International Organisations and State Sovereignty: The World Health Organisation and COVID-19

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The World Health Organisation (WHO) has been criticised during the current pandemic on a number of grounds, almost all of which are unwarranted. They include its failure to include Taiwan, its delayed declaration of 'pandemic' and its subservience to China. These criticisms fail to distinguish between the WHO as an international organisation (IO) constituted of 194 member states who determine its membership and policies and the WHO Secretariat as a technical body mandated to seek the good health attainment of all people, regardless of their location, nationality, religion, ethnicity or ideological orientations, within the responsibilities delegated by the member states. This article considers the validity of the criticisms within the context of the WHO's history, constitution and delegated responsibilities. It argues that global health needs a global institution and the WHO needs support against ill-informed or self-interested critiques. Political issues that concern individual member states can only be addressed by member states, and states alone.

KEY WORDS: WHO, International organisations, COVID-19, multilateralism, health

As Covid-19 roared across the globe, accusations of responsibility were abundant. Many blamed China; some criticised their own governments. A constant target was the World Health Organisation (WHO): the WHO 'failed to exercise global health leadership' and warn countries early enough about the pandemic (Fidler 2020); the WHO was bought by China and amplified everything China said; the WHO 'severely mismanaged and covered up the spread of the coronavirus.' This is not the first time the WHO was in the firing line at the peak of a health crisis: in 1970, it was criticised for exceeding its authority by reporting an outbreak of cholera in Guinea (Fidler 2004); in the 1980s and 1990s, for having overreached its mandate by demanding countries report their HIV/AIDS cases; in 2003, for having acted outside its existing authority by warning travellers to avoid Hong Kong, Toronto, Taiwan and parts of China in an effort to curb the spread of SARS; in 2009-10, for having 'conspired with the pharmaceutical industries' by announcing H1N1 as an influenza pandemic when H1N1 was much less fatal; and for declaring the Ebola outbreak a global crisis when it was restricted in West Africa. On all these occasions, the opposite condemnation was made equally loudly: the WHO had failed to fulfil its responsibilities to protect the health of millions.

The WHO, along with other international organisations (IOs), was created to manage problems that states found difficult, and increasingly impossible, to manage individually. While IOs, despite their flaws, have contributed significantly to post-WWII stability, economic prosperity and spread of democracy, they are often used as a punching bag by both the left and the right whenever it is convenient for their political agenda. Yet, IOs, including the WHO, have never been in greater need of defence, support, and strengthening when a long list of issues – health risks, climate change, refugees or human rights – do not recognise artificial territorial borders, are beyond control of any government in one country, and thus demand cooperation and collaboration among states (for example Lancet Commission 2014; Independent Commission on Multilateralism 2017; G20 Eminent Group 2018).

IOs are ultimately 'member-driven' organisations. They were created because states decided to 'surrender' some of their independent decision-making power to pursue collective actions. IOs are 'global governors' only when member states allow them to be so; states negotiate to decide their missions, delegate authorities, set general directions for their action and agree on all political matters, such as who can become a member or an observer, and on what terms (Pelc 2011; Schneider and Urpelainen 2012), who can lead iOS, and/or how they are funded (Weiss and Daws 2018). States, not IOs, decide how the game is played and how they interact with each other under the rules they have agreed upon. IOs work with

their member states to pursue 'common' interests. As institutions, IOs are accountable to their member states, not one but all.

The WHO has a technical health mandate and is charged with the promotion and protection of health globally. The WHO's staff – the doctors, scientists, researchers, among many others – undertake technical and operational public health work. The controversies around its role in managing COVID-19 are, at their best, due to the lack of understanding how IOs operate, and at their worst, seeking to undermine multilateral institutions for short-term and domestic political gains (Goldin 2013; Linn 2018; Pascal 2019; Kickbusch 2020). They thus call for a better understanding of the WHO – its nature, its mission, its organisational design and its operation (Burci and Vignes 2004) – and a distinction between the WHO as a political and a technical organisation. History tells us if there had not been a WHO, the international community would have created one to manage infectious diseases and global health in general. After all, the spread of yellow fever from South America to the United States in the late 19th century led to the creation of the Pan-American Health Organisation (PAHO) in 1902, one of the six regional offices of the WHO today. To control the spread of cholera, plague and other contagious diseases, the League of Nations created a Health Organisation in 1919, the predecessor of the WHO.

The current WHO was established in 1948 as a special agency within the United Nations. As an IO, it has authority when, through its governing body – the World Health Assembly – its member states decide to delegate it. As a special technical organisation, the WHO is mandated to seek 'the attainment by all peoples of the highest possible level of health' (WHO 1948, Preamble). The highest level of health is more an aspiration than a political reality as, when societies develop, the objectives of healthcare evolve too. This is as true of global healthcare systems as it is for national healthcare ones. The WHO Constitution grants the organisation a broad mandate on health, such as seen in Article 2: 'directing and co-ordinating international health work,' through policy, technical and normative work. Given a wide range of health issues, where the WHO's attention and resources should go has always been controversial. The debate is often as much about health as politics – should the WHO focus on communicable or non-communicable diseases; is health inequality part of the authority of the WHO; or should more resources go to normative work or technical assistance? Difficult choices have to be made even on infectious diseases and health emergencies – from polio, measles, malaria, Ebola, HIV to TB. Over these complex health issues, the World Health Assembly decides broad guidelines for the WHO's work.

Serving ALL people

The WHO is mandated to seek the good health attainment of all people – people regardless of their location, nationality, religion, ethnicity or ideological orientations. People in Taiwan or in Palestine receive the same technical information, advice and assistance from the WHO as those in its 194 member states. This seemingly simple mandate is not without controversies. The media reports on Taiwan and the WHO during the Covid-19 resemble the conflict between the WHO under its Director General (DG) Hiroshi Nakajima and the United States over the issue of Palestine (Siddiqi 1995). For the WHO, the health of people is its mandate; its professionals work with experts in all countries and regions on health issues, especially in managing infectious diseases. During the current coronavirus outbreak, the WHO did exactly that, as Dr Maria van Kerkhove, the WHO's technical lead for Covid-19, explained at the WHO briefings on 15 and 17 April:

> We have been working with colleagues from Taiwan on the technical side throughout this pandemic … I personally myself have briefed members from Taiwan CDC, public health professionals and scientists. We've had an exchange of information about what is happening at the global level in different regions and in Taiwan as well. We have a number of people from Taiwan who are serving in our clinical networks and our infection prevention and control networks. We regularly meet through teleconferences. This is an invaluable opportunity when we exchange information peer-to-peer and with people who have first-hand experience with patients to discuss how diseases are developing, how we can treat them, and how we can prevent further transmission. There has been a regular and open dialogue throughout the pandemic.

Steve Solomon, the WHO Principal Legal Officer, added:

> There is a point of contact within Taiwan CDC (Centre for Disease Control) that has access to the International Health Regulations (IHR) event information site. This is the key platform for exchanging information among all the parties and stakeholders in the IHR. There are two of the key clinical networks that Taiwanese experts participate in – the clinical management network and the infection prevention and control network. These networks meet at least once a week, sometimes twice a week and there is a direct contact between the WHO at a technical level and Taiwan CDC. These are very important to ensure an exchange. The formal participation in WHO governance bodies like the World Health Assembly is in the hands of member states.

The distinction is clear: the WHO as a technical organisation works with experts everywhere on all areas of health. The WHO is also part of the UN system; its membership is decided by its members, not by the WHO staff, nor its DG. Making the distinction helps clarify one key controversial issue during the COVID-19 crisis – that is, the WHO was attacked for not recognising Taiwan as a member. While working closely with professionals in Taiwan, the WHO staff do not have authority over its membership. The irony is that while member states in their own diplomacy accept the 'one-China policy' and their representatives at the World Health Assembly maintain this position, some of their politicians and critics attack the WHO for something their governments, rather than the WHO staff, have sole control over.

International Health Regulations

Infectious diseases have an inherent international dimension; pathogens do not stop in front of territorial boarders or recognise sovereign authority. After a century of diplomacy, the international community in 1948 empowered the World Health Assembly under the WHO Constitution to 'adopt legally binding regulations that enter into force automatically by a specified deadline for non-dissenting states in a number of areas, including on quarantine requirements and other procedures designed to prevent the international spread of disease' (Burci 2018: 680). The WHO was given the primary responsibility to implement the International Health Regulation (IHR) that was first adopted in 1951. There were successes, such as eradication of smallpox by 1977, and failures, such as the WHO's powerlessness to control the worldwide progression of HIV/AIDs in the 1980s and 1990s. After a decade warning about the spread of global infectious diseases, member states decided to strengthen the IHR at the beginning of the 21st century (CDC 1998, Fidler 2004).

Following the failure of China to share information of the SARS breakout in a timely manner, 'a public admonishment by the WHO was issued' (Goldin 2013: 86). The 'unprecedented' and proactive intervention of the WHO during the SARS outbreak was not without controversy, as its then DG, Gro Harlem Brundtland, recalled, 'It wasn't just China. The mayor of Toronto flew to Geneva to tell us take down the travel recommendation – while at the same time he was not containing the outbreak. He had people with SARS riding around the subway, no contact tracing, no following up. He couldn't accept we were telling him what to do!' (cited in Buranyi 2020). The WHO's intervention during the SARS outbreak catalysed the debate over more binding rules regulating infectious diseases and their spread. Surveillance and information sharing are at the heart of international health regulations over infectious diseases and the centre of the debate was whether countries should cede more power and authority to the WHO to manage global health and health crises.

The push for tougher global regulation led to the adoption of the International Health Regulation 2005 by member states at the World Health Assembly (Davies et al. 2016). IHR 2005 expanded WHO's power to declare public health emergencies, to authorise disease surveillance, and to issue recommendations about travel and trade restrictions. The determinations and recommendations of health emergencies must be based on 'scientific evidence and a contextual risk assessment' (Burci 2018: 683). The DG, after consulting experts and professionals, is authorised to declare a 'public health emergency of international concern' (PHEIC) – the highest-level health warning to the international community, and to issue temporary recommendations for its management and control. The other side of the bargain of IHR 2005 was that member states agreed to assess all unusual health events occurring on their territory and notify the WHO of all events that may constitute a PHEIC (Articles 5 and 6 of IHR 2005; Brown et al. 2006).

While the IHR 2005 offered a collective approach in managing infectious disease outbreaks and 'states agreed to share the duty to prevent, detect and respond to major disease outbreaks' (Davies 2019: 1), states still bear the primary responsibility to 'govern the most important public health action' in their own country (Smith 2009: 9). The basis of the WHO's authority in managing infectious disease outbreaks remains 'the expert and delegated model' (McInnes 2015). The negotiations of IHR 2005 said this much, explained Gian Luca Burci, the then WHO's legal counsel:

> The centralisation of decision-making power in WHO and the relative strictness of IHR-based obligations are counterbalanced by the parties' right under Article 43 to apply national health measures going beyond WHO's recommendations or even breaching some of their obligations when considered necessary to respond to PHEIC or public health risks. This possibility … reflects states' ambivalence to transferring substantial authority to an international body (Burci 2018: 683).

To complicate the delicate balance between the wish for the WHO to act and member states on their sovereign control over health issues within their territories is the asymmetric relationship between countries' health professionals who work with the WHO and political and diplomatic representation at the WHO. Health professionals seldom control the political agenda at home while diplomatic representatives have very different priorities. WHO, like all IOs, struggles to survive amid this maze of relationships within its member states. For these reasons, since IHR 2005 entered force in 2007, every declaration of a PHEIC has been controversial because

the decision will always involve a trade-off between public health considerations and the retention of the ultimate political power.

According to the IHR 2005, when there is an event that is preliminarily determined a 'public health emergency of international concern,' the DG must seek the view of an IHR Emergency Committee. Members of the Emergency Committee are appointed by the DG from a roster of experts from a wide range of health fields: from disease control, virology, vaccine development, to infectious disease epidemiology, and from countries and institutions other than the WHO. At least one member should be an expert nominated by the state within whose territory the event arises. Based on the advice provided by the Emergency Committee, the DG decides whether and when to declare a PHEIC. There will always be those who challenge the decision on either the timing or the actions recommended.

On 11 June 2009, Dr Margaret Chan, DG of the WHO, announced: 'I have conferred with leading influenza experts, virologists, and public health officials; I have sought guidance and advice from an Emergency Committee established for this purpose. On the basis of available evidence, and these experts' assessments of the evidence, the scientific criteria from an influenza pandemic have been met.' The H1N1 pandemic eventually did not turn out to be as deadly as expected, either because of the quick, harsh measures taken by the Mexican government (Mackey and Liang 2012) and actions taken by other states, or because the disease was indeed not so fatal that it deserved PHEIC status. Governments that, following the 2004 WHO pandemic guidelines, stockpiled antivirals found their health budget tied to antivirals stacked in warehouses. The WHO and its DG were immediately accused of being involved in a scam and having conspired with the pharmaceutical industry in declaring the PHEIC (Cohen and Carter 2010).

Five months after receiving notice of the emergence of Ebola in West Africa, the WHO declared the PHEIC in August 2014. The WHO was attacked for having made the declaration as Ebola affected only a few West African countries; it was also criticised for making the declaration too late (Third Word Quarterley 2016). While all accept that the Ebola outbreak became a disaster because of the lack of sufficiently trained personnel, limited resources, weak national health systems, mistrust of government and health officials, in addition to a civil war in the region, they felt it legitimate to criticise the WHO, although its member states were seriously divided over what the WHO should focus on – normative or technical work on the ground. The United Nations stepped in and the UN Secretary General established the first ever health-related UN field operation.

Post-pandemic reviews are required in IHR 2005; changes to IHR 2005 have been made after each review in the past decade (Ottersen et al. 2016). For instance, in 2009, names of members serving at the Emergency Committee were kept confidential to protect them from potential harassment. In response to the criticism of conflicts of interests, during the COVID-19 outbreak the WHO published names of those who served both as the members of and advisors to the Emergency Committee when the Committee met the first time on 22 January 2020.

International health regulations are, and will be, subject to criticism. The lack of national capacity to report and manage outbreaks, the political unwillingness to report them, or the unknown nature of the new diseases all pose threats to global health and the capacity of the WHO to implement IHR 2005 effectively. The WHO is only one among many players in fighting for global health. Understanding what it can or cannot do and, more importantly, identifying the key cause of each outbreak may help us manage global health as a practical reality rather than an abstract concept.

Public Health Emergencies of International Concern and Pandemics

One recent controversy is whether the DG should have declared COVID-19 a pandemic earlier than 11 March 2020. For the WHO, its DG, its senior staff and health professionals, the characterisation of the disease as a pandemic is merely a description of the event, not a legal obligation of the WHO. Bruce Aylward, senior adviser to the WHO DG, made the point bluntly at an early stage of the outbreak. At the WHO briefing on 25 February 2020, he said: 'you keep hearing the debate on TV and everywhere, which fascinates me, is this a pandemic or not? Folks, this is a rapidly escalating epidemic in different places that we have got to tackle superfast to prevent a pandemic.' For some, such as Michael Ryan, Director of Emergencies, declaring an outbreak a pandemic is beyond the legal power delegated by member states to the WHO. The WHO *is* legally bound by IHR 2005 to call a meeting of the IHR Emergency Committee when a member state reported an outbreak.

WHO had already reacted. Within 24 hours of China notifying of a cluster of pneumonia with unknown causes, the WHO set up the Incident Management Support Team across three levels of the organisation (HQ, regional and country offices). Disease outbreak news was published and sent to all its member states on 5 January. How it should react is not just a timeline provided by the WHO, it reflects divisions of what the public expects the WHO to do during infectious disease outbreaks and what authority their governments have given the WHO.

On 22 January 2020, the DG convened the Emergency Committee. In the WHO briefing, Dr Didier Houssin, a French national who chaired the Emergency Committee, told the media that 'the Committee members could not reach an agreed recommendation to the DG after listening to the report from China, reports about the situation in Japan, in Thailand, and in Korea, and analysis from the WHO secretariat staff.' They nonetheless 'formulated a series of recommendations concerning the improvement of containment and mitigation measures which are already important in China, and about the measures that should be taken by member states.' They had been told what the WHO was doing, 'Our team is on the ground in China as we speak, working with local experts and officials to investigate the outbreak and get more information,' reported the WHO DG (WHO 22/01/2020). Dr Mike Ryan added a loud and clear warning:

> In the face of this evolving epidemic, WHO has been on full activation of our incident management system since the last day of 2019, across the three levels of our organisation. The primary issue is to limit human-to-human transmission, to reduce secondary infections, especially amongst close contact and particularly in healthcare environments. We need to prevent transmission through amplification events and super-spreading events, and obviously prevent further international spread.

After the committee members split, the DG asked the committee to meet the following day. Members at the Committee still did not reach an agreement and the DG asked them to meet again in 10 days. At this stage, the DG decided not to declare the coronavirus outbreak a PHEIC because 571 out of 581 reported cases were still in Hubei province, but he warned the international community, 'Make no mistake. This is an emergency in China, but it has not yet become a global health emergency. It may yet become one' (WHO 23/01/2020). From 23 January onward, the WHO held a daily briefing, reporting developments, providing technical guidelines and advice to all member states. One consistent message was early detection, identification, isolation and treatment. The WHO team leading the effort may be small, but they are the experts who had been involved in all major pandemic outbreaks in the past three decades, from polio, yellow fever, cholera, SARS, Zika, MERS to Ebola. Their advice was taken seriously by a few governments in East Asia that had learnt from the SARS outbreaks. Taiwan, Hong Kong and Singapore had started their travel restrictions, case identification, isolation and preparedness soon after their officials were invited to Wuhan in late December 2019. Outside the region, life went on as normal. After the first patient was identified in the US, President Trump responded to CNBC on 22 January: 'we have it totally under control… it's going to be just fine.' President Trump was not alone; most governments took no actions.

On 30 January the Emergency Committee met again. The DG accepted its recommendation and declared the novel coronavirus outbreak (2019-nCov) a public health emergency of international concern – *the highest level of emergency alert available under IHR 200*5. At the time, there were 82 confirmed cases and no deaths outside China. Before and after 30 January, the WHO repeatedly sent out alerts and warned countries to 'take actions and be ready for any cases that come from the epicentre' (29/01/2020). Some governments took the warning seriously and acted early; others ignored the advice. Even after the widely broadcast outbreak of COVID-19 on the *Diamond Princess* on 4 February off the coast of Japan, many cruise ships started their journeys without proper disinfection. In a Congressional hearing on 27 February, four weeks after the declaration of PHEIC, the director of Centres for Disease Control and Prevention in Atlanta (CDC) told politicians that 'It's important to note that this virus is not spreading within American communities at this time [and] the immediate risk to most Americans is low, at this point' (Redfield 2020). Even after the term of pandemic was used on 11 March and despite the WHO's warning against 'amplification events and super-spreading events,' ministers in some countries continued to encourage their citizens to go to football games, horse racing or large religious gatherings (Barnes et al. 2020; Grey and MacAskill, 2020). This is in part because governments made different calculations – health or economy; life or livelihood. It is in part the nature of governing. That is, at any given day, governments, wherever they may be, face multiple problems and urgent matters that demanded immediate attention: in the US, the impeachment of President Trump did not end until 5 February; in Australia, raging bushfire was not contained until 13 January; Britain officially exited EU on 31 January.

It is the responsibility of the WHO to warn countries about disease outbreaks and provide technical advice for their prevention. The WHO does not have authority or power to 'order' countries to take actions as states do not cede their sovereignty to IOs. 'The WHO is not NATO; the WHO is not the Security Council,' some commented (Buranyi 2020). Mike Ryan echoed: 'The only power we have at the WHO is persuasion.' In hindsight, some say, declaring the outbreak of COVID-19 a 'pandemic' probably meant more to countries than experts at the WHO thought (Cliff 2020). Hindsight is always 'a cheap form of wisdom.' Technical advice is always subject to political contestation. Politicians may or may not accept medical advice from the WHO in dealing with COVID-19; yet they have medical experts standing right next to them to provide legitimacy when they announce their decisions. Anthony Fauci and

Deborah Birx in the US, Chris Whitty in UK, Teresa Tam in Canada and Brendan Murphy in Australia suddenly became household names. They, like the WHO, can be frustrated as their advice is often not heeded.

The contrast in the actions taken by governments is stark: Asian countries were affected some 5-6 weeks before the virus became a problem in Europe. Their fatality rates per million people was a fraction of that in Europe. One cannot help but ask why in some countries the figure is in single digits, while in others triple digits when they received the same advice and technical guidelines from the WHO? Some argue their existing health system makes a difference (Maiziand and Felter, 2020; Sell and Williams 2020). Others think the warmer weather in countries, such as Singapore and Vietnam, kept fatality rates low. Yet, dramatic differences can be seen among countries with similar temperature patterns, population density, political culture. Different policies seem to be the single most important factor and governments have the sole authority to make policies on behalf of their population. The WHO can advise, alert, and provide technical guidelines and technical assistance; the WHO does not have the authority to force any government to do anything. That decision belongs to member states (see Table 1 for variations in deaths per million).

Coordinating Scientists and Research

The political authority of the WHO may be limited. As a global technical health organisation, the WHO has a body of dedicated professionals, specialised in a wide

Table 1 Comparison of Deaths at 12 June 2020:

Country	Population (million)	Death	Death/million
North America			
USA	326.7	112 810	345
Canada	37	7 960	215
Mexico	126.2	15 357	122
Scandinavian countries			
Norway	5.3	242	46
Sweden	10.2	4 814	472
Denmark	5.8	593	102
Finland	5.5	325	59
West Europe			
France	67	29 284	437
Germany	82.9	8 763	106
Netherlands	17.2	6 044	351
Belgium	11.4	9 636	845
Switzerland	8.5	1 674	197
UK	66.5	41 279	621
Southern Europe			
Italy	60.4	34 167	566
Spain	46.8	27 136	580
Portugal	10.3	1 504	146
Asia-Pacific			
Australia	25	102	4.1
New Zealand	4.8	22	4.6
Indonesia	267.7	2 000	7.5
Philippines	106.6	1 036	9.7
Malaysia	31.5	118	3.7
Singapore	5.6	25	4.5
Thailand	69.4	58	0.8
Japan	126.5	922	7.3
South Korea	51.6	277	5.4
China	1392.7	4 643	3.3
Latin America			
Brazil	209.5	39 680	189
Argentina	44.5	741	17
Chile	18.7	2 648	142
Peru	32	5 903	184

range of health issues. It coordinates and facilitates the collaboration of large operational and technical networks of scientists and partners; supports its response to numerous health emergencies and implements initiatives for better preparedness, prevention, and detection of infectious diseases. The Global Outbreak Alert and Response Network (GOARN), formed 20 years ago, is a network of over 350 institutions that responds to acute public health events, with the deployment of staff and resources to affected countries. GOARN is coordinated by an operational support team at the WHO and led by Dr Michael Ryan; he explained the initiative:

> No one institution in the world has all of the capacity to deal with epidemics, that we were stronger together and we could find solutions together. GOARN was set up on 12 guiding principles, has never had a bureaucracy, a theocracy, a constitution or law to underpin it. What it has had is a tribe of committed, very different organisations; our colleagues at CDC in Atlanta, our colleagues at MSF (Medecins sans Frontieres), our colleagues at UNICEF, our colleagues in small and large scientific institutions; the Robert Koch Institute; Singapore, Korea, China; so many institutions from around the world with one thing in mind; to come together to serve humanity, to serve those communities who are facing the terror of epidemics (WHO 29/04/2020).

As COVID-19 developed fast, these broad networks coordinated by the WHO have played a key role in identifying the virus, exchanging clinical information and diagnostic issues and developing test kits, vaccines and treatments. On January 9, 2020, 10 days after identifying the existence of the problem, the Chinese health authorities and the WHO announced the discovery of a novel coronavirus, known as 2019-nCoV, which was confirmed as the agent responsible for the pneumonia cases. Over the weekend of 11-12 January, the scientists in China identified the full sequence of the coronavirus genome, detected in samples taken from the first patients, and shared the sample of the genome with scientists around the world via the WHO (CIDRAP 11/01/2020; Lancet 24/01/2020; Science News 31/01/2020). There are accounts that there was frustration within WHO that it might have been released quicker, but only by a few days. The initial viral genome formed the basis for coronavirus tests worldwide and some of today's promising clinical trials can trace their origins to early Chinese research on disease.

Most of the scientific research is multinational. For instance, the Centre of Vaccine Research at the University of Pittsburgh 'is collaborating with the Pasteur Institute in Paris and the Austrian drug company Themis Bioscience. The consortium has received funding from the Coalition for Epidemic Preparedness Innovation, a Norway-based organization financed by the Bill and Melinda Gates Foundation and a group of governments, and is in talks with the Serum Institute of India, one of the largest vaccine manufacturers in the world' (Apuzzo and Kirkpatrick 2020). Its director, Dr Paul Duprex, said now they were able to share findings with scientists around the world on a WHO conference call within two hours. 'It is pretty cool, right,' he tweeted. 'You cut the crap, and you get to be part of a global '.

Other scientists agree. On 22 January, a 'Wuhan Clan' was created at the Wisconsin National Primary Research Centre to share information among scientists and to coordinate research and make sure results are comparable. 'This is a very different experience from the outbreaks that I have been part of,' said Marc Lipstich of Harvard T.H. Chan School of Public Health (Kupferschmidt 2020). Most of these researches include collaboration not only in different countries but also across fields. Scientists at Wuhan Institute of Virology have been working with scientists at EcoHealth Alliance funded partially by the National Institute of Health (until the president ordered they withdrew financial support) and USAid, with scientists at University of Sydney. Dr. Francesco Perroneat of Massachusetts General Hospital is part of a team of Harvard doctors testing the effectiveness of inhaled nitric oxide on coronavirus patients; the research is being carried out in conjunction with Xijing Hospital in China and two hospitals in northern Italy. Harvard Medical School joined its T.H. Chan School of Public Health with Guangzhou Institute of Respiratory Disease, funded by one of the largest financial institutions in China.

Health has become global health when many scientists forgo their publications and work together in sharing data, observations, experience and research findings (both successes and failures) across borders in order to halt the diseases and save lives, Indeed, when large countries cooperate via IOs, all benefit. After SARS hit China, the US CDC sent 40 experts under the auspice of the WHO, helping their Chinese colleagues create records, contact trace, ensure proper isolation. This was successful with SARS being primarily contained in Asia; only 27 Americans were infected, and none died (Mason 2016). The collaboration between the CDCs in China and the US on epidemic controls continued for HIV/AIDS (2003-18), avian flu (2005), swine flu (2009), H7N9 (2013) and Ebola (2014). In the past 15 years, at its peak, the US CDC had 47 scientists working in the same building at the China CDC in Beijing. After budget cuts in 2019, the US CDC closed all its offices there, and moved the remaining three to the American embassy (Beinart 2020; Bouey 2020). In February Fauci's call to increase the presence

of the US CDC was simply rejected by the White House (Klain 2020). The US lost its direct access to information in China, and the world lost this valuable collaboration.

Politicising the WHO for domestic purposes

The WHO is an easy target for politicising a health crisis; the world needs multilateral institutions more than ever. It needs their expertise, professionalism and more importantly, their push for cooperation and collaboration. While the leadership of IOs is always limited, people working at IOs by and large are committed to collective interests and common goals. They are the butt of criticism not just because, as some argue, the WHO staff 'are disease experts and ill-equipped to deal with the intricacies of global diplomacy that allows the WHO to be pushed around by its member states' (Kickbusch 2020). Rather, politicians in member states politicise health crises for their short-term political gains. IOs are created to pursue common interests, rather than those of any individual states, but the latter can seldom agree what common interests are.

The evidence is not difficult to find: while shipments of medical equipment – from surgical masks to ventilators – were hijacked from countries such as Canada, Brazil, France, Germany and India to the United States, the WHO coordinated donations of test kits and PPEs from member states and philanthropists to the poor countries from early February (BBC 4 April 2020; Willsher et al. 2020). While the G7 failed to adopt a communique to ensure that no one country would monopolise new vaccines for COVID-2019, the WHO initiated the Solidarity Trial to speed up the process of developing vaccines and treatment. The program would enrol patients in one single randomised trial to facilitate the worldwide comparison of unproven treatments. In less than three weeks, scientists in over 90 countries participated; working together to find effective therapeutics via a trial that was estimated to reduce the time needed to devise a treatment by 80%. 'There is only one way the world can exit this pandemic – and that is through science,' argued Dr Jeremy Farrar, Chair of the WHO R&D Blueprint Scientific Advisory Group. 'The WHO's Solidarity trial will provide this by testing existing and new drugs to treat COVID-19 and ensure equitable access to any drugs that prove effective.'

On 24 April, world leaders, with an obvious absence of the United States, endorsed the initiative led by the WHO and its partners of the Access to COVID-19 Tools Accelerator or the ACT Accelerator. 'This is a landmark collaboration to accelerate the development, production and equitable distribution of vaccines, diagnostics and therapeutics for COVID-19. Our shared commitment is to ensure all people have access to all the tools to defeat COVID-19,' stated the DG. Ursula Von Der Leyen, President of the EU, promised, 'This vaccine will be our universal common good and I want to invite everyone – governments, business leaders, philanthropists, artists and citizens – to raise awareness about the pledging effort and to help us create a united front against coronavirus. The European Union will spare no effort to help the world come together against coronavirus because united we will make history with a global response to the global pandemic' (WHO 24/04/2020). Five days after President Trump announced that the United States would halt its funding to the WHO, the WHO partnered with Global Citizens, musicians, celebrities and philanthropists and held a marathon concerts from home and raised $128 million. The same day Trump announced that the US would terminate its funding to the WHO, Costa Rica and the WHO launched a voluntary project to share intellectual property, scientific data, and know-how to fight the coronavirus pandemic – the COVID-19 Technology Access Pool.

When the WHO DG warned politicians to work together and 'quarantine politicising COVID-19 to save lives,' his advice was not only ignored but also triggered escalating attacks on him as well as the WHO. His warning was defended by the former White House Ebola Response Coordinator, Ronald A Klain, as early as on 5 February at the House Committee on Foreign Affairs:

> I am an outspoken political partisan – this is well known. But we need to put partisanship and politics aside; the coronavirus will not ask any person's partisan affiliation before infecting them. There is no Democratic or Republican approach to fighting infectious diseases; only sound and unsound measures (2020).

Politicisation of COVID-19 and attacking the WHO are particularly bad in the US, as political strategists there made it an election issue. In March 2020, the National Republican Senatorial Committee (NRSC) for the GOP campaigns adopted a strategy document for the candidates running for the November elections. The strategy lists four targets: China, WHO, political correctness and Democrats soft on China. It specifically lists three 'crimes' of the WHO:

- The WHO aided and abetted the Chinese hit-and-run and advanced their cover up of the facts – they acted as the handmaiden of the Chinese Communist Party. China had campaigned for Tedros, the current director, and he owed them a favour.

- The WHO found out about the virus on December 30 and had a broad knowledge of the Chinese history of covering up infectious diseases, but it took them until March 11 – two and a half months later – to declare the disease a pandemic.

- The WHO repeated the greatest hits of Chinese propaganda over and over, including amplifying lies like: the Chinese have the virus under control while it was ripping through Wuhan; the Chinese are being transparent – mounting a model response – while they were arresting and repressing doctors and whistle blowers; and, they were validating outrageous claims about the numbers of cases and deaths, despite China's long history of lying about outbreaks (NRSC 2020).

Not only are all three wrong and/or misleading; they have little to do with what the WHO might have or have not done, but everything to do with 'the ongoing geopolitical wrangle between the US and China, and about diverting attention from US failings in its own response to coronavirus in the run-up to the US presidential election' (Cliff 2020). Instead of helping the US or any country deal with the pandemic, the document attacks the WHO for doing what it is good at, managing global health crisis.

Conclusions

Whether countries take the advice of the WHO seriously and whether politicians decide to politicise pandemics makes a difference in terms of lives and deaths, as the DG had warned. The evidence shows (a) IOs can and do coordinate actions, whether about health, trade, climate change or financial stability; (b) IOs remain by and large 'member driven' organisations in the sense that if member states do not want to delegate their authority to IOs, it is very difficult for IOs to push the boundaries; (c) government is ultimately responsible for the wellbeing of its citizens, and all politics is local.

Plenty of people need to take responsibility for the COVID-19 – from the poor who tried to make a living from selling and trading wild animals, to the central, provincial and local governments that did not diligently regulate such commerce in China, and to governments elsewhere that did heed precautionary warning and take preparedness seriously. The WHO this time around is not responsible for, and should not be blamed for, the spread of coronavirus. It sent out plenty of warnings from early January onward if governments wanted to listen.

The normative and operational authority of the WHO in managing infectious diseases always depends on the willingness of member states to cooperate. Richard Horton, editor of the influential medical journal the Lancet, warned: 'The WHO has been drained of power and resources and its coordinating authority and capacity are weak. Its ability to direct an international response to a life-threatening epidemic is non-existent' (cited in Buranyi 2020). This is not new. But it is not just a matter of resources. IOs have always been subject to the willingness of member states to 'surrender' some of their autonomy and to cooperate. When they decline to do so, when they will not collaborate through multilateral organisations, the consequences are self-evident.

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