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

“Il y a eu dans le monde autant de pestes que de guerres. Et pourtant pestes et guerres trouvent les gens toujours aussi dépourvus."[[1]](#footnote-1)

The Question

1. The International Health Regulations 2005 (IHR) contain their purpose:

“The purpose and scope of these Regulations are to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade.”[[2]](#footnote-2)

1. The task of the IHR, then, is not simply or only to prevent disease. Rather, they were intended to maintain proportionality, between national public health efforts on one hand and international freedom of commerce and movement on the other, the World Health Assembly having assumed an inherent tension between these two spheres. Do the IHR succeed in this? If not, can they succeed?

Preliminary matters

1. This essay is written in interesting times. The author is thus compelled to make certain non-legal assumptions about the prevailing circumstances, namely, that the present COVID-19 pandemic remains a grave and serious risk to global health; that international trade and traffic have been severely if not incalculably damaged thereby; and the IHR thus face an existential test. Whilst topicality always hazards presumption, it would be facile to ignore this context, even if much necessarily remains unknown.

Introduction

1. The IHR are the only area of binding international law to address the threat of global infectious disease. They were developed from the International Sanitary Conventions (ISCs) of the nineteenth century, which were adopted by WHO in 1951, and underwent only minor amendment until 2005. Prior to that, the ISCs and the pre-2005 IHR dealt only with a short list of named diseases (cholera, yellow fever, and other sufficiently threatening conditions); prohibited States Parties from health measures beyond those specifically permitted; and as regards information, placed the World Health Organisation (WHO) in complete reliance on official notifications from affected states parties to the detriment of all other sources. Unsurprisingly, compliance was poor. Any criticism of the IHR must acknowledge that they occupy a body of law which has existed for 128 years[[3]](#footnote-3), that they constitute a definite improvement on that law, and that the reform required for that improvement took 10 years to achieve.[[4]](#footnote-4)
2. Emergent diseases such as HIV/AIDS, and later SARS, demonstrated the inadequacy of the old approach. The “set menu” was replaced by the concept of a Public Health Emergency of International Concern (PHEIC), intended to catch all infectious diseases. Correspondingly, the WHO was placed under a pro-active duty to surveil, and freed to accept non-governmental information. The Emergency Committee, a panel of experts widely drawn from the World Health Assembly (WHA), would assist in determining a PHEIC and in issuing to states parties the Temporary Recommendations addressing it, although qualified deviation from these recommendations was allowed. These improvements notwithstanding, COVID-19 prompts the closest scrutiny of the IHR and their application.
3. This essay dismisses complaints as to enforcement but considers the IHR open to criticism in two principal areas, both specific to the 2005 reforms. The first concerns the informational provisions, relating to surveillance, notification, information-sharing, and verification, up to the determination of a Public Health Emergency of International Concern (PHEIC). I demonstrate that these mechanisms have been inevitably distorted by political pressure but remain fundamentally serviceable. The second area comprises the recommendatory provisions, of particular importance after a PHEIC has been declared, specifically the Temporary Recommendations which may be issued by the WHO Director General, and the leeway enjoyed by states parties to deviate from them. I outline how the perceived duty to give rolling and disease-specific advice has cost the WHO legitimacy and caused confusion. I conclude that whilst their stated purpose may rest on a false opposition, the IHR remain the best-suited conceivable international legal instrument to address the spread of infectious disease.

Enforcement and compliance

1. It is in the spirit of the WHO, the IHR, and the Hippocratic Oath, that the fight against disease is co-operative and based on good faith. That the IHR do not allow for the penalisation of defaulting states rests on the same reasoning whereby the NHS does not seek to prosecute overdose patients for drug offences. This is not to say that such penalisation or prosecution is undesirable, but it should not be done within the IHR. Those who favour an emboldened WHO, ready to make findings of fact in the face of a hostile member state, should recall the profound difficulties experienced by supposedly independent UN missions such as UNSCOM and UNMOVIC. Open co-operation and voluntary notification are essential components of the IHR. The flow of information will only be hindered by the threat of enforcement proceedings and the adversarial dynamic they would instil. Further, political interference in any such enforcement action may render it disproportionate and thus doubly harmful. For example, calls to make China “pay” for COVID-19 threaten a peaceful country with reparations potentially greater than those of the Treaty of Versailles. This can hardly be said to inspire co-operation from WHO member states. It is therefore incorrect to criticise the IHR for its lack of enforcement provisions.

The informational provisions

1. The importance of the IHR’s informational provisions is related to the fact that the IHR must address new and emergent diseases, about which little can be known. For this reason the IHR put WHO under a duty of active surveillance and allow it to receive information from non-governmental channels, as not all its member states will be best-placed to accurately evaluate the public health risks developing in their jurisdictions. The IHR thus places the WHO in the position where it can be accused of negligence. The United States’ President did exactly that in his “explanatory letter” to the WHO Director General during the 73rd World Health Assembly. It is the nature of pathogens that each of them could have been discovered sooner, but the WHO cannot be a police force: that would run contrary to its purpose, and the resources are unavailable. In any case, notification by states parties (or reports from states parties whose territory is unaffected) will unavoidably trigger the IHR’s escalating provisions, regardless of any surveillance undertaken by the WHO.
2. Those who wished the IHR placed a greater duty of active surveillance on the WHO should reflect that the duty is made easier to meet by modern technology. WHO’s China office first heard of viral pneumonia in Wuhan through a statement the website of the Wuhan Municipal Health Commission made on 31 December 2019 (its open-source Epidemic Intelligence unit picked up on an on-line media report that same day).[[5]](#footnote-5) Considering the first known hospitalisation occurred on 16 December 2019[[6]](#footnote-6), this is reasonably timely. As regards the earlier Ebola outbreaks in the Democratic Republic of Congo and in Guinea, there has been scant criticism as regards WHO surveillance, even though WHO reports were much more delayed. The seriousness of COVID-19 aside, the IHR is demonstrably functional as regards surveillance and non-state sources.
3. Criticism has also been made of China’s failure to adhere to the IHR’s duty of notification, and again, its lack of enforcement provisions in relation thereto. However, the duty of surveillance the IHR imposes on the WHO, and the freedom it gives the WHO to consider unofficial data, lessens the importance of governmental notification. Indeed, a pro-active WHO can trigger notification by an affected but reluctant member state. Article 6(1) of the IHR requires states parties to notify WHO of events which may constitute a PHEIC within 24 hours of that state’s IHR-prescribed assessment. In China, this duty arose on 31 December 2020 at the latest. The next day WHO made a request of China under the article 10 verification provisions, which gave China a further 24 hours to respond. The request was repeated again on 2 January 2020, when WHO shared the information it had already received with major public health agencies, laboratories, sister UN agencies, international organizations and NGOs, as it was now entitled to do under article 11. China finally began reporting to WHO the day after. China’s breach is thus ipso facto, but not by an aggregate exceeding 48 hours. Despite the seriousness of COVID-19, this breach is de minimis, particularly when contrasted by the serial non-compliance of other states parties to the IHR. Additionally, the incident proved that the IHR can hold states to their notification duties.
4. The IHR’s provisions for the determination of a PHEIC have been criticised for some years, including by the WHA and by WHO itself. The decisions of the Emergency Committee are made behind closed doors, and minutes are not published. Until recently, the membership of the Emergency Committee was kept secret. It has been said that these reflect failures of accountability and transparency that result directly from IHR inadequacies in how PHEICs are determined.[[7]](#footnote-7) This criticism is not without merit, but it must be considered that declaring a PHEIC is inescapably a highly politicised process. In this light it may be that opacity protects the process as much as it hinders it. No WHO member state would wish to be subject to a PHEIC, and though it only stating the obvious, all experts of the Emergency Committee are citizens of member states. From a human perspective, it is apparent that the Emergency Committee have before now allowed the consequences of declaring a PHEIC to affect their objective appraisal of whether a PHEIC has occurred. In the North Kivu Ebola outbreak, the conditions for declaring a PHEIC were arguably present from October 2018 onwards, but despite being convened multiple times, the Emergency Committee did not recommend a PHEIC until 17 July 2019. In its meeting on 17 April 2020 the Committee’s formal statement expressed that “there is no added benefit to declaring a PHEIC at this stage”.[[8]](#footnote-8) The question of added benefit shows decision-making entirely extraneous to that provided by the IHR.
5. Regarding China, the Committee had to be reconvened twice before it recommended a PHEIC. Despite exported cases and a preliminary human-to-human transmission range of R1.4-2.5, the first meeting declined to recommend a PHEIC “given its restrictive and binary nature”.[[9]](#footnote-9) Again, Committee members appear to have been swayed by the effects of their decision rather than the factors the IHR obliged them to consider. When the Committee did recommend a PHEIC, it couched it in language atypically conciliatory to China:

“The Committee emphasized that the declaration of a PHEIC should be seen in the spirit of support and appreciation for China, its people, and the actions China has taken on the frontlines of this outbreak, with transparency, and, it is to be hoped, with success.”[[10]](#footnote-10)

Political pressures may make such gestures desirable, but they sacrifice the impartiality the WHO relies on to function.

1. The difficulties in promptly determining a PHEIC have led to calls for its replacement by a graded system whereby a proportional level of emergency could be invoked.[[11]](#footnote-11) This would do nothing to alleviate the challenge of determining a maximal level event where circumstances objectively warranted it. The answer lies not within the IHR but in collective political will. The first test of the IHR came with the 2009 swine flu outbreak. Many, including the IHR’s own Review Committee[[12]](#footnote-12), retrospectively judged the declaration of a PHEIC precipitous, given the H1N1 virus proved of low relative harm. Some went so far as to accuse the WHO of conspiring with pharmaceutical companies, some of which had government contracts that would be triggered by the declaration. The Emergency Committee’s reluctance to advise a PHEIC arose during this criticism. But if WHO member states cannot tolerate false alarms, then they must expect delayed declarations, and if perfection is expected, then every determination of a PHEIC will always be either too late or too soon.

The recommendatory provisions

1. The informational provisions of the IHR reflect the WHO’s intended status as a neutral and observing body, which acts as an internationally agreed conduit for official data. The IHR oblige it to collect and verify information relating to public health risks, and if that information meets certain criteria, a PHEIC is declared. However, in abandoning the fixed limits to permissible national health measures found in preceding regulation, the IHR instead obliged the WHO to issue outbreak-specific recommendations, even where the disease was entirely unknown. It was not enough for the WHO to identify a PHEIC, it now also had duties analogous to diagnosis and treatment. These ambitions can only result in controversy. The WHO is not well-suited to issuing ongoing and up-the-minute advice on emergent pathogens in vital matters such as asymptomatic spread, entry screening and human-to-human transmission, where it is easy to be wrong, and mistakes come at the expense of much-valued confidence.
2. This second function which the IHR places upon the WHO is complicated by the IHR’s purpose: these recommendations must resolve public health risk but also facilitate international trade and traffic. The paradox is that having proclaimed a pandemic to the world, the Emergency Committee must then, in advising on Temporary Recommendations, set about the contrary purpose of ensuring that minimal disturbance is caused to business and travel. Many organisations have to serve conflicting or contrary purposes and this is not in itself fatal to the IHR. The flaw arises around maximal level events where profound economic damage is unavoidable, and where severe short-term disruption to trade and traffic may afford greater long-term economic protection to states parties. It is submitted that that the present pandemic is one such event, and that in compelling the WHO to always safeguard movement and commerce, the IHR demands it attempt the impossible.
3. The WHO and the Emergency Committee have advised against travel restrictions throughout COVID-19, yet by the end of March 2020 it was apparent that almost every country in the world had implemented some arbitrary restriction on international travel.[[13]](#footnote-13) An untold number of WHO member states, but it may reasonably be assumed to be a majority, had also breached their obligation under article 43 to notify the WHO of the additional health measures these restrictions represented. This is non-compliance en masse, which comes at an additional cost to the WHO’s legitimacy, and which is made more expensive still by the human reluctance to declare a PHEIC, and the diplomatic language the PHEIC was couched in when it came.

Conclusion

1. Thankfully, it is not necessary to defend the IHR in order to protect it. Under article 55 the IHR contains the seeds of its own renewal. Amendments may be proposed by any state party or the Director General, and after a minimum circulation period of four months, can be approved by the next WHA. Much like all pathogens, in fact, the IHR are designed with self-survival in mind. In this light ongoing assessment and reform is no more than due diligence, or to continue the metaphor, evolution, and hence the IHR provides for its own introspective Review Committee. Despite the ideological foundations of the UN, and that globalization is itself a catalyst for pandemics, the concept that nation states are obliged to co-ordinate in the face of global infectious disease rests on ancient principles of jus cogens. The IHR is but its contemporary incarnation. One could posit that its informational and recommendatory functions be split between different bodies (certainly the same Emergency Committee should not be responsible for both), but reform will only strengthen it. That, at base, is the sign of an organism fit for purpose.

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1. Albert Camus, *La Peste* (Folio, 1972) 41 [↑](#footnote-ref-1)
2. Article 2, International Health Regulations 2005 (World Health Organization) [↑](#footnote-ref-2)
3. The first International Sanitary Convention was adopted in 1892. [↑](#footnote-ref-3)
4. Revision and updating of the International Health Regulations, World Health Assembly Resolution 48.7 (12 May 1995) [↑](#footnote-ref-4)
5. These dates derive from WHO’s own novel coronavirus 2019 timeline, < <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/interactive-timeline>> accessed 25 September 2020. [↑](#footnote-ref-5)
6. Chaolin Huang et al, ‘Clinical features of patients infected with 2019 novel coronavirus in Wuhan, China’ *The Lancet* (vol 395, issue 10223) 499 [↑](#footnote-ref-6)
7. Mark Ecclestone-Turner and Adam Kamradt-Scott, ‘Transparency in IHR emergency committee decision making: the case for reform’ *British Medical Journal Global Health* (25 April 2019). [↑](#footnote-ref-7)
8. Statement on the meeting of the International Health Regulations (2005) Emergency Committee for Ebola virus disease in the Democratic Republic of the Congo on 12th April 2019 (WHO, 12 April 2019). [↑](#footnote-ref-8)
9. Statement on the first meeting of the International Health Regulations (2005) Emergency Committee regarding the outbreak of novel coronavirus (2019-nCoV) (WHO, 23 January 2020). [↑](#footnote-ref-9)
10. Statement on the second meeting of the International Health Regulations (2005) Emergency Committee regarding the outbreak of novel coronavirus (2019-nCoV) (WHO, 30 January 2020). [↑](#footnote-ref-10)
11. 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 25 September 2020. [↑](#footnote-ref-11)
12. Report of the Review Committee on the Functioning of the International Health Regulations (2005)in relation to Pandemic (H1N1) 2009 (64th World Health Assembly). [↑](#footnote-ref-12)
13. Barbara von Tigerstrom and Kumanan Wilson, ‘COVID-19 travel restrictions and the International Health Regulations (2005)’ *British Medical Journal Global Health* (17 May 2020). [↑](#footnote-ref-13)