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DECISION-MAKING AUTHORITY OF THE WORLD HEALTH ORGANIZATION IN A PANDEMIC: INSTITUTIONALISM AND BEYOND[1]

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Abstract: This paper discusses the World Health Organization's decision-making power in a pandemic through the analysis of its formal rules and regulatory arrangements. It concludes that the authority of the Organization remained mainly within soft law, which means it is nonbinding and advisory in nature. But, since the author assumed the growing perception of the binding nature of WHO's decisions in the general public, she proposes ways to investigate this phenomenon beyond the conventional institutional approach and through the naming and shaming processes and the so-called multistakeholder regime.

Keywords: WHO, decision-making, authority, legitimacy, recommendation, non-binding advice, soft law, international law, theory of international relations, institutionalism, intergovernmentalism, multilateralism, transnationalism, multistakeholderism, naming and shaming.

INTRODUCTION

The World Health Organization (WHO), a United Nations specialized agency founded in 1948, has established itself as the natural coordinator in the COVID-19 crisis of 2020 and consequently assumed the greatest responsibility for the international response to the pandemic. Perhaps the most serious attack on the

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Organization's authority came from former US President Donald Trump in the form of an accusation of being unduly influenced by China alongside a threat to pull United States funding for the WHO. Had that happened, the WHO would have found itself in the unprecedented position of having one private actor, the Gates Foundation, as its top donor.[3] The authority of the WHO has been referenced by many politicians worldwide in urging compliance with anti-epidemic measures or in the contestation of the Organization's authority by protesting the very measures. Indeed, what is the role, mandate and responsibility of the WHO, and what it can and cannot do in a pandemic and vice versa? What are the sources and limits of its decision-making authority regarding international public health issues, and what is the nature of its decisions? This paper answers these questions through the institutionalist approach with a focus on explicit rules and the regulatory mechanism of the WHO. It also offers some concluding remarks for further research beyond institutionalism because the current COVID-19 crisis illuminates a changing landscape which warrants a new systemic theoretical approach and more quantitative research. But first of all, several basic concepts and the main analytical framework are outlined.

Analytical Framework: Authority, Institutionalism and Beyond

The term "institutionalism" is employed here in the style of international relations (IR) theory (Novičić, 2007). It is about explicit international rules and directly tangible law, and about concrete regulatory organizations and administrative arrangements, explored mainly in relation to the state (cf. Scholte, 2021a, pp. 179-183). "Authority" in international affairs is studied likewise in modern political theory as a "limited decision-making power" over an issue area that is "generally regarded as legitimate by participants" (cf. Quack, 2016, p. 363). "Legitimacy", as a "core attribute of power", refers to the "belief and perception that a governor has the right to rule and exercises it appropriately" (Scholte, 2020, pp. 22-23). For IR institutionalism, the root sources of legitimacy are in the "purpose, procedure, and performance of the global governance organizations", in its "mandate, operations, and/or its results"; "governance" is understood here as a "process of establishing, enacting, evaluating, and changing regulatory arrangements in society" (Scholte, 2021a, pp. 183-184). Institutionalism obviously expresses a persistent bias toward intergovernmentalism (i.e., multilateralism).

[3] See the top 20 contributors to the WHO Programme budget for 2018-2019 (Figure 6) in: WHO, 2019, p. 13. The Gates Foundation accounts for some 10% of its budget, as the second-largest contributor, behind the US and close to the United Kingdom.

For the purpose of this paper, "decision-making authority" is taken in its minimalist conception as normative power to impose duties, with a focus placed on formal decision-making and binding rules that "stand alongside a panoply of more informal instruments, such as soft law, rankings, assessments, guidelines, and best practices" (Krisch, 2016, p. 25). But in the transnational sphere, it seemed that authority was not necessarily associated with governmental actors and could be obtained by civil society organizations, business corporations, researchers, technicians, and the public at large. So-called multistakeholderism recommends itself as a desirable, almost life-saving alternative through which the private and corporate world sees a "way to legitimize its role in global governance" (cf. Gleckman, 2018, p. 1). Indeed, increasingly new regulations in many areas of international cooperation are emerging through informal trans-governmental networks, private mechanisms, and multistakeholder arrangements. Some of them "deliberately side-line the state", which must prompt increased attention to "legitimacy beyond the national sphere" (Scholte, 2021b, pp. 299, 303).

Hence, the multistakeholder approach, thereby, "fundamentally shifts the institutional locus of global governance in the process often challenging (either implicitly or explicitly) the multilateralist approach" (Scholte, 2020, p. 5). But global governance here might be less "directly visible" and "less obviously embodied", "more hidden" and even "opaque" forms of rule, and that is the reason why the "contestation around the legitimacy of global governance institutions has persisted for several decades; think only of anti-globalist" movements (cf. Scholte, 2021a, p. 183). And indeed, as Scholte rightly asks: "Is it appropriate for private agents to make public policy in global affairs" (2021b, p. 299)? "Who answers for what happens (or does not happen) in a global multistakeholder regime? To whom is such an institution accountable, by what means, how effectively, and for what purpose?" (2020, p. 23).

As a right to rule, legitimacy implies "underlying confidence and trust" (Scholte, 2020, p. 25) and "could greatly boost governing power: the more a regulatory apparatus has legitimacy, the less it needs to invoke coercion, trickery, and secrecy to sustain itself" (Scholte, 2021b, p. 303). That is particularly important "when it might cause harm" (Scholte, 2020, p. 23), as in international public health issues. Thus, we need to examine the deeper structures that have powerful impacts on institutional arrangements. The understanding of this "broadening dynamics of legitimacy" (Scholte, 2021a, p. 184) could provide "important clues about future trends in global governance" (Scholte, 2021b, p. 300).

A useful analytical framework for further grasping the decision-making authority of the WHO, as a global governance institution in the previously described changing institutional landscape, can be found in the book "Who Governs the Globe" (Avant,

Finnemore, and Sell, 2010). The authors distinguish five bases of authority for "global governors" (pp. 9–14): institutional (i.e., holding office in an organizational structure), delegated (from authoritative actors, e.g., states or sub-state agencies), expert (from specialized knowledge), principled (from service to a widely accepted set of principles, morals, or values), and capacity-based (from perceived competence and capability for solving problems, e.g., corporate). Their focus has been placed on those sources of changes that are "endogenous to governors and governing", but for our purpose, the more appropriate are "exogenous shocks" that imply, for example, structural changes in international politics (such as the end of the Cold War, for example), or the emergence of new technologies (Avant, Finnemore, Sell, 2010, p. 18). Infectious diseases of high virulence, such as COVID-19, can certainly be included in this type of "a shock for the system of global health governance" (McInnes, 2015, p. 1300).

THE GENERAL STRUCTURE AND DECISION-MAKING OF THE WHO

Below, we suggest a conventional institutional analysis of the WHO regulatory arrangement. It answers the question of how legally binding the WHO decisions are. In the first part of the section, we consider the general structure and types of WHO decisions. In the second part, we analyse the legal regime of the International Health Regulations (2005) designed for the state of a pandemic.

The structure of the WHO

The Constitution of the WHO declared as its most general goal "the attainment by all peoples of the highest possible level of health" (Art. 1), the enjoyment of which is regarded as the "fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition" (Preamble).[4] The structure of the Organization consists of three layers. At the global level, the main bodies are the World Health Assembly, the Executive Board, and the Secretariat, which is led by the Director-General (Art. 9 WHO-Constitution). The WHO has a decentralized regional structure as well as national offices worldwide.

[4] The Constitution of the WHO was adopted by the International Health Conference held in New York from 19 June to 22 July 1946, signed on 22 July 1946 by the representatives of 61 states, and entered into force on 7 April 1948. In this paper, we use the edition including amendments up to 31 May 2019 (WHO, 2020, pp. 1-20). Hereinafter referred to as the "WHO-Constitution".

The World Health Assembly (hereinafter the Assembly or WHA) is the primary decision-making body, meeting in plenary once a year (usually in May) and on special occasions as needed (Art. 13 WHO-Constitution). The Assembly consists of delegations from the member states, each of which has a maximum of three delegates with the highest technical qualifications in the field of health, preferably from national health administrations (Art. 10-11 WHO-Constitution). The WHA sets the general WHO policy guidelines, adopts the annual budget and oversees financial policy, and elects members of the Executive Board as well as the Director-General as the Head of the Secretariat. It also approves and instructs members' activities and reports, forms committees with special responsibilities to assist it in its work, considers the recommendations of other UN bodies related to health and draws their attention to relevant health issues, conducts and promotes research related to health, etc. (Art. 18 WHO-Constitution).

Considering a fair geographical distribution, the WHA selects 34 member states, each of which has the right to appoint one member of the Executive Board as "a person technically qualified in the field of health" (Art. 24 WHO-Constitution). The members of the Executive Board are, therefore, persons elected in their individual capacity rather than representatives of particular governments. They are elected for three years (Art. 25 WHO-Constitution), and they meet twice a year (Art. 26 WHO-Constitution), usually in January and after the plenary assembly in May. The Executive Board, as the Assembly's executive body, oversees the implementation of its policy and performs any other conferred functions and competencies (Art. 28-29 WHO Constitution). The Board advises the Assembly on questions referred to it or on its own initiative, submits proposals, prepares its agenda, as well as a general programme of work covering a specific period (Art. 28 WHO-Constitution). An important function of the Executive Board is that it can take immediate action and especially that, according to the Constitution of the WHO, it can authorize the Director-General "to take the necessary steps to combat epidemics" [Art. 28 (i)].

The Secretariat comprises the technical and administrative staff required by the WHO (Art. 30 WHO-Constitution) and is led by the Director-General as the chief technical and administrative officer appointed by the WHA for a five-year term on the nomination of the Executive Board and subject to its authority (Cf. Art. 31 WHO-Constitution). Ex officio, the Director-General serves as Secretary of the Assembly, the Executive Board, and all WHO commissions and conferences, with prerogatives to delegate these functions (Art. 32 WHO-Constitution). The Director-General prepares and submits financial statements and budget estimates of the WHO to the Executive Board, and he employs the staff of the Secretariat while keeping in mind the Secretariat's efficiency, integrity, and internationally representative character, i.e., geographical basis (Art. 34-35 WHO-Constitution). According to the WHO Constitution,

the Director-General and Secretariat's personnel are international officers, which means that they shall not seek or receive instructions from any government and any authority external to the WHO (Art. 37 WHO-Constitution). In principle, all WHO member states must adhere to this. A special agreement with the member states may regulate direct access to national health administrations by the Director-General's (or his representative's), and he may establish direct relationships with other international organizations dealing with similar issues (cf. Art. 33 WHO-Constitution).

Policies and activities of the WHO are therefore determined through the Assembly and implemented through the Secretariat as an administrative body with the Executive Board overseeing the process. Hence, the authority of the WHO was traditionally based on "delegated" and "expert" models (McInnes 2015, p. 1300). It originated from the member states, on the one hand, and specialized knowledge, on the other hand. This is a "delicate balance" that the WHO must achieve between "the wish for the WHO to act" and the member states' claims on "their sovereign control over health issues within their territories" (Yi-Chong, Weller, 2020, p. 52).

The further administrative organization of the WHO is currently complemented by six regional offices, which are occasionally defined by the WHA and the Board. They are headed by regional directors who implement WHA decisions within defined regions (Art. 44, 45, 51 WHO-Constitution). This regional organization of the WHO is "somewhat unique" in the entire United Nations system "in its degree of independence and decision-making power", which is also "a source of constant tension" (Lee, 2009, pp. 25, 31). In addition, there are WHO country offices and representatives in administrative and technical capacities. They are not determined by the WHO Constitution, but practically they have been established in nearly 145 countries (territories or areas) that are deemed to require that level of support.[5] The liaison offices are, usually, housed in state ministries of health and are formed by the WHO competent regional offices to whom they report. They are criticized as "a way for regional directors to distribute political favours" and their contribution to the WHO mission is contested (Lee, 2009, p. 34).

Decision-Making in the WHO

Each member state of the WHO has one vote in the WHA (Art. 59 WHO-Constitution), meaning all states are formally equal in the decision-making. Decisions on important questions are made by a two-thirds majority of the WHA

[5] See WHO offices in countries, territories, and areas (valid from 23 May 2016) at: https://www.who.int/country-cooperation/where-who-works/who-offices-in-countries.pdf

members present and voting. These questions include the adoption of conventions or agreements and the approval of agreements with other organizations (the UN, etc.). Decisions on other questions, including the determination of additional categories of questions to be decided by a two-thirds majority, are adopted by a simple majority. Voting on analogous matters in the Executive Board and in committees of the WHO is conducted in the same way (cf. Art. 60).

The WHO's *conventions* or *agreements* enter into force in the member state only when accepted in accordance with its constitutional procedure within eighteen months after the adoption by the WHA. Each member notifies the Director-General of the action taken, and if it does not accept such a convention or agreement within the time limit, it furnishes a statement of the reasons for non-acceptance (Art. 19-20 WHO-Constitution).

The WHA also has the authority to adopt *regulations* (Art. 21 WHO-Constitution) designed to prevent the international spread of disease (sanitary and quarantine requirements), nomenclatures with respect to causes of death and public health practices, standards with respect to diagnostic procedures, etc. These regulations come into force for all members after due notice has been given of their adoption by the WHA, except for non-compliant members notifying the Director-General of *rejection* or *reservations* within the period stated in the notice (Art. 22 WHO-Constitution). In addition, the WHA has the authority to make *recommendations* to the members with respect to any matter within the competence of the WHO (Art. 23 WHO-Constitution).

The prescribed decision-making regime is quite interesting and while "some means at hand is rather common or even unexciting, WHO-law provides one very unique feature": the Organization has the authority to issue legally binding regulations, but "[t]he kicker is the entry-into-force" (Frau, 2016). The way for a state to opt-out of such a binding agreement is to notify the Director-General of its rejection or reservation.

A delicate balance is made here between transnational decision-making (i.e., binding decisions adopted by majority vote) and traditional intergovernmentalism expressed in the right to reject. Ultimately, formal decision-making in the WHO remains within the principle of *delegated responsibilities*. The WHO has the authority to advise, warn, and provide technical guidance and assistance, but it does not have the authority to compel any government or state to do anything.

AUTHORITY OF THE WHO IN A PANDEMIC

The International Health Regulations were adopted on the basis of the WHO Constitution (Art. 21), as a "key global instrument for protection against the

international spread of disease" (IHR, 2005).[6] The substantive revision took place in 2005 following the political events surrounding the first global public health emergency of the 21st century – SARS (2002-2003).[7] The declared purpose and scope of the 2005 Regulations are "to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade" (Art. 2 IHR). According to the IHR, a pandemic is defined as a "public health emergency of international concern" (hereinafter: PHEIC), that is "an extraordinary event" which constitutes "a public health risk to other States through the international spread of disease", and "potentially requires a coordinated international response" (Art. 1 IHR). The WHO Director-General has the authority to determine, "on the basis of the information received, in particular from the State Party within whose territory an event is occurring", whether an event constitutes a PHEIC (Art. 12 IHR) and to issue "temporary recommendations" (Art. 15 IHR).

In short, the said provision of the IHR "expanded the WHO's power" (Yi-Chong, Weller, 2020, p. 52) based on "scientific evidence and a contextual risk assessment" (Burci, 2018, p. 683), but the question is whether the IHR did create new binding rules for states. A novelty brought by the IHR regime is the duty of the WHO member states to notify the WHO about any public health event within their territory that might constitute a PHEIC. In addition, the IHR prescribes a detailed procedure for communicating the public response, which could involve, alongside states, expert bodies, as well as the general (national and global) public (such as non-governmental and other intergovernmental organizations).

But it turns out that the WHO's authority to obtain information independently or compel states to provide information was seriously limited (cf. Berman, 2020). Besides, there is a type of dispute settlement regime concerning the interpretation or application of the IHR, with the World Health Assembly as the main oversight mechanism (Article 54 IHR) to which disputes between the WHO and a member

[6] The IHR were first adopted in 1969 (WHO Official Records, No. 176, resolution WHA22.46 and Annex I). The document was preceded by the International Sanitary Regulations adopted by the Fourth World Health Assembly in 1951. Initially, it covered six "quarantinable diseases" and they were subsequently amended (in 1973 and 1981) primarily to reduce the number of covered diseases from six to three (yellow fever, plague and cholera) and to mark the global eradication of smallpox.

[7] The IHR of 2005 were adopted by the Fifty-eighth World Health Assembly (23 May 2005) and entered into force on 15 June 2007. In this paper we use the WHO 2016 edition; hereinafter referred to as the "IHR, 2005" or just "IHR".

state may be submitted (Article 56.5 IHR). But this mechanism is effectively obsolete during an emergency, and it has never been invoked.

Disease Surveillance and Risk Assessment

The new commitments for the WHO states parties are related to surveillance and risk assessment, i.e., the duty to develop "the capacity to detect, assess, notify and report" health risks on their territory, which may constitute a PHEIC. They are required to notify the WHO Director-General within 24 hours of the health risks and any consequential health measures (e.g., case definitions, laboratory results, source and type of risk, number of cases and deaths, etc.). They should consult the WHO, which might also collect public health reports from other sources, eventually confidential in nature, but it would always consult and obtain verification from the state concerned (Art. 5-8 IHR).

Besides, other states shall, as far as practicable, inform the WHO within 24 hours of receipt of evidence of a public health risk identified outside their territory that may cause international disease spread (Art. 9 IHR). Finally, there is a possibility for the WHO to obtain information from unofficial and, ultimately, non-governmental sources ("other standard-setting organizations"; Art. 10 IHR), but such sources must also be verified by the state concerned within 24 hours.

The received public health information the WHO might communicate, in confidence, to other states parties and, as appropriate, to relevant intergovernmental organizations. Such information shall not be made available to the general public as long as there is no evidence the event is determined to constitute a PHEIC; and until the information has been confirmed in accordance with established epidemiological principles, or the very nature of international traffic requires the immediate application of such measures. But in this case also, the WHO must consult the state party in whose territory the event is occurring (Art. 11 IHR).

The above procedures evidently indicate the WHO is at the centre of gathering information pertaining to events that may constitute a PHEIC. But the Organization does not have the authority to carry out inspections within the states and cannot compel them to notify of emergencies or to provide information. In other words, the WHO has no formal enforcement mechanism for the described disease surveillance and risk assessment regime.

It seems the WHO applied this approach in China at the outbreak of the COVID-19 crisis. The Organization has been accused, mostly by the US, but also by other countries, of relying on information provided by China or having been unduly influenced by that country. But judging by the provisions of the global regulations (IHR), the WHO had to use a "soft approach" to cooperate with the country in whose

territory the event is occurring. In addition, it has no formal enforcement mechanism even if China were to be found to have violated the IHR (cf. Berman, 2020).

The authority of the WHO to obtain information independently from the state on whose territory the threat has emerged or compel the state to provide information is seriously limited. In the described process of information sharing, there is some possibility of "sidelining the states parties in the case of non-collaboration" (Villarreal, 2020), specifically through "the public naming, shaming, or commending of governments depending on their performance against WHO standards", but that is, in effect, the "strongest tool in the WHO's emergency box" (Kreuder-Sonnen, 2020). The following section of the paper deals with the nature of the WHO authority and its decisions once a PHEIC is declared.

Declaration of a PHEIC and Recommendations

Since the IHR entered into force in 2007, the WHO Director-General has had the effective and powerful authority to assess and declare whether an event of public health interest constitutes a PHEIC.[8] In doing so, only two other "players" must be consulted by the Director-General: the member state in whose territory the outbreak occurred, and the Emergency Committee established for this occasion (Art. 12 IHR). The Committee is composed of experts appointed by the Secretary-General himself (48.1 IHR), selected from the existing IHR Expert Roster (Art. 47 IHR), with at least one member of the Committee being an expert appointed by the state in whose territory the outbreak occurred. The Expert Roster is composed of experts in all relevant fields of expertise appointed by the Director-General himself and in a number determined by him as well (Art. 54.4). One member of the Emergency Committee should be appointed at the request of each state party and, as appropriate, by relevant intergovernmental and regional organizations (Art. 47 IHR).

The state where the threat has emerged remains significantly involved in the PHEIC decision-making process. The Director-General shall consult with the state regarding the "preliminary determination", but if they do not come to a consensus within 48 hours, he should make the "final determination" after obtaining the opinion of the Emergency Committee (Art. 12.3.; Art. 49.5 IHR). Obviously, the concerned state has room to try to influence the decision-making process, which led some commentators to conclude that "the IHR, by design, institutionalises

[8] It was used on five other occasions before the modern coronavirus crisis, with some of the diseases still active today as PHEIC. The following epidemics were declared PHEIC: swine flu – 2009; poliovirus – 2014; Ebola – 2014; Zika virus – 2016, Ebola – 2019, coronavirus – 2020.

conflicts of interest into the process" (Berman, 2020). But it is fair to stress that the Director-General has the upper hand in the case of disagreement, relying solely on the opinion of his expert team.

The Director-General also has the authority to issue recommendations following the declaration of a PHEIC considering the views of an Emergency Committee. "Temporary recommendations" apply on "a time-limited, risk-specific basis" (Art. 1 IHR) and consist of proposed health measures for the states regarding "persons, baggage, cargo, containers, conveyances, goods and/or postal parcels to prevent or reduce the international spread of disease and avoid unnecessary interference with international traffic" (Art. 15.2 IHR). For routine or periodic application, the WHO may also issue "standing recommendations" (Art. 16 IHR). The WHO can issue several rather technical and regulatory measures as well, including, for example, vaccination, quarantine, isolation, contact tracing, etc. (Art. 18 IHR). But not all the categories of decisions are *non-binding advice* (Art. 1 IHR), i.e., soft-law measures.

In addition, states could adopt "additional health measures" that have a purely national dimension. Such measures are not prohibited if they achieve the same or greater level of health protection, are not more restrictive on international traffic, and are not more invasive or intrusive to persons (Art. 43 IHR). However, if the measures "significantly interfere with international traffic", the state shall provide the WHO with "the public health rationale and relevant scientific information" within 48 hours of implementation. In case of disagreement as to the measures, the IHR proposes information sharing, consultations, and the reaching of a "mutually acceptable solution". The "dispute settlement" mechanism is thereby exhausted.

CONCLUDING REMARKS

The focused analysis of the explicit rules and administrative mechanisms of the WHO indicates some institutional features to be summarized in the conclusion. In addition, it gives a hint to the further theorizing, analysis, and investigation of the changing environment of the Organization that might go beyond institutionalism.

Summary of the Institutionalist Analysis

The WHO's institutional arrangement revealed several interesting features that, however, remain of soft-law nature. The general authority of the WHO has traditionally originated from the member states, but, on the other hand, it arises in one part from specialized knowledge. That has created, in effect, some type of "expert and delegated model" of authority (McInnes, 2015, p. 1302), that is a "delicate balance" between the two models that must be achieved in practice. The

general decision-making regime of the WHO demonstrates features that are "somewhat unique" in the United Nations system. Namely, the WHO may adopt legally binding decisions by a qualified or simple majority, but the procedure of entry into force gives the member states a channel for opting out by notifying the WHO of their rejections or reservations. This is not the case in transnational organizations such as the EU, in an increasing number of issue areas where there are no possibilities for opting out of a decision not adopted unanimously.[9]

There is no formal enforcement mechanism for compelling states to provide information prior to or during a pandemic. The WHO has limited authority to obtain surveillance and risk assessment information independently from the state on whose territory the threat has emerged. The state concerned remains involved in the decision-making on the PHEIC determination as well. But, it must be clearly stressed that in the declaration of a PHEIC, the Director-General has the upper hand in relying on the opinion of the expert body. This sole competence is powerful enough, given the social and economic implications of such a declaration as has been witnessed in the COVID-19 crisis. Concerning WHO recommendations (i.e., the Director-General) during a pandemic, they are by nature advisory and exclusively non-binding.

The strongest emergency tool of the WHO is the possibility of public "naming and shaming" through information-sharing with other states, non-governmental and intergovernmental organizations, and the general public. Even when states are reluctant to share information about outbreaks in their countries, the Director-General might "become active" (von Bogdandy, Villarreal, 2020) via the mechanism of public pressure. This "raising alertness about the risk" is "an instance of executive decision-making" (Vierck, Villarreal, Weilert, 2020), but it should be emphasized that "[t]his is in no way a legal enforcement mechanism; it may work for policy reasons only" (Frau, 2016).

Beyond Institutionalism

The aforementioned mechanism of public pressure may lead to a growing perception that the WHO regulations are of binding nature, even if there is a certain deficit of mandatory rules. Finally, public accusations displayed in other issues might "play a constitutive role, constructing new norms, including customary international law" (Finnemore, Hollis, 2020). This outlines possible directions of future research, either towards studying the "naming and shaming" process in the context of the WHO, or towards the involvement of other actors in research, which appropriately

[9] For the elaboration of these issues in the EU setting, see: Novičić, 2019.

encompasses a multistakeholder concept. Strictly institutional and legal analyses generally "leave this black box unopened" followed by "notable gaps in knowledge" (Scholte, 2020, pp. 16, 26). That is true in international public health issues as well.

"Naming and Shaming" in International Public Health Issues

To say that the current COVID-19 crisis has been accompanied by a "shaming pandemic" (Max, 2020) might feel exaggerated, but "shaming" has been a part of each similar outbreak in the past, from the Spanish Flu of 1918 to AIDS and SARS at the start of the new millennium. Yet nothing prepared the world for the "ubiquity" of shaming in the digital age, at a time when ordinary social life has nearly been eliminated. "Digital shaming" seems to become "particularly virulent" when there is no agreement on what constitutes correct behaviour. Many COVID-19 statutes are "vague", and the epidemiology behind the disease is "in flux" (Max, 2020). Obviously, the Internet and new social media are empowering an ever-broader pool of state and non-state actors with the means to expose non-compliance and publicly condemn targeted actors. It is assumed that "naming and shaming" are likely to increase in international politics in the future (Friman, 2015b, p. 217).

Given the said "ubiquity" and "constitutive role" of these processes, it seems that carefully theorized explanations and more quantitative research are needed. Some instruction may be found in other areas of international relations where "mobilization of shame" has been extensively examined (Friman, 2015), such as human rights (Risse, Ropp, Sikkink, 2013). "Using public exposure of noncompliance" is a preferred constructivist tactic of "shaming" in which "argumentative discourse" could "mobilize domestic and international support, alter the targeted government's behaviour, pressure its supporters, and serve as a deterrent to the actions of others" (Friman, 2015a, p. 2). It is not unfamiliar in earlier international relations debates either; for example, Hans Morgenthau assumed that public opinion was mobilized rather than spontaneous (Morgenthau, 1948; in Friman, 2015, p. 12), etc.

Researchers in other areas identified the problem in multiple potential causal dynamics that are at play here (Friman, 2015, p. 18) and that "specific causal mechanism(s)" behind successful and failed naming and shaming efforts have remained "elusive" (Busby, Greenhill, 2015, p. 105). By all means, the potential for further research of "naming and shaming" dynamics exists, and it is especially important in issues with a potential for causing harm, such as international public health issues. In the end, just to mention a "politicization paradox" identified here, i.e., the "practices meant to punish" certain behaviours can also "operate in such a way as to encourage, reward, and perpetuate them" (Terman, 2021).

Toward Multistakeholderism in International Public Health Issues?

How to encompass "various state and non-state constituencies who have a stake in (i.e., affect and/or are affected by) the problem at hand" (Scholte, 2020, p. 3), which in this paper is the decision-making authority of the WHO in pandemics. McInnes tried that regarding the events surrounding the Ebola Crisis (2014) and referring to the aforementioned five sources of "global governors" authority. He identified shifts in sources of WHO authority from the traditional "expert and delegated model" to a more technocratic, "capacity-based model", but concluded that ultimately, the traditional model has not been replaced (p. 1302). One of his indicators was the WHO's budget and financing (pp. 1314-15), which is still a pressing question for the Organization. According to the data, in recent years, the WHO has received about three-quarters of its support from voluntary contributions (see Note 1). Such a budgetary structure reveals the need for the WHO to be "responsive to the policies, agendas, and preferences of various donors" (Lee, 2009, p. 41). The WHO bodies seem willing to acknowledge that relying heavily on voluntary and private donations poses a systemic challenge, so earlier this year the Executive Board established a working group to make recommendations regarding "sustainable financing" in early 2022 (WHO, 2021).

An insight into the history of the WHO reveals that it has been internally burdened by the longstanding competition between two perspectives on its policy and agenda (Cueto, Brown, Fee, 2019, p. 2): one is a socio-medical perspective (horizontal and multi-sectoral) and the other is a technocratic, biomedical perspective (vertical and mono-focal). The first perspective can be recognized in the WHO constitutive document (Preamble), suggesting that diseases are conditioned both socially and economically, and their restraint requires a broad social response. The second perspective assumes that "epidemic diseases are basically biomedical events that need technological interventions alone to tame them".

These remarks urge deeper examination of the impact of the funding mechanism and the political economy on WHO decision-making. Here, the multistakeholder approach imposes itself with a claim to assemble business, state and civil society actors under one research umbrella. For example, Scholte's research has suggested a concept of "complex hegemony" and hints that "global multistakeholder initiatives have emerged due to a combination of sponsorship by leading states, enactment by a transnational elite network, capitalist drives for global accumulation, and certain dominant discourses" (Scholte, 2020, p. 19). It seems that power hierarchies influence the supposed "horizontality" of multistakeholder settings, but obviously, well-grounded synthesizing of academic analyses is lacking.

More research, both theoretical and empirical, is needed on the WHO in multistakeholder settings. And just as Scholte concluded in tracing a "transformed global governance theory" in a general sense (Scholte, 2021a, p. 187), this does not mean advocating a "politicization" of analysis in which "passion trumps logic and evidence", but rather urging "careful and explicit attention to the motivations and implications" and anticipating the "potential political use (and misuse)" of research findings. It seems this is even more pressing in issues with the potential to cause so much damage and polarization for societies and international relations in general as well, such as public health.

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