“The WHO’s International Health Regulations are not fit for purpose.” Discuss.

1. It has been suggested that a political shock is needed to bring about change in international law.[[1]](#footnote-1) The SARS pandemic of 2003 was the political shock that refocused international attention on finalising the International Health Regulations 2005 (‘IHR’), a legally binding instrument with the aim of preventing the international spread of disease that was already in its eighth year of negotiations. There had been a growing appreciation that the realities of modern life  made the spread of communicable diseases a  tangible, global threat, but the SARS outbreak demonstrated the immediacy of that threat. A decade and a half later, another airborne respiratory virus has provided a rude awakening as to the severity and longevity of a pandemic’s impact. As we approach the seventh month of social distancing and lockdown measures, the question has to be asked: are the International Health Regulations fit for purpose?
2. Boasting 192 signatory states, the IHR is a truly global agreement. However, what at first glance appears to be a testament to the IHR’s success is actually symptomatic of its underlying weakness: the lack of concrete enforcement mechanisms. It would be misguided, however, to assert that this weakness renders the IHR unfit for purpose. Properly implemented, the IHR provides for a robust and coordinated response to outbreaks of communicable disease. The root cause of poor responses to public health emergencies since the IHR’s ratification is the culture of non-compliance amongst States Parties and the WHO Secretariat’s reluctance to use the legal framework of the IHR to its full potential.
3. The self-proclaimed purpose of the IHR 2005, set out in Article 2, is 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.’[[2]](#footnote-2) There is nothing radical about the Article 2 mission statement. Preventing the international spread of disease while avoiding disproportionate interruption of trade and travel was the purpose of all of the IHR’s predecessors, tracing back to the 19th century International Sanitary Conventions.[[3]](#footnote-3) It was not the broad purpose of the IHR 2005 but rather its strategy in achieving this purpose that caused it to be heralded as a “seminal event”.[[4]](#footnote-4)
4. In terms of fitness for the purpose of preventing international spread of disease, it is not an exaggeration to characterize the IHR 2005 as a “quantum leap forward”.[[5]](#footnote-5) While the IHR 1969 had focused on preventing cross-border movement, the IHR 2005 appreciated that the key to outbreak prevention was surveillance and early detection at the point of origin, and therefore each individual country’s domestic public health capacities were of global concern. The IHR required States Parties to develop certain ‘core capacities’, or minimum national public health structures and resources.[[6]](#footnote-6)
5. The IHR 2005 is far better suited to preventing the international spread of disease as it was designed to apply to a wide range of public health threats. The flexible nature of Annex 2 ‘decision instrument’ means that any threat to international public health, whether of biological, chemical or radiological origin, could amount to a Public Health Emergency of International Concern (‘PHEIC’) and trigger a series of State Party and WHO obligations.[[7]](#footnote-7) This contrasts starkly with the IHR 1969, which only applied to three prescribed diseases.
6. The new IHR also learned the lesson of the SARS outbreak – namely that State Party transparency was key to outbreak prevention. The IHR 2005 granted WHO new power independent from the States Parties, in that it can rely on non-state sources of information to launch investigations into potential PHEIC events and can coordinate a response even without the collaboration of the State Party in which the disease originated. [[8]](#footnote-8) The IHR thereby disincentivised attempts to cover-up public health threats, as China had done with SARS.
7. The IHR went even further in its efforts to encourage State Party transparency in Article 43. The IHR recognised that delayed notification was generally motivated by fear of its economic consequences. A ‘quid pro quo’ was therefore placed at the heart of regulations: in exchange for prompt notification, the origin country would not be subjected to disproportionate interference with trade and travel.[[9]](#footnote-9) Any State Party imposing additional health measures that were more restrictive of international traffic would be required to provide scientific justification.[[10]](#footnote-10) Article 43 is fundamental to the IHR’s ability to prevent the international spread of disease, as a strategy of early intervention depends on state transparency. It has rightly been identified by the WHO as the “cornerstone” of the IHR. [[11]](#footnote-11)
8. Few faults can be found with the general strategy codified by the IHR. Beyond arguments for the introduction of a number of preliminary stages of alert with a lower threshold than a PHEIC declaration, there has not been notable criticism of the IHR’s basic approach to epidemic prevention.[[12]](#footnote-12) There has, however, been abundant criticism of the IHR’s implementation.
9. Non-compliance of states parties with their IHR obligations is a persistentproblem. States Parties regularly ignore the WHO Director-General's temporary recommendations upon declaration of a PHEIC, imposing travel or trade restrictions that have been expressly identified by the Director-General as unnecessary. This was seen in the response to the first ever PHEIC of the 2009 H1N1 pandemic, with a number of states banning pork imports and implementing travel restrictions.[[13]](#footnote-13) Disregard for Article 43 obligations has become a pattern of behaviour, seen again on a much larger scale in the current pandemic. 145 countries introduced entry restrictions of varying degrees of severity, contrary to the WHO’s temporary recommendations.[[14]](#footnote-14) Most of these states have not even attempted to uphold a façade of IHR compliance, with only 45 states officially informing WHO of their additional measures as required under Articles 43.3 and 43.5 (according to the WHO’s 10 March Situation Report).[[15]](#footnote-15)

1. Non-compliance is not limited to the activity of States Parties following a declaration of PHEIC. It is a pervasive issue, with States Parties consistently reneging on their core capacities obligation.  In 2014, two years after the initial 2012 deadline for meeting these capacities, only 64 States Parties claimed to have fulfilled this obligation.[[16]](#footnote-16) In an even more concerning display of indifference, 48 States Parties did not even respond to WHO’s request to report on their core capacities.[[17]](#footnote-17)
2. Due to widespread non-compliance, the lack of enforcement mechanisms within the IHR framework is frequently identified as a major flaw of the IHR. Indeed, the WHO’s Review Committee on the functioning of the IHR 2005 and the H1N1 pandemic declared the lack of sanctions as ‘the most important structural shortcoming of the IHR’.[[18]](#footnote-18) The absence of any concrete enforcement mechanisms is undoubtedly a significant flaw of the IHR. The 2012 deadline for meeting the IHR core capacities requirements did not come with any consequences, and the deadline was in any event extended to 2016 for all 81 requesting States Parties by State Party representatives at the 68th World Health Assembly.[[19]](#footnote-19) The granting of an additional extension to more than 40% of States Parties is a far cry from the ‘exceptional’ circumstance envisioned by Article 13.2 of the IHR.

1. Even Article 43, the proclaimed ‘cornerstone’ of the entire agreement, lacks a robust enforcement device. Article 43 authorises WHO to request that a State Party reconsider its implementation of an additional measure, but ultimately the State Party can impose measures that significantly interfere with international traffic and trade without consequence. Indeed, there are not even any formalities provided for an article 43 ’reconsideration’ that might propel a State Party to drop an additional measure, such as a requirement to provide written evidence of reconsideration or additional justification for the measure. That States Parties do not have to answer for their insistence on implementing disproportionate measures undermines the foundational ‘quid pro quo’ of the IHR.
2. There have been numerous proposals for enforcement mechanisms from global health law scholars, WHO Review Committees and Independent Oversight and Advisory Committees alike. It has been suggested that core capacities might be taken into consideration in International Monetary Fund’s ‘country reports’, [[20]](#footnote-20) or that the availability of the World Bank’s Pandemic Emergency Facility should be associated with external/independent WHO assessments of core capacities. [[21]](#footnote-21) Such measures would likely help to dismantle the culture of non-compliance with the IHR.
3. However, to claim that the lack of sanctions makes the IHR framework unfit for purpose would be misguided. Indeed, if the absence of sanctions was enough to dismiss a legal instrument as unfit for purpose, much of the existing body of international law would also be branded unfit. The lack of robust enforcement mechanisms is a frequent impediment to the implementation of international law. [[22]](#footnote-22) The lack of enforcement devices does not mean that international agreements have purely symbolic value. International law does not obtain its ’bindingness’ from the drafting of an impenetrable web of enforcement mechanisms dragging reluctant nation states into compliance. The ‘bindingness’ of these agreements comes from a shared understanding of a formal legal agreement as a credible commitment. [[23]](#footnote-23) The collective agreement to honour international legal obligations, set out in Article 26 of the Vienna Convention on the Law of Treaties 1969, means that the violation of international law carries reputational costs. The cost is significant for even the most brazen of governments. International law is the way in which inter-state relations are defined and regulated. A state that is seen to breach international law will therefore find it difficult to build on inter-state relations or indeed to criticise others for their non-compliance with international law.
4. To frame ineffectiveness in responses to PHEICs as caused by the lack of IHR enforcement mechanisms is to overlook the reason for such a conspicuous omission: states were unwilling to agree to a higher level of commitment. A provision to enforce Article 43 by way of compulsory arbitration of disputes over additional measures was envisioned in the 1998 IHR Draft, but was later abandoned.22 States Parties were willing to commit to global cooperation, but only insofar as it remained compatible with national self-interest. All international legal agreements limit signatory states’ discretion and therefore require the surrender of some degree of their national sovereignty.23 The IHR deals with both border controls and domestic policy, and therefore engages substantial national sovereignty issues. For all the lip service paid to the necessity for cooperation, States Parties were ultimately not willing to delegate more power over these central sovereignty issues to WHO.
5. Drafting the IHR therefore presented a dilemma. The IHR could be drafted to include more concrete obligations, clear enforcement mechanisms and a higher degree of delegation to WHO, but this would inevitably attract fewer signatory states. Alternatively, the IHR could be drafted as a ‘softer’ form of agreement, without an instrument for enforcement or express financial obligations, but have the assent of most states in the world. Both options threatened to render the IHR ineffective in its aim of global health security. With a ‘harder’ agreement, the purpose of the IHR could be prima facie undermined by state absences. For instance, negotiators of the Kyoto Agreement chose a ‘harder’ form of agreement with more concrete commitments, but these commitments apply to less than 20% of global emissions.[[24]](#footnote-24) With a ‘softer’ agreement, the IHR could be undermined by continued non-compliance.
6. Ultimately, in a world where the exclusion of even one nation state could compromise global health security, negotiators of the IHR opted for the ‘softer’ approach. This is evident not only in the exclusion of sanctions for violations, but also in the overall framing of the regulations. Interestingly, drafters of the IHR deliberately avoided framing Article 43 as a delegation of authority to WHO. Although the purpose of the article is to prevent states from introducing additional measures, the opening statement of the article is that ‘[t]hese Regulations shall not preclude States Parties from implementing health measures […] which achieve the same or greater level of health protection than WHO recommendations.’[[25]](#footnote-25) This framing reveals an awareness that Article 43 was encroaching on sensitive territory and a recognition that global assent was needed if the IHR could credibly claim to provide a legal framework for global health security.

1. Developments since the IHR’s ratification confirms that the primacy of national interest that required a ‘softer’ IHR has remained largely unchanged. Self-interest is clear in the routine disregard for Article 43 during PHEICs. It can be seen even in moments of apparent cooperative spirit. For instance, Western aid in response to the Ebola PHEIC of 2014 – 2016 was only forthcoming when the first cases of Ebola reached Europe and the United States. [[26]](#footnote-26)  Self-interest was also the dominant response to the current pandemic. Although the necessity of cooperation in overcoming COVID-19  was the common refrain of the States Parties’ representatives’ at this years’ World Health Assembly,  the actual responses to the outbreak tell a different story. [[27]](#footnote-27)  By late March 2020, when the Italian experience made it clear that COVID-19 could bring even the most developed health care systems to their knees, more than 50 States Parties had introduced some ~~form of~~ restriction on the export of medical supplies and drugs.25 the initial response was to  and keep the valuable supply for its own citizens. The Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme lamented the ‘palpable lack of global solidarity and common purpose’ in its interim report on the response to COVID-19. [[28]](#footnote-28)
2. However, state non-compliance does not excuse the WHO’s Secretariat’s unwillingness to harness the IHR legal framework against the culture of non-compliance. The WHO Secretariats complacency has fed into this culture, and has created the impression of an inadequate IHR. After declaring the H1N1 PHEIC, the Director-General failed to use the term ‘temporary recommendations’ when issuing recommendations pursuant to Article 15 of the IHR. This was rightly criticised by the Review Committee, which noted that the term was important as it carried/carries ‘specific legal implications.’[[29]](#footnote-29) This is just one example, although admittedly a minor one, of the WHO Secretariat failing to utilise the IHR framework in its interactions with States Parties. Express use of the IHR terminology would serve as a reminder of the legally binding agreement and could increase pressure to comply.
3. It was anticipated that States Parties would comply with the IHR out of fear of being ‘named and shamed’[[30]](#footnote-30), but WHO has avoided doing this. In its response to the COVID-19 PHEIC, WHO did not publish a list of states who failed to notify the WHO of additional measures within 48-hours of implementation as required by Article 43.5. Neither did WHO publicly exercise its Article 43.4 power to request that any States Parties ‘reconsider’ their additional measures.[[31]](#footnote-31) In fact, WHO appears to have tacitly accepted obviously inadequate justifications for additional measures. In its 28 February 2020 Situation Report, the WHO simply stated that the ‘public health rationale for these additional measures is mainly linked to vulnerabilities […] and the uncertainties about the virus transmission and disease severity.’[[32]](#footnote-32) The IHR 2005 was specifically designed to apply to a broad range of public health crises, rather than be limited to known and defined diseases like its 1969 predecessor. Unlike the 1969 IHR, the 2005 IHR presupposes its application to previously unknown diseases. Therefore, accepting uncertainties about the disease as a justification for disproportionate trade and travel restrictions undermines the entire purpose of the IHR. This justification could be invoked by States Parties with respect to many PHEICs, eroding any protection against unnecessary border restrictions.
4. The WHO was not always so reluctant to mobilise the law to its advantage. WHO declared that the requirement for AIDS-free certificates introduced by several member states were in violation of the IHR; a bold use of the IHR given that AIDS was clearly not one of the diseases to which the IHR 1969 applied.[[33]](#footnote-33) It is perhaps WHO’s desire to uphold their identity as a neutral, science-driven organisation that has caused the Secretariat to avoid ‘naming and shaming’. WHO’s failure to utilise the IHR to its full potential means it would be unfair to dismiss the IHR as unfit for purpose.
5. While the IHR 2005 may not have delivered on its promise of global health security, that does not mean that it is unfit for purpose. The revolutionary strategy of the IHR was never fully implemented by the States Parties or by the WHO Secretariat. Whether COVID-19 will be the ‘political shock’ that sparks an amendment of the IHR to include accountability mechanisms remains to be seen. Much depends on how the rest of the pandemic unfolds, but the fact that some of the states who have been most successful in controlling the virus (Taiwan, Singapore, New Zealand and Australia) were also those who were quickest to close their borders makes it unlikely that such self-interested measures will be abandoned in the future.
1. Paul Diehl, Charlotte Ku and Daniel Zamora, ‘The Dynamics of International Law: The Interaction of Normative and Operating Systems’ (2003) International Organization 157. [↑](#footnote-ref-1)
2. IHR 2005, Art. 2. [↑](#footnote-ref-2)
3. David P Fidler, ‘From International Sanitary Conventions to Global Health Security: The New International Health Regulations’ (2005) Chinese Journal of International Law 325. [↑](#footnote-ref-3)
4. *Ibid*., 392. [↑](#footnote-ref-4)
5. Morten Broberg, ‘A Critical Appraisal of the World Health Organization’s International Health Regulations (2005) in Times of Pandemic: It Is Time for Revision’ (2020) European Journal of Risk Regulation 205. [↑](#footnote-ref-5)
6. IHR 2005, Annex 1. [↑](#footnote-ref-6)
7. Fidler (n 3) 363. [↑](#footnote-ref-7)
8. IHR 2005, Art. 9, Art. 10. [↑](#footnote-ref-8)
9. Sara E Davies , Adam Kamradt-Scott and Simon Rushton, *Disease Diplomacy: International Norms and Global Health Security* (1st edn, JHUP 2015) 72; IHR 2005, Art. 43. [↑](#footnote-ref-9)
10. IHR 2005, Art 43. [↑](#footnote-ref-10)
11. WHO, *Strengthening response to pandemics and other public‐health emergencies: report of the Review Committee on the Functioning of the International Health Regulations (2005) and on Pandemic Influenza (H1N1)* (2009) 63. [↑](#footnote-ref-11)
12. Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme, *Interim report on WHO’s response to COVID-19: January – April 2020* (2020) 4-5. [↑](#footnote-ref-12)
13. Lawrence O Gostin and Rebecca Katz, ‘The International Health Regulations’ in Sam F Halabi, Lawrence O Gostin and Jeffrey S Crowley (eds), Global Management of Infectious Disease After Ebola (OUP 2017). [↑](#footnote-ref-13)
14. Adam Ferhani and Simon Rushton, ‘The International Health Regulations, COVID-19, and Bordering Practices: Who Gets in, what Gets Out, and Who Gets Rescued?’ (2020) Contemporary Security Policy 458. [↑](#footnote-ref-14)
15. *Ibid.*, 468. [↑](#footnote-ref-15)
16. Gostin and Katz (n 13) 111. [↑](#footnote-ref-16)
17. *Ibid.,* 111. [↑](#footnote-ref-17)
18. WHO (n 11). [↑](#footnote-ref-18)
19. Gostin and Katz (n 13) 104. [↑](#footnote-ref-19)
20. Broberg (n 5) 207. [↑](#footnote-ref-20)
21. Gostin and Katz (n 13) 119. [↑](#footnote-ref-21)
22. Clare Wenham, ‘Ebola respons-ibility: moving from shared to multiple responsibilities’ (2016) Third World Quarterly 436. [↑](#footnote-ref-22)
23. Kenneth W Abbott and Duncan Snidal, ‘Hard and Soft Law in International Governance’ (2000) International Organization 421. [↑](#footnote-ref-23)
24. European Commission, ‘Kyoto 1st commitment period (2008–12)’ (*Climate Action – European Commission*) <https://ec.europa.eu/clima/policies/strategies/progress/kyoto\_1\_en> accessed 23 September 2020. [↑](#footnote-ref-24)
25. IHR 2005, Art. 43. [↑](#footnote-ref-25)
26. Wenham (n 22) 443. [↑](#footnote-ref-26)
27. Pedro A Villarreal, ‘Pandemic Intrigue in Geneva: COVID-19 and the 73rd World Health Assembly’ (EJIL:Talk!, 22 May 2020) <https://www.ejiltalk.org/pandemic-intrigue-in-geneva-covid-19-and-the-73rd-world-health-assembly/> accessed 17 September 2020. [↑](#footnote-ref-27)
28. Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme (n 12) 11. [↑](#footnote-ref-28)
29. WHO (n 11) 60. [↑](#footnote-ref-29)
30. Wenham (n 22) 441. [↑](#footnote-ref-30)
31. Ferhani and Rushton (n 14) 469. [↑](#footnote-ref-31)
32. Ferhani and Rushton (n 14) 468. [↑](#footnote-ref-32)
33. Fidler (n 3) 340. [↑](#footnote-ref-33)