Preparing for the next pandemic: The International Health Regulations and World Health Organization during COVID-19

Forthcoming in Yearbook of International Disaster Law, vol. 2(1) (2020)

Gian Luca Burci, Adjunct Professor of international law at the Graduate Institute of International and Development Studies, Geneva, Switzerland

Mark Eccleston-Turner, Lecturer of Global Health Law, University of Keele, Newcastle-under-Lyme, UK

Introduction

The COVID-19 crisis shows how a major challenge for global health security greatly exceeds immediate health concerns and disrupts innumerable essential aspects of global governance regulated by dedicated legal and institutional regimes. In this respect we have such a dedicated agency for health protection – the World Health Organization (WHO) – and a dedicated international law instrument, the International Health Regulations (2005) (IHR 2005). Adopted by the World Health Assembly (WHA) under Article 21 and 22 of WHO's Constitution, it entered into force in June 2007 and is legally binding on 196 States Parties. The IHR aim 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".[1]

This chapter argues that, even though the IHR 2005 and WHO remain the first line of defence against the international spread of disease, a sustained and long-term response to a major health crisis such as COVID-19, and crucially the preparation for future major disease outbreaks, require a strategic and critical reflection of the role of WHO and the IHR 2005 in global health security.

[1] Article 2, International Health Regulations (2005)

In this chapter we will focus on how the current IHR have limited utility *during* a pandemic, most notably in respect of a coordinated approach among states and international institutions and across international legal regimes to deliver the assets that are most important to sustain a global response, reduce the economic and social suffering, and allow the international community to "build back better".[2] We argue that the Regulations themselves are inadequately balanced at present, with insufficient attention given to the third and fourth aims of the Regulations: to "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."[3] In this chapter, we firstly outline some of the key strengths and distinguishing features of the IHR as an international legal instrument, which we caution against diluting or removing in the event of the IHR being revised post-COVID. From this we also identify one major area for future reform of the IHR, highlighting how the world and WHO can be better prepared to sustainably respond to the next pandemic.

The IHR: an innovative tool for health security

Despite this chapter ostensibly being about reform of the International Health Regulations and their institutional framework, and highlighting the shortcomings of the instrument as a way to propose a path forward, it is worth pausing for a moment to reflect upon the characteristics and strengths of the instrument itself.

The all-hazards approach

[2] UNGA, 'Sendai Framework for Disaster Risk Reduction 2015–2030' 23 June 2015, A/RES/69/283
[3] Article 2, International Health Regulations (2005)

The 2005 revisions to the International Health Regulations were the result of more than 150 years of international cooperation to prevent the spread of infectious diseases which began in 1851 at the first international sanitary conferences in Paris.[4] For our purposes it is necessary to jump ahead over 100 years to 1969 where the Twenty-Second World Health Assembly adopted a revised version of the International Sanitary Regulations, renaming them the International Health Regulations; some further minor amendments came in 1973 and 1981.[5] These pre-2005 IHR were limited in a number of respects. Firstly, they were concerned only with disease surveillance and notification at points of entry into a state; secondly, their functioning was dependent on official country notification to WHO of even a single case of a notifiable disease, which was not always forthcoming including for fear of overreactions by other states, and thirdly, WHO lacked the authority to coordinate the international response to prevent the international spread of those diseases. Perhaps the most noteworthy limitation was the narrow scope of notifiable diseases, with the IHR applying only to smallpox (until its eradication in 1981), cholera, plague, and yellow fever.[6] The 2005 revision replaced an exhaustive list of diseases as the material scope of the instrument with an 'all-hazard approach' that covers all events that may spread disease internationally including intentional acts. This all-hazards approach has a number of benefits. Firstly, the all-hazards approach of the IHR 2005 does allow for a public health response to biological, chemical, and radionuclear events. This is a strong and important recognition that these events are not merely security events but health ones with a high risk of international spread. Indeed, the IHR would have applied the Fukushima nuclear disaster in Japan,[7] had WHO had the political will to apply the instrument

[4] David P Fidler, 'From International Sanitary Conventions to Global Health Security: The New International Health Regulations' (2005) 4 Chinese Journal of International Law 325.
[5] Lawrence O Gostin, 'International Infectious Disease Law: Revision of the World Health Organization's International Health Regulations' (2004) 291 JAMA 2623.
[6] Gostin (n 5).
[7] Lawrence O Gostin, Mary C DeBartolo and Eric A Friedman, 'The International Health Regulations 10 Years on: The Governing Framework for Global Health Security' (2015) 386 The Lancet 2222.

in those circumstances, as was intended. The IHR 2005 adopts a holistic notion of risk that responds to the reality of the globalized world of the 21st century. Moreover, the all-hazards approach shifts the fulcrum of national preparedness and response from solely international entry points – as was the case under the previous Regulations - to the whole national health system.[8] This radical change is confirmed by the fact that developing, strengthening and maintaining such "core capacities" is an unconditional obligation under Articles 5 and 13 as well as Annex 1 that spells out the various levels of responsibility. As COVID-19 and other recent disease outbreaks have shown, it is undeniable that the weakness and lack of preparedness of national health systems - at whatever level of development - facilitate the international spread of diseases and pose an immediate risk to other countries. From this perspective, national health systems under the IHR 2005 become an issue of legitimate international concern and must correspondingly generate accountability and responsibility akin to those arising from *erga omnes* obligations. The intrusiveness and implications of the core capacities obligations under the IHR 2005 are one of its most striking features and were probably underestimated during the revision process.

Collaborative approach to risk

The open-ended structure of the IHR 2005 implies that there cannot be a single rigid model for surveillance, assessment and response to health risks. Building on the practice developed by the WHO Secretariat to remedy the growing obsolescence of the previous Regulations, the IHR 2005 codify a dynamic and collaborative approach that is supposed to build confidence and transparency, generate reliable information, data and analyses, build an evidence base for the provision of guidance and alert and facilitate international coordination. This is one of the

[8] Lawrence O Gostin and Rebecca Katz, 'The International Health Regulations: The Governing Framework for Global Health Security' (2016) 94 The Milbank Quarterly 264; Feng-Jen Tsai and Rebecca Katz, 'Measuring Global Health Security: Comparison of Self- and External Evaluations for IHR Core Capacity' (2018) 16 Health Security 304.

major innovations of the IHR 2005 and constitutes the normative core of WHO's "emergency functions". It has been insightfully noted that this approach constitutes "governance by information". [9]

Under Article 4 of the IHR 2005, in particular, every state party must designate focal points that serve as immediately identifiable and permanently available channels for communication, dissemination and coordination of national inputs.[10] Article 6 raises the crucial obligation for states parties to assess health events using a reasonably detailed decision tree, and to immediately notify WHO of events that reach a defined threshold of gravity and may constitute a "public health emergency of international concern" (PHEIC). It should be noted that the IHR 2005 (with some residual exceptions listed in Annex 2) don't require an identification of the causal agent as a condition for notification, precisely in order to avoid delays and trigger the collaborative assessment process. Articles 9 and 10 strengthen the surveillance and assessment mechanism by requiring states to report events occurring outside their territory and enabling WHO to use them, as well as reports from non-state sources, to seek verification and direct reports by the state concerned. An uncooperative attitude by that state may lead WHO to disclose the information received even against the objection of the state concerned, both for the purpose of alerting other states as well as indirectly putting pressure on the recalcitrant one. This power, that echoes WHO's reactions to China's concealment of the SARS outbreak in 2003, represent one of the high marks in the IHR in terms of centralization of alert and information functions. Under Article 11, finally, WHO has an equally remarkable authority to

[9] Armin Von Bogdandy and Pedro A. Villareal, 'International Law on Pandemic Response : A First Stocktaking in Light of the Coronavirus Crisis' (MPIL Research Paper Series No. 2020-07, 26 March 2020) available at: https://dx.doi.org/10.2139/ssrn.3561650

[10] Implementation has been uneven, with a number of focal points unable institutionally to escalate rapidly incoming information and coordinate outgoing reports. This can lead to counterproductive delays and miscommunications. WHO has been providing guidance on best practices to achieve a measure of harmonization in national practices. WHO, 'WHO Benchmarks for International Health Regulations (IHR) Capacities' (WHO, 2019) available at: https://www.who.int/ihr/publications/9789241515429/en/ last accessed 3rd July 2020

keep information received under the previous articles confidential unless a number of conditions require their disclosure. This provision aims at avoiding damaging overreactions by other states and actors in the absence of a clear epidemiological picture, and again entrusts WHO with a wide managerial discretion that requires not only delicate scientific assessment but also political considerations. It is not clear how much the Secretariat has in fact availed itself of this possibility, but the recent allegations of WHO's "collusion" with China at the outset of the COVID-19 pandemic shows the political risks of withholding sensitive information or delay their release, if indeed that's what happened. [11]

Consistency with order bodies of international law

It is important to recognize that whilst primarily a health event, COVID-19, and indeed any international health emergency of such magnitude, is not just about health, nor is the response one solely driven by public health considerations. As the UN Security Council's response to the 2014-2016 West African Ebola outbreak demonstrated, health emergencies can also be security events,[12] can have a dramatic impact on global trade and traffic,[13] and can bring with them significant human rights implications as shown in dramatic fashion in the response to COVID-19.[14]

[11] Jason Hoffman and Maegan Vazquez, 'Trump announceds end of relationship with World Health Organization' (CNN, 29 May 2020) <https://edition.cnn.com/2020/05/29/politics/donald-trump-world-health-organization/index.html> last accessed 13 July 2020

[12] UNSC Res 2177 (18th September 2014) UN Doc/S/Res/2177; Gian Luca Burci, 'Ebola, the Security Council and the Securitization of Public Health' (2014) 1 Questions de Droit International.

[13] WTO, 'Joint Statement on A/H1N1 Virus' (2 May 2009) <https://www.wto.org/english/news_e/news09_e/jt_stat_02may09_e.htm> accessed 1 June 2020.

[14] Patrick M Eba, 'Ebola and Human Rights in West Africa' (2014) 384 The Lancet 2091; Brigit Toebes, 'Health and Human Rights: In Search of the Legal Dimension' (2015) 9 Human Rights & International Legal Discourse 212; Mark Eccleston-Turner, 'Operationalizing the Right to Health through the Pandemic Influenza Preparedness Framework' (2018) XII Global Health Governance 22; Gian Luca Burci and Brigit Toebes, *Research Handbook on Global Health Law* (Edward Elgar Publishing 2018)

The need to ensure consistency with other rules of international law was a major concern for negotiators, aware that the broad scope of the IHR 2005 would inevitably lead to interferences and limitation in the enjoyment of rights of both states as well as other actors (including individuals) under various international legal regimes. The regulatory approach of the IHR 2005 addresses the need for consistency and harmonization by grounding risk management measures both by states as well as by WHO in a similar test of their necessity, proportionality and reliance on an evidence-based risk assessment. A similar approach is employed, for example, under the WTO SPS and TBT agreements[15] or for the limitation of civil and political rights under the relevant human rights treaties.[16] This is evident in Articles 12 (declaration of a PHEIC), 17 (criteria for WHO recommendations) and 43 (additional national health measures), where measures have to be based *inter alia* on scientific advice and principles, relevant international standards and a comparative risk assessment to avoid unnecessary interference with international traffic and trade.

Human rights standards

Having been absent in previous versions of the IHR, human rights are strongly and directly embedded in the 2005 iteration of the Regulations. Human rights manifest themselves in two distinct manners, firstly as a discrete obligation in respect of travellers, but secondly, and arguably more importantly, as a guiding interpretive principle for the IHR 2005 in their entirety. In the first instance, human rights are expressly referenced in one provision of IHR - Article 32 on the Treatment of travellers and indirectly in other articles concerning health measures applicable to them.

[15] WTO, Agreement on the Application of Sanitary and Phytosanitary Measures (1995) 1867 U.N.T.S. 493; WTO, Agreement on Technical Barriers to Trade (1995) 868 U.N.T.S. 120

[16] UN Commission on Human Rights, The Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights, 28 September 1984, E/CN.4/1985/4

Article 32 states that 'In implementing health measures under these Regulations, States Parties shall treat travellers with respect for their dignity, human rights and fundamental freedoms and minimize any discomfort or distress associated with such measures'.[17] This statement is followed by a non-exhaustive list of considerations for States Parties to consider, including courtesy and respect,[18] taking into consideration the gender, sociocultural, ethnic or religious concern,[19] and provision of food and water.[20] Article 32 is clearly not without problems, including lack of definitions regarding dignity, respect, or even what human right standards are relevant. Further clarifying and strengthening these human rights provisions where they exist, would of course be welcome in any future iteration of the IHR, in order to provide a universal minimum standard.

Moreover, the definition of what constitutes a "Traveller" for the purposes of Article 32 limits the scope of application of the Regulations in a peculiar manner. That term is limited to "a natural person undertaking an international voyage"[21] and therefore the human rights standards contained within Article 32 only become engaged when an individual crosses an international frontier. This became of real concern in the early stages of the COVID-19 outbreak in January, when China placed a *cordon sanitaire* around Wuhan to prevent travel from the region during the Chinese Lunar New Year – the largest mass migration on the planet.[22] This concern has only amplified and reached a global scale in light of the unprecedented and often draconian "lockdowns" and *cordons sanitaires* imposed by most countries in the world during 2020. The grave concerns generated by such restrictions, the increase in surveillance and the lack of

[17] Article 32, International Health Regulations (2005)
[18] Article 32(a), International Health Regulations (2005)
[19] Article 32(b), International Health Regulations (2005)
[20] Article 32(c), International Health Regulations (2005)
[21] Article 1, International Health Regulations (2005)
[22] Jing Wu, Michelle Gamber and Wenjie Sun, 'Does Wuhan Need to Be in Lockdown during the Chinese Lunar New Year?' (2020) 17 International Journal of Environmental Research and Public Health

democratic control over such measures have been well documented in recent scholarship as well as in statements by most international human rights institutions.[23] The IHR 2005 as such has a regulatory vacuum when it comes to purely domestic measures, but becomes applicable when persons cross international borders and thus become "travellers". At the same time, the provisions on the recommendations that can be issued by the Director-General under the IHR (2005) refer to measures applicable to "persons". [24] It is unclear whether this different terminology was the result of an oversight or what the normative implications of the inconsistency can be. It seems counterintuitive that the personal scope of recommendations could be broader than that of the specific health measures applicable under the rest of the Regulations. This paradox can be explained by the historical focus of the Regulations on transboundary health risks and the role played by travellers (a term which may include migrants and refugees) in spreading diseases. This is reflective in the operationalisation of the Regulations too, indeed, the overwhelming majority of events declared as a PHEIC had already crossed international frontiers at the point the declaration was made, though that is not a requirement.[25] As discussed in this chapter, the lack of specific attention to domestic measures and their impact is another confirmation of the weakness of the IHR 2005 as a normative tool for response to pandemic and similar international events. The main exception to this statement, of course, are the obligations related to the establishment and maintenance of core capacities as noted above, since they relate to the structure and functioning of national health

[23] UNSG, 'COVID-19 and Human Rights: We are all in this together' (April 2020) available at: https://www.un.org/sites/un2.un.org/files/un_policy_brief_on_human_rights_and_covid_23_april_2020.pdf last accessed 3rd July 2020; Michelle Bachelet, 'COVID-19 pandemic - Informal briefing to the Human Rights Council: Statement by UN High Commissioner for Human Rights' 9 April 2020 available at: https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25785&LangID=E last accessed 3rd July 2020; UNOHCHR, 'Emergency Measures and Covid-19: Guidance' 27 April 2020 available at: https://www.ohchr.org/Documents/Events/EmergencyMeasures_COVID19.pdf last accessed 3rd July 2020

[24] Articles 15 to 18, International Health Regulations (2005).

[25] Polio resurgence was declared a PHEIC in 2014, despite the fact there was no international spread. There were cases in Pakistan, Afghanistan, and Nigeria, though these were all unrelated to each other, and no cross-border transmission had occurred at the point of the PHEIC declaration. 'WHO statement on the meeting of the International Health Regulations Emergency Committee concerning the international spread of wild poliovirus' 5 May 2014 at: https://www.who.int/mediacentre/news/statements/2014/polio-20140505/en/

systems; however, those obligations are functional to preventing or controlling the international spread of disease rather than having an independent standing. The COVID-19 experience shows that the IHR 2005 and WHO have to play a much stronger role much earlier in the course of a disease outbreak, when national and international containment is more feasible and political positions are less entrenched.

In addition to the specific standards at Article 32, a number of other provisions in the IHR do go some way towards limiting the authority and discretion of states in a way that directly or indirectly respects human rights. Article 31 prevents States Parties from requiring "invasive medical examination, vaccination or other prophylaxis as a condition of entry." It does allow the requirement of medical examination, vaccination or other prophylaxis or proof of vaccination as a condition of entry, providing the measure is the least invasive that would achieve the public health objective, and it is in compliance with Article 23 of the Regulations. Article 23 expressly requires the prior informed consent of travellers before they are subject to medical examination, vaccination, prophylaxis or other health measures under the Regulations. This requirement exists except where "there is evidence of an imminent public health risk", in which case travellers may be advised or compelled to submit to examination", even so, this examination, regardless of consent must be the least invasive available to achieve the public health objective. Article 23 further states that any requirement in respect of travellers being subject to health measures must be 'in accordance with the law and international obligations of the State Party'. Unfortunately, however, no further specification of what the lowest level standard required in this respect is provided, meaning that significant variation can occur across States Parties.

Some further limitations on state authority does come via Article 23(5) which requires that "Any medical examination, medical procedure, vaccination or other prophylaxis which involves a risk of disease transmission shall only be performed on, or administered to, a traveller in accordance with established national or international safety guidelines and standards so as to minimize such a risk." In determining whether to implement these additional health measures States Parties shall base their determinations upon: "(a) scientific principles; (b) available scientific evidence of a risk to human health, or where such evidence is insufficient, the available information including from WHO and other relevant intergovernmental organizations and international bodies; and (c) any available specific guidance or advice from WHO." [26] Article 23 demonstrates one of the key strengths of the IHR, in that they introduce minimum standards which indirectly impact upon human rights, but do so via medical standards and best practice, which can be more palatable to States Parties than the sometimes controversial human rights standards international law has to offer.

More broadly, human rights are embedded within IHR as a fundamental principle for interpreting and implementing the Regulations. Article 3 provides the principles that guide the interpretation and implementation of the Regulations, which state firstly that "The implementation of these Regulations shall be with full respect for the dignity, human rights and fundamental freedoms of persons."[27] And secondly that "The implementation of these Regulations shall be guided by the Charter of the United Nations and the Constitution of the World Health Organization."[28] Each of these guiding instruments contains further references to human rights and could be useful in providing guidance regarding how human rights should be interpreted and applied in the IHR. Within the Constitution, it is recognised that "[t]he

[26] Article 43 (2), International Health Regulations (2005).
[27] Article 3(1), International Health Regulations (2005)
[28] Article 3(2), International Health Regulations (2005)

enjoyment of the highest attainable standard of health" as a fundamental right[29]. Moreover, Article 55 of the Charter states that "the United Nations shall promote…universal respect for, and observance of, human rights and fundamental freedoms for all without distinction as to race, sex, language, or religion."[30] The inclusion of human rights standards, particularly universalised standards such as the Charter, is clearly an important step in mainstreaming human rights during health emergencies. However, as we have seen in a number of recent health crises, including COVID-19, these standards are not always upheld or respected.[31] Finally, Article 42 contains another important statement of principle, relevant also from a human rights perspective, that should guide the interpretation and implementation of health measures taken under the IHR 2005, to the effect that such measures shall be applied in a "transparent and non-discriminatory manner". National measures with an evident discriminatory intent not supported by a plausible risk assessment, or where their scientific basis is withheld from the public, WHO and other states, can be considered in breach of the IHR 2005.

Beyond and before the emergency

When the IHR 2005 have been discussed in recent times at an academic of policy level, it has always been in the context of a health crisis and often unfortunately to lament their inadequacies. In these cases, attention is inevitably focused on the "emergency" component of the Regulations and the corresponding functions of WHO in view of the leading role it plays in this connection. However, continuing the legacy of the previous Regulations and the international sanitary conventions before them, the IHR 2005 contain a number of provisions (Parts IV to VII, Articles 19 to 41) covering more "routine" issues such as spelling out core

[29] World Health Organization, Constitution of the World Health Organization (1946) UNTS 14
[30] Article 55, United Nations, Charter of the United Nations, 24 October 1945, 1 UNTS XVI
[31] Patrick M Eba, 'Ebola and Human Rights in West Africa' (2014) 384 The Lancet 2091; Kai Kupferschmidt and Jon Cohen, 'Can China's COVID-19 Strategy Work Elsewhere?' (2020) 367 Science 1061.

capacities requirements at points of entry and the role of competent authorities (Articles 19 to 22); detailing measures applicable to travellers, conveyances and goods (Articles 23 to 34); regulating health documents and certificates required for international travel and trade (Articles 35 to 39); as well as defining responsibilities and criteria for charges deriving from the application of health measures or the issuance of health certificates (Articles 40 and 41).

These measures, which again are hardly mentioned in recent discussions, are nonetheless extremely important in that they spell out in detail the more general obligations of core capacities with particular regard to the traditional entry points where infections or contaminations can often be detected and eliminated. If the question of accountability for core capacities forms part of future discussions on the strengthening of the IHR 2005, the provisions in question will offer clearer and more specific metrics than Articles 5 and 13. From a complementary perspective, the measures considered here are also essential components of the surveillance, prevention and containment part of the IHR 2005's objective, and are often seamlessly integrated in the daily functions of public agencies, local authorities, port and airport operators as well as private companies such as airlines and shipping companies.

The formulation of the provisions in question echo the approach of maximum measures typical of the previous versions of the Regulations. However, rather than setting rigid limits that proved to be one of the main weaknesses of the old IHR, the IHR 2005 prescribe the general powers of competent authorities as well as the measures that can be implemented in particular circumstances, e.g. in case evidence of a public health risk is found aboard a conveyance (Article 27). Most importantly, there is a clear emphasis on securing respect for human rights and dignity with regard to travellers and on enforcing the requirement of the least intrusive measures necessary and proportional to address evidence-based risks (e.g. Article 31).

Finally, several provisions in parts IV to VII recognize the authority of states parties to adopt "additional health measures" (e.g. Article 27 on affected conveyances) or subject the limits to their authority to Article 43 that recognizes their right to adopt additional measures to address specific health risks or PHEICs. This approach, that acknowledges the variety of situations facing in practice competent authorities, gives wide powers to states to go beyond the general limits imposed by the relevant articles and protects them from responsibility provided that they respect the substantive and procedural disciplines imposed by Article 43. A graphic example of the implications of this additional power comes from Article 28 which, subject to Article 43, enjoins states parties from refusing "free pratique"[32] to ships and aircrafts for public health reasons. However, even though it was not reported whether port authorities explicitly referred to Article 43, the ordeal endured by the Diamond Princess and no less than other 20 cruise ships with COVID-19 cases on board show the latitude enjoyed by states in responding to their assessment of the risks deriving from specific occurrences. Whether those measures could be considered necessary and proportionate, and thus compliant with the IHR 2005, remains an open question considering the hardship endured by both passengers and crew.[33]

The IHR 2005: prevent, protect, and respond?

[32] *"Free pratique"* is defined in Article 1 of the IHR 2005 as "permission for a ship to enter a port, embark or disembark, discharge or load cargo or stores; permission for an aircraft, after landing, to embark or disembark, discharge or load cargo or stores; and permission for a ground transport vehicle, upon arrival, to embark of disembark discharge or load cargo or stores"

[33] Natalie Klein, 'International Law Perspectives on Cruise Ships and COVID-19' Journal of International Humanitarian Legal Studies (2020) DOI: 10.1163/18781527-bja10003

It is important that, in the event of the IHR 2005 being re-opened for reform post-COVID-19,[34] their strengths and distinguishing features are not lost. However, COVID-19 has clearly and unequivocally highlighted a number of crucial weaknesses in the design of the IHR 2005. It is our contention that these weaknesses are the product of the underlying assumptions which went into the design and development of the regulations in the first place. The 2005 IHR are very much a product of the response to another coronavirus pandemic, the 2003 SARS outbreak. The alert and response mechanisms of the IHR are modelled on the tools, processes and assumptions that characterized the global response to SARS.[35] What has become clear in the intervening 15 years is that the successful self-assertion of emergency powers by WHO, and lack of a constraining legal framework that make the difference to the response to SARS, has not been replicable in the 2005 IHR. In particular, the design of the 2005 iteration of the IHR imported certain assumptions about the compliance pull and effectiveness of WHO's alert and guidance that were generated by the response to the 2003 SARS outbreak. However, what we have seen over subsequent outbreaks, particularly the outbreaks of Ebola Viral disease in West Africa and in the Democratic Republic of the Congo, and the ongoing COVID-19 pandemic is that those assumptions appear to have been misplaced, and the success of WHO's alert and guidance from SARS has not been replicated in a number of outbreaks. In short, what worked for SARS without the legal framework of the IHR 2005 and the practical distribution of power between states and the WHO Secretariat, does not seem work as well for COVID-19 and the other emergencies declared under the IHR 2005 since 2009. In the event that the States Parties do seek to enhance or revise the IHR so that they are fit to ensure a modern response to modern health emergencies, it is imperative that the role of the WHO in responding to health

[34] While there were already calls for reform prior to COVID-19, it is likely these calls will only intensify through the After-Action Reviews for COVID-19: Rebecca Katz, 'Pandemic Policy Can Learn from Arms Control' (2019) 575 Nature.
[35] Fidler (n 4).

emergencies is clarified and strengthened, in order to improve the Regulations effectiveness. The rest of this section outline some of the key issues which we contend require reform in the post-COVID era. In particular, we outline what we contend is the main overarching failure of the 2005 IHR – that it places insufficient emphasis on the response element to a health emergency.

As noted above, the International Health Regulations (2005) are the dedicated instrument for global health security, and therefore, are integral to the detection of, and response to, health emergencies, such as the COVID-19 pandemic. States parties to the IHR have four main obligations under the IHR: firstly, to achieve and maintain the "core capacities" in respect of their health system, so that they have the ability to 'prevent, detect, and respond' to health emergencies within their territory[36] (as opposed to simply at points of entry as was the case for the 1969 IHR). States enjoy a transitional period to achieve those outcomes, but otherwise the obligations are not progressive or resource-related. The obligations in question, which constitute an absolute condition for the viability of the IHR 2005 framework, are quite intrusive on national sovereignty as they impose specific requirements for states parties on how to organize and resource their national health systems. On the other hand, the extreme diversity of structures, resources, level of development and fundamental philosophy about health care and public health make uniformity or even harmonization extremely challenging. The COVID-19 crisis has shown the catastrophic consequences of under-investment in primary health care and of a neo-liberal approach that prioritizes market efficiency and profitability when faced with a major crisis; besides ethical and policy considerations, those national choices or - for many developing countries - lack of resources also constitute breaches of IHR-based obligations.

[36] Article 5(1), International Health Regulations (2005)

Secondly, states parties must cooperate in good faith with WHO and one another by assessing health events occurring on their territory, notifying WHO of these events which reach a certain threshold of severity, providing detailed information and the measures taken to address the event.[37] They must also report events occurring outside their territory and verify events reported by other states parties as occurring within their territory. [38] Thirdly, States parties must ensure that national health measures, regardless of whether or not they are in response to public health emergencies and of the presence of recommendations by WHO, are necessary, proportionate to the risk, and based on a risk assessment.[39] Finally, states parties undertake to collaborate with each other, to the extent possible in the development, strengthening and maintenance of the public health capacities required under the IHR. Regulations as well as to facilitate their implementation.[40]

It is clear that the IHR have great prominence in the build up to, and declaring of a public health emergency of international concern (PHEIC), however during a pandemic or health emergency the importance and primacy of the IHR as the normative tool driving national and international response appears to wane. This is certainly the case with COVID-19: despite the considerable emphasis which was placed on the IHR in the build-up to COVID-19 being declared a PHEIC the Regulations have subsequently largely disappeared from the media, policy statements and even WHO's own narrative as the legal framework of reference. The only operational development which has occurred since the PHEIC declaration on 30 January 2020, was the renewal of the PHEIC mandate, a legal requirement under the Regulations,[41] and the issuing of updated "Temporary Recommendations" on 30 April. Even Director-General Tedros, in his frequent press statements, hardly mentions the Regulations, or the role they are currently

[37] Article 6, International Health Regulations (2005)
[38] Articles 9 and 10, International Health Regulations (2005)
[39] Article 43, International Health Regulations (2005)
[40] Article 44, International Health Regulations (2005)
[41] Article 15(3), International Health Regulations (2005)

playing in the management of the response to COVID-19. However, the IHR are intended to be a key aspect of this response, as the legal instrument which aims to "prevent, protect against, *control* and *provide a public health response* to the international spread of disease.." [emphasis added].

While WHO nonetheless continues to be the central institution for ensuring a coordinated international response to a health emergency, it is unclear whether its most relevant activities in an acute health emergency (mostly the provision of guidance and technical information, awareness-raising, country support and, when applicable, supply of medical equipment and products) fall functionally under the IHR 2005.[42] Certainly the legal framework of the IHR is not formally required in order to enable these activities to be fulfilled. Indeed, WHO was already carrying out some of these activities prior to the 2005 revisions to the IHR, albeit to a lesser degree than they currently are.[43] However, the major expansion of WHO's role in the response to health emergencies did not come from the mandate of the IHR, but through the establishment of the WHO Health Emergencies Programme (WHE) in 2016, as part of the post-West African Ebola outbreak reforms. The WHE was a significant reform in WHO operations designed to "complement[..] WHO's traditional technical and normative role with new operational capacities and capabilities for its work in outbreaks and humanitarian emergencies."[44] The secretariat of the IHR falls organically within the WHE since 2017; functionally, it plays a different but complementary role to the operational components of the WHE in order to achieve synergies and mutual support among the services most directly

[42] Gian Luca Burci, 'The Outbreak of COVID-19 Coronavirus: Are the International Health Regulations Fit for Purpose?' (EJIL: Talk!, 27 February 2020) <https://www.ejiltalk.org/the-outbreak-of-covid-19-coronavirus-are-the-international-health-regulations-fit-for-purpose/> accessed 1 June 2020.
[43] Marcos Cueto, Theodore M Brown and Elizabeth Fee, *The World Health Organization: A History* (Cambridge University Press 2019).
[44] WHO, Reform of WHO's work in health emergency management: WHO Health Emergencies Programme Report by the Director-General, 5 May 2016, A69/30

dedicated to the prevention and control of health emergencies. The WHE assesses and responds to a broad range of health events in accordance with WHO's Emergency Response Framework, [45] even if those events are not specifically handled under the IHR 2005 and even when a PHEIC has not been declared. It should also be noted that WHO has taken a very active leadership role in facilitating research and development of new therapeutics and vaccines against COVID-19 and trying to ensure universal and equitable access, crucial functions in the response to COVID-19, which nevertheless fall well outside of the legal framework of the IHR. The legal authority to carry out this, and many other activities in which the WHO is involved in the response to COVID-19 stems not from the International Health Regulations, but the Constitution of the World Health Organization or other mandate entrusted by the World Health Assembly to the Director-General.

The main reason for the apparent neglect of the IHR 2005 during the response to COVID-19 (and other health emergencies) is, in our view, that their relevance during a raging pandemic is questionable because of the design of the instrument, its limited scope and the equally limited role played by the secretariat. That is not to say that the Regulations are not important, or do not provide some benefits to global health security in the prevention and detection of emerging health threats, but the Regulations in their present form aim at preventing or containing an international spread of disease through international surveillance, alert and coordinated risk assessment and management, with insufficient attention given to the response. With the exception of Temporary Recommendations that the Director-General can issue during a

[45] WHO, Emergency Response Framework (2nd ed. 2017). Available at: https://apps.who.int/iris/bitstream/handle/10665/258604/9789241512299-eng.pdf?sequence=1

PHEIC, [46] rather weak provisions on assistance and cooperation[47] which do not specifically reference assistance or cooperation during a health emergency or PHEIC, as well as equally weak provisions on monitoring of additional health measures by the secretariat, there is little in the way of a regulatory approach to a health emergency embedded within the IHR. Indeed, in respect of a PHEIC or health emergency, Article 44 is (much like the rest of IHR) overly focussed on the surveillance mechanisms for the detection of health emergencies through the Core Capacities.[48] The Regulations do not furnish the tools for managing a pandemic and its effects such as resource mobilization, coordination of research of medical countermeasures, a coordinated approach to necessary and proportional travel and trade restrictions as well as a strong accountability mechanism to build mutual confidence and deter non-compliance. Instead, those vital activities, where they do occur, are performed on the basis of the reserved powers afforded to the WHO and Director-General by the WHO Constitution as well as separate mandates by the WHA. This is certainly an adequate basis from which the WHO can act from a policy perspective,[49] however, these activities lack the normative authority and weight of actions taken in line with the Regulations themselves.

What are the main problems and what could be done about it?

Just as in the case of the 2014-2016 Ebola outbreak in West Africa, also the challenges posed by the COVID-19 pandemic have unleashed a veritable storm of reactions among scholars,

[46] Though Temporary Recommendations are often ignored by member states: Ali Tejpar & Steven J. Hoffman, *Canada's Violation of International Law during the 2014–16 Ebola Outbreak*, 54 Canadian Yearbook on International Law 366 (2017); Asha Herten-Crabb & Suerie Moon, Outbreak-Related Travel Restrictions: Health & Economic Consequences (2017), https://repository.graduateinstitute.ch/record/295277/files/Briefing_Note_Outbreak-Related_Travel_Restrictions_FINAL; Nicole J. Cohen, *Travel and Border Health Measures to Prevent the International Spread of Ebola*, 65 MMWR Suppl (2016).

[47] Roojin Habibi, Gian Luca Burci, Thana de Campos et al, Do not violate the International Health Regulations during the COVID-19 outbreak, The Lancet (2020) 395(10225), 664-666.

[48] The only meaningful reference to collaborating and assisting in the pubic health response to be found at Article 44 is: States Parties shall undertake to collaborate with each other, to the extent possible, in:(a) the detection and assessment of, and response to, events as provided under these Regulations;

[49] International Court of Justice, Certain Expenses of the United Nations (Advisory Opinion) [1962] ICJ Rep 151

many of whom have focused wholly or partly on the role played by the IHR 2005 and how to address their weaknesses. From a policy perspective, the evaluation requested by the Health Assembly in May 2020 [50] - and announced by the Director-General on 8 July 2020 [51] - will hopefully lead to a thorough reconsideration of the structures, assumptions and power distribution underpinning global health security as well as of the role of WHO.

Scholarly contributions so far have usefully highlighted a number of issues that we are not going to reiterate in this chapter, such as the need to move away from the rigid and binary alert system based on PHEICs, the need to inject effective accountability for states' compliance with IHR obligations, as well as the enhancement of WHO's authority and independence in its alert functions. [52] For the purpose of this chapter, we are going to focus more narrowly on a specific issue of more immediate relevance to the role of the IHR 2005 as a legal tool for responding to acute international health emergencies and that, to our knowledge, has been overlooked in recent academic and policy discourse.

As noted above, the IHR 2005 have codified and regulated the surveillance and alert practices developed by the Secretariat since the 1990s. They proved very effective at containing the SARS outbreak in 2003, but also revealed the extent of WHO's power in an emergency situation outside of a legal framework. Given the pressure to revise the Regulations due to the fear of an avian influenza pandemic, the successful blueprint used by the Secretariat became the foundation of the IHR 2005. However, states used the revision to circumscribe the powers

[50] WHA, 'Res. WHA73. COVID-19 response' (19 May 2020), paragraph 9 (10).
[51] 'Independent Panel To Evaluate Global COVID-19 Pandemic Response, Including WHO's Actions' (Health Policy Watch, 9 July 2020) < https://healthpolicy-watch.news/independent-evaluation-of-who-global-covid-19-pandemic-response-announced/>
[52] Gian Luca Burci, (n42); Lawrence O. Gostin, Roojin Habibi and Benjamin Mason Meier, 'Has Global Health Law Risen to Meet the COVID-19 Challenge? Revisiting the International Health Regulations to Prepare for Future Threats', (2020) 48 Journal of Law, Medicine and Ethics, 376.

of the Director-General and to retain ultimate authority in deciding national control measures without significant risks of accountability. The IHR 2005 are therefore based on the fragile assumption that soft top-down coordination of international response to a PHEIC through temporary recommendations, coupled with equally soft monitoring of additional national health measures, would command significant conformity through their basis in a binding instrument and the "epistemic authority" of the WHO Secretariat. [53] This assumption has been disproved in practice; Article 43 gives states parties a very wide discretion to adopt measures based on their own risk assessment, and they have largely done so in response to the PHEICs declared since 2009, in particular to close off their borders with dramatic consequences for other states and non-state actors as well as for the integrity of globalized supply chains. The COVID-19 crisis has proved once and for all that states are not prepare to delegate to an international secretariat authority over policies and measures of high political sensitivity and that can assume an existential significance for the stability and the survival of society. COVID-19 has also shown the reluctance of states to exercise self-restraint toward one another or to try to coordinate their respective actions. The proliferation of uncoordinated and at times disproportionate measures, in particular in the early phases of the pandemic, has affected the sustainability of necessary health measures and facilitated the polarization of a "health versus the economy" discourse.

Article 43 requires states implementing additional measures, firstly to base them on an objective scientific basis and to adopt the least restrictive to pursue the appropriate level of health protection. Secondly, states have to report additional health measures and their rationale to the WHO Secretariat, which is required to assess their necessity and proportionality and may

[53] Jan Klabbers, 'The Normative Gap in International Organizations Law : The Case of the World Health Organization', (2019) 16 International Organizations Law Review, 272.

even request implementing states to reconsider their measures. However, the Secretariat does not disclose publicly the communications exchanged with states parties or the findings it may have reached, but posts them on a password-protected web site accessible only to states parties and implementing partners such as the European Union. Moreover, the annual reports on the implementation of the IHR 2005 submitted by the Secretariat to the WHA contains aggregate statistical information on additional health measures but does not provide information on individual states. [54] The Secretariat does not feel it has the authority to engage in public disclosure and states parties certainly don't favour a more transparent system that could put pressure on their risk assessment or political motives. There may also be legitimate reasons to avoid a confrontational posture with states parties that could compromise cooperation and access to important data and information. At the same time, the lack of public scrutiny and of a "naming and shaming" effect decreases accountability and its deterrent effects and is inconsistent with good governance principles of transparency and legitimacy.

As counterproductive as the uncoordinated response to COVID-19 may be, from a legal point of view states have purposely institutionalized a "subsidiarity" regime whereby WHO's recommendations provide a general default from which states can deviate with minimal risks of responsibility or accountability. Moreover, similarly to Article XX GATT, states parties may take actions that would otherwise breach a set of provisions listed in Article 43.1.(b) provided they are necessary and proportional to the health risk as assessed by them; only openly arbitrary or unjustifiably discriminatory measures will clearly breach IHR obligations; one example could be President Trump's decision to suspend flights from continental Europe while

[54] For a recent example, see WHO, 'Annual report on the implementation of the International Health Regulations (2005)' (4 April 2019), WHO doc. A72/8.

maintaining air traffic with the United Kingdom that was showing a similar or worse epidemiological profile as other Western European countries. [55]

Given WHO's limited oversight authority and in the absence of a functioning dispute settlement system under the IHR 2005, the legality and appropriateness of additional health measures can in practice only be tested *a posteriori* under the monitoring or dispute settlement procedures of other legal regimes such as trade, investments, transport and human rights. Such an assessment will depend on the dynamics of those regimes and will focus on their object and purpose and policy priorities rather than specifically health security considerations. The IHR 2005 will constitute in those cases another source of obligations or else a "fact" or expression of scientific consensus.

Whether states are prepared to reduce their discretion and strengthen WHO's oversight will inevitably be discussed in post-COVID-19 policy discussions. Given the current political climate and the interests at stake, major changes in this direction seem unlikely. An alternative policy approach to reduce the uncertainties created by the Regulations in this connection, therefore, would be to complement WHO's recommendations and national "Article 43" authorities with a compulsory consultation mechanism that would require states to compare their respective risk assessment and the measures they intend to adopt as a procedural condition for their legality. WTO transparency and consultation obligations could provide a familiar blueprint, especially since trade is one of the sectors at highest risk. The purpose of this exercise would be to create an institutional space for early consultations and hopefully coordination and complementarity of national measures. Any mechanism of this nature will have to rely on

[55] Maanvi Singh, Mario Koran and Vivian Ho, 'Trump suspends travel from most of Europe amid coronavirus outbreak' The Guardian (12 March 2020) < https://www.theguardian.com/world/2020/mar/11/coronavirus-outbreak-us-trump-latest>.

coordinated technical support by the competent international organizations and will have to provide a flexible forum open to states and other concerned operators. Most importantly, this approach may help in reducing disruptions and distortions and incentivize cooperation only if it is triggered at an early stage of a health crisis, when the health situation may still be under control, there is more political space for coordination, national policies are less entrenched and panic has not yet set in. The main challenge of this direction would be the inherent difficulties at coordinating diverse institutional and regulatory sectors, in particular under a health framework; and secondly, to agree on a set of incentives and deterrents that may trigger a virtuous circle of cooperation and self-restraint. Still, an effective mechanism of this nature could strengthen the sustainability of long-term international response to a pandemic or similar international health emergency by softening the overall social and economic impact of national health measures.

In terms of possible institutional models to concretize this proposal, recent scholarship has pointed to UNAIDS as a promising precedent for inter-institutional and intergovernmental coordination.[56] Regardless of the historical and political considerations surrounding the establishment and development of UNAIDS, it presents a number of features that arguably respond to the concerns and requirements noted above.[57] It has been established by an intergovernmental body (ECOSOC in that case) jointly with endorsing decisions by the governing bodies of co-sponsoring organizations, and in parallel by an agreement among the executive heads of those organizations, which was accepted by agencies joining at a later

[56] Allyn Taylor and Roojin Habibi, The Collapse of Global Cooperation under the WHO International Health Regulations at the Outset of COVID-19: Sculpting the Future of Global Health Governance, 24 ASIL Insights 15 (2020) available at: https://www.asil.org/insights/volume/24/issue/15/collapse-global-cooperation-under-who-international-health-regulations last accessed 3rd July 2020

[57] Lars Kohlmorgen, 'International Governmental Organizations and Global Health Governance: the Role of the World Health Organization, World Bank and UNAIDS' in In: Wolfgang Hein, Sonja Bartsch, Lars Kohlmorgen (eds) *Global Health Governance and the Fight Against HIV/AIDS* (Palgrave Macmillan, 2007)

time.[58] This complex process, which does not necessarily have to be exactly replicated in our case but whose intent is politically important, would facilitate sustained buy-in by both states and organizations. Its governance includes an intergovernmental body (the Programme Coordinating Board, PCB), which is essential for managing the political dimension that inevitably characterizes an international crisis of the magnitude of the COVID-19 pandemic. Unlike the rotating membership of the PCB, where states are elected for 3-year terms by ECOSOC on a regionally proportional basis, an intergovernmental organ on pandemic response coordination may have to look at a different and innovative approach to make sure that the states and regions most directly concerned are represented. It could also be envisaged that the forum in question have regional or sub-regional components to facilitate consultations and coordination among neighbouring countries. As importantly, that body is and should remain open to non-state participants and voices that carry the legitimacy of the interests directly affected by the problem at hand. While in the case of HIV/AIDS, the interests most affected were those of the communities living with the disease, in the case of a health crisis affecting international travel, trade and transport the legitimate interests that should be represented include those of the economic sectors directly impacted by the restrictions imposed to contain the spread of disease. It should not be forgotten, in this connection, that the decisions to stop flights with China and other countries affected by COVID-19 were often not taken by governments but directly by airlines. A multi-stakeholder approach to the coordination process we are proposing is therefore essential for its credibility and effectiveness. At the same time, UNAIDS features an organ composed of the co-sponsoring agencies that both prepared the work of the PCB, oversaw the implementation of its decision and provided a forum for direct inter-institutional coordination. A possible similar model complementing and strengthening the IHR will require close participation by the relevant international organizations, to provide the

[58] Burci and Vignes, *World Health Organization* (Kluwer Law International, 2004) p.85-89

evidence and scientific basis to facilitate coordination, consultation and harmonization of national measures. Ideally, participating organizations could also be enabled to play a "good offices" role to manage political controversies and strive to channel them into an objective science-based discourse.

Whether or not a possible future consultation and coordination mechanism follows a "UNAIDS model", an important question will be under whose leadership it will be established and consequently how its function and purpose will be framed. The challenge in this connection will be to ensure the priority of health measures in the context of the balancing act that a coordination mechanism will have to manage. Assigning this responsibility to WHO, either within the framework of the IHR 2005 through an amendment of its text, or as a self-standing initiative for example under its emergency programme, would ensure that intergovernmental coordination use public health and epidemiological considerations as the central metrics for decision-making, against which to assess and balance economic considerations. At the same time, from a political perspective, it may be questioned whether WHO has the "traction" or arguably the constitutional mandate to centralize this kind of coordination authority over issue areas clearly transcending public health. The cautionary message imparted in this connection by the International Court of Justice in refusing to answer WHO's question about the legality of nuclear weapons [59] has not had a chilling effect on the organization's handling of increasingly political and inter-sectoral issues affecting health outcomes, as testified by the adoption in 1993 of the Framework Convention on Tobacco Control without significant jurisdictional challenges. [60] This apparent openness by states to accept health framing and leadership for complex inter-sectoral issues could also be strengthened by the establishment of

[59] ICJ, *Legality of Nuclear Weapons* (*Advisory opinion*) [1996] ICJ Rep 4.
[60] World Health Organization, Framework Convention on Tobacco Control (2003) UNTS 3202

an inter-agency mechanism as proposed in this chapter, which participating international agencies would "co-own" rather than being convened by WHO within the framework of its governance and structure.

Conclusions

The COVID-19 crisis is a major challenge for global health security, and the World Health Organization, as the UN Specialised Agency for health. Throughout this health emergency (and a number of preceding ones) it has become apparent that the dedicated international law instrument for health security, the International Health Regulations are not appropriately equipped to manage health emergencies. This chapter has focussed on the lack of utility for the Regulations *during* a pandemic, most notably in respect of a coordinated approach among states and international institutions and across international legal regimes to deliver the assets that are most important to sustain a global response, reduce the economic and social suffering, and allow the international community to "build back better".[61]

[61] UNGA, 'Sendai Framework for Disaster Risk Reduction 2015–2030' 23 June 2015, A/RES/69/283