in the age of the Coronavirus* who assessed the flaws of the Organization in the bigger framework of the UN-modelled organizations. In particular, following this line of reasoning, Lee and Piper underlined the crucial fact that the goal of the WHO of becoming a crucial pillar in the protection of health had been severely constrained in its effective authority by "[…] remain[ing] curtailed as a Member States organization".[206] Moreover they highlighted the strong disconnect between the aspirations of the Organization and its effective authority and its being caught between visionary positions of *health for all* and a pragmatic present dominated by diseases and an ongoing pandemic. As practical examples of this disconnection they reported the many disagreements that were brought by the enlargement of the Organization from 55 member states in 1948 to 194 in 2020. An increase in the number of states involved which was accompanied by disagreements on how to best support the needs of the newly added low and middle income countries and which contributed to the emergence of many debates between the Organization and its main rich contributors such as the United States. In this context, considering the WHO as an organization caught between two completely different and irreconcilable positions, the authors reported the possibility of dismissing it as an old and irreparable computer. They reported the idea of viewing it as an old institution belonging to a completely different past and resumed the most important approaches that such a consideration might lead to. In this sense, they included the

[205] (Lee & Piper, 2020), p. 526.
[206] Ibidem.

polar opposite approaches represented by the globalist and isolationist positions with the former strongly willing to introduce a new and stronger Organization and the latter preferring a return to states' centrality and bilateral agreements. Whatever the path to be taken in the future, the suggestion made by the authors for this kind of approach is to bear in mind the fact that "an emerging multipolar world order may mean greater diversity of perspective. The relative roles of states and non-state actors must be grappled, while taking account of the diversity and stark inequities among their ranks.". [207] A theoretical framework which should translate itself, according to the authors, in the practical creation of a funding formula shared by each player, deemed as fair and adequate to the fulfilment of the goals of the newly created organization.

The second reforming approach presented by Lee and Piper consists in the implementation of what the authors defined in a hi-tech language as *add-ons,* namely external components to be added to the overall structure of the Organization. In this respect such a proposal is less impactful vis à vis the first one given the fact it tries to reform the WHO by keeping its basic architecture as it is and working on new specialized offices and tasks to meet the everchanging needs of global health. An idea which, according to the authors, has also represented in some ways the de facto evolution of the Organization itself, given its expansive mandate and the number of new different tasks it was asked to perform even "[…] without commensurate increases in resources or authority.".[208] Particularly in this respect the authors quoted as an example the more than triplicated amount of organizational subdivisions that were added between its foundation in 1948 and 1981. [209] According to their view, such an evolutionary path with the constant resort to add-ons of divisions, departments and programs perfectly reflected "[…] an internal response to conflicting external views of what role the WHO should play, and

[207] (Lee & Piper, 2020), p. 527.
[208] Ibidem.
[209] (Lee & Piper, 2020), p. 528. It is interesting to note how at the establishment of the Organization in 1948 its Secretariat consisted of the Office of the Director-General and three departments which comprised in total four divisions, three sections and two offices. Less than forty years later, in 1981, these numbers were triplicated with five assistants directors-general who oversaw the portfolios of fifteen divisions, six programmes and three offices.

relatedly which health issues should prioritize.".[210] A kind of debate which, as it has been noted before, has always accompanied the work of the Organization since its moment of foundation and has increased with the unprecedented and unexpected emergence of the Covid 19 pandemic.

It is interesting to note how the reasons behind this unstable situation in the overall system of global health protection can be attributed in the opinion of Lee and Piper to the Constitution of the WHO itself which, setting out a broad definition of health and twenty six functions, in a way amplified the competing expectations of the global scene towards such an Institution. In particular they also went further in underlining how, as far as 1981, the Organization was perceived as a tangled garden as a result of the efforts to expand its scope through the constant use of add-ons. A situation which led to increasing concern over the WHO's bureaucratic structure in times in which agility and nimbleness were perceived as vital and which produced a shift of the major donors towards new initiatives outside the Organization. And, precisely for the above mentioned reasons, Lee and Piper defined the *Add-ons* evolutionary model as one already abandoned in the 1990s and as an approach which, without major changes in structure and financing, would only contribute to further overloading the WHO's structure.

Then, after having analysed the main characteristics and the effective impracticability of the second approach they presented, the authors moved on to the third one which they titled as *The WHO as Network Coordinator*. This proposal is based on an understanding of the Organization as just a part of a bigger network of different organizations and, for this very reason, it is helpful in understanding the general evolution of global health cooperation towards donor preferences and perceived priorities. In this respect Lee and Piper mentioned the importance of what they defined as a *perpetual circle* which strongly damages the World Health Organization. Indeed, they highlighted how this last one is becoming more and more marginalized given the fact that it lacks the proper funding to reach its main goals and, precisely for this reason, is perceived as ineffective and inefficient by its

[210] Ibidem.

donors. A perception which has the negative effect of furtherly reducing the incentives to increase the budget of the Organization thus creating a loop effect in which it becomes almost impossible for the WHO to successfully complete its tasks. A situation which is helpful also in partially explaining the increasing number of private foundations, private-public partnerships, bilateral donors, UN agencies and other actors which, as it has been noted in the previous pages, have taken a stronger role in the architecture of global health protection. It is precisely in this respect, moreover, that the authors suggested the reforming idea of repositioning the WHO as a network coordinator proposed by Allyn L. Taylor and Roojin Habibi. Quoting them directly, Lee and Piper reported how the "WHO has neither the legal and political authority nor the technical capacities to address economic, social, and health consequences of devastating global pandemics alone.". And starting from such an acknowledgment they proposed "the establishment of a framework in which the WHO continues to serve the central role envisaged by parties to the IHR in using its scientific, medical and public health capabilities, as well as its normative role to effectively assist states to prevent, detect, and respond to disease outbreaks.".[211] They also went further in quoting one of the most relevant examples and potentially a model for this kind of network coordinator approach in reforming the WHO's structure: the Access to Covid-19 Tools (ACT)-Accelerator. This initiative, launched by the WHO in April 2020 brings together different actors, from governments to the science community and the civil society in the pursuit of an equal distribution of the equipment needed to reduce Covid 19's mortality and diffusion. In particular, they also quoted the vaccine arm of the ACT-Accelerator, the COVAX Facility, as an example of the high capacity of the WHO to rapidly mobilize many different actors in situations of emergency and to direct the global health protection network towards its most important goals. However, despite the many beneficial effects in terms of resource mobilisation and efficiency, they also reported the two most important challenges that such initiatives, and the network model as a whole have to face. First of all they mentioned the trust in and

[211] (Lee & Piper, 2020), p. 529.

compliance with the WHO leadership and in particular the necessity to reaffirm, as a consequence of Covid 19, the leadership of the Organization as a technical leader for international health cooperation. A leadership which, as it has been clearly underlined especially in the previous chapter, has lost part of its strength as a consequence of the issues with China, the temporary retirement of fundings under Donald Trump's presidency and the overall impact of the management of the early stages of the pandemic on the global public opinion. The second challenge reported by the authors for the network modelled reforming approach is represented, on the other hand, by what they defined as "the laissez-faire evolution of existing actors, creating gaps and overlaps in function and management.".[212] A challenge, this last one, which has represented the reason behind many of the flaws of the World Health Organization analysed in Chapter III and which implies a strong rethinking of the overall structure of the organization, together with a restating of its highest relevance among the other players, in order to be effectively overcome by the global community.

The fourth and final reforming proposal presented by Lee and Piper is based on one of the most important elements of the technological approach, one which can be defined in the line of Research and Development applied to the theme of Global Health Governance. Indeed, in order to frame this proposal, they resorted to the concept of *Innovation* and applied it to the reimagining of the World Health Organization in the post-Covid 19 world. Using a business metaphor in a different way than the ones analysed by Tine Hanrieder in *Priorities, Partners and Politics* and proved not always successful if applied to global institutions, they underlined the crucial importance of innovation for both private firms and international institutions. Indeed, even if safe from the risk of being perceived as old and consequently losing their grip of the market typical of private firms, also international organizations have a "[…] need to remain fit for purpose" which is "no less critical.".[213] In this respect Lee and Piper reported the same kind of acknowledgment of the WHO as an organization modelled in a post-war

[212] (Lee & Piper, 2020), p. 530.
[213] (Lee & Piper, 2020), p. 530.

environment to carry out routine functions in a stable and predictable manner which has been described by Alvarez and reported in Chapter III. A model which is "[…] arguably out of step in a world where adaptation to more rapid change, greater complexity, and closer interconnectedness is critical to institutional resilience.".[214] Under such a perspective the whole concept of Global Health Governance as it is right now should be reimagined and reinvented in order to increase societies' resilience across "[…] a full range of threats, including climate change, pandemic diseases and economic crises.".[215] A reformulation of the architecture of global health protection that would be conceptualized as part of a more complex adaptive system in order to finally overcome the gridlock which Thomas Hale and David Held defined as "deadlock or dysfunctionality in existing organizations and the inability of countries to come to new agreements as issues arise.".[216] Issues which, emerging as they are from an highly interconnected society, totally incomparable to the previous centuries, could only be overcome with an increased and solidified cooperation among all the players involved on the global scene. A renewed understanding which, hopefully, a totally unprecedented and unexpected pandemic such as Covid 19 will be crucial in fostering as it fostered debates, critiques and reforming ideas of the global health protection main actor: the World Health Organization.

[214] Ibidem.
[215] Ibidem.
[216] Ibidem.

V – Health and Environmental Protection: The Berlin Principles and the G-20 Rome Declaration as Guidelines to the Post-Covid 19 World.

V . 1 - Introduction

Up to this point the analysis at the hearth of the present thesis has underlined how the creation and establishment of a commonly shared global health protection system has very old roots and has undergone several major changes through the decades. It has been underlined the large number of different private and public actors which, at the same time and at an expanded rate during the last years, have worked together in order to guarantee the protection of the health of the global population. Among such actors, the World Health Organisation has been identified as the most important one and as a sort of coordinator of all the other players at stake. It represents, indeed, the only institution provided with the legal framework and the technical expertise to guide its creators, namely independent nation states, towards the attainment of the highest possible standards of health. In this respect, however, it has also been strongly underlined how such a global health protection project has undergone several different major crises which have exposed both its intrinsic flaws and its strong necessity to cope with the ever-changing needs of the global interconnected societies. In particular, the focus of the attention has been devoted to a family of diseases which can be considered, as stated in Chapter II, as one of the main drivers of change for the global health protection system as a whole: the Coronaviruses. Among them the crucial relevance has been attained by the 2003 SARS outbreak and the ongoing, unprecedented, pandemic of SARS-CoV-2. The former, as it has been deeply analysed in Chapter II, has represented a turning point for the architecture of global health protection given the fact that, after being brought under control and curbed through a strong and unprecedented action by the WHO, it became the trigger for many reforming debates. In particular, it led to the 2005 Revision of the International Health Regulations, the basic legal document at the heart of the whole system, which should have increased the capacity and the

effectiveness of the WHO in gathering data over disease outbreaks and thus, in curbing them in their early stages. However, as it has been noted in Chapter III, the provisions reformed in 2005 did not manage to reach their final goal and presented some important structural flaws which, together with a series of other external elements, contributed to the diffusion and the inability of controlling the other turning point for global health protection: SARS-CoV-2, namely Covid 19.

This last disease, in particular, can be considered as an historical moment which will be remembered and will have repercussions on the human societies for years and even decades after its final dissolution. Indeed, it has represented almost the only virus in the whole contemporary history of mankind to reach a full global expansion thus attaining the definition of pandemic. It managed to do so thanks to the highly interconnected human society of the present times and the facility in which goods and people can travel across the whole globe. An unprecedented expansion which has been accompanied, unfortunately, by hospitalization and mortality rates especially in the elder part of the populations which have put the national health systems under extraordinary pressure. For these very reasons Covid 19 has also triggered many new measures on part of states to try to control it and to reduce its spreading among the society. In this respect, the notions of social distancing, quarantine and lockdown to which the global population is quite accustomed now represented a major shift in the habits of the human community as a whole. Unprecedented measures which, together with the strong ex post willingness of finding ways to protect global health on part of the global community, deeply exposed all the unpreparedness and the flaws of both the World Health Organization and many of its member states. And, precisely as it was the case with the strong reforming debate following the 2003 SARS outbreak it is almost sure that Covid 19 too will mark a strong turning point in the literature and in the decisions that the global community will have to take, an even stronger one compared to its 2003 predecessor. In this respect, Chapter IV of the current thesis has represented an attempt to enlist and to critically analyse the most important contributions to such reforming debate, trying to highlight what could be the best and most probable strategies for the following years. In particular, it has been noted

the large number of different theoretical and practical approaches to the theme which entail different outcomes in terms of proposals to reform the system and reduce its flaws. Ranging from the opposing fronts of the isolationist to globalist approaches, they entailed the many possibilities of retrenching into a newly established national superiority, reforming the existing WHO in several different ways in order to solidify it and ameliorate its weaknesses vis à vis its member states or even creating a completely new institution with similar tasks but with a different structure and internal organisation. Such proposals, together with the many others expressed in more detail in Chapter IV, are crucial in representing the strong debate which Covid 19 has already generated in the public opinion towards both the global health protection system and the role the WHO should possess in it. In this respect, the large number of different and in certain cases unconcealable proposals, may create a sort of confusion over the actual path that the global community will decide to follow. Anyway, despite the sense of discomfort arising from such an intricate debate, one of the most useful elements to clarify the position of the global leadership over the issue and thus, unravelling what will most probably be the reforming path of the future is represented by the Rome Declaration of May 2021. This important document, arising from the so called Global Health Summit that took place on the 21st of May 2021 under the G-20 Italian Presidency and in partnership with the European Commission is fundamental since it contains all the basic principles which the leaders of the twenty most influential nations of the world have decided to set as guides towards the end of the pandemic. A Declaration which, moreover, has also been reaffirmed and clearly strengthened by the following signing of the related Rome Pact on the distribution of vaccines that took place on the 7th of September during the meeting of the Health Ministers of the G-20. Such a document, as can be easily understood, represents a clear statement on part of the wealthiest and most powerful states of the world on the guiding principles that will drive the global community towards a healthier and safer future. It is also of the highest importance in the context of the present thesis given the fact that it represents a sort of apex of all the lessons and the considerations that have been analysed throughout the whole text and the synthesis of the different reforming

proposals enlisted in Chapter IV. It contains, indeed, 16 basic principles on the theme of global health in general, with a particular focus on its most relevant institutions, namely the World Health Organization and the International Health Regulations. However, before coming to the heart of the matter and analysing more in detail what these principles claim and how they were shaped by the G-20 leaders it is of absolute importance to make here some preliminary considerations. Indeed, even if the most part of the global health protection system has been analysed in the previous chapters, it is crucial to add here another aspect which represents a sort of underlying principle at the heart of the Rome Declaration itself.

V . 2 – Preliminary Considerations on the Nature of Covid-19

The first consideration that has to be made in order to reach the common understanding and the general framework which, in a way, shaped the outcome of the G-20 meeting in May 2021 is on the strongly all-encompassing nature of Covid 19. Indeed, as it has already been noted before and as it is quite clear from the personal experience of almost every citizen of the world, such disease did not represent just a threat to health but also a damaging element to all the different fields of human life. Indeed, even for those who did not suffer from its strictly physical symptoms and who experienced it asymptomatically, it represented an unprecedented turning point for the personal, economic and psychological consequences of the many lockdowns and the isolation needed to overcome it. Consequences that, as can be easily understood, had a strong impact on the health systems of almost every country of the world, their economic performance and in general on the overall equilibrium of their societies. Precisely in this respect it is very interesting to briefly quote here an Opinion by Sandro Galea and Salma M. Abdalla published in the *Journal of the American Medical Association* on the 21st of July 2020. This brief article titled *Covid 19 Pandemic, Unemployment, and Civil Unrest - Underlying Deep Racial and Socioeconomic Divides* is strongly focused on the United States and on their social internal divisions but is also very interesting in the present context for having underlined the effects of Covid 19 as a social

disease too. Indeed, in the own words of the authors, "[…] the consequences of Covid 19 have not been experienced evenly. Emerging data clearly show that the risk of acquiring Covid 19 has been greater among minorities and persons of lower socioeconomic status; these same groups are also at greater risk of dying of Covid 19 once they contract the disease.".[217] Such an element, united to the important economic consequences that the very same outbreak brought with it, is crucial in understanding the enormous impact that SARS-CoV-2 had on many different societies and on the increasing divides inside them.

This very same assessment of the stronger impact of Covid 19 over the poorest elements of the society in a wealthy country such as the United States is even more interesting if linked to another crucial feature of this threat. Indeed, exactly as it affected the underdeveloped and more isolated portion of national societies it also affected, in a sort of specular way, the less advanced and developed countries of the world. In this respect it is particularly important to quote here a crucial contribution by Jennifer Cole and Klaus Dodds titled *Unhealthy Geopolitics: can the response to Covid 19 reform climate change policy?* and published on the 30th of November 2021 on *The Bulletin of the World Health Organization*. The article, as can be easily understood from its title, raised a question over the possible existence of a correlation between Covid 19 and the environmental crisis the world is also facing. In doing so, proposing a theme that will be crucial in the following pages of the current chapter, the authors also noted how, as it was mentioned above, the less developed countries of the world were precisely those where the consequences of Covid 19 were more dire and difficult. In particular, they noted how "for the poorest countries of the world, pandemics join a list of other challenges that are exacerbated by pressures of scarce resources, population density and climate disruption" which have the crucial role of worsening even further the already difficult consequences of the outbreak itself.[218] Moreover, they also noted how "climate change and its

[217] Galea, Sandro, Abdalla, Salma M. (July 2020), Covid 19 Pandemic, Unemployment, and Civil Unrest – Underlying Deep Racial and Socioeconomic Divides, published in *The Journal of the American Medical Association*, Volume 324, Number 3, p. 228.

[218]Cole, Jennifer, Dodds, Klaus (November 2021), Unhealthy Geopolitics: can the response to Covid 19 reform climate change policy?, published in The Bulletin of the World Health Organization, p. 151.

drivers – particularly biodiversity loss and land-use change – makes the emergence of novel infectious diseases and their spread more likely to happen in poorer, rural communities, often far from centres of power.”.[219] Such a close relationship between disease outbreaks, climatic conditions and wealth (both among states and among their citizens) is precisely the focal point of the article by Cole and Dodds and the theme that has to be analysed before moving forward to the principles of the Rome Declaration. Indeed, moving from this understanding of Covid 19 and of the general problem of disease outbreaks, the authors raised a crucial question over the real nature of such issues. In particular they noted how both climate change and pandemics can be considered as an example of *super-wicked problems*, namely problems which entail the urgency to find a solution in a framework which, most of the time, is particularly difficult and constraining. Quoting the authors directly, they basically stated how “pandemics share these similarities with climate change, both issues are complex and urgent, and if left unchecked will continue to place huge burdens on the future health and well-being of humanity and the biosphere.”.[220]

V . 3 – The Super Wicked Problem Approach: main characteristics and applicability to both health and environment

Before moving to the implications of this understanding of both the health of the planet and the health of the human being it is important to briefly devote some attention to the theoretical framework surrounding the analysis by Cole and Dodds. In this respect, in particular, the most important source to be mentioned here is an essay titled *Overcoming the tragedy of super wicked problems: constraining our future selves to ameliorate global climate change* and published in the journal *Policy Sciences* on May 2012, which has been a crucial reference in the article analysed up to this point. Despite being completely focused on the issue of climate change and environmental problems and not properly considering the related health issues, the essay was indeed precious in that it outlined and carefully described the

[219] Ibidem.
[220] (Cole & Dodds, 2021), p. 148.

main characteristics of super wicked problems. In particular it divided them into four macro areas which, as noted before, were considered by Cole and Dodds as applicable also to the theme of pandemics. These four areas have been defined as: "time is running out; those who cause the problem also seek to provide a solution; the central authority needed to address them is weak or non-existent; and irrational discounting occurs that pushes responses into the future".[221]

The former element can be described as the fact that, specifically environmental issues, create a problem which cannot be postponed and for which there is not the possibility to come back. To be more specific, in the words of the authors of the essay, "the time dimension means the problem will, at some point be too acute, have had too much impact, or be too late to stop or reverse.".[222] Bearing in mind such a consideration it is almost immediate to think about the issues posed by climate change and more generally by the progressive degradation and pollution of the planet. Anyway, such a consideration may be also applicable in certain cases to the health protection and disease outbreak control. Indeed, it is sufficient to consider the increasing rate of emerging and re-emerging diseases discussed in Chapter I and what would have happened in the case of a virus with even higher mortality and infectivity rates compared to Covid 19 to understand how the issue of global health protection is of the highest importance for the human society as a whole. Strong and important actions should be taken in brief by global decision makers in order to improve the mechanisms of protection and to curb from the beginning other future possible disease outbreaks.

The second feature of super wicked problems, namely the fact that those seeking to end the problem are also causing it, can be resumed by stating that "every concerned person trying to reduce climate change has contributed to climate change. Everyday activities, including proportionally higher per capita emissions in wealthier countries, are major culprits.".[223] Such a feature, easily applicable to the theme of

[221] Levin, K., Cashore, B., Bernstein, S.et al. (May 2021), Overcoming the Tragedy of Super Wicked Problems: constraining our future selves to ameliorate global climate change, published in Policy Sciences, p. 124.
[222] (Levin, Cashore, Bernstein, & Auld, 2012), p. 127.
[223] Ibidem.

environmental protection, can also be ascribed to the theme of global health. In particular, it does not involve a consideration on the emergence of new diseases per se but on the many debates and all the insufficient measures taken by the global community to definitively curb the problem. In this sense, it is sufficient to think about the analysis of the WHO intrinsic flaws made by Alvarez and reported in Chapter III or about the ineffective outcome of the 2005 Revision process of the International Health Regulations to understand how the flaws of the global health protection system and thus, the emergence of new outbreaks can be partially ascribed to its very designer, namely the international community. A theme, this last one, which is also particularly intertwined with the third feature of super wicked problems: no central authority. Indeed, this characteristic described by the authors as the fact that "decision makers within public authorities do not control all the choices required to alleviate pressure on the climate" can be ascribed also to health, especially in the light of what has been said in Chapter III.[224] In this respect it is almost immediate to look at the World Health Organization as the central authority which would be needed in order to overcome the issue but, bearing in mind its many flaws and weak spots, such an authority appears as very difficult to be obtained if not impossible at all. As it has been said before, the Organization over the years developed a role which is more a coordinating and facilitating one rather than a properly authoritative one. Of course there have been some deviations from this path, it is sufficient to quote here the 2003 response to SARS involving a stronger role of both the WHO and of its Director General, but such moments of change did not completely translate into a renewed and more authoritative Organization.[225] A situation which is particularly interesting if considered under the perspective of the "general problem of cooperation under anarchy that characterizes any global collective action problem.". A "lack of centralized governance [which] has repercussions at multiple levels in case of climate change since responses require

[224] (Levin, Cashore, Bernstein, & Auld, 2012), p. 127.
[225] It is important in this respect to bear in mind how, despite the increased power showed by the WHO and by its Director General during the 2003 SARS outbreak, its outcome, namely the 2005 Revised International Health Regulations, did not proceed on the line of such changes and presented several weak spots which have been underlined in Chapter III.

coordination not just among states themselves, in a variety of different circumstances, but also across different economic sectors and policy subsystems at multiple political levels.".[226] A quotation, this last one, which would be totally valid also to the theme of health issues which, as it has been noted up to this point, involve several multiple problems in almost every area of the political field.

Finally, the fourth and last element characterizing super wicked problems consists in what the authors defined as *policies discounting the future irrationality*. In this respect, they noted how "[…] super wicked problems generate a situation in which the public and decision makers, even in the face of overwhelming evidence of the risks of significant or even catastrophic impacts from inaction, make decisions that disregard this information and reflect very short time horizons. ".[227] And once again this last feature can be easily ascribed to both the domains of climate and health protection for several different reasons. In particular, devoting more attention to the actual focus of the current thesis, two elements have to be underlined which concern choices at the national and international levels. For the former case it is sufficient to think about the irrationality of certain states deliberately avoiding to report to the WHO data and information over newly emerging outbreaks. A situation which, as it has been already said, is caused by the priority given to short-term, socio-economic, strictly national considerations vis à vis the protection of global health. Short term decisions that, as described in Chapter III for the early stages of Covid 19, had severe repercussions on the whole world leading to a pandemic whose effects are still being experienced by the global community as a whole. The latter case, on the contrary, is represented by international decisions and can be described as the insufficient level of attention posed by global leaders to the issue of emerging and re-emerging diseases which, as it has been noted in Chapter I, was already of the highest importance several years before the emergence of Covid 19.

[226] (Levin, Cashore, Bernstein, & Auld, 2012), p. 127-128.
[227] (Levin, Cashore, Bernstein, & Auld, 2012), p. 128.

V . 4 – The Linkages between Health and Environment

Bearing in mind these consideration over the applicability of the notion of super wicked problems to both health and environment protection it is not surprising to see how the two issues were strongly linked together by Cole and Dodds in their *Unhealthy Geopolitics: can the response to Covid 19 reform climate change policy?*. In particular it is very interesting to report here a statement in which they affirmed how "an increase in the incidence of vector-borne and zoonotic disease emergence and transmission [such as Covid 19 for example] is a long predicted consequence of environmental change."[228] They also went further in noticing another crucial connection between the issues, referring this time to the responses they triggered among the decision makers. In particular they reported how "it has been noted that world leaders who have responded more slowly and less effectively to the current pandemic, resulting in high case numbers and deaths within their borders, also tend to play down their country's responsibility for preventing climate change.".[229] These two elements, together with the considerations mentioned previously, created in the perspective of the authors a scenario divided among three interconnected thematic areas which only a geopolitical framework could help explaining: the working geopolitics of institutions, the possibility of overcoming infectious disease only globally and the emergence of rebellion and resistance.

According to Cole and Dodds the former element is profoundly marked by a return of political rivalries among players like China, the Russian Federation and the US which contributed to the creation of "[…] war-like language and blame narratives around the origin and spread of the virus [which] make it more difficult for an expert body such as the WHO to demonstrate international leadership […]".[230] In particular, they noted how "[…] geopolitical framings that encourage anti-Chinese sentiment are likely to imperil information-sharing and collective action […]"[231] thus shifting away the attention of the global community from the second and most

[228] (Cole & Dodds, 2021), p. 149.
[229] (Cole & Dodds, 2021), p.149.
[230] Ibidem.
[231] Ibidem.

important element of this geopolitical framework, namely the fact that outbreaks can only be overcome globally. This second element, in particular, is profoundly characterized by the understanding of the fact that "[…] long term sustainability needs institutional frameworks to better understand the complex relationship between users and resource system" and that "[…] the pursuit of a narrowly national or strategic advantage generates real dangers.".[232] A consideration which leads to the conclusion that "neither pandemics nor the adverse effects of climate change can be kept at national borders" and that, in the process of approaching these issues internationally, both states and non-state actors must be taken into consideration by the global community. In particular, in the words of Cole and Dodds, "pleas have been made to world leaders to be mindful of their *natural desire to put their own people first* and to come to early agreements not only with each other but with the private sector, so that money spent on tackling the pandemic can be spent most efficiently.".[233]

Finally, the third thematic area presented in the geopolitical framework by Cole and Dodds consists in the emergence of "[…] a growing number of international nongovernmental organizations that call for greater global cooperation in tackling not only ill health but the economic and environmental drivers that lie beneath it.".[234] Such element, less resounding vis à vis the other two but still of the highest importance, is crucial in testifying the increasing acknowledgment among the public opinion of both the relevance and the pressing nature of the issues. Something that shows "[…] the desire to cut across national borders and encourage more global and cosmopolitan sensibilities […]" much needed in order to effectively overcome the threat posed by super wicked problems.

[232] Ibidem.
[233] (Cole & Dodds, 2021), p. 150.
[234] Ibidem.

V . 5 – The Berlin Principles on One Health

After having analysed the theoretical framework at the core of an understanding of health and environment as profoundly related issues, it is almost impossible not to reach the very same conclusion reached by Claire and Dodds over the urgency for the global community to act immediately. As in their own words "threats to global public health provide a clear reason to act, whether the threat itself comes from pathogenic viruses and bacteria or from environmental damage", always bearing in mind the fact that "[…] susceptibility to Covid 19 has been exacerbated by air pollution, and by obesity and diabetes linked to food and social system that challenge the ability of the poor and disadvantage to live healthily.".[235] And it is precisely on the line of such a strong and urgent call to action that the *Berlin Principles on One Health* or the G-20 Rome Declaration were developed by the global community. In particular, the latter has already been mentioned at the beginning of the chapter and will be analysed more in detail later on, while the former, on the contrary, has to be briefly introduced right here insofar as it represents a sort of ideal precedent of the Declaration itself. It has its roots back to 2004 when the Wildlife Conservation Society (WCS) brought together different stakeholders to discuss global health challenges at the heart of human, animal and ecosystem health and gave birth to the so-called *Manhattan Principles*. They basically entailed a collaborative, trans-disciplinary approach similar to the one expressed before which gave rise to the expression "One World – One Health", or its simpler version "One Health". It was only on the 25th of October 2019 when a group of 12 experts from different fields convening for the WCS *One Planet, One Health, One Future* conference gave birth, as a prior call to action, to the *Berlin Principles on One Health.* Such principles, which are a sort of update of the Manhattan ones, were carefully described in an article published on the 12th of October 2020 and titled *The Berlin principles on one health – Bridging global health and conservation*. The authors of this precious contribution described them

[235] Ibidem.

as an attempt at "[…] reintegrating ecosystem health and integrity while also addressing current pressing issues, such as pathogen spill over, climate change, and antimicrobial resistance.".[236] They also underlined how "notably, these discussions and the derivation of the Berlin Principles predated the Covid 19 outbreak and subsequent pandemic by several months", something that reinforces the already mentioned idea of a pandemic which was "[…] predicted and largely inevitable, and [most importantly] will happen again if decisive actions are not taken.".[237]

The team of authors proposed a very helpful description of the ethical foundations and the basic principles at the heart of the One Health approach which will be fundamental in the understanding of the Rome Declaration too. In particular, they noted how the basic framework underpinning the Berlin Principles consists in a broad aim to "[…] foster the health of humans, animals, and their shared environments and to endorse collaboration that breaks down disciplinary and policy silos to this end.".[238] An understanding of the notion of health and environmental protection which is based on the very same conception of solidarity which has been described in Chapter IV as one of pillars to reform the WHO and which, translated in the context of the Berlin Principles, gave birth to ten distinct elements "[…] to overcome the most important systemic policy and societal barriers […]" in the pursuit of *health for all*.[239] These points are characterized by the recognition of the essential health linkages between humans, animals and the planet and the willingness to develop strong institutions that "invest in the translation of robust science-based knowledge into policy and practice.".[240] They established the crucial nexus between alterations in the ecosystem and the emergence of always new disease outbreaks with the aim of devising "[…] adaptive, holistic, and forward-looking approaches to the detection, prevention, monitoring, control and mitigation

[236] Gruetzmacher, Kim, Karesh, William B. et al. (2021), The Berlin principles on one health – Bridging global health and conservation, published in Science of the Total Environment, Issue 764, p. 2.
[237] Ibidem.
[238] (Gruetzmacher, et al., 2021), p. 2.
[239] Ibid., p. 3.
[240] Ibidem.

of emerging/resurging diseases […]".[241] Finally, they prescribed a constant and progressive integration of biodiversity conservation perspectives and human health through both increased cross-sectoral investment in the ecosystem and in trans-disciplinary health surveillance. Measures that are all devoted to the final crucial intent of forming "participatory, collaborative relationships among governments, NGOs, Indigenous Peoples, and local communities" in order to raise the "[…] awareness for global citizenship and holistic planetary health approaches among children and adults […] while also influencing policy processes […].".[242]

V . 6 – The G-20 Rome Declaration: the future path towards Global Health Governance?

Only after having understood such a theoretical framework, as proposed by Cole and Dobbs and by the Berlin Principles, and having outlined all the different steps that have characterized the emergence and global spread of Covid 19 it is possible to move on to the final element of discussion of the present thesis: the G-20 Rome Declaration. As it has been already said before, this important document, ratified in May 2021 and reasserted in September 2021 during the meeting of the G-20 health ministers, represents a crucial step in the acknowledgement of the unprecedented turning point represented by Covid 19 and the reaffirming of the urgency to act globally on the issue of global health protection. In particular it is based on 16 different principles shared by the 20 most important countries of the world and deemed to be essential in order to overcome this pandemic and to avoid the emergence of new disease outbreaks in the future. Such principles represent a sort of roadmap of what will be the decisions made by the global leadership on this theme and, for these very reasons, represent the ending point of the discussion that has been made up to this point. A sort of path towards the overcoming of the flaws of both the World Health Organization and the International Health Regulations discussed in Chapter III and the ending point of the debate on the best solution to

[241] Ibidem.
[242] Ibidem.

reform the global health protection system.

The first of the sixteen principles enlisted by the Declaration is of the highest importance especially considering all the considerations that have been made up to this point. Indeed it states the willingness to "support and enhance the existing multilateral health architecture for preparedness, prevention, detection and response with an appropriately, sustainably and predictably funded, effective WHO at its centre […]".[243] A crucial restatement of the importance of the Organisation as leading institution of the global health protection system which goes in line with the second principle of the Declaration stating the urgency to "work towards and better support the full implementation of, monitoring of and compliance with the IHR, and enhanced implementation of the multi-sectoral, evidence based One Health approach […]".[244] Two principles which perfectly summarize all of the content and all the evaluations made in the course of the current thesis and which, together with the third principle on the responsibility of governments, reaffirm the willingness on part of states to create an environment of real global cooperation and interconnectedness for the protection of health. An environment in which crucial importance is given to the already existing global institutions opportunely reinforced and reformed through a series of crucial improvements. Something that is true non only for the health and environmental spheres but also for the economic one as stated in the fourth principle with the promotion of a "[…] multilateral trading system, noting the central role of the WTO, and the importance of open, resilient, diversified, secure, efficient and reliable global supply chains.".[245]

Strictly connected to this issue of a more sustainable and resilient trading system there is also the crucial theme of access to resources and proper medical tools promoted by principles five and six. In particular the former entails the importance of enabling "[…] equitable, affordable, timely, global access to high-quality, safe and effective prevention, detection and response tools […]" while the latter is more focused on the support that low and middle income countries must receive in "[…]

[243] Global Health Summit (May 2021), The Rome Declaration, Rome, p. 3.
[244] Ibidem.
[245] (Global Health Summit, 2021), p. 3.

build[ing] expertise, and develop local and regional manufacturing capacities for tools […].”[246] An attention towards the less developed countries which is at the heart of principles seven and eight too with an important focus on the creation of proper preparedness and prevention structures and the facilitation of data sharing and capacity building with the crucial goal of “[…] ensuring no one is left behind.”.[247] A clear statement of idealistic principles which is then followed, in the subsequent points, by the structural ways through which obtaining such a development. In particular the leaders of the G-20 stated the importance of investing in worldwide health and care workforce and in multilateral WHO-led mechanisms to facilitate assistance and response capacities. They also reported the importance of investing in “adequate resource, training and staffing of diagnostic public and animal health laboratories, including genomic sequencing capacity […]” in order to rapidly obtain accurate data over the newly emerging disease.[248] Finally, they reaffirmed the crucial importance of investing in the development of early warning information, surveillance, and trigger systems and in the domestic and multilateral cooperation in research, development, and innovation for health system tools and non-pharmaceutical measures. In this very respect, in principle number thirteen, it has also been added a crucial reflection over the need to coordinate pharmaceutical and non-pharmaceutical measures and emergency responses bearing always in mind that “policies should accelerate progress towards achieving the SDG [the UN Sustainable Development Goals], combat the root causes of health emergencies, including social determinants of health, poverty structural inequality and environmental degradation, build human capital, accelerate green and digital transitions, and boost prosperity for all.”.[249]

Goals and objectives which are very much wide in scope and reach but which naturally arose from the severe consequences of an unprecedented and unexpected global crisis such as Covid 19. A pandemic which completely changed the perspective of both public opinion and global leadership and which will surely lead

[246] Ibid., p. 3-4.
[247] Ibid., p. 4.
[248] Ibidem.
[249] (Global Health Summit, 2021), p. 4-5.

the global health protection system toward a much needed, newly designed architecture. Pandemic lessons expressed through the Rome Declaration which have to be learnt in order to fully protect the future of humankind, at least as a form of respect for the effort and the sacrifice of the many lives that this cruel virus has taken away.

References

Agartan, T. I., Cook, S., & Lin, V. (2020). Introduction: Covid 19 and WHO: Global Institutions in the Context of Shifting Multilateral and Regional Dynamics. *Global Social Policy, 20*, 367 - 373.

Alvarez, J. E. (2020). The WHO in the Age of the Coronavirus. *American Journal of International Law, 114*(4).

Benvenisti, E. (2020, June 30). The WHO - Destined to Fail? Political Cooperation and the Covid-19 Pandemic. *Research Paper No. 24/2020*. University of Cambridge Faculty of Law.

Brown, T. M., & Ladwig, S. (2020, August). Covid 19, China, the World Health Organization, and the Limits of Internartional Diplomacy. *American Journal of Public Health, 110*(8), 1149 - 1151.

Centers for Diesease Control and Prevention. (2017, December 6). *Severe Acute Respiratory Syndrome (SARS) - Basic Fact Sheet*. Tratto da CDC Official Website: https://www.cdc.gov/sars/about/fs-sars.html#outbreak

Centers for Disease Control and Prevention. (2020, February 15). *Human Coronavirus Types*. Tratto da CDC Official Site: https://www.cdc.gov/coronavirus/types.html

Cole, J., & Dodds, K. (2021, November 30). Unhealthy Geopolitics: can the response to Covid 19 reform climate change policy? *Bulletin of the World Health Organization*, 148-154.

Constitution of The World Health Organization. (1946, July 22). *Basic Documents, Forty-fifth edition, Supplement, October 2006*.

Davies, S. E., & Wenham, C. (2020, September). Why the Covid 19 response needs International Relations. *International Affairs, 96*(5), 1227 - 1251.

de Campos, T. C. (2020, July 27). Guiding Principles of Global Health Governance in Times of Pandemics: Solidarity, Subsidiarity, and Stewardship in Covid-19. *The American Journal of Bioethics, 20*(7), 212-214.

Galea, S., & Abdalla, S. M. (2020, July 21). Covid 19 Pandemic, Unemployment, and Civil Unrest - Underlying Deep Racial and Socioeconomic Divides. *The*

Journal of the American Medical Association, 324(3), 227-228.

Global Health Summit. (2021, May 21). The Rome Declaration. Rome.

Gostin, L. O. (2020, June 16). Covid 19 Reveals Urgent Need to Strenghten the World Health Organization. *Journal of the American Medical Association, 323*(23), 2361 -2362.

Gostin, L. O. (2021, March). The Coronavirus Pandemic 1 Year On - What Went Wrong? *Journal of the American Medical Association, 325*(12), 1132 - 1133.

Gostin, L. O., & Wetter, S. (2020, May 6). Using Covid 19 to Strenghten the WHO: Promoting Health and Science Above Politics. *The Milbank Quarterly*.

Gruetzmacher, K., Karesh, W. B., Amuasi, J. H., Arshad, A., Farlow, A., Gabrysch, S., . . . Walzer, C. (2021). The Berlin principles on one health - Bridging global health and conservation. *Science of the Total Environment*, 1-4.

Hanrieder, T. (2020). Priorities, Partners, Politics - The WHO's Mandate beyond the Crisis. *Global Governance, 26*, 534-543.

Jones, K. E., Nikkita, P. G., Levy, M. A., Storeygard, A., Deborah, B., Gittleman, J. L., & Daszak, P. (2008, February 21). Global Trends in Emerging Infectious Diseases. *Nature, 451*, pp. 990-994.

Kahn, J. S., & Kenneth, M. (2005, November). History and Recent Advances in Coronavirus Discovery. *The Pediatric Infectious Disease Journal, 24*(11).

Lee, K., & Piper, J. (2020). The WHO and the Covid-19 Pandemic - Less Reform, More Innovation. *Global Governance*(26), 523-533.

Levin, K., Cashore, B., Bernstein, S., & Auld, G. (2012, May 23). Overcoming the Tragedy of Super Wicked Problems: constraining our future selves to ameliorate global climate change. *Policy Sciences*, 123-152.

Morales, C. (2021, January 20). Biden restores ties with the World Health Organization that were cut by Trump. *The New York Times*. Tratto da https://www.nytimes.com/2021/01/20/world/biden-restores-who-ties.html

Stuckelberger, A., & Manuel, U. (2020). WHO International Health Regulations (IHR) vs Covid-19 Uncertainty. *Acta Biomed, 91*(2), 113 - 117.

Taylor, A. L., Habibi, R., Burci, G., Dagron, S., Eccleston - Turner, M., Gostin, L. O., . . . Hoffman, S. J. (2020, June 19). Solidarity in the wake of Covid 19:

reimagining the International Health Regulations. *The Lancet, 396*, 82 - 83.

Wenham, C. (2021, February 04). What Went Wrong in the Global Governance of Covid 19? *The British Medical Journal - BMJ*.

World Health Organization. (2016). *International Health Regulations (2005) - Third Edtion.* Geneva, Switzerland.

World Health Organization. (2021, July 12). *About WHO - Collaborating Centres*. Tratto da World Health Organization Official Site: https://www.who.int/about/partnerships/collaborating-centres

World Health Organization. (2021, February 5). *Fact Sheets - Detail - Cholera*. Tratto da World Health Organization Official Site: https://www.who.int/news-room/fact-sheets/detail/cholera

World Health Organization. (2021, February 23). *Fact Sheets - Detail - Ebola virus disease*. Tratto da World Health Organization Official Site: https://www.who.int/news-room/fact-sheets/detail/ebola-virus-disease

World Health Organization. (2021). *Health Topics - Severe Acute Respiratory Syndrome (SARS) - Overview*. Tratto da WHO Official Website: https://www.who.int/health-topics/severe-acute-respiratory-syndrome#tab=tab_1

World Health Organization. (2021, September 12). *World Health Organization - Official Website*. Tratto da WHO Coronavirus (COVID-19) Dashboard: https://covid19.who.int/

World Health Organization. (23 April 2020). *Coronavirus disease 2019 (COVID-19) Situation Report - 94.* WHO.

Zacher, M. W., & Keefe, T. J. (2008). *The Politics of Global Health Governance.* New York: Palgrave Macmillan.

Executive Summary

Covid 19 will certainly be considered as a major turning point in the history of human societies. It represented a totally unprecedented crisis which, still going on today, has completely changed all the common habits and lifestyles of the population of the world. It is not a case that, at least for the contemporary world, SARS-CoV-2 represented the only threat to reach a full global expansion, thus obtaining the title of pandemic. Indeed, every single state of the planet has been touched by its devastating effects in terms of contagions and mortality rates with a strong impact on their national health systems. Moreover, it has not been just a health crisis per se but involved also major repercussions on every possible political and human field, given the number of severe and unprecedented measures that states had to take in order to curb its expansion. In this respect, it is sufficient to quote the profound economic crisis and the recession caused by the strong limitations on the free movement of people and goods around the globe to fully acknowledge the scope of Covid 19's collateral effects. Economic repercussions that had a stronger impact on the less developed areas of national societies and, in a specular way, also on the less developed states of the global community thus connotating the pandemic with severe social repercussions too. A multilateral and multi-level health crisis which, precisely for its unprecedented impact on society, triggered widespread debates over one of the international instruments that should have defended the world from such a threat in the first place: the Global Health Protection system. In this respect, indeed, Covid 19 had also the crucial effect of deeply exposing all the flaws and the systemic problems of international cooperation over the issue of health. And in doing so it had the unexpected effect of deeply questioning and discrediting two of the most relevant actors of the whole system: the World Health Organization and its main legal instrument, the International Health Regulations. It is precisely taking into consideration the scope and the extent of the critiques that have been raised towards these institutions since the beginning of the pandemic that the present thesis has moved its first steps. Indeed, it represents an attempt at clarifying several different Covid 19-related

topics, crucial in order to fully understand both the relevance of the issue for the future of international cooperation and its strong impact on the future of the planet itself. Indeed, moving from a general assessment over the main characteristics of the global health protection system, it then proceeds on a more detailed analysis of the current pandemic with the general aim of clarifying what has been the role of the World Health Organization and what will be its mandate in the post-Covid world. Moreover, it also represents an attempt at providing a better understanding of the strong interconnection between global issues such as health and environment protection. In this respect, it tries to underline what has been the theoretical framework at the heart of the May 2021 G-20 Rome Declaration, the crucial statement of the wealthiest nations of the world on the principles to finally end the pandemic and control the future emerging threats. An analysis which represents a useful tool in order to properly understand what will most probably be the future of global health governance in the context of the large number of reforming proposals presented in the course of the text.

After having clarified what has been the general framework and the final aim of the present thesis, it is important to devote some attention to what has been the research method and, as a consequence, how the general content of the work has been structured. In this respect, it is important to state that it has represented an analysis of the issue of global health governance and its main actors from several different standpoints with an eye well fixed on the framework represented by the pandemic. An analysis which has developed itself throughout five different but highly interconnected chapters moving from the past of the system to its pandemic and deeply criticized present, in order to reach a better understanding of its possible future. In particular, Chapter I and II have devoted specific attention to the history of the issue with a descriptive eye on the main actors and instruments of the system and what kind of issues it had to face throughout contemporary history. In particular, Chapter II has represented the analysis of the most important outbreak of the pre-Covid years, namely 2003 SARS. A crucial analysis given the fact that, precisely as SARS-CoV-2, the virus belongs to the very same family of human Coronaviruses

and has triggered a series of crucial attempts at reforming the International Health Regulations, leading to their complete Revision in 2005. In this respect, the chapter had the aim of underlining how both of the viruses, connected as they are by a strong biological similarity, functioned as strong drivers of change for the system of global health protection. Indeed, SARS led to the Revision of the IHR while Covid 19, which had the possibility to spread itself thanks precisely to the flaws of that reforming process, will surely trigger a major and even stronger reforming momentum among the international community.

Chapter III and IV, on the other hand, represent a more detailed analysis of global health governance in the present context of Covid 19 pandemic. In particular, the former represents an attempt at clarifying the history of the uncontrolled spread of Covid 19 and what sort of flaws of the WHO and the IHR it managed to expose. It is also very much helpful in highlighting the responsibilities of member states too with a crucial eye on the behaviour of People's Republic of China in the early stages of the pandemic. The latter, on the contrary, moves from all the faults detected in the previous chapter and tries to shed a light on the large number of academic contributions over the possible reforms to improve or definitively substitute the World Health Organization. In this respect, it enlists some of the most relevant contributions of the field trying to maintain an ample scope and to include several different possibilities from even opposite standpoints.

Finally, Chapter V of the present thesis represents the ideal conclusion of the work and a sort of simultaneous point of arrival and departure. It contains, indeed, an assessment over the real nature of Covid 19 in the light of all the considerations made during the text as an highly multifaceted and deeply global issue. It then moves on to the proposal of a general understanding of all health issues as strongly intertwined with other global problems such as the environmental one in the first place. It is in this respect that the precious framework of super wicked problems is proposed in order to properly assess the best way to overcome such global issues with a strong and renewed global cooperation of all the actors involved. And it is also in this very line of acknowledgment of the health-environment strong interconnection that the Berlin Principles and Rome Declaration are proposed and

analysed. Indeed, they represent the crucial understanding on part of the global community of the high relevance of such issues and the ideal starting point of a new path towards increased cooperation and resilience at the international level. In particular, the Rome Declaration represents the ideal conclusion of all that has been said in the course of the thesis in its nature of strong multipolar statement over the future of the system of global health protection. A conclusion which sheds a light over the large number of different proposals expressed in the previous chapter and which clearly shows the urgency, perceived on part of states too, of strongly improving and reinforcing the structure of global cooperation over global, deeply interconnected issues.

After having briefly introduced the general structure and the way in which the chapters were designed, it is important to devote some more attention to each one of them and to briefly resume what was their main content and what sources have been used in their drafting.

Chapter I, titled *Global Health Governance: a brief recollection of its main pre-Covid features*, represents the historical background of the whole issue and a necessary contextualisation of the theme of global health governance. The chapter started with a description of global trends in infectious diseases and with the acknowledgment of their increasing number as a cost of human development. However, the main source at its heart has been represented by a 2008 book by Mark Zacher and Tania Keefe titled *The Politics of Global Health Governance*. This resource, and in particular its third chapter, has been very much useful in outlining the history of the major outbreaks, the responses they triggered and the principal actors involved. In particular, the analysis moved from a first assessment over the three different macro-areas of diseases, namely emerging and re-emerging threats and bioterrorism with the first two as the crucial ones in the context of the current thesis. It then passed to the description of each of the three elements needed to counteract them: surveillance systems, emergency responses and transborder regulations. The former element, in particular, has been analysed under the lens of the important developments it underwent during the 90s thanks to the improvements

in the technological field. Such developments proved themselves fundamental in expanding the actors involved and the diseases under scrutiny, leading to the creation of some fundamental surveillance networks such as the Global Influenza Preparedness Network, ProMED, GPHIN and many others. However, the authors also exposed the crucial problems at the heart of the system as far as 2008, which have been reported giving the high relevance they had also in the context of Covid 19. In particular, a special mention has been made to the themes of unbalance between developed and developing countries, the deliberate hiding of data on part of states and the immobility in animal disease surveillance. The analysis, then, moved on to the emergency response issue with a description of the main actors involved in such a highly complex phase. In this respect, the key role of the WHO as conductor of knowledge and technical expertise and its strong connection with the research laboratories worldwide has been underlined. It has also been reported the importance of national Ministries of Health, medical specialized NGOs and other UN bodies which, together with the WHO and its associated laboratories, form the Global Outbreak Alert and Response Network. Finally, an important space has been given to a brief recollection of the main outbreaks of contemporary history and the responses they triggered among the global community.

Chapter II, titled *The Coronaviruses ad drivers of change: an analysis of the 2005 IHR Revisions in the light of the 2003 SARS epidemic*, followed the first one precisely on the line of describing the main contemporary outbreaks. In particular, it consists in a more detailed description of a virus particularly relevant to the argument of the thesis for two different reasons. Indeed, belonging as it does to the same family of the human Coronaviruses, it represented a strong standard of comparison with Covid 19 and an important turning point in the history of global health governance. In order to fully understand its relevance and scope, the analysis started from a more general description of the Coronaviruses family, its division into two groups and its strong connection with the theme of animal contagion. It then moved on to a more detailed description of SARS and the history of its 2003 outbreak in China. In this respect, it included a recollection of its main characteristics: its subtle spreading among humans and its quick progression to a

more severe syndrome. Moreover, crucial relevance has been given also to its ability to spread from China to distant countries like Canada and the US before being definitively curbed and to the economical dimension it implied with 40$ to 80$ billion of global losses. A consideration which has been crucial also in the explanation of the reticence on part of China in giving proper information to the WHO over the disease and in allowing the international experts to conduct research on its national territory. However, it has also been underlined how, precisely as a consequence of this national unwillingness to cooperate, the Organization strongly improved its position and fully claimed its fundamental role. In this respect, a crucial reference to be mentioned here, has been an article by Stuckelberger and Urbina published on *Acta Biomed* in which the strong response by the WHO and its then Director General, Dr. Gro Harlem Brundtland, was described as the main reason behind the curbing of the virus. In particular, the authors mentioned as fundamental the issuance of travel advisories, the role of recommendations and the strong decisions towards China, publicly blamed for its inadequate reporting and forced into a diplomatic dispute won by the international organization. A victory over a member state and over the outbreak, finally curbed in July 2003, which was considered at the time as an unprecedented one and which triggered a series of major reforms to the International Health Regulations too. The analysis of such proposals, culminating in the 2005 Revisions of the IHR, was precisely the theme of the last part of Chapter II. In this respect, it has been proposed a brief recollection of the history of the Regulations, a description of their main legal features and an assessment of the main provisions of the 2005 revision process. In particular, concerning this last topic, crucial relevance has been given to the new decision making bodies added (Expert Rooster, Emergency Committee and Review Committee), to the expansion of both covered diseases and sources of information available and to the commitment on part of states to increase their reporting capabilities. Finally, important attention has also been devoted to the Annex II of the document in which is stated the theoretical framework beneath the issuance of a Public Health Emergency of International Concern (PHEIC).

Chapter III of thesis, titled *What went wrong with Covid 19: early timeline, member*

states' responsibilities and WHO's main flaws, moved from the acknowledgment of the huge international victory represented by the end of SARS in order to assess what went wrong in the case of Covid 19 which, on the contrary, managed to reach the pandemic status. In order to properly answer such a question the analysis has been developed starting from a preliminary evaluation of the history of the early stages of the pandemic. In this respect, the crucial reference to be mentioned here has been an editorial by Brown and Ladwig which comprised a detailed recollection of all the most important developments from the first pneumonia cluster detected in Wuhan to the declaration of PHEIC by the international authorities. Several different elements of this period have been underlined as very much interesting in order to fully understand the emergence of Covid. Among them it is fundamental to mention here the reticence on part of China in declaring the biological characteristics of the threat which was isolated on the 7th of January and announced only on the 12th. Another important element is represented by the series of contradictions that involved the assessment of the possibility of human-to-human transmission, denied by the Chinese authorities for a long period of time, even when data suggested the opposite. Finally, another crucial element has been the too long timespan between the first cases and the declaration of a PHEIC which, according to an author like Lawrence Gostin, has been one of the key reasons for the uncontrolled spread of the disease. After this brief recollection of the early history of the outbreak, the analysis moved to the wave of critiques and accusations that have been raised towards both China and the WHO by a global public opinion looking for a responsible. In this respect, the crucial contribution represented by the *Independent Panel for Pandemic Preparedness Response* has been mentioned as one of the best ways to properly verify what did not work in the management of Covid. In particular, the panel underlined the strong inadequacy of the WHO for several different structural problems which the chapter, as a consequence, tried to outline and analyse. In this respect, it resorted to some crucial contributions made by different authors of the field who underlined, from different perspectives, the Organization's most important flaws. Among them it has to be quoted here the contribution of Jose Alvarez who, moved by the US withdrawal of funds to the

Organization and the wrong idea of cancelling it, analysed the WHO under the more general perspective of the UN modelled institutions. In particular, he highlighted five different disorders common to every international organization of the kind: an excessive dependence on member states, the overreliance on soft-law, the inflexibility of emergency declarations such as PHEIC, the absence of cross-regime collaboration over multidisciplinary issues and the hazard of expertise, namely an excessive bureaucratization and specialization of these kind of institutions. Another crucial contribution, on the other hand, has also been a paper by Eyal Benvenisti who deeply exposed the problem of absence of political cooperation at the heart of global health protection. He moved from the analysis of the difference between coordination and cooperation to clearly highlight how this last element is more difficult to be obtained. He also enlisted all the factors which severely constrain international cooperation and which, in the case of health issues, reach the highest difficulty as in the case of environmental protection. Finally, it has been noted how, in his opinion, the WHO lacked the right tools to obtain the results needed from the moment of its very design and how the Revisions to the IHR of 2005 still presented some major structural problems on the crucial issues of responding power, information gathering and travel advisories. Finally, bearing in mind the predominant role of states underlined up to that point, in the last portion of the chapter it has been mentioned an analysis made by Davies and Wenham over the highly political environment in which the WHO is set.

It is precisely by starting from this analysis and the considerations made by its authors over the need for international relations in global health protection that Chapter IV moved its first steps. In particular, under the title *Reforming the World Health Organization in the light of Covid 19: main ideas and proposals*, the chapter tried to propose a recollection of the most important contributions on the theme of how to properly reform the WHO. In particular, it started by mentioning the contribution by Davies and Wenham which concluded Chapter III by analysing the five entry points that, according to them, international relations can offer to global health protection. First of all, they mentioned the importance of comparative analysis in understanding the different political landscape in which the actions of

the WHO take place. Then they mentioned the topic of Governance as an improved understanding on part of the Organization of its mandate and the positions and expectations of its member states. The third element consisted in considerations over the theme of political economy and in the identification of possible ways to increase the low budget of the Organization at national and regional levels. Finally considerations on the theme of human rights have been proposed in the last two entry points with the aim of highlighting the importance of protecting whistle-blowers and other unofficial sources of information and also considering the crucial role of women in health protection and the necessity of an improved gender inclusion. As a sort of counterpart to the proposals by Davies and Wenham, the chapter then moved to the contribution of Gostin and Wetter who stated, on the opposite hand, the necessity of a WHO totally free from politics and diplomacy. In asserting the crucial role of science and technical expertise for the Organization, they also proposed the areas which, in their opinion, needed strong and rapid reforms. Such areas included a stronger role for the Director General, an improved funding free from decision-constraining voluntary contributions, the possibility to resort to unofficial data sources and the creation of compliance enhancing incentives for states. Moreover, two other proposals by Gosting have been mentioned in this portion of the chapter: the necessity of close cooperation between different international organizations and the idealistic transfer of the WHO Headquarters to Sub Saharan Africa. A kind of proposal, this last one, which paved the way to another crucial set of ideas presented by the chapter under the umbrella of the principle of solidarity. Connected to this issue have been included the proposals made by a team of scholars in a comment published in *The Lancet* and Thana de Campos' reinterpretation of Prah Ruger's PG/SHG model. The former consisted in a request to states by the team of authoritative authors to renounce their willingness to control information and to improve their national accountability in the name of global solidarity. It also included some discussions over the theme of the PHEIC issuance process and how to increase its transparency and over the creation of multilateral dispute resolution mechanisms. The latter, on the other hand, presented an extension of the Provincial Globalism/Shared Health Governance

model by Prah Ruger on the basis of three different principles: solidarity, subsidiarity and stewardship. An article very much interesting in underlining the importance of a World Health Organization with narrower tasks but performed in a better way, with an eye on its role of coordinator of the whole system of global health protection. And it is in this very line of setting a list of priorities to improve the performance of the WHO, that the chapter also proposed the contribution of Tine Hanrieder who presented a list of ideas taken from the consultancy and management world. In this respect, she underlined three different possibilities for the Organization: focus on pandemics, the setting of priorities and the finding of the right niche. The crucial element emerging from her analysis, however, has been the difficulty in implementing each of these proposals and the impossibility to apply market ideas to the theme of health protection. In this respect, an expansion of the Organization's funding and the development of clear conflict of interest policies have been deemed as crucial to overcome the impasse. Finally, the last contribution analysed in the context of the chapter consisted in the proposals made by Lee and Piper in their *The WHO and Covid 19 Pandemic.* The authors, in particular, presented an interesting metaphor of the WHO as an aging computer and used it to propose four different reforming approaches. The former consisted in the possibility of acknowledging the end of its mandate and of retiring it while the second in the addition of several different add-ons to amplify the structure of the Organization. An approach, this last one, deemed inefficient already during the 90s and dropped in the pursuit of the third proposal, that is the acknowledgment of the WHO as a sort of network coordinator. In this respect the authors mentioned the example of the (ACT) Accelerator and the COVAX initiatives which, in any case, presented some problems connected to the authority of the WHO and the laissez-faire approach developed over the years. Finally, the fourth and last path foresaw by Lee and Piper consisted in the themes of innovation and research and development applied to Global Health Governance. In this sense, they presented the possibility of substituting the post-war modelled organization with a completely new approach based on increased global cooperation and coordination.

Finally, as a conclusion to every issue presented in the course of the thesis, Chapter

V titled *Health and environment protection: the Berlin Principles and the G-20 Rome Declaration as guidelines to the post-Covid 19 world* presented an assessment of both the theoretical and practical frameworks essential for the future of global health protection. It started with a resume of all the considerations made up to that point and then moved on to a preliminary assessment, very much needed in the pursuit of a better understanding of the issue. Indeed, it presented an article by Galea and Abdalla over the high social costs of Covid 19 on the less developed areas of the US society, thus clarifying the nature of the disease as a social one too. Then, moving from this preliminary consideration, it resorted to another fundamental contribution by Jennifer Cole and Klaus Dodds in order to clarify the crucial linkage between health issues and environmental ones. In doing so, the chapter presented the crucial theme of the super wicked problems approach and tried to give a proper definition of these kinds of issues before practically moving to the correlation between health and environment. Indeed, quoting a precious paper titled *Overcoming the tragedy of super wicked problems*, it managed to describe their main features and how they can be easily applied to both the themes of environmental and health protection. In particular, it presented the four characteristics proposed by the paper: the pressing urgency of such issues, the fact that those who try to solve the problem are also those causing it in the first place, the absence of a central authority and, finally the irrationality of certain near-sighted policies only focused on the present. Then, after having clarified such characteristics, the chapter came back to the crucial linkage between health and environment presented by Cole and Dodds and tried to analyse it in a more detailed way. In this respect, it presented the crucial connection between the emergence of zoonotic diseases and the environmental change the world is facing. It also clarified how the very same governments who performed in the poorest way during the outbreak were also those who played down environmental change and other connected issues. And following these considerations made by the pair of authors, the chapter also included the tripartite scenario they proposed as a conclusion of their precious contribution. A scenario in which the crucial role of geopolitics is strongly reasserted taking into consideration the blame narratives between China

and US and the strong diplomatic disputes in which the WHO found itself caught. A scenario in which, moreover, the urgent need of a strong and coordinated global response is perceived as fundamental by both the international community and by many resistance, non-governmental movements. And it is precisely following this evaluation of the urgency of a new and stronger global approach that the chapter moved to its final considerations over the Berlin Principles and the G-20 Rome Declaration. Both of them were described as the ending point of all the reforming debates presented in Chapter IV but also as a strong point of departure for the future of global cooperation and of mankind in a wider sense. In particular, the former represented the background from which the Rome Declaration took inspiration for the elaboration of its 16 fundamental principles. For this reason, thanks to the contribution of a precious paper by Gruetzmacher and other scholars, it has been described and carefully analysed in its trans-disciplinary approach and in its linking together health and environment both in a theoretical and practical way. Finally, only at the very conclusion of the chapter, after having analysed all these important elements, the analysis moved to the final evaluation of the 16 principles presented in the G-20 Rome Declaration. It started from the first two of them reasserting the absolute willingness of reinforcing both the WHO and the IHR and moved to the following ones which stated the need to improve global cooperation on every field, comprising the economic one and the access to crucial tools and resources. It then focused on the remaining, more practical, principles of the Declaration in order to finally understand the path that will most probably lead to the future of Global Health Governance. A future, as stated by the wealthiest nations of the world, in which much more attention will be devoted to developing countries in order to reach a fully implemented and finally effective cooperation on all those issues such as health and environmental protection which, being strongly global in nature, require strong global responses too.