Why do International Organizations Fail in Responding to Epidemics? An Analysis of State Incentives Through the Lens of International Organizations

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Abstract

Epidemics, while variable in nature, are continually prevalent in the fabric of life. As such, understanding the varied response to epidemics/pandemics is integral to inhibiting transmission and limiting mortality rate. This inquiry is timely not only because of COVID-19 global prevalence, but also due to the general need for improved response to pandemics. Classically, pandemics are recognized within and restricted to the field of medicine and epidemiology. Nonetheless, a perspective from that of International Relations (IR) can improve mechanisms of addressing epidemics. Therefore, research asked why and when the World Health Organization (WHO) intervenes in epidemics and how this reflects state action. Research across three case studies directed the context for analysis to explain the current pandemic strategy. Research has found that epidemics see rapid response rates only in certain cases. In others, responses can lag before states step in to contain the pandemic. As such, the data demonstrated that a realist IR approach best explains that states (and, by proxy, the WHO) act out of interest. A realist approach expects the WHO only to act when its interests are impacted, whereas; the expectation of an International Organization (IO) is that it will act via a humanitarian approach, that is, the need to do good for the sake of helping humanity. When examining the following epidemics: SARS, H1N1 and Ebola (2014-2016), states acted in a timely fashion only when there was an immediate impact on their interests. Ebola had a delayed response due to the lack of incentive and the WHO only intervened when Western states had substantial cases. The research demonstrates a need to revise WHO policies to diminish realist motivations as well as demonstrates pertinent extrapolations for COVID-19. With these findings, methods and incentives can be reformed to increasingly improve both the WHO and efficiency in pandemic containment.

Introduction

The world is in a state of crisis. What factors converged to contribute to the languishing epidemic response to COVID-19? And, why does a minute biological entity have such macroscopic implications for International Relations?

Epidemics have plagued generations creating immense human suffering. Each epidemic has undermined societal and political development. For instance, during the Peloponnesian War, the epidemic had direct political implications, ending the feudal system.[1, 2] Nonetheless, there is inconsistency in health in the context of International Relations (IR) and in the subsequent approach towards controlling epidemics.

When an epidemic becomes pandemic states traditionally have prioritized disease containment despite its political implications. What are the mechanisms for disease containment, and who is responsible when disease crosses man-made borders? Despite historians and physician discourse, global health’s impact on International Relations has largely been overlooked. The interplay between politics, its theories and health is vastly uncharted.

Surprisingly, global health has only been seriously introduced in IR dialogue in the last two decades given the centuries of epidemic existence.[3, 4] The recent inclusion of epidemics in IR underscores the lack of discourse and data, thereby limiting expansive understanding and effective policy creation. As Davies et al questions, why would one separate “survival” from health when “human mortality rates go hand-in-hand with global inequality”? [1, 5] Considering a state’s survival, the health and well-being of its populations is paramount to its security.[1, 2, 6] Yet, some scholars do not perceive nor prioritize security in the same realm as military power.[1, 7, 8] By focusing on traditional security and ignoring such threats as health, disease, bioterrorism, etc., a state becomes vulnerable. How states define security is integral to their survival and thus should understand security as encompassing any threat “likely to provoke conflict.”[1] The national intelligence estimate conferred the use of health as a measure of state security and considered diseases to be a threat to social and political instability both at home and in “regions in which the U.S. has significant interests.”[6] Healthy populations determine productivity, thus affecting economic development, education, military and political institutions, which in turn defines state viability.[1, 3] Health has proven to impact issues pertinent to operationalizing IR scholars’ theories despite not holding a legitimate platform within IR.

Health is not confined within states nor to domestic politics, and thus demands collective state response when outbreaks cross borders. Conventional wisdom leads scholars to believe that humanitarian impulse drives response and international organization (i.e. the World Health Organization (WHO)) involvement.[5, 9] Whereas the international order is in anarchy, and by definition lacks hierarchy, healthcare is in direct opposition in its vertical organization. This shapes the response to inter-governmental health issues.[3, 9, 10] Inter-governmental institutions were created to address this dilemma in the early twentieth century.[5, 9, 11]

International Organizations (IOs) are comprised of stakeholders; they are beholden to great power interests.[12] Therefore, how IOs act, or fail to, can reveal state incentives and perceived responsibilities.[12] Separately, nations may invoke travel bans or other defensive measures to protect their interests. Yet, to create a public good requires an inter-governmental process.[3] States must cooperate to improve the health of their populations, especially when
considering the ease of human migration and malleable borders, which cannot contain disease nor ill-health.\textsuperscript{9} The intersection of politics and global health is timely as it presents implications on the COVID-19 pandemic.

With epidemics, one overlooked question is why states become incentivized in resolving outbreaks. Frequently, health is considered within the context of shared humanitarian norms and responsibilities. Unfortunately, the conventional IR wisdom around this impulse fails to explain the lack international community inertia. Therefore, we must investigate epidemic response pathways to explain this absence. The answer lies within how states navigate perceived epidemics in accordance with their interests.

\textbf{Methods}

This paper will coalesce an understanding around epidemic response, since there is a considerable gap between theory and reality in state action towards infectious disease.\textsuperscript{13-16} While the conventional wisdom creates a normative basis to answer global health issues, a materialist approach better demonstrates empirically and holistically why states become incentivized towards epidemics. Literature has demonstrated that infectious disease can affect security and state interests, making abstract health a tangible entity. Diseases can cause shortages in eligible workers, inhibiting production and attractiveness of trade deals, or be weaponized as security threats.\textsuperscript{17} These factors affect government efficacy, investment viability and regime power.

To understand state health threat response, this paper positions the WHO as a proxy to state incentives and foreign policy, which engender response robustness. With the cases examined, all had widespread disease propagation across borders, WHO and international response and a state of emergency. Each case’s theoretical and ontological understanding of IR realism demonstrates the discrepancy of crisis response.

This paper investigates which parameters allows the WHO to succeed or delay in its response. Success is defined by the ability to contain the epidemic and/or the amount of attention and resources devoted by WHO. The epidemics examined in this argument are pandemic; they are characterized by disease movement, explosiveness, minimal population immunity, severity.\textsuperscript{18} WHO publications, leader statements, norms and published guidelines from IOs, state and non-state actors’ decisions were analyzed. Global anxiety and existential fear generated by pandemics is tied to state insecurity.

The WHO response during the Severe Acute Respiratory Syndrome (SARS) epidemic is first examined as a pathway to success. Second, as a result of stakeholder interest, the H1N1 epidemic was markedly contained. Finally, the WHO failure of the Ebola Virus Disease (EVD) epidemic (2014-2016) is examined. As the WHO is seen as a proxy for state intentions, the material motivations to protect security are examined, i.e.: travel bans, WHO measures and foreign policies in conjunction with response timeline. These cases are key since they captured the international arena, crossed borders and demonstrated response success or failure. This paper will probe and debunk the conventional understanding of health to argue how realism optimally accounts for delayed response due to the lack of state security interests.

\textbf{Alternative Explanations}

\textbf{Constructivism}

Scholars take issue with constructivism because of its complete ambiguity.\textsuperscript{19} Constructivism operates as a feedback loop in which state actors are instructed by international norms, and their actions then influence the status quo, etc. It can be helpful to describe how non-state actors help to engineer the global order.\textsuperscript{3} Norms, such as that of WHO’s International Health Regulations (IHR) (2002), regulate and construct the pathways through which states operate.\textsuperscript{20} Constructivism can help to understand why health has become global health, positing descriptive value, yet does not proffer adequate timelines of when events will happen or why.\textsuperscript{15} Thus, constructivism may be a useful reflective device, but it cannot be the explanatory mechanism for state incentives around pandemics.

Constructivism does not explain case variation with epidemic responses. For constructivism, the outcome would depend on norms that constituted the conventional wisdom surrounding global health.\textsuperscript{20} Indeed, after the IHR publication, a constructivist approach would have expected the Ebola virus to be contained in a matter of months, as with SARS and H1N1. This variation remains unexplained by constructivism and strategy, which the norms and humanitarian impulse are meant to shape the outcome.

\textbf{Liberalism}

A liberal framework relies on materialism, emphasizing domestic politics, public opinion and audience costs.\textsuperscript{21} Liberalism argues states are interdependent to improve health, and motivation stems internally from public opinion.\textsuperscript{3}

Liberalism focuses on domestic structure, and the accumulated discourse from public opinion and congressional pressures contribute to state policy adoption, with leaders acting accordingly in fear of possible pushback.\textsuperscript{3, 21} The extent to which domestic politics affects international health, however, has been controversial.\textsuperscript{3} Cowhey argues that commitment credibility depends on the structure of government and the sway that populations hold. Although the structural aspect of Cowhey’s argument fits into realism, it is too based in the transparency of the state system and does not allow power differentials. While Keohane’s argument that a robust institution engenders increased cooperation stability does actually fit this paper’s paradigm, it fails to identify the root that creates a robust health system.\textsuperscript{21}

In the context of this argument, liberalism would have posited US news and public statements to rapidly identify the severity of the EVD outbreak and mark earlier success than actually seen.\textsuperscript{22} Necessitating a more comprehensive theoretical framework, we turn to realism to fill in the gaps of why states act when faced with external health threats.

\textbf{Argument}
According to realism, the structure of the international system is anarchic with no superseding power. States, therefore, compete with one another to increase their material power while watching for threats to their security and material interests. [3, 9, 23] Waltz argues that the major focus must be in security rather than power as a multipolar world muddies the responsibilities of states. [23] Realism understands epidemic response as the product of security interests.

A more practical explanation to categorize state action towards health and disease is necessary. Realism posits health within a state’s materialistic calculations in relation to other states. [3] Historically, Africa has largely been called the “Dark Continent” due in part to the AIDS epidemic alongside the stereotype from Europeans and the international community. [1] Mearsheimer argues that states will utilize whatever means to tip the power towards their favor. While a humanitarian perspective would have come to the aid of suffering African nations, a realist perspective demonstrates that states will alter objectives to favor their own agendas due to competition for limited resources in anarchy. [14] Peterson argues that states, “co-op…the rhetoric of national security for infectious disease…relieving states of their moral obligations to respond to crises in developing countries.” [24] States act through self-help to ensure they provide for their own security and survival. [23] Realism allows for variation in power politics as Waltz argues, “states are alike in the tasks they face, though not in their abilities to perform them.” [26] Therefore, in identifying health as a security issue and security as a materialistic entity that states covet, infectious disease falls within the realist framework.

In a multipolar world, Waltz argues, “A state worries about a division of possible gains that may favor others more than itself.” [26] Waltz’s argument extrapolated illustrates that states will skew the objectives of IOs to their benefit rather than that of the common good. Through a realist perspective, IOs cannot be separate entities that autonomously make decisions. Instead, the level of success depends on the nations that use IOs as proxies. [3]

The empirical data will demonstrate the validity of realism as the explanatory power behind each of the cases. The WHO was delayed in its response to EVD despite humanitarian norms and public outcry, because Western states initially did not feel threatened. The response period for the Ebola epidemic cannot be separate from the fact that the state of security was not present. The level of success depends on the level of security a state perceives. Realists argue that because states are in a state of anarchy, they act in their self-interest and not in the interest of others. Security thus is the motivating factor for action. This is because states are in a state of competition for power and survival.

Case Studies

SARS: Success in Response

How does the international community retaliate when a new disease emerges suddenly, hard to identify and even harder to treat? SARS first emerged in China in November 2002. The hysteria of this disease – rendering it worse than AIDS in some regards – incentivized state action in addition to its apparent lack of vector. People were made to “feel so vulnerable that [they] started to wear surgical masks as they went about their daily lives.” [17] What pushed the WHO to respond rapidly? First, diseases can be weaponized. In 2002, the anthrax scare meant an increased threat of bioterrorism. Therefore, many great powers like the U.S. were anxious about the security threat infectious disease posed. [27] Second, international air travel increased globally, meaning exponential spread via airports. Third, SARS propagated quickly and symptoms went largely unseen until after others were infected. Numerous great powers were at risk with little defense against the unknown disease. Together, these factors contributed to the gaping security threat for states across the globe.

No state was immune to the SARS threat, making all incentivized towards resolution. The fear factor set in as one doctor singlehandedly spread SARS to at least sixteen others. The next day, the virus went global, emerging in Toronto, Vietnam, Hong Kong City and Singapore. [17] Moreover, there was no known cure for SARS: it masqueraded as the flu. The WHO contacted health authorities to impose travel limitations and quarantines. [31] The WHO travel advisories stepped up the rhetoric as the issue worsened. Dr. Stohr, leading the WHO SARS response, commented, “Before we were saying, ’Be careful.’ With the travel alert we were saying, ’This is a crisis.’ ”[30] With the extent of travel advisories and contact tracing, the WHO declared all “known chains of human-to-human transmission” to be broken within two months. [17] With state interests as the central motivator, SARS containment was a success.

Potential economic upheaval was another key reason that SARS became such a security threat to great powers. Disease affects all aspects of life, with no distinction between a “combatant” and “civilian” as during war. SARS impacted tourism, political and socioeconomic stability and trade. [1, 33] In Toronto, tourism and general economic activity plummeted with the pandemic’s onset. [38] Afraid that this could happen at home, the United States started to strain its relations with the Chinese. [39, 40] Nonetheless, only a third of “U.S. respondents said they [were] either very or somewhat worried that they or a family member will be exposed to [SARS].” [37] This demonstrates that public opinion was not the motivating factor, but rather stakeholders pushing the WHO to respond to a security threat. [30]

Why did the successful response manifest so efficiently? In a realist perspective, security interests spur action. When the disease went global, it instilled fear and a need to compete for survival. More than fifteen various countries worked together alongside the WHO and its regional affiliates. The WHO was able to quickly coordinate responses and contain the outbreak within six months. [29, 30, 32] States had a security incentive to step up and find a response, lest they become prey to the incurable disease and face damages toward their economies, governments and survival. The tangible fear forced great powers to get involved, and, by proxy, the WHO responded successfully and effectively. The SARS epidemic response was an efficient and robust success because of the interests and assets at state. This trend of response with great power stakeholders’ involvement continues through to the H1N1 outbreak.

H1N1: Success in Response

The H1N1 outbreak, known as Swine Flu, largely broke in the U.S., with some European spread. Despite no existing immunity when it first arose in 2009, it was successfully contained within a year due to the almost immediate WHO response and efforts towards finding a cure. [42] Within ten days and amid state panic, the WHO had already declared Swine Flu to be a Public Health Emergency of International Concern (PHEIC). WHO officials agreed, “the current situation constitutes a public health emergency of international concern.” [43] With the world keyed into events as they unfolded, the WHO acted swiftly to identify a cure and vaccine. [44] In the second month, the WHO raised the pandemic alert level to Phase 6, meaning it had spread to other
parts of the world. Some at the time likened the expected repercussions of the outbreak to that of Hurricane Katrina. Like in the SARS case, the WHO and Center for Disease Control (CDC) worked painstakingly to identify the chain of infections to see if there was a relationship to swine. By the end of 2009, the world had a viable vaccine.

The response was almost immediate due to the pressing issue of epidemic at the front door of European countries. Indeed, President Obama declared a public health emergency three times in six months in addition to taking unprecedented action to mobilize all U.S. states to respond. Nineteen countries issued some level of warning about H1N1, and four issued travel bans on any person travelling from Mexico. The WHO held committees to discuss the cure and recruited global experts to prevent further economic burden on the stakeholders that comprised its funding basis. Response was so bolstered, because states felt threatened by an infectious disease so close to home.

At the end of the H1N1 crisis, it turned out to be a relatively ordinary strain of the flu with a low death rate of 0.026%. Yet, the world reacted in such a staggering fashion and with such alacrity because of the threat’s proximity. Like SARS, when the cases are present in great power territories, they pose a security threat and states work collaboratively and swiftly towards eradication. Some may point out that the immediacy of detection was due to the infrastructure already present in the United States and Europe. Yet, the SARS case was also handled rapidly despite its remote origins. Nevertheless, research has demonstrated that, typically, quicker responses occur when U.S. citizens are infected rather than any other factor including large case quantity.

Moreover, diseases of this nature routinely require six to nine years to isolate and find a cure. Within two weeks, the WHO responded in full force because one of its main stakeholders – the United States – was severely and existentially threatened for its survival, especially glaring as, according to chief medical officer Liam Donaldson, “The first influenza pandemic of the 21st century [was] considerably less lethal than was feared” and did not deserve the pandemic classification. In stark contrast from this hyperactive response is that of the Ebola epidemic from 2014-2016, which has been highly criticized both during and after its resolution.

## Ebola: Delayed Response

EVD surpassed both SARS and H1N1 in cases and countries affected, demonstrating the failure to prevent an uncontrollable death toll. This contradicted the supposed preparedness from the 1995 Ebola outbreak in the Democratic Republic of the Congo, with efforts then to improve epidemic response. How did the WHO fail West Africa so strikingly? EVD has been documented since 1976, with an average of fewer than 500 cases, spread restricted to Central Africa and a lack of epidemic status.

The outbreak started December 2013 in a remote Guinea village, but due to porous land borders, rapidly spread to neighboring Sierra Leone and Liberia. Despite the exponential rise in cases and pleas for help, the WHO failed to act or prioritize a response. Like SARS, EVD spreads before detected, presenting a tangible fear of infecting any nation. Moreover, for the first time, urban cities were impacted by EVD, thus increasing the odds of contamination. Many warned of a state of emergency: Joanne Liu, International President of MSF (Doctors Without Borders), condemned the global response as “lethally inadequate.” It is striking how unprepared the WHO was at both identifying the epidemic’s severity and responding in kind considering the history of EVD, with scientists regularly researching a vaccine. Yet, when WHO stakeholders’ interests were affected, this changed.

It was a nine months before the WHO declared a PHEIC and a year before it collaborated with states’ Ministries of Health and the U.S. government agencies to formulate a response. Moreover, while, the WHO designated EVD as a Phase 3 epidemic, H1N1 was declared a Phase 6 within only a few months. By the time the WHO removed the state of emergency in 2016, there were 28,000 cases and 11,000 deaths in West Africa alone, notwithstanding cases worldwide.

When finally contained, EVD left a 4.3 billion USD hole and investment injury for West Africa. Agriculture was negatively affected: impacting food security, causing an international trade breakdown. Among the many failures, coordination and slow response, the WHO lack of inertia stands in the face of countless deaths in the region. In the aftermath of EVD, Barbara Stocking, former Oxfam CEO released a report, stating there is a “strong, if not complete, consensus that WHO does not have a robust emergency operations capacity or culture.” The WHO lacked a plan and coordination, leaving MSF workers stranded and strapped for funds. The WHO was so uncoordinated prior to state incentivizing that there was no WHO centralized bank to fund the response, especially after budget cuts were made based on stakeholder interests. The humanitarian impulse would have seen the WHO follow its set of rules from the IHR. Yet, beholden to its stakeholders, the WHO was absent from the scene.

After cases propagated in the U.S., the fear of a home-grown pandemic spurred America and others to pledge several billion dollars to eradicate the epidemic, and the WHO to call a state of emergency. With germs traveling at the speed of planes, federal officials required temperature checks at major airports to guard borders. President Obama announced that the U.S. military would send almost three thousand troops to the EVD epicenter, costing 730 million USD. About sending aid and military personnel, Obama announced, “If we don’t make that effort now, and this spreads not just through Africa, but other parts of the world, there’s the prospect...[that] it could be a serious danger to the United States...we have to make this a natural security priority.” The U.S. perceived Ebola to be a security threat, making it a material interest for survival. The prospect of a domestic epidemic rattled the U.S. and other great powers. Thus, the WHO finally stepped in and responded with alerts, travel bans and road-mapped solutions – at last containing EVD.

In understanding health as a security issue, states only intervene when they feel threatened. Ebola was not a concern until it transmuted itself to the West, becoming an international security threat. In March 2016, more than two years after Patient Zero, the WHO removed the PHEIC status and the crisis was finally over, yet the damage was done leaving both an economic and immeasurable human loss in its wake.

## Conclusion

West, becoming an international security threat. In March 2016, more than two years after Patient Zero, the WHO removed the PHEIC status and the last containing EVD.
In conclusion, infectious disease is pertinent to IR, with material interests being a key dictator of robust health response. All states, no matter their power or prestige, combat epidemics effectively or they risk economic burden, death tolls and their survival. Security is paramount to state viability and furthering global interests. Despite the limited discourse on Global Health in IR, which has been centered on humanitarian impulse, the case studies have demonstrated a lack of humanitarian action and inability to explain response delay. The turning point in EVD was, rather, dependent on U.S. and Western survival interests, which, when threatened, forced the WHO to finally assume direction and dedicate containment resources. This reveals the inherently selfish nature of states, which are beholden to material interests.

Reviewing the WHO, epidemics reveal that action is two-pronged. The WHO must assume leadership, but states must also retain interest. For both parties, shirked responsibility and lack of investment could transmute into uncontrollable infection. In 2012, the WHO changed its spending and finances to benefit its largest stakeholders, which favored European and Western powers. WHO funds have depended largely on great powers, and these entities hold sway over the WHO. Because states are self-interested, they are motivated to prioritize their own gains. States pursued their agendas by controlling how the WHO operated via funding rather than supporting issues needed to improve health in all corners of the world.

Globalization has enabled disease spread from remote villages in Africa to communities in China to urban cities in the United States. The case studies have shown that the WHO, the purported leader for epidemic containment, is beholden to great powers’ interests. Presently, COVID-19’s eradication will predicate state robustness. States must not only perceive but also embrace the security threat to adequately materialize the necessary containment in a timely fashion. No state is immune, and if state leaders do not recognize the threat, then epidemic response will languish and populations will suffer.

With society’s health needs hanging in the balance, the rise of infectious disease mandates immediate attention no matter its origins. There is no preventing or predicting a future outbreak, but states can be prepared, propelling WHO action to prevent the issue from deteriorating to a pandemic crisis. This argument and its international ramifications have superseding urgency. As this paper demonstrates, states are inherently selfish fighting for their power or prestige, combat epidemics effectively or they risk economic burden, death tolls and their survival. Security is paramount to state viability and furthering global interests.

References
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