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China vs the WHO: a behavioural norm conflict in the SARS crisis

Christian Kreuder-Sonnen

At the height of the SARS¹ crisis in spring 2003, the World Health Organization (WHO) and China fought a silent battle over the prevalence of two competing norms in global health governance. On the one hand, the established norm of sovereignty, particularly the principle of non-interference, had structured a regime for dealing with infectious disease outbreaks that provided ground rules of conduct but ascribed decision-making authority to member states alone. It explicitly ruled out foreign or supranational interference. On the other hand, the emerging norm of global health security was built on an understanding of infectious disease outbreaks as international security problems requiring supranational coordination and governance capacity. In effect, it implied the subordination of national economic and political interests to global disease detection and containment efforts. Its proponents thus sought a prominent role for the WHO in taking decisions in response to global health emergencies which would entail interference with state sovereignty. By the time of the SARS outbreak, this normative tension was far from being resolved. On the contrary, the two central actors in this episode, the Chinese government and the WHO secretariat, turned it into a manifest norm conflict by demonstrating incompatible positional differences over the relative priority of the two norms.²

Intriguingly, however, neither China nor the WHO resorted to discursive modes of contestation by justifying their respective positions with reference to normative arguments. Almost exclusively, they displayed incompatible normative expectations in the way they put the norms into practice. The WHO acted as if the norm of global health security had already been widely accepted, supplanting those aspects of the sovereignty norm with which it conflicted. Without prior legal or political authorization to do so, the organization took a set of unprecedented measures. Most importantly, it issued travel warnings for affected regions, devised emergency recommendations, and put pressure on governments (the Chinese in particular) to comply—clearly challenging the non-interference

¹ Severe Acute Respiratory Syndrome.

² On the manifestation of norm conflicts, see Michael Zürn, Benjamin Faude and Christian Kreuder-Sonnen, *Overlapping spheres of authority and interface conflicts in the global order: introducing a DFG research group*, WZB Discussion Paper SP IV 2018-103 (Berlin: Wissenschaftszentrum Berlin für Sozialforschung, 2018), <https://bibliothek.wzb.eu/pdf/2018/iv18-103.pdf>. (Unless otherwise noted at point of citation, all URLs cited in this article were accessible on 19 Jan. 2019.)

principle.³ Conversely, China acted in accordance with the sovereignty norm as enshrined in the 1969 International Health Regulations (IHR), which provided that member states retained the right to decide whether or not to communicate disease outbreaks to the WHO and that all activities by the WHO were dependent on member-state approval. Not only did China conceal vital information on the outbreak and defy the travel warnings, it also obstructed on-the-ground inspections by WHO teams—clearly challenging the norm of global health security.

Here, then, was a ‘behavioural’ norm conflict between China and the WHO, characterized by non-verbal expressions of positional differences. Both actors engaged in *behavioural contestation*, defined in this special section of *International Affairs* as those instances ‘when the actions of relevant actors imply the existence of conflicting understandings of the meaning and/or (relative) importance of a norm’.⁴ It is thus not about arguments advanced by the actors involved, but about actions in implementation, or interference with implementation, of a norm that reflect divergences in actors’ norm valuation.⁵ Why did the actors resort to behavioural rather than discursive contestation? And with what consequences? By addressing these questions, this article sheds light on the so far understudied phenomenon of behavioural norm contestation and provides first insights on its use by fundamentally different types of actors, namely states and international organizations (IOs). Moreover, it adds to the norm contestation literature, whose focus has predominantly been tied to ‘within-norm contestation’, that is, discursive contestation of a single norm, by analysing forms and effects of contestation ‘from outside’, that is, over the relative priority of two competing norms.⁶

In a nutshell, my argument is that the *recourse* to behavioural rather than discursive contestation on both sides of the conflict can be explained by the strategic benefits reaped from silent forms of contestation when actors must fear a backlash against an open and direct norm challenge. That is, behavioural contestation makes it possible to give effect to a certain conflictual norm understanding without imposing the need to justify the full range of normative implications of this understanding. To the extent that these implications are likely to be rejected, it can be advantageous to conceal them by merely implicitly contesting a norm through particular actions. The WHO had to fear that open contestation of the sovereignty norm, which was still deeply entrenched and legally valid, would spur defensive reactions by many states concerned about their autonomy, not only the few directly affected by its actions. China, on the other hand, had to fear that open contestation

³ David P. Fidler, ‘Constitutional outlines of public health’s “new world order”’, *Temple Law Review* 77: 2, 2004, pp. 247–90; Tine Hanrieder and Christian Kreuder-Sonnen, ‘WHO decides on the exception? Securitization and emergency governance in global health’, *Security Dialogue* 45: 4, 2014, pp. 331–48.

⁴ Anette Stimmer and Lea Wisken, ‘The dynamics of dissent: when actions are louder than words’, *International Affairs* 95: 3, May 2019, doi: 10.1093/ia/iiz019.

⁵ Stimmer and Wisken, ‘The dynamics of dissent’.

⁶ For the focus on ‘within-norm contestation’, see e.g. Antje Wiener, *A theory of contestation* (Berlin and Heidelberg: Springer, 2014); Nicole Deitelhoff and Lisbeth Zimmermann, *Things we lost in the fire: how different types of contestation affect the validity of international norms*, PRIF working papers no. 18 (Frankfurt am Main: Hessische Stiftung Friedens- und Konfliktforschung, 2013), <https://nbn-resolving.org/urn:nbn:de:0168-ssoar-45520>; but see also Wayne Sandholz, ‘Dynamics of international norm change: rules against wartime plunder’, *European Journal of International Relations* 14: 1, 2008, pp. 101–31.

of the norm of global health security by privileging sovereignty would lay bare its low esteem for the health and survival of people beyond its borders; this could not be expected to resonate well with a global public aware of a global health threat.

Furthermore, I argue that the *outcome* of such behavioural norm conflicts is likely to depend on the practical effects of the contentious actions. Most behavioural contestation will at some point turn into discursive contestation in order to settle the conflict. I hold that the terms of this settlement should be affected by the material effects of the previous contesting behaviour, as these effects influence the extent of actors' rhetorical capacities in discursive contestation.⁷ In other words, the practical effects of behavioural contestation influence the outcome of later episodes of discursive contestation. Empirically, the article shows that the WHO's assertive crisis intervention (by which it undermined/contested the sovereignty norm in practice) was widely appreciated as effective and functionally important. The renewed process of revising the IHR after the SARS outbreak allowed the WHO and other proponents of global health security to more forcefully advance their normative agenda by pointing to the positive effects that would accrue from their norm interpretation.

Competing norms for governing infectious disease outbreaks

Today, the WHO is the leading authority in preventing and containing the international spread of infectious diseases, meagrely funded, but armed with the competence to declare Public Health Emergencies of International Concern (PHEICs) and to autonomously devise emergency measures to cope with them. This stands in stark contrast to the architecture of global health governance prevailing up until the early 2000s, in which the WHO had been forced to watch the spread of epidemics as a bystander because it lacked the competence to intervene autonomously and the member states refused to authorize such actions.⁸ This section of the article shows, first, that the traditional governance arrangement was built on a very strong sovereignty norm which put final responsibility for combating infectious disease outbreaks in the hands of state governments; and second, that, starting in the 1990s, an alternative norm of global health security emerged which put the timely detection and effective containment of infectious disease outbreaks centre stage and thus allowed for infringements on state sovereignty, strictly defined.

The sovereignty norm in global health governance

The international governance of infectious disease has traditionally been approached as a matter of interstate agreements. From the first International

⁷ This argument builds on the assumption that the extent to which justificatory arguments have the desired effect of being accepted as valid by the audience is strongly influenced by the social and material context in which they unfold. See Ronald R. Krebs and Patrick Thaddeus Jackson, 'Twisting tongues and twisting arms: the power of political rhetoric', *European Journal of International Relations* 13: 1, 2007, pp. 35–66 at p. 47.

⁸ Mark W. Zacher and Tania J. Keefe, *The politics of global health governance: united by contagion* (New York and Basingstoke: Palgrave Macmillan, 2008).

Sanitary Conferences in the second half of the nineteenth century, states considered the issue of contagious pathogens as a problem of two sorts. On the one hand, they sought protection from diseases imported from other countries. To that end, they applied defensive measures such as quarantines at borders and ports. On the other hand, they had the shared interest of not disproportionately disrupting cross-border travel and trade by imposing such measures excessively on one another. The first intergovernmental agreements regulating this complex issue thus gave particular prominence to the question of how to strike a balance between these two countervailing interests. Overall, the ambition was not to contribute to the general betterment of global health conditions or to find ways to cooperatively tackle transnational health threats.⁹ Instead, states self-interestedly tried to preserve a right to unilaterally impose restrictions on aliens while promoting freedom of action for their own citizens abroad. International rules hence aimed at restricting rather than enhancing states' protection efforts without interfering in their internal affairs. To cede authority to an international institution was out of the question.¹⁰ This understanding of governing infectious disease, which relies on interstate agreements to reduce the negative side-effects of domestic containment efforts without supranational interference, is what I call the sovereignty norm in global health. While it has been softened over time, the sovereignty norm has largely structured the entire governance architecture in global health, including the function and design of the WHO.

In fact, at least before 2003, the WHO secretariat's formal and informal authority has met a sharply defined limit in member-state sovereignty.¹¹ The WHO's constitution essentially ruled out any interference with members' sovereignty through the supranational organ by premising any type of direct intervention in member states on their explicit request or acceptance.¹² The same principle also applied specifically to the surveillance of and response to infectious disease outbreaks. The IHR, adopted in 1969, set out in concrete form both the member states' and the WHO's rights and duties in this policy field.¹³ The purpose of the IHR was and remains to ensure maximum security against the international spread of diseases while keeping interference with international traffic and trade to a minimum.¹⁴ Their basic substantive tenets were threefold.¹⁵ First, states had a duty to notify the WHO regarding outbreaks on their territory of only three infectious diseases, namely cholera, plague and yellow fever.¹⁶ Second, states had the duty to maintain certain public health capabilities at ports and airports,¹⁷ and were permitted to

⁹ Norman Howard-Jones, 'The origins of international health work', *British Medical Journal*, vol. 1, 6 May 1950, pp. 1032–37 at p. 1035.

¹⁰ See also Fidler, 'Constitutional outlines', pp. 258–60.

¹¹ Yves Beigbeder, *The World Health Organization* (The Hague: Nijhoff, 1998), p. 15.

¹² WHO constitution, art. 2(c, d).

¹³ The IHR (1969) were preceded by the largely similar International Sanitary Regulations (ISR), adopted in 1951. Prior to the major reform of 2005, the IHR were amended only slightly in 1973 and 1981. My references apply to the latter version, which was published by the WHO as the Third Annotated Edition of the IHR in 1983.

¹⁴ IHR (1969), foreword.

¹⁵ David P. Fidler, *SARS: governance and the globalization of disease* (New York: Palgrave Macmillan, 2004), pp. 33–5.

¹⁶ IHR (1969), arts 3–9.

¹⁷ IHR (1969), part III.

take, but not to exceed, certain health measures against the spread of diseases subject to the regulations, such as disinfection, quarantines and the examination of vaccination certificates.¹⁸ Third, the WHO secretariat was required to gather and process all epidemiological information received by member states and to disseminate the relevant information of international importance to all national health administrations.¹⁹ With the consent of the member states concerned, it could also investigate particularly serious outbreaks of the mentioned diseases, in order to assist governments in organizing an appropriate response.²⁰

Before the SARS outbreak in late 2002, then, the field of infectious disease outbreak surveillance and control was governed by a 'Westphalian' contractual legal order in which political authority resided solely with sovereign states.²¹ The WHO secretariat was relegated to the role of an observer and service provider.²² The most important restriction to its function in combating infectious diseases was that member states held an effective veto over whether the WHO could publicize outbreaks on their territory or not, because the secretariat was only allowed to disseminate information officially received from member states.²³

The emerging norm of global health security

Two problems with this governance architecture built on the sovereignty norm led to mounting criticism. On the one hand, it became more and more obvious that states routinely disregarded their reporting obligations under the IHR for fear of economic losses in trade or tourism.²⁴ On the other hand, the emergence of two risk factors highlighted the shortcomings of the existing governance system in terms of reach and capacity: (a) rising concerns about so-called 'emerging and re-emerging infectious diseases' (EIDs) that might bring about unknown and/or multi-resistant transmissible pathogens through microbial mutation or adaptation; and (b) analyses of economic and societal globalization from which it became clear that increased volumes and speed of travel and trade could lead to the global spread of infectious diseases within days.²⁵ In 1995, the World Health Assembly (WHA), the main decision-making body of the WHO, officially started a reform process for the IHR in order to render the international community better prepared to meet such health threats.²⁶

¹⁸ IHR (1969), part IV.

¹⁹ IHR (1969), art. 11(1).

²⁰ IHR (1969), art. 11(3).

²¹ Fidler, 'Constitutional outlines'; see also Christian Kreuder-Sonnen and Bernhard Zangl, 'Which post-Westphalia? International organizations between constitutionalism and authoritarianism', *European Journal of International Relations* 21: 3, 2015, pp. 568–94 at p. 572.

²² Tine Hanrieder, 'WHO orchestrates? Coping with competitors in global health', in Kenneth Abbott, Philipp Genschel, Duncan Snidal and Bernhard Zangl, eds, *International organizations as orchestrators* (Cambridge: Cambridge University Press, 2014), pp. 191–213.

²³ Zacher and Keefe, *The politics of global health governance*, p. 41.

²⁴ Fidler, *SARS*, p. 35.

²⁵ Adam Kamradt-Scott, *Managing global health security: the World Health Organization and disease outbreak control* (Basingstoke: Palgrave Macmillan, 2015), pp. 102–108.

²⁶ Resolution WHA48.7 (1995).

In the course of the revision process, the WHO secretariat, together with transnational health advocates and a small group of like-minded states, promoted an alternative approach to the governance of infectious disease. Its radical difference from the prevailing regime lay in the reorientation towards another primary goal: from minimal interference with travel, trade and sovereignty to prevention, early detection and concerted containment of infectious disease outbreaks. The goal was to establish a norm of global health security which was built on the understanding that communicable diseases were by their very nature not a domestic or bilateral matter but always an issue of international concern. Moreover, given the potentially disruptive repercussions of large-scale border-crossing pandemics for the social, economic and eventually also political cohesion of affected societies, the collaborative management of outbreaks was portrayed as critical to national and international security.²⁷ This important shift in priorities also implied that, for the attainment of the global public good of health security, more international cooperation and also more binding obligations for states were necessary. If global health security was to be the primary political goal, state sovereignty could no longer remain inviolable. In effect, the normative shift would strengthen the WHO's capacities to act on such public health events to the detriment of member states' discretion. It is here that the norm of global health security intersects and conflicts with the sovereignty norm in global health.

By the end of 2002, however, the new norm of global health security was far from established in the sense of prevailing over the sovereignty norm and being legally endorsed. In the IHR revision process, member states were very reluctant to agree on a new framework which could curtail their sovereignty. The latest proposal circulating before the SARS outbreak partly reflected compromises that had already been struck, but partly also issues that remained to be negotiated.²⁸ Most importantly, it was agreed that the limitation of IHR coverage to the three designated diseases should be given up in favour of an approach based on general risk indicators that would capture all PHEICs. Also, the WHO Secretariat would be allowed to collect, assess (in consultation with the member states concerned) and disseminate outbreak information from non-state sources.²⁹

On the other hand, the 2002 proposal for revising the IHR remained silent on who would have the final say in determining the existence of a PHEIC and on how this decision would be reached.³⁰ The proposed development of an algorithm or decision tree seemed to be geared towards the aim of formalizing and thus preregulating the question.³¹ In any case, before SARS, the question was far from settled and nothing indicated that the WHO director-general (DG) should be entrusted with this task. Moreover, it was unclear whether and, if so, to what

²⁷ Sara E. Davies, Adam Kamradt-Scott and Simon Rushton, *Disease diplomacy: international norms and global health security* (Baltimore: Johns Hopkins University Press, 2015).

²⁸ WHO, *Global crises—global solutions: managing public health emergencies of international concern through the revised International Health Regulations* (Geneva, 2002), https://extranet.who.int/iris/restricted/bitstream/10665/67300/1/WHO_CDS_CSR_GAR_2002.4.pdf.

²⁹ WHO, *Global crises—global solutions*, p. 5.

³⁰ Hanrieder and Kreuder-Sonnen, 'WHO decides on the exception?', p. 337.

³¹ WHO, *Global crises—global solutions*, p. 5.

extent the WHO should be able to autonomously formulate recommendations or directives in the event of a PHEIC, i.e. whether it should be given formal 'emergency powers'.³² The proposal advocated the development of a list of key measures which could be recommended to states by the WHO, but provided that the concerned states would choose the appropriate measures together with the organization.³³ This sediment of the unfinished IHR revision process reveals the limited degree to which the emerging norm of global health security had been accepted prior to the SARS outbreak: the powers conferred upon the WHO to deal with infectious disease outbreaks remained extremely limited and—apart from the outbreak information issue—mostly subject to member-state agreement.

SARS and the silent battle over global health governance

In November 2002, a coronavirus that had emerged in bats in the Chinese province of Guangdong crossed the species boundary to humans, causing infectious respiratory illness. This hitherto unknown form of pneumonia was later named Severe Acute Respiratory Syndrome (SARS).³⁴ SARS eventually spread to 32 areas around the world, infected 8,096 people and killed 774 of them.³⁵ This section of the article analyses the actions of China and the WHO during the SARS crisis as representing a behavioural norm conflict over the relative priority of sovereignty and global health security. Its peculiar characteristic is that China never openly challenged the WHO's authority in matters of global health and the WHO never openly denied China's sovereignty rights. Both portrayed the situation on the ground in a way that allowed them to act in accordance with their preferred norm understanding. As a result, the actions of each party de facto conflicted with the other's norm understanding. First, the WHO's emergency measures to counter SARS, including travel warnings and naming and shaming practices, are described as a form of behavioural contestation of the sovereignty norm. Second, I show that China counteracted the implicit norm shift by also behaviourally contesting the emerging norm of global health security through misinformation and obstruction. Third, I provide an explanation for this behavioural norm conflict, pointing to the potential negative implications for each actor of discursively challenging the respective norm.

The WHO's behavioural contestation of the sovereignty norm

The most intensive period of WHO activity on SARS started in March 2003 with the publication of a global alert regarding an unknown respiratory disease.

³² See Christian Kreuder-Sonnen, *Emergency powers of international organizations: between normalization and containment* (Oxford: Oxford University Press, forthcoming 2019).

³³ WHO, *Global crises—global solutions*, pp. 8–10.

³⁴ For detailed accounts of the SARS episode, see David P. Fidler, 'SARS: political pathology of the first post-Westphalian pathogen', *Journal of Law, Medicine and Ethics* 31: 4, 2003, pp. 485–505; Tim Brookes, *Behind the mask: how the world survived SARS, the first epidemic of the 21st century* (Washington DC: American Public Health Association, 2005).

³⁵ WHO, *Summary of probable SARS cases with onset of illness from 1 November 2002 to 31 July 2003* (Geneva, 21 April 2004), http://www.who.int/csr/sars/country/table2004_04_21/en/.

Only days later, DG Gro Harlem Brundtland decided to issue an emergency travel advisory that for the first time named the spreading disease as ‘SARS’ and listed all the eight regions, including in China, from which the WHO had so far received reports on suspected cases. It said that ‘this syndrome, SARS, is now a worldwide health threat’ and provided information for passengers and airlines on how to detect and deal with infections.³⁶ While these technical guidelines were well received by most governments around the world in what was widely perceived as a situation of growing crisis,³⁷ health ministries in several countries also complained that they had not been consulted prior to the WHO’s ringing the alarm bells.³⁸ This should be no surprise, given that the DG had autonomously and effectively declared SARS a global health emergency—a decision with huge potential consequences for traffic, trade and tourism. Most importantly, however, the WHO not only determined that a global health emergency existed; subsequently, it also adopted emergency measures which clearly deviated from the organization’s established practice and legal framework—even exceeding the then current IHR reform proposal.³⁹ In particular, it issued concrete travel warnings for SARS-affected regions without member-state consent and assumed the role of a ‘government assessor and critic’,⁴⁰ breaking with the foremost rule characterizing the WHO’s prior norm structure, namely the inviolability of state sovereignty.

As the WHO received cumulative information that more and more areas around the world had developed local chains of SARS transmission that could be connected to international travel, especially from Hong Kong, its ‘worries on these issues became so severe that it took actions unprecedented in the history of the Organization’.⁴¹ On 2 April 2003, the WHO issued a direct travel warning, recommending passengers with destinations in Hong Kong and the Guangdong Province of China to postpone all non-essential travel.⁴² While the decision to include the Chinese province was related to an official government report indicating a sharp rise in SARS cases in the region,⁴³ the Chinese authorities had never consented to Guangdong being the subject of a global travel warning. In fact, China publicly rejected the warning as unwarranted and demanded it be ignored. The WHO stood firm, arguing that its recommendations were based on objective risk assessments.⁴⁴ In accordance with this approach, it soon extended the travel warnings to cover additional areas in China (Beijing and Shanxi Province) and also in Canada

³⁶ WHO, *World Health Organization issues emergency travel advisory*, 15 March 2003, http://www.who.int/csr/sars/archive/2003_03_15/en/.

³⁷ Kamradt-Scott, *Managing global health security*, p. 92.

³⁸ ‘Inside the WHO as it mobilized to fight battle to control SARS’, *Wall Street Journal*, 2 May 2003, p. 1.

³⁹ Andrew P. Cortell and Susan Peterson, ‘Dutiful agents, rogue actors, or both? Staffing, voting rules, and slack in the WHO and WTO’, in Darren Greg Hawkins, David A. Lake, Daniel L. Nielson and Michael J. Tierney, eds, *Delegation and agency in international organizations* (Cambridge, UK: Cambridge University Press, 2006), pp. 255–80 at p. 270; Hanrieder and Kreuder-Sonnen, ‘WHO decides on the exception?’, p. 337.

⁴⁰ Kamradt-Scott, *Managing global health security*, pp. 94–9.

⁴¹ Fidler, *SARS*, p. 90.

⁴² WHO, ‘Update 17—Travel advice—Hong Kong Special Administrative Region of China, and Guangdong Province, China’, 2 April 2003, www.who.int/csr/sars/archive/2003_04_02/en/.

⁴³ WHO, ‘Update 18—SARS outbreak: WHO investigation team moves to China, new travel advice announced’, press release, 2 April 2003, www.who.int/csr/sars/archive/2003_04_02a/en/.

⁴⁴ Nathalie Brender, *Global risk governance in health* (Basingstoke: Palgrave Macmillan, 2014), pp. 74–6.

(Greater Toronto Area).⁴⁵ In the period from 2 April to 2 July 2003, the WHO advised against travel to a total of ten areas in Canada, China, Hong Kong and Taiwan.⁴⁶

While it never openly contested the validity of the sovereignty norm or the legal system underpinning its authority, the WHO's crisis management activities reflected an understanding of the two norms of sovereignty and global health security according to which the first was declining in importance and the second rising in importance. Without verbalizing this understanding, the WHO acted in accordance with the main ideas and principles of global health security and relegated sovereignty to a subordinate position.⁴⁷ It thus represents a prime example of behavioural norm contestation.

China's behavioural rebuttal

China was not the only country subject to travel restrictions and other emergency recommendations by the WHO, but it was the first and most strongly affected. From the beginning, it obstructed the WHO's efforts to interfere with what it perceived to be its internal affairs. In contrast to Canada, for example, which disputed the inclusion of the Toronto area in the WHO's list of affected regions subject to travel restrictions on factual grounds but accepted the organization's authority in principle,⁴⁸ China did not recognize the WHO as competent to require information from Chinese authorities and tell them how to manage public health. While this became obvious in the way in which China interacted with the WHO, the Chinese government never openly argued that the organization was violating the sovereignty norm and/or that sovereignty should take precedence over global health security.

In January and February 2003, the WHO's surveillance networks detected more and more online rumours and reports of a mysterious disease outbreak in southern China, and on 10 February the secretariat decided to lodge an official request for information with the Chinese government.⁴⁹ Beijing promptly replied, reporting an outbreak of acute respiratory syndrome in Guangdong Province but stating that it was under control and declining.⁵⁰ By 27 February, the Chinese Ministry of Health was declaring the outbreak over and denying any connection to what it claimed to be cases of H5N1 avian influenza outside Guangdong Province.⁵¹

⁴⁵ WHO, 'Update 37—WHO extends its SARS-related travel advice to Beijing and Shanxi Province in China and to Toronto Canada', 23 April 2003, www.who.int/csr/sars/archive/2003_04_23/en/.

⁴⁶ See the collection of SARS-related travel advice issued by the WHO at <http://www.who.int/csr/sars/travel/en/>.

⁴⁷ David L. Heymann, 'SARS and emerging infectious diseases: a challenge to place global solidarity above national sovereignty', *Annals Academy of Medicine* 35: 5, 2006, pp. 350–53.

⁴⁸ Health Canada, *Learning from SARS: renewal of public health in Canada. A report of the National Advisory Committee on SARS and Public Health* (Ottawa, 2003), <http://www.phac-aspc.gc.ca/publicat/sars-sras/pdf/sars-e.pdf>, pp. 37–8.

⁴⁹ David L. Heymann and Guenael Rodier, 'SARS: a global response to an international threat', *Brown Journal of World Affairs* 10: 2, 2004, pp. 185–97 at p. 190.

⁵⁰ Fidler, *SARS*, pp. 74–5.

⁵¹ WHO, 'Influenza A(H5N1) in Hong Kong Special Administrative Region of China—update 2', 27 Feb. 2003, http://www.who.int/csr/don/2003_02_27a/en/.

Notwithstanding this denial of the disease's persistence in China, the WHO included a region in China in its travel warning of 2 April. On the day immediately after its release, the Chinese Minister of Health publicly ignored the WHO's travel advisory, urged travellers to visit the province and said that 'a mysterious lung ailment that apparently originated there is now under control'.⁵²

In the following days and weeks, a game of cat and mouse developed between the WHO and the Chinese authorities. WHO headquarters and field officers in China repeatedly made official requests for information and offered their assistance to China in combating the SARS outbreak. However, Chinese officials continually understated the actual progress of the disease on the ground and provided both the WHO and the public with faulty or ambiguous information.⁵³ Moreover, while WHO teams were indeed formally admitted to inspect outbreak sites to enable them to gain an appreciation of the situation, in practice they were time and again escorted to peripheral locations and denied access to the very centres of the SARS epidemic.⁵⁴ This went on for a couple of weeks before the WHO and its DG started openly criticizing, indeed denouncing, the Chinese government for covering up the true extent of the SARS outbreak in both the Guangdong Province and later in Beijing. These public rebukes directed critical international attention towards China, which eventually felt compelled to react by pledging cooperation and providing transparent information.⁵⁵ Even so, over the following months China continued to deviate from this path, prompting WHO officials to resume their criticism and attempts to influence the Beijing regime. In late May, WHO representatives were even quoted as threatening to withdraw all its assistance from and suspend working with Beijing if the government did not ensure full compliance and cooperation with the organization.⁵⁶

While China's actions were morally and politically highly questionable, they were in accordance with the established and long-undisputed sovereignty norm. The country was effectively under no legal obligation to report cases of SARS, a disease outside the purview of the valid IHR rules,⁵⁷ or to accept instructions from the WHO. It would thus be misleading to treat this as a case of simple non-compliance. Indeed, China did not comply with the WHO's prescriptions. But from the Chinese perspective, it was the WHO which had implemented a radical shift in its principles of interaction with states that represented an affront to China's sovereignty.⁵⁸ China and the WHO simply operated according to

⁵² 'China says disease is in check; health minister encourages tourism despite WHO advisory', *Washington Post*, 4 April 2003, p. A15.

⁵³ John Pomfret, 'Underreporting, secrecy fuel SARS in Beijing, WHO says', *Washington Post*, 16 April 2003, <https://www.washingtonpost.com/archive/politics/2003/04/17/underreporting-secrecy-fuel-sars-in-beijingwho-says/c52f3982-35df-4069-b9d1-9206cfc6115a/>.

⁵⁴ Fidler, *SARS*, pp. 93–102; Kamradt-Scott, *Managing global health security*, pp. 97–8.

⁵⁵ 'China orders end to SARS cover-up; officials begin belated campaign against disease', *Washington Post*, 19 April 2003, p. A08.

⁵⁶ See Fidler, *SARS*, p. 101.

⁵⁷ To be sure, it had already become accepted that the WHO could gather and disseminate information on any disease potentially posing a global health threat; but there was no obligation on member states to actively report these cases, nor was the WHO empowered to declare a PHEIC and take measures it deemed necessary.

⁵⁸ Fidler, *SARS*, pp. 108–10.

different normative logics. Since China, like the WHO, did not explicitly state its opposition to the other party's approach, but merely demonstrated it in practice, we may speak of a 'behavioural norm conflict' between the two actors over sovereignty and global health security.

Explaining behavioural contestation

Why did both the WHO and China resort to behavioural rather than discursive contestation? At first glance, it might appear puzzling that the two actors refrained from direct contestation at the discursive level. For the WHO, as for IOs more generally, norm promotion and advocacy are usually seen as part of its core business.⁵⁹ IOs profit from ascriptions of legitimacy which bolster their authority as norm entrepreneurs and, by implication, as norm testers.⁶⁰ Still, the WHO, whose expert authority has long been widely appreciated, counteracted the sovereignty norm to advance global health security only behaviourally. For China, on the other hand, the surprise attaching to the choice of behavioural contestation relates to the high degree of legalization of the sovereignty norm in the IHR.⁶¹ Formally speaking, the state had the law on its side and could, in purely legal terms, have rejected the WHO's interference with its internal affairs much more resolutely. And yet the Chinese authorities preferred to uphold a semblance of compliance with the WHO's emergency recommendations while defying them only in practice.

While the immediate causes and contexts of their actions are different for the two parties, I hold that both shared the same incentive for behavioural contestation: namely, the avoidance of the social or political costs to be expected from discursive contestation. To substantiate this claim, I resort to counterfactual analysis, carefully constructing hypothetical accounts of the consequences for the two actors of choosing contestation through words and not actions. While obviously not providing causal process accounts, counterfactuals have a strong bearing on the plausibility of arguments about avoidance and may thus usefully be employed to explain choice between a limited number of options.⁶²

For the WHO, the problem with discursive contestation stemmed from the fact that the immediacy of the SARS crisis and the perceived necessity to react swiftly and assertively stood in conflict with the tenacious struggle among member states on how to reform the IHR and thus give expression to a normative shift in global health governance. In the reform process, the WHO itself had been a part of the argumentative interaction, openly promoting the norm of global health security

⁵⁹ Martha Finnemore, 'Norms, culture, and world politics: insights from sociology's institutionalism', *International Organization* 50: 2, 1996, pp. 325–47.

⁶⁰ On the relation between legitimacy and authority, see Michael Barnett and Martha Finnemore, *Rules for the world: international organizations in global politics* (Ithaca, NY: Cornell University Press, 2004).

⁶¹ Legalization of a norm is typically assumed to bolster its standing *vis-à-vis* other norms: see Kenneth Abbott, Robert O. Keohane, Andrew Moravcsik, Anne-Marie Slaughter and Duncan Snidal, 'The concept of legalization', *International Organization* 54: 3, 2000, pp. 401–19.

⁶² Richard Ned Lebow, *Forbidden fruit: counterfactuals and International Relations* (Princeton: Princeton University Press, 2010).

and thus discursively contesting the sovereignty norm.⁶³ But when the SARS outbreak began, the norm was not yet established. If it were not to stand idly by while the SARS crisis unfolded, the WHO would have to take a course of action which was incompatible with the sovereignty norm for all practical purposes. It could choose only between justifying its actions by openly arguing that global health security was more important than state sovereignty and refraining from discursive contestation while still acting according to the norm of global health security.

The consequences of the first strategy, that of discursive contestation, would most probably have been a strong political backlash against the WHO, for three main reasons. First, by justifying its actions contravening the sovereignty norm on the basis of the emergent alternative norm of global health security, the organization would have publicly acknowledged that it was purposefully and consciously violating the norm on which its authority structure as an international organization was built. Against the background of the restrictive IHR of 1969 which were still in force in 2003, this would have led to questions of legality being asked much more forcefully. Second, the WHO's actions were very specifically geared towards a small number of member states which had to undergo infringements of their sovereignty rights, whereas the majority of states remained untouched but benefited from the constraints imposed on others. Their sovereignty thus did not seem at stake. Had the WHO discursively contested the sovereignty norm in global health by arguing that the principle of global health security should take precedence, this would have undermined the sovereignty norm in general and thus exposed all states to potential incursion. In all likelihood, this would have been met with far less approval. Third, discursive contestation by the WHO, coupled with its self-empowerment to declare SARS a global health emergency and to devise political measures to contain it, would have added a 'constitutional' dimension to the relationship between the WHO bureaucracy and the member states. In view of the complicated and periodically stalling IHR revision process, in which member states struggled to strike a balance between their wishes to preserve sovereignty and their wishes to build a functional international regime to confront infectious disease outbreaks, the WHO's self-empowerment would have appeared as a usurpation of political authority.⁶⁴ This would have raised the much more fundamental question of who holds the constituent power to determine the allocation of competencies in global health governance. Presumably, the member states, even those favouring the norm of global health security, would have felt the need to set bounds to the WHO's sphere of competence.

In sum, the WHO had little to gain from direct contestation, but much to fear in terms of negative side-effects arising from how its actions would be perceived by member states and thus their willingness to accept the WHO's radical move. China, on the other hand, was arguably predominantly occupied by the reputation costs it could incur for discursively contesting the approach of global health

⁶³ Sara E. Davies, 'Securitizing infectious disease', *International Affairs* 84: 2, March 2008, pp. 295–313.

⁶⁴ On the usurpation of political authority see Kreuder-Sonnen and Zangl, 'Which post-Westphalia?'

security on the basis of the sovereignty norm.⁶⁵ Amid the globally spreading SARS crisis and the public panic which it caused, the country simply found itself in a position from which it was very difficult to make normatively convincing arguments *against* global health security. China's rhetorical resources were extremely limited when it approached the disease as a domestic issue precluding external interference, whereas denying the extent and severity of the outbreak could in fact have negative consequences for states and societies everywhere. In essence, the Chinese handling of SARS and its attempt to limit the impact on Chinese trade and tourism by playing down its actual extent had to seem purely selfish to international observers—whatever the normative underpinning of the actions. Openly justifying this practice as being in accordance with the sovereignty norm would merely have given greater exposure to the behaviour and thus opened the door for international criticism. For China too, then, there was little to expect from discursive contestation except the prospect of condemnation by the international community.

Taking these factors together, the indirect norm conflict between sovereignty and global health security enacted by China and the WHO reveals a simple explanation for the resort to behavioural rather than discursive contestation: discursive contestation would have been more 'costly' and unlikely to succeed. In both cases, this relates to potentially contestable/normatively questionable elements in the actors' practices which they tried to cover up in the subtlety of behavioural contestation.

Reconfiguring global health governance after SARS: WHO prevails?

The SARS crisis proved to be a catalyst for the IHR revision process, which had stagnated or made only slow progress throughout the preceding decade.⁶⁶ The WHA established an intergovernmental working group (IGWG) to draft a revised version of the IHR.⁶⁷ It took just two years to substantially revise the existing regulations and agree on previously contentious issues such as the determination of a PHEIC. The new IHR were formally adopted by the 58th WHA in May 2005 and entered into force in 2007.⁶⁸ In many respects, the new IHR legally enshrine the principles of global health security and clearly relegate state sovereignty to a secondary position.

Most importantly, the revised regulations contain elements of a proper WHO 'emergency constitution' that allocate special powers within the organization for the case of a global public health emergency.⁶⁹ Member states are now required to report all disease outbreaks and 'health events' with potential international repercussions to the WHO, and the organization can also draw on non-state sources

⁶⁵ See also Davies et al., *Disease diplomacy*; Kamradt-Scott, *Managing global health security*.

⁶⁶ Zacher and Keefe, *The politics of global health governance*, pp. 65–7.

⁶⁷ Resolution WHA56.28 (2003), preamble, para. 7, para. 2 (1).

⁶⁸ See generally David P. Fidler, 'From International Sanitary Conventions to global health security: the new International Health Regulations', *Chinese Journal of International Law* 4: 2, 2005, pp. 325–92 at pp. 358–88.

⁶⁹ Hanrieder and Kreuder-Sonnen, 'WHO decides on the exception?', p. 338.

to assess threats. The ultimate decision about whether health events constitute a PHEIC rests with the WHO DG, who ‘shall make the final determination on this matter’.⁷⁰ The emergency powers for the WHO that derive from a PHEIC declaration are basically twofold. On the one hand, the organization is allowed to share with other states parties and make publicly available the information it has received from state or non-state sources—even if the states concerned decline collaboration with the WHO.⁷¹ On the other hand, the WHO may issue temporary recommendations regarding health measures to be implemented by the states experiencing the PHEIC or by other states parties to prevent or reduce the international spread of disease.⁷²

Of course, the WHO has not become an all-powerful governor of infectious disease outbreaks and member states have not forfeited their sovereignty entirely.⁷³ In fact, in order to preserve sovereign prerogatives, member states rejected several more far-reaching proposals by the WHO that would have increased its authority in compliance monitoring and verification.⁷⁴ Nevertheless, the new IHR legalize fundamental principles of the norm of global health security at the expense of member state sovereignty.⁷⁵ Compared to the legal arrangement pertaining before the SARS crisis, the reforms represent a seismic shift in the architecture of global health governance that reflects one norm more than the other.

Why did the WHO’s behavioural contestation of the sovereignty norm lead to a normative shift in global health governance, whereas China’s attempt at opposition and preservation of the primacy of sovereignty remained futile? With an exclusive focus on the norms at play, the outcome could again seem puzzling. After all, the sovereignty norm was and still is widely shared and established across policy fields. Many states routinely reject proposals for more intrusive supranational authority beyond individual control. This also applied to the IHR revision process. After SARS, just as in the years before, states remained reluctant to formally relinquish the final authority over infectious disease outbreak control.⁷⁶ And yet, in the end they did. What changed? I argue that the most important explanatory factor was endogenous to the WHO’s behavioural contestation. First, as argued above, the fact that the WHO resorted to behavioural, not discursive contestation helped

⁷⁰ IHR (2005), art. 49(5).

⁷¹ IHR (2005), arts 10(4), 11(2).

⁷² IHR (2005), art. 15(1–2). In determining the beginning and end of a state of emergency, the DG shall take into account, as well as the WHO’s ‘temporary recommendations’, the views of an Emergency Committee whose members are selected by the DG from the IHR expert roster: IHR (2005), arts 47–8. See also Adam Kamradt-Scott, ‘The evolving WHO: implications for global health security’, *Global Public Health* 6: 8, 2011, pp. 801–13.

⁷³ Andrew T. Price-Smith, *Contagion and chaos: disease, ecology, and national security in the era of globalization* (Cambridge, MA: MIT Press, 2009), pp. 153–4.

⁷⁴ Jan Thiel, ‘The rational design of IO performance problems: explaining the World Health Organization’s failures during the 2014 Ebola crisis’, paper presented at International Studies Association annual convention, San Francisco, 2018, pp. 16–22. The paper offers exclusive insights from still undisclosed documentation from the IHR negotiations.

⁷⁵ Fidler, ‘From International Sanitary Conventions’, pp. 377–9; David P. Fidler and Lawrence O. Gostin, ‘The new International Health Regulations: an historic development for international law and public health’, *Journal of Law, Medicine and Ethics* 34: 1, 2006, pp. 85–94 at p. 90.

⁷⁶ Mary Whelan, *Negotiating the International Health Regulations*, Global Health Programme working paper no. 1 (Geneva: Graduate Institute, 2008), pp. 8–9; Davies et al., *Disease diplomacy*, pp. 63–7.

tame the counter-reaction by the defenders of the sovereignty norm. Second, and more importantly, given that behavioural contestation works at the level of implementation action, it can produce material effects traceable to the contesting actors. Depending on the perception of these effects by the relevant audience as broadly positive or negative, they may become independent sources of or obstacles to rhetorical power when it comes to discursive contestation. In a nutshell, the practical effects of behavioural contestation can be expected to influence the odds in subsequent discursive contestation. In the case at hand, the WHO's emergency measures were widely regarded as highly effective in containing the outbreak. This positive perception reflected on the norm of global health security on which the WHO had implicitly based its actions. It thus unleashed argumentative resources for the proponents of the norm shift. While several member states tried to defend the sovereignty norm by narrowing the range of the organization's competencies under the new IHR,⁷⁷ the positive example set by the supranational intervention for the norm of global health security reduced the power of their counter-move.⁷⁸

The post-SARS negotiation process was kicked off by a working draft of the new IHR, written by the WHO secretariat, that was circulated in January 2004.⁷⁹ Throughout the year, WHO regional offices convened consultation meetings in which country delegations could formulate comments and recommendations to the IGWG, which convened two plenary sessions in November 2004 and May 2005.⁸⁰ In the process, several member states, including China but also Canada, the United States and many African and Latin American countries, voiced concern over what they considered excessive sovereignty losses that would ensue if the initial WHO proposal were adopted.⁸¹ However, the opposition to the far-reaching proposals was minimal in comparison to what it could have been if the WHO's norm contestation in the SARS episode had been discursive and direct, and/or the practical effects of behavioural contestation had been less positive. While the critics were able to impose limits on the WHO's accrual of authority, all states eventually agreed to grant the DG the power to declare a PHEIC and decide on the measures to be taken in response. Arguably, the SARS crisis and its handling by the WHO had set a cognitive framework in which the emphasis on global health security forestalled a return to the 'Westphalian' status quo ante.

In line with this reasoning, debates about the revised IHR were dominated by security-related arguments which stressed the risk of EIDs as showcased by SARS, and arguments highlighting the effectiveness of the path taken by the WHO to confront this risk. The first real experience with a previously unknown infectious disease brought into focus the dangers associated with EIDs in general and thus

⁷⁷ Price-Smith, *Contagion and chaos*; David P. Fidler and Lawrence O. Gostin, *Biosecurity in the global age: biological weapons, public health, and the rule of law* (Stanford, CA: Stanford University Press, 2007).

⁷⁸ See also Davies et al., *Disease diplomacy*, pp. 70–72.

⁷⁹ WHO Intergovernmental Working Group on the Revision of the International Health Regulations, IGWG/IHR/Working Paper/12.2003, 12 Jan. 2004.

⁸⁰ Documentation of the two IGWG meetings, including summary reports of the preceding regional consultations, are available at <http://apps.who.int/gb/ghs/e/>.

⁸¹ Thiel, 'The rational design of IO Performance Problems', pp. 20-22; Whelan, 'Negotiating the International Health Regulations', p. 9.

fundamentally altered the risk calculations of the actors involved. Widespread fears of the next outbreak provided argumentative resources to support the WHO secretariat's claim that an institutionalization of centralized emergency capacities was necessary. These arguments were given further credibility by the co-occurring spread of the H5N1 avian influenza virus in birds in 2004 and 2005, which was considered to pose a severe pandemic risk.⁸² Overall, recent literature agrees that the SARS crisis and the discursive framing of global health in its aftermath represent key steps in a progressive 'securitization' of EIDs by which such pathogens have come to be considered as potentially existential threats to the international community.⁸³

In promoting the contours of its revision proposal, then, the WHO could point to SARS as representing the prototypical danger associated with EIDs that needed strong supranational response mechanisms. It could also invoke its own emergency measures as an example of how to successfully contain an outbreak. Having led an unprecedented international campaign to halt a previously unknown disease—a campaign that had achieved its goal of ending human-to-human transmission only a few months after the 'discovery' of the disease—the WHO was given credit for its exceptional measures as effective tools for the governance of this global health crisis.⁸⁴ As Kamradt-Scott observes, 'in the wake of SARS, a wide range of diplomats, policy-makers, health professionals, and academics publicly praised the Secretariat for its handling of the event'.⁸⁵ One of the most outspoken of these academics was David Fidler, who claimed that 'stopping SARS "dead in its tracks" less than four months after the appearance of this new virus ... will undoubtedly rank as one of the great success stories in the history of global public health efforts on infectious diseases'.⁸⁶ Media reports of the WHO's performance also asserted, for example, that 'humanity had never responded so quickly, cohesively and effectively to a new international disease threat'.⁸⁷

In the IHR revision process, and during the regional consultations in particular, members of the WHO secretariat and representatives of the respective regional offices drew heavily on these argumentative resources to convince member states of the appropriateness of the proposed changes. It appears from the documentation of at least some of the regional consultations that the WHO had even managed to present the general thrust of this approach as established fact in the 'background information' to the meetings, declaring that 'increasing globalization and the emergence of new diseases such as severe acute respiratory syndrome (SARS) have highlighted the importance of establishing a more effective basis for coordinating

⁸² Christian Enemark, 'Pandemic pending', *Australian Journal of International Affairs* 60: 1, 2006, pp. 43–49.

⁸³ Davies et al., *Disease diplomacy*; Kamradt-Scott, *Managing global health security*; Hanrieder and Kreuder-Sonnen, 'WHO decides on the exception?'

⁸⁴ As Brender (*Global risk governance in health*, p. 68) calculates, the measures enabling containment of the SARS outbreak were even cost-effective, considering the counterfactual costs of inaction and the possibility of the disease becoming endemic.

⁸⁵ Kamradt-Scott, *Managing global health security*, p. 100.

⁸⁶ Fidler, 'Constitutional outlines', p. 105.

⁸⁷ 'SARS exposed world's weak spots; experts welcome hotline for public health emergencies, new powers for WHO', *Washington Post*, 15 June 2003, p. A27.

the response to international threats to human health'.⁸⁸ Moreover, the WHO sent senior staff members to the meetings in order to explain the proposed IHR revisions. As exemplified in a statement by Dr Max Hardiman, project leader in the WHO Communicable Disease Surveillance Unit, their approach was to take SARS as a prototypical example of a global health threat that would necessarily recur. In his address to the Western Pacific consultation group, he explained that the revision process was driven by 'the need to respond in a responsible, effective, and credible way to the sudden development of public health events that threaten to spread, as illustrated by the SARS experience. Further serious and unusual disease events are inevitable.'⁸⁹ At the same meeting, Dr Shigeru Omi, WHO Regional Director for the Western Pacific, similarly linked the case of SARS to the broader problem of emerging health threats in order to argue for the IHR revisions: 'Many of you have been on the front line in the fight against severe acute respiratory syndrome (SARS), avian influenza and other emerging infectious diseases. But from these threats also come opportunities. The revision of the International Health Regulations is such an opportunity.'⁹⁰

In the end, this argumentative strategy prevailed to the extent that it achieved an 'absolute common sense of purpose' among the negotiators. 'It was exceptional that governments on this occasion, agreed on the nature of the threat and the nature of the solution.'⁹¹

Conclusion

The SARS crisis activated a previously latent norm conflict over the prevalence of rules relating to sovereignty and global health security. With China and the WHO in leading roles, this conflict remained largely behavioural, with both parties refraining from discursive contestation. Instead, they silently expressed their understanding of the relative importance of the two norms through implementation actions. This article has set out to uncover the reasons why these actors opted for behavioural contestation and to understand the feedback effects of this choice on discursive contestation.

As this article has shown, the resort to behavioural rather than discursive norm contestation is attributable to the expected social and political costs of openly contesting the norms at issue. Behavioural contestation makes it possible to conceal problematic or unpopular implications of the preferred norm understanding that are likely to arouse resistance. Actors that 'have something to hide' may thus prefer

⁸⁸ WHO Regional Office for South-East Asia, Second Regional Consultation on the Proposed Revised International Health Regulations, New Delhi, India, 29 June–1 July 2005, Project ICP CSR 002, p. 14. The summary reports of the regional consultation meetings on the IHR revision differ widely in the amount of information provided. While some give a narrative summary of the whole consultation process as well as the verbatim records of selected introductory statements, others merely submitted a few unstructured bullet points. The reports can be found at <http://www.who.int/ihr/revisionprocess/commentsregions/en/>.

⁸⁹ WHO Regional Office for the Western Pacific, Report of the Consultation on the Revision of the International Health Regulations (IHR), Manila, Philippines, 28–30 April 2004, p. 4.

⁹⁰ WHO Regional Office for the Western Pacific, Report of the Consultation on the Revision of the International Health Regulations (IHR), annex 4, p. 47.

⁹¹ Whelan, 'Negotiating the International Health Regulations', p. 16.

contestation by way of implementation action as it delivers them from justifying all the normative implications of their position. China could have openly insisted on the predominance of the non-interference principle over global disease detection and containment efforts, because that was the state of the law. But in doing so it would have had to confront the normative question of why its sovereignty rights were more important than the lives of (a potentially high number of) people around the world—a question it preferred to avoid. The WHO could have argued that the goal of mitigating a risk to global health security should trump states' sovereignty rights, justifying the infringement of the principle of non-interference represented by its assertive intervention. Yet this would have prompted questions about the legality of its actions and exposed the challenge to the sovereignty norm for all states, not just the ones affected by its actions in this case. By opting for behavioural contestation, the WHO could avoid that expected backlash.

The second claim of the article was that the longer-term consequences of behavioural norm contestation are a function of the practical effects produced by the contentious implementation action. As norm contestation makes the transition (back) from behavioural to discursive forms, the material effects of the contestants' behaviour and their valuation by relevant audiences influence the argumentative resources available to actors. That is, practical effects of behavioural contestation (de)legitimate the norm underlying the contentious behaviour and thus feed back into subsequent episodes of discursive contestation. In the present context, the case-study revealed how the perceived problem-solving effectiveness of the WHO's intervention—by which it behaviourally contested the sovereignty norm—provided an argumentative resource in discursively contesting the sovereignty norm in the subsequent IHR revision process. This resource proved decisive for the settlement of the norm conflict in favour of global health security.

Overall, the article testifies to the analytical value of studying forms of norm contestation that rely not on words but on actions.⁹² Not only does behavioural contestation provide actors with an alternative avenue for expressing a certain norm understanding or a certain understanding of the relationship of two or more norms, it also has distinct effects on norm development. Linking actions to arguments, behavioural contestation influences the social and material context in which discursive contestation plays out.⁹³ Future research should enquire further into the conditions under which behavioural contestation eventually leads to progressive norm change or to norm decay.

⁹² Stimmer and Wisken, 'The dynamics of dissent'.

⁹³ See also Sandholz, 'Dynamics of international norm change'.