CHAPTER 7

Decision-Making

Abstract Chapter 7 focuses on decision-making. It introduces and discusses the relevant actors and agents responsible for identifying health risks, and developing and ordering responses at the local, national, and international levels. Then it delves into the functions of trust and history in disordering (and potentially re-ordering) health: such as the role of reactance and the ostensible reclaiming of rights by refusing vaccination(s). The latter has been the case in the former East Germany for example, which experienced a large measles outbreak in 2015, as well as in California. The chapter explores ways and means for overcoming such political and policy gaps to promote health rights and responsibilities. Finally, the chapter explores ways in which decision-makers and decision-making respond to health threats that can(not) be contained.

Keywords Decision-makers · Actors · Agents · Institutions · States

This chapter focuses on decision-making. It takes into account actors and agents at the local, national, international and global levels of response. The preceding chapters collectively make the case, first, that diseases with epidemic/pandemic potential in general and EIDs in particular are on the increase; and, second, they illustrate that there is actually no global health coordination in response.

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This chapter takes a step back and focuses on the decision-making structures that drive—or not—epidemic/pandemic response from a systems' level. In other words, it dissects the decisions that lead to the comparisons and contrasts in the responses detailed in the case studies in preceding chapters. In doing so, it looks at how states, together with other actors—international organizations (IOs), non-governmental organizations (NGOs), non-state actors (NSAs), charities and others—decide to respond, or not, to epidemic/pandemic risks and threats. It analyses the panoply of possible responders and the loci of (their) decision-making and from there the arbiter(s) of responsibility for global health security.

The assumption introduced at the beginning of this book bears repeating here: health security, ideally achieved through global health coordination, is an enabler for health. It assumes that there can also be no complete delimiting of health risks and threats. Nonetheless, containment of risks and threats, and mitigation of acute risks and threats, should and must be possible. First, it is necessary to identify health risks and threats; second, it should be feasible to respond, and to do so in a way that respects of rights of the infected and affected individuals and communities, a key lesson of the responses to HIV and AIDS and Ebola; third, policy plans, tools and mechanisms, should be in place to limit the scope of any outbreak; fourth, it is in the interest of all responders, and it is possible, to coordinate a standby response to identify and address the implications, both immediate and medium- and long-term, of an outbreak's occurrence. Finally, the world should expect both post-outbreak health problems and problems associated with social, economic and political fragility, and be at the ready to react again and again.

Responses

Responses depend upon technical capacities, but political knowledge and will are the factors that determine if, when, and how a response will take place. Political knowledge and will in turn are supported or undermined by the general level of knowledge of disease and prevention (options) of the affected population, their prioritization of a particular disease risk or threat, and their correlated level of risk tolerance. The bottom line is that infectious diseases and (re)emerging infectious diseases (EIDs) exist, are endemic, and carry the potential to spread into epidemics or pandemics. It remains the right of all to health, and the responsibility of states and other actors to enable that health.

This circular relationship between population and (state) politics is the foundation of the modern notion of state responsibility to citizen (rights):

here the state receives legitimacy from the population, whose security, including health security, it is obligated to protect, while citizens enjoy the right, including the right of health, while adhering to the rules of the state. This is reflected in international norms and agreements on health responsibilities which hinge upon the enactment of state obligations to provide and protect the health security of its population.

Rights

Thus, Article I of the UN Charter and Article 25 of the Universal Declaration on Human Rights proclaims on ensuring the right to health:

> • Everyone has the right to a standard of living adequate for… health and wellbeing of himself and his family, including food, clothing, housing, medical care and the right to security in the event of… sickness, disability… Motherhood and childhood are entitled to special care and assistance.[1]

The World Health Organization (WHO), the entity charged with coordinating the international response to health, places the onus for realizing that human right to health squarely on the shoulders of states:

> • Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life (WHO 1978).

The fact that the WHO's governing body, the World Health Assembly, and its Executive Board are constituted by representatives of states has something to do with this. So does the historical reality that at the founding of the UN and the WHO, states were just about the only actors in international affairs as well as domestic politics. They determined the

[1] Article 1 of the UN Charter, and Article 25 of the Universal Declaration of Human Rights, UN 1948.

priorities and extent to which health, and its definition, would be included in and pursed on both political levels.

In the intervening decades, the state–citizen relationship has remained sacrosanct. The right of individuals to health has ascended the political agenda. However, the reality of the realization of that right, now elevated in the movement for Universal Health Care (UHC), has seen scores of NGOs, NSAs, philanthropies and other actors enter into the arena. Their presence, without a restructuring of the state–citizen relationship, has clouded the location of the responsibility to that right.

This means that while global health has first been transformative in terms of articulating and protecting human rights—as seen in the responses to HIV and AIDS, and Ebola in particular—it has also created new tensions. Global health rights highlighted equity, the realization of which becomes more important with each EID and its potential to become a global pandemic. Second, global health rights likewise elevated the notion of universal human rights and rendered them tangible in terms of health and, especially, access to health care. In doing so, human rights, and the human right to health, reinforced the idea and the tangibility of equity. Finally, global health, and in particular the response to HIV and AIDS, illustrated the opportunity of health as a global justice issue, which radiated to other sectors. The tension that remains is that between the right of health and global health and the responsibility for providing and protecting it.

Actors and Factors in Decision-Making

The point of tension—a tension knot—is the answer to the unanswered question: who decides who will assume, bear and account for the responsibility for health and health security?

Untying the knot is a function of political will, political skill and the mechanisms of response. If political will is defined as "the determination of an individual political actor to do and say things that will produce a desired outcome," then political skill refers to the competency necessary to be effective in organizations—in other words, to get others to do what the agent wielding the political skill wants.[2] In terms of untying the tension knot, those agents with the political decision-making power must possess the knowledge and the

[2] Ferris, Gerald R. et al. (2007). "Political Skill in Organizations," *Journal of Management*, Vol. 33, Issue 3, 290–320. (June).

will to identify, in this case, a health security risk or threat, will a response, and mobilize their skills to: convince all of the relevant political and technical actors required to agree upon a policy; formulate and fund an organizational response; and implement that response. The mechanisms of response thus include the legal frameworks under which the policy and its implementation are approved and deployed, as well as the technical elements themselves, including personnel, equipment and security.

The political decision-makers include states, international organizations (IOs), non-governmental organizations (NGOs), non-state actors (NSAs) and additional advocates and implementers, such as philanthropies. Each of these can perceive and define a health risk or threat from its own perspective, which may or may not align with that of the other actors. Each weighs different factors in conceptualizing, articulating and responding to health risks and threats, such as epidemics/pandemics. While each may also formulate a policy position, formulate, fund and implement a response, one overarching factor remains relevant to all: namely that the state remains responsible for the health security—protection and provision—for its citizens.

According to this logic, decision-makers at the state level, or through state representation at the international level, are the most pertinent. This leads us to states, and the international organizations of global health governance. Here, a distinction can be made between "front-line" states, those experiencing or adjacent to an epidemic outbreak, and "peripheral" states, buffered by geography. The line between the two can be blurred by global travel. Nonetheless, varying degrees of preparedness, of preventive treatment and palliative health infrastructure reinforce these lines. International organizations (IOs), notably the United Nations system in general and the World Health Organization (WHO) in particular, receive their legitimacy from the backing of their member states. The same holds true for the European Union (EU) and the European Centres for Disease Prevention and Control (EUCDC).

In addition, as noted above, NGOs, NSAs, philanthropies and other actors also play a role. This is amply evident in the work done by advocacy organizations such as ACT-UP and the TAC to raise awareness on the burgeoning HIV and AIDS pandemic; in the treatment and care provided by MSF in Guinea as Ebola was spreading; and in the critical role of the US Centers for Disease Control and Prevention (USCDC) in publishing information and travel recommendations (restrictions) in response to the ongoing Zika outbreak in Latin and South America. However, these influential actors remain advocates: they do not write official state policies

(though in some instances, they are consulted and even contribute to drafts) or international guidelines.

In responding to a health risk or threat, these actors work independently, in competition, or in concert with one another. Thus, MSF responded to Ebola at the outset of the epidemic in Guinea and then raised a global alarm; MSF and the WHO were in competition over the necessity of declaring the Ebola outbreak of 2014–2015 a Public Health Emergency of International Concern (PHEIC) over the five months it took the WHO to declare a PHEIC; currently the travel guidelines for Zika-plagued regions of Latin and South America are in conflict between the USCDC and the WHO; on HIV and AIDS, UNAIDS and the WHO coordinate goals and policy guidelines, which are reflected in state-level national HIV and AIDS strategies, which in turn serve to coordinate treatment regimens and research foci, sometimes whether or not they are the most appropriate local approaches.

States

In deciding upon their responses, states factor together their competing priorities against their possible expenditure, exposure to either domestic or international sanctions, which may include travel restrictions (see above), lost investment, or other impacts, and potential loss of independence in the juxtaposition between guaranteeing human security and the security of the state. Marrying the two includes, succinctly, safety within physical and territorial borders, economic conditions which enable the population to secure livelihoods and political organization according to a rule-based system.[3] States also take into account the positions and pressures of external actors, both local and international, which may seek influence over policies, eroding the decision-making room of the state itself.

> The importance of sovereign independence is often overlooked by overseas policy makers. Independence is hugely prized in countries that were under colonial rule just a generation or two ago. But, as many analysts have

[3] See also Hösle, Vittorio. (2003). *Morals and Politics*. Notre Dame: University of Notre Dame Press; and Krasner, Stephen. (1999). *Sovereignty: Disorganized Hypocrisy*. Princeton: Princeton University Press.

> pointed out, independence is somewhat fictional if a government is unable to make real choices over its social and economic policies.[4]

This means that as states may jealously guard their independence, health response could lose relative prioritization as weighed against economic growth and financial investment; education policy, or policing and justice, for example. Much of the initial South African reluctance to admit to the extent of its HIV and AIDS epidemic was tied to concern over (desperately needed) foreign investment and tourism as the isolationist apartheid era came to an end. It was arguably also the case when Indonesia invoked its "viral sovereignty," though in that instance it was as much to deny external patenting and the subsequent need to purchase any (for Indonesia) unaffordable vaccine based on viral sequencing. This can be interpreted as a reverse sanction against an unwelcome international intervention that would have detrimental effects on Indonesia's sovereignty (over its viral strains) and its ability to provide its population health security.

On the other hand, states can react to a health risk or threat and cast other policies adrift.

> Given the domestic political (and media) pressure governments frequently find themselves under pressure to do whatever is thought to be necessary to protect their respective populations and industries . . . difficult not to overreact.[5]

In either instance—of relativizing health or prioritizing it—the prevailing condition within which decisions must be rendered is one of uncertainty.

> While ideally such decisions are made on the basis of sound scientific evidence and medical advice (as the IHR requires), the reality is that until such time as the causative agent (i.e., pathogen), its epidemiological impact (such as the overall infection and case fatality rates), and appropriate control

[4] De Waal, Alex. (2006). *AIDS and Power: Why There is No Political Crisis—Yet*. Cape Town: Zed Books, p. 79.

[5] Davies, Sara E., Adam Kamradt-Scott, and Simon Rushton. (2015). *Disease Diplomacy: International Norms and Global Health Security*. Baltimore: Johns Hopkins University Press, p. 120.

> measures (i.e., vaccines, antivirals, antibiotics, quarantine, social distancing, etc.) are known, the decision-making process about how to respond takes place in a situation of uncertainty.[6]

This makes the domestic and international contexts in which the state evaluates and renders its policy decision-making a critical factor in that process.

Dr. Rüdiger Krech, director, Health Systems and Innovation, Office of the Assistance Director-General of the World Health Organization, highlights the particular importance of the media in this context. He argues that the indications emitted from domestic and international media and international organizations, especially the "linguistic space" and "group space"[7] they create, delineating who is and who is not being addressed and who is affected play a constitutive role in states' assessments of a health risk and threat and the national and international responses.[8]

Mass communications' media are often the first point of contact for individuals, but also for state governments assessing the domestic mood. International organizations also can use media both to communicate their message(s) on health risk or threat response, and to gauge the receptivity of a population to proposed and later implemented interventionist or supportive measures. As Krech notes, the media's job is to tell a story. Each story has an origin perspective and a prospective audience: both determine what makes a story (whether it is a story worth being told), and how it is told.[9] It is against these backdrops—and the backdrop is not the same for each actor—that decision-makers must decide.

International Organizations (IOs)

Just as states weigh various factors in setting their policy priorities, so too do international organizations (IOs). Most importantly, they are influenced by their member states, as well as by NGOs and NSAs and the media. In and of themselves, IOs are comprised of member states. These, on the one hand, retain their sovereign authority over their territories and populations, and on the other they throw the weight of their sovereignty

[6] Ibid.

[7] Original: "*Sprachraum*" and "*Gruppenraum.*"

[8] Interview with Dr. Rüdiger Krech, April 13, 2015.

[9] Interview with Dr. Rüdiger Krech, April 13, 2015.

behind the governance of some IOs, enabling them to advocate and, for example, issues guidelines on health crises response, with a legitimacy they would otherwise lack. Yet states do not legally, share, transfer or delegate their sovereign responsibilities to IOs.

Two key differences define their decision-making. States, as noted above, are responsible and accountable to their populations (citizens) for all of their human security needs, including health, physical safety (policing), economic welfare (conditions within which to work and earn a livelihood) and political stability (rule of law).

> Only States are parties to the Covenant, and thus ultimately accountable for compliance with it, all members of society—individuals, including health professionals, families, local communities, intergovernmental and non-governmental organisations as well as the private business sector have responsibilities regarding the realisation of the right to health.[10]

IOs belong structurally to international society. They *are* in essence the "international community." In that vein, however, they share responsibilities but not accountability for the realization of the right to health.

IOs are beholden to their member states, which can withdraw their support, damaging the IO's legitimacy. Responsibility for human health and security remains with the sovereign state. What remains is both domestic and international judgment on the performance of the state against its own and international guidelines and expectations. This creates a dilemma for states operating with/out or in concert with IOs.

> Public officials charged with responsibility for protecting their populations are confronted with a dilemma: if they respond slowly or do not take sufficient steps to protect their citizens, people may become very ill or die, and significant political costs may result. … Conversely, if administrations respond forcefully and swiftly, taking all available measures—even if those actions are not based on sound scientific evidence and even if they are later found to be an over-reaction—they may be in breach of their IHR obligations. Yet the (domestic) political costs of this latter course of action may be lower.[11]

[10] Committee on Economic, Social and Cultural Rights (ECOSOC), 2000.

[11] *Disease Diplomacy*, p. 121.

The IHRs are the International Health Regulations Mentioned in Chapter 5 with regard to H5N1 and SARS. Agreed to in 2005, they came into force in 2007. "All governments adopted the IHR (2005) framework, and accordingly every member state has a responsibility to do what it can to meet its obligations."[12] States were given an initial five-year period, with a possibly extension of an additional four years, to implement the IHR recommendations. However, while officially binding, the IHRs are not outfitted with either automatic support mechanisms or with sanctions to compel states to invest in their capacities and capabilities in order to meet these obligations. "No coordinated, adequately funded global health initiative is underway to deliver assistance to such countries to implement the IHR (2005)."[13] Hence,

> - Whether because of lack of capacity or will, many states failed to make significant progress toward a comprehensive institutional framework for managing acute pandemics, and many developing states lacked the requisite infrastructure to fulfill the obligations outlined by the IHRs and PIP. Further complicating matters, Indonesia—with initial support from other states—invoked the notion of "viral sovereignty," the principle that viruses belong to the state in which they are discovered, to prevent and delay sharing data and samples of H1N1 influenza.[14]

This evident lack of capacity or will is exacerbated by risk:

> Compliance is arguably made even more fraught when governments are confronted by a rapidly changing, unpredictable, and unquantifiable event that they see as presenting a risk to their national security and to the health of their population.[15]

IOs may present evidence of a health crisis or impending health crisis, including a PHEIC. They may make recommendations and even mobilize a response to an outbreak—such as establishing UNAIDS and UNMEER

[12] Ibid., p. 133.

[13] Ibid., p. 130.

[14] Garrett, Laurie. (2013). Global Health Update (via email). Council on Foreign Relations, p. 5.

[15] Davies et al. *Disease Diplomacy*, p. 121.

and publishing guidelines on Zika risk and prevention. Yet they rely on states to implement these.

The Ebola outbreak response in West Africa in 2014–2015 is a case in point. By July 2014, Dr. Atai-Omoruto of Uganda had arrived in Liberia at the request of the WHO, along with 14 additional Ugandan health workers. Given that Uganda is not known for a surplus of health workers itself, this generosity to Liberia came at a cost to the Ugandan health system even as it represented positive regional support and international media coverage. At the same time, however, "nongovernmental organizations were pulling their workers out of the country; and many governments were unwilling to send medics."[16] Thus both affected and (potentially) responding unaffected states decisions can be aided and abetted, both positively in facilitating health rights, and negatively in undermining these, by the actions of IOs and other states themselves. This again makes clear that individual states, the member states of these IOs, are the actors which decide whether and how or not to follow through.

What remains is that when crafting responses and rendering decisions on health outbreaks, especially those with epidemic and pandemic potential, both states and IOs will rely for their national security on the WHO's advice. "The accuracy of that advice is crucial to building the necessary trust to persuade governments that they can safely delegate the decision on appropriate measures to the WHO."[17] The WHO in turn, will

> Be required to demonstrate its ability to provide rapid, authoritative, and instructive guidance on how best to respond to a particular disease outbreak as soon as it is identified as a potential PHEIC, but it will have to do so repeatedly, with every successive event.[18]

This decision-influencing role of the WHO on member states, and in reverse in terms of member states' decision-making compliance as legitimizing WHO guidance, is hard to overstate. It applies not only at the global level, but also regionally, including, for example, in the European Union.

[16] MacDougall, Clair. (2016). "Anne Deborah Atai-Omoruto, Who Helped Lead Ebola Fight in Liberia, Dies at 59." *New York Times* (May 10).

[17] Davies et al. *Disease Diplomacy*, p. 124.

[18] Ibid.

At the European Union (EU) level

The European Union, through the European Commission, works closely with the WHO both on the regional and the global levels. The EU Delegation in Geneva is represented on the Boards of both the WHO and the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria, a prominent NGO. In addition, the EU Commission, which published *Council Conclusions on the EU Role in Global Health* in 2010, is taking part in the US-led Global Health Security Agenda.[19]

Germany, in line with its generally multilateral approach to leadership abroad, particularly in the realm of foreign or development aid, is throwing more of its influence behind global IO, NGO and NSA efforts to anticipate and contain health threats. For instance, during its G7 presidency, Germany hosted the replenishment conference for Gavi, the global vaccine alliance initiative. Pledges—not disbursements—even exceeded the initial target of US$7.5 billion. Chancellor Angela Merkel also unveiled the German government's six-point plan to improve responses to international health crises and strengthen health systems, and launched the "Healthy Systems—Healthy Lives" initiative. The latter aims to develop common understanding of health system strengthening and to support actionable commitments at the country level.[20]

This does not mean, however, that it is shifting its decision-making processes or power away from the sovereign state. Member states of the EU act at times in concert and at times in conflict with WHO recommendations; in either case, they do not shift their decision-making to the WHO. Likewise, the EU Commission's cooperation with the Global Health Security Agenda remains a cooperation, not a treaty agreement.

Influencers

As such, it becomes clear that decision-making remains the remit of a sovereign state policy process when addressing health security. Nonetheless, it is equally obvious that states neither engage in that process nor implement its

[19] See "Global Health Security Agenda," available at: https://ghsagenda.org/.

[20] See "Health Systems—Healthy Lives"; see, for example German Federal Ministry for Economic Cooperation and Development at http://health.bmz.de/what_we_do/hss/ and International Health Partnership at http://www.internationalhealthpartnership.net/en/.

outcome, in terms of health security interventions in particular, in a vacuum or on their own. International organizations, NGOs and NSAs are influential in and on decision-making on health, health rights and health risks. The most important leaders among these include the WHO; surveillance networks, notably the WHO's GOARN; among NGOs, MSF; NSAs and legal frameworks such as the IHRs, the Global Health Risk Framework Commission, and the proposed Framework Convention on Global Health. These target the national, regional and international decision-making levels; a select few, such as MSF also act on the individual and community levels.

WHO

The WHO is and remains the international organization legitimized and mandated to identify, coordinate, and on occasion to facilitate the direct response to a global health threat.

> The role of the WHO secretariat in providing rapid, informative, evidence-based information on how to appropriately respond to disease outbreaks will be absolutely critical to avoiding any doubt over appropriate measures and to promoting internationalization of the norm among the organisation's member states.[21]

However, "At present it remains unclear to what extent the WHO secretariat has been able to link the global health security discourse with appropriate state action in the event of an outbreak."[22] A key reason for this is that the WHO is that it is politically constrained; it must obtain governments' permission to work in their territory.[23]

Successful WHO coordination of a health response depends on those member states, and their willingness to identify both a health threat and their capacity (problems) for responding to it, to heed WHO advice, and to implement or enable external implementation of interventions to (re)establish health security for their populations.

[21] Davies et al. *Disease Diplomacy*, p. 124.

[22] Ibid., p. 124.

[23] Shah, Sonia (2015). Snapshot. "The Next Cholera Epidemic. How the Disease Could Spread from Syria." *Foreign Affairs* (November 10): available at: https://www.foreignaffairs.com/articles/syria/2015-11-10/next-cholera-epidemic.

Dr. Krech,[24] compares the WHO response and the *necessary* WHO response to an outbreak to a fire brigade responding to a fire. As he sketches it, a fire brigade boasts numerous operationally coordinated elements. These are organized vertically and include: one—pre-determined, published—telephone number to be called for immediate help; a recognized leader, in the person of a chief fire officer giving orders that are followed; a working fire engine with hoses; adaptability to prevalent fire hydrants with adequate water flow. In Krech's rendering, however, the WHO's fire-fighting, or outbreak intervention is hindered at nearly every one of these response levels:

- There is not one number to call for immediate help. Instead, both member states, and (eventually) the WHO are the recipient of myriad calls (from (other) member states, the affected state itself, from NGOs on the ground, from NSAs, and social media actors).
- Then, instead of a chief fire officer arriving to give orders, both member states and the WHO are tasked with formulating and implementing a response. This is the equivalent instead of the chief fire officer coming to *discuss* how the member state could response to the disease outbreak itself.
- Assuming the member state is capable, it will likely respond to the outbreak with its own resources. If not, this hierarchy reduces it to begging the WHO to send assistance.
- This in turn leads to the WHO, made up of its member states, having itself to seek support—operational and financial—to respond. It translates roughly into preparing the fire engine to come, while having to go house-to-house to collect water (funding). Furthermore, administrative incompatibilities may also hamper water flow as hoses are not compatible with either buckets or existing fire hydrants.
- Finally, despite a member state's plea to the one WHO, it is possible that not just it, but ten other fire brigades—the aforementioned other states, NGOs or NSAs—try to respond: resulting in their crossing, keeping each other from reaching the burning house.[25]

[24] Director, Health Systems and Innovation, Office of the Assistance Director-General of the WHO, interview May 18, 2016.
[25] Ibid.

At this point, the disease outbreak has spread, and possibly erupted into an epidemic or pandemic. The house has burned down and has possibly set off fires in the houses next door. Yet the very fact that the WHO is and remains the world's global health response coordinator offers a sheath of fire protection.

The WHO Secretariat and its vertically bound response system are dependent upon member states, which presents a host of hindrances to the WHO's ability to provide "rapid informative, evidence-based information on how to appropriately respond to disease outbreaks";[26] nonetheless, it does collect, collate and deliver both guidelines and initial response interventions. (Lessons stemming from its weaknesses and recommendations for improvements are to be found in Chapter 8.)

Towards those ends, WHO mounted GOARN, the Global Outbreak Alert Response Network (GOARN).[27] As explained in more detail above, GOARN collects a host of health outbreak information from both government and non-governmental (NGOs and social media platforms) sources. Optimally, it gathers not only epidemic information, but also tracks decisions and actions by the WHO and partners.

Supporting GOARN are additional surveillance networks operating regionally. These are significant because, first, data are often lacking at the level of individual governments and states; and, second, porous borders makes (potential) disease outbreaks a regional concern almost immediately. Such networks include: EAIDSNet, the East African Integrated Disease Surveillance Network; MDBS, the Mekong Delta Basin Surveillance network; and SACIDS, the South African Centre for Disease Surveillance.

In addition, on April 13, 2015, US Secretary of State, John Kerry, and Nkosazana Dlamini Zuma, chairperson of the African Union Commission, signed a Memorandum of Cooperation (MOC) to formalize "collaboration between the African Union Commission and the US Centers for Disease Control and Prevention in creating the African Centers for Disease Control and Prevention (African CDC)."[28] Given that the

[26] Davies et al. *Disease Diplomacy*, p. 124.

[27] See WHO, "Emergencies Preparedness, Response, Guiding Principles for International Outbreak Alert and Response," available at: http://www.who.int/csr/outbreaknetwork/guidingprinciples/en/.

[28] See USCDC, "African Union and U.S. CDC Partner to Launch African CDC," available at: http://www.cdc.gov/media/releases/2015/p0413-african-union.html.

mission of the new agency ("CDC Africa") includes "working in concert with African local governments to help establish an emergency medical response system to assist in disease forecasting and emergency health delivery,"[29] it complements—but hopefully does not compete with—the WHO's or GOARN's mandate to optimize global health emergency outbreak response. Hope is a fragile pillar in which to build a global health security response.

Indeed, the establishment of the CDC Africa illustrates the global role of institutional actors operating in the image and likeness of the WHO, which thereby reinforces the role and influence of the WHO itself. Nonetheless, nothing can replace the WHO.

NGOs and NSAs

In a league apart from the WHO, NGOs, influence decision-making *in* both the WHO and its member states. On the one hand, by operating outside of the vertical chain of command emanating from member states to the WHO and back again, NGOs can offer politically unbiased (if not neutral) information on an emerging health crisis. They can also lobby member states and the WHO itself to acknowledge and address a health crisis such as a disease outbreak. On the other hand, NGOs are just that: non-governmental organizations without the legitimacy and clout to mobilize a national or internationally needed political and policy response.

NGOs such as MSF (see Chapter 4 on Ebola), founded in 1971, bring a reputational history girded by decades of proven on-the-ground health aid and expertise. In addition, as Michael Edelstein (Chatham House) notes, MSF, and like it, Save the Children, have "almost the same budget as the WHO, but more field expertise and credibility."[30] It is their credibility that builds NGOs' reputations, which, when combined with financial resources can serve as an influencer on both the discursive and the implementation levels.

For instance, NGOs can raise an alarm and call for WHO and international assistance. MSF did this in West Africa during the Ebola pandemic, while continuing to provide care: the crucible of its credibility. NGOs can

[29] See "CDC Africa," available at: http://www.cdcafrica.com/index.html.

[30] Interview with Michael Edelstein, April 1, 2016.

also, as did ACT-UP and the TAC during the AIDS pandemic, call attention to a marginalized group, galvanize human rights' activists, and, by accessing and administering the first ARV medications themselves, prove that such treatments can be feasibly delivered around the world. In doing so they influenced policy makers to legislate treatment access, and also convinced pharmaceutical companies to develop, manufacture and sell ARVs around the world.

As these examples show, NGOs are actors on the local level and influencers nationally and /or internationally. They can be overwhelmed in the face of an epidemic or pandemic outbreak, as was MSF during the Ebola crisis. NGO accountability lies outside of the state/international member state system, despite proliferating efforts to account for their activities and spending to the benefit of local aid recipients.[31] At the same time, NGOs are also gaining influence via consultative status, notably at the United Nations. This status has three levels: General, Special and Roster. Under the application and accreditation rules, an increasing number of NGOs have gained consultative access at the United Nations, notably the UN Department of Economic and Social Affairs (ECOSOC). Currently 4,189 NGOs enjoy this status.[32] That is a number which has risen exponentially since 1996, which coincidentally or not follows the 1994 UNDP report on human security, wherein health plays a prominent role. These NGOs, are not, however, granted decision-making powers. Nor do they have consultative status at the General Assembly or the United Nations Security Council (UNSC). This limits NGO influence precisely by keeping them at remove from mechanisms of decision-making, the assumption of formal responsibility for a health intervention, and account-taking.

It is also unlikely to change. Both states and NGOs have an interest in maintaining the current order of health responsibility. Dr. Maximillian Gertler of MSF and the Institute of Tropical Medicine and International Health, Berlin, notes that the state is, should and should continue to be, responsible for the health of its population.[33] He argues passionately in two directions:

[31] See Doctors without Borders, "Accountability," available at: http://www.doctorswithoutborders.org/about-us/history-principles/accountability.

[32] See UN, "NGO Branch Department of Economic and Social Affairs, Basic Facts about ECOSOC Status," available at: http://csonet.org/?menu=100.

[33] Interview with Dr. Max Gertler, Institute of Tropical Medicine and International Health Berlin, June 8, 2016.

first, for states to invest in prevention measures and health capacities to meet the needs and response to unexpected health crises in their populations: he emphasizes the process analyzed throughout this book, focusing on the primacy of communication; second, heeding the reality that not every state[34] can meet each health need or respond to every health crisis, Gertler extends the writ of communication to the international level. He argues that states must *ask* for health aid. Here he returns to the WHO as the only actor with international and national legitimacy to prepare, guide and coordinate the implementation of health (crises) responses.

NSAs do not change but, rather, reinforce this system. The key difference between NGOs and NSAs is that the former are non-governmental and non-profit organizations. Like NGOs, NSAs operate outside of the prevailing state/member state system. A prominent example is Gavi, the global vaccine alliance initiative noted above. It operates independently of states, but receives multilateral funding to promote and implement its agenda of increasing vaccine access and coverage around the world.

NSAs, too, can be powerful influencers, particularly as they emerge from the ranks of business (in)to charity. The Bill and Melinda Gates Foundation is a prime example, bringing business acumen, innovative drive including prizes to inspire research, hired expertise in health and ample funds. Also like NGOs, however, NSAs are not bound by legal edict to respond or continue to provide response to health—or other—crises. This issue and its implications for global health response will be explored in more detail in Chapter 8.

Legal Frameworks

Despite the dearth of formal laws to capture the allocation of responsibility and accountability in global health between NGOs and NSAs and states /member state organizations, legal frameworks both exist and are being developed. These include the IHRs, the Framework Convention on Tobacco Control[35] and the proposed Framework

[34] Gertler mentions Libya and Somalia as two states lacking the, indeed any, health infrastructure up to the task of meeting heath needs or responding to health crises.

[35] See for example WHO, "Framework Convention on Tobacco Control," available at: http://www.who.int/tobacco/framework/WHO_FCTC_english.pdf.

Convention on Global Health.[36] Further research towards legal procedures for protecting health and influencing national and international health response is being done by the Global Health Risk Framework Commission,[37] and the WTO (World Trade Organization) Sanitary and Phytosanitary Committee.[38] While the IHRs are a legally binding agreement in theory, and the framework conventions are agreements in practice, they operate on incentive structures, including "naming and shaming." They have no recourse to coercive measures such as sanctions or automatic support systems (such as triggering external aid) to ensure compliance. In comparison, the TRIPS agreement, also operated under the WTO, has enforcement mechanisms which include sanctions.

This dual reality showcases the reliance even of legal frameworks on the existing state/member state system. At the same time, it also highlights the growing role and importance of both voluntary and binding legal frameworks to influence global health responses. It is possible that that in the future more, and/or streamlined frameworks will emerge which are the legal equivalent of treaties, uniting both moral obligation to respond with operational guarantee of coordinated responses.

Conclusion

It is possible to respond to disease threats, including outbreaks. It is possible to identify risks, to confront threats, and if all else fails, to contain and stem the spread of epidemics and pandemics. In order to succeed, decisions have to be taken: at the individual, local, community, national, international and global levels. These decisions can be influenced by states,

[36] See "Platform for a Framework Convention on Global Health," available at: http://www.globalhealthtreaty.org/.

[37] See National Academy of Medicine (2016). "Commission on a Global Health Risk Framework for the Future: The Neglected Dimension of Global Security—A Framework to Counter Infectious Disease Crises," (January 13), available at: http://www.who.int/about/finances-accountability/evaluation/Commission-on-a-global-health-risk-framework-for-the-future.pdf?ua=1.

[38] See "The WTO Agreement on the Application of Sanitary and Phytosanitary Measures (SPS Agreement)," available at: https://www.wto.org/english/tratop_e/sps_e/spsagr_e.htm.

by IOs, NGOs, NSAs, and legal frameworks. Individuals, too, as advocates and leaders, can play a role.

In order to understand the best possible decision-making in response to disease outbreaks and local/global epidemic and pandemic threats, Chapter 8 addresses lessons learned and offers some concrete policy recommendations.