Challenges and Shortcomings of the International Health Regulations

How the COVID-19 Pandemic Has Shown the Limits of the IHR

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1 Introduction

For more than two years, no other topic dominated the public discourse as much as the COVID-19 pandemic and the world's common efforts in combatting it. From questions regarding the gravity and effects of the virus itself, to discussions on the necessity and efficiency of the wide range of measures to contain the virus, the debates were manifold. All around the world, mandatory face masks, regional and national lockdowns, and compulsory social distancing in public places have become a part of everyday routine. On an international level, international health law – more precisely, the World Health Organization (WHO) and the 2005 International Health Regulations[1] (IHR) – contribute their piece to the puzzle that is choosing the right approach in combating (inter-)national health crises. Especially in the first year of the pandemic, however, the aims pursued were contrasted by delayed reports of initial spreads of the virus[2] as well as nationalist tendencies in state's responses,[3] despite the WHO's and other world leader's appeals for cooperation.[4]

This chapter seeks to discuss the functioning of the IHR in general and during COVID-19. After a brief introduction to the key components of international health law applicable to global health crises (2), three issues of the IHR's functioning and implementation that became apparent during this pandemic: structural and communica-

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1 International Health Regulations, 23 May 2005, 2509 UNTS 79.

2 P. Aavitsland et al., Functioning of the International Health Regulations during the COVID-19 pandemic, Review Committee on the Functioning of the International Health Regulations (2005) during the COVID-19 Response, in: The Lancet 398 (10308) (2021), p. 1286.

3 F. Bieber, Global Nationalism in Times of the COVID-19 Pandemic, in: Nationalities Papers 50 (1) (2022), pp. 19 ff.

4 European Council, COVID-19 shows why united action is needed for more robust international health architecture, 30 March 2021, https://www.consilium.europa.eu/en/press/press-releases/2021/03/30/pandemic-treaty-op-ed/ (accessed on 24.04.2022).

tive shortcomings in National Focal Points, uncertainties surrounding the exemption clause of Article 43 IHR measure, and the lack of an enforcement mechanism, will be analysed (3). We will close this contribution by providing a brief outlook on pending developments (4).

2 The World Health Organization and the International Health Regulations

To assess the IHR's role and evaluate its performance in combatting COVID-19, the general role and functioning of the WHO (2.1) and the IHR (2.2) shall briefly be presented.

2.1 The World Health Organization

The WHO is the UN specialized organisation[5] tasked with promoting the attainment of the highest possible level of health for all people.[6] To this end, the WHO mainly serves in a directing and coordinating manner but it also has legal means at its disposal.[7] The World Health Assembly (WHA) can adopt regulations concerning specific health related topics binding on its member states[8] and serves as a legislative body, providing member states with an opportunity to directly engage in the organisation's dealings.[9] The WHO Secretariat serves as WHO's autonomous administrative organ,[10] which regularly and prominently published recommendations on COVID-19 through its Director General.[11] Furthermore, under Article 38 WHO Constitution, the Director General may establish committees to serve any purpose within the competence of the WHO. For example, a committee has been tasked with reviewing the IHR's functioning and performance during the COVID-19 pandemic.[12]

5 Closing paragraphs of the preamble and Art. 19–22 of the Constitution of the World Health Organization, 7 April 1948, 15 UNTS 185 (WHO Constitution).
6 Art. 1 WHO Constitution.
7 Cf. Art. 2 WHO Constitution.
8 Art. 21 WHO Constitution.
9 Art. 10, 18 WHO Constitution.
10 Art. 37 WHO Constitution.
11 Art. 30, 31 WHO Constitution; Art. 15 IHR.
12 The Review Committee on the Functioning of the International Health Regulations (2005) during the COVID-19 Response was established by World Health Assembly (WHA) Resolution WHA73.1 as requested by the WHO Director-General to, *inter alia*, initiate a stepwise process of impartial, independent, and comprehensive evaluation of the WHO-coordinated international health response to COVID-19, including by using existing mechanisms such as the Review Committee under the IHR. WHO, Review Committee on the Functioning of the International Health Regulations (2005)

2.2 The International Health Regulations

The most recent IHR were adopted in 2005 by the WHA in accordance with Articles 19 ff. WHO Constitution.[13] They are the result of a ten-year-effort to revise international health law,[14] seeking to compile and develop existing legal instruments, including the 1969 IHR.[15] Normatively, the 2005 IHR portrayed a revolutionary step by extending the scope from a few specific diseases to implementing an open clause which is applicable to a multitude of new diseases.[16] The IHR declare their object and purpose to be preventing, protecting against, controlling and providing a public health response to the international spread of disease while deploying the least restrictive available measures.[17] To this end, the IHR rely on a regulatory set of standards[18] to maintain the functioning of international traffic[19] during public health emergencies, as well as on guidance provided by the WHO.[20] Nevertheless, WHO recommendations are per definition non-binding, Article 1 IHR.

Central to its response mechanism is the so-called *Potential Health Emergency of International Concern* (PHEIC), defined in Article 1 IHR as "an extraordinary event which is determined [...] (i) to constitute a public health risk to other states through the international spread of disease and (ii) to potentially require a coordinated international response." Ever since the 2005 IHR were adopted, six PHEICs have been declared by the WHO,[21] COVID-19 being the most recent one.[22] The declaration of a situation to

during the COVID-19 Response, https://www.who.int/teams/ihr/ihr-review-committees/covid-19 (accessed on 24.04.2022).

13 Preamble, IHR; WHA, Revision of the International Health Regulations, 23 May 2005, Resolution 58.3.

14 Drafting was initiated in 1995 under: WHA, Revision and Updating of the International Health Regulations, 12 May 1995, Resolution 48.7. Since then, the IHR have been receiving minor tweaks, most recently in 2014 in with newly revised technical guidance on vaccinations in Annex 7 IHR, WHA, Implementation of the 2005 International Health Regulations, 24 May 2014, Resolution 67.13.

15 Cf. Art. 58 IHR.

16 D. Fidler, From International Sanitary Conventions to Global Health Security: The New International Health Regulations, in: Chinese Journal of International Law (CJIL) 4 (2) (2005), p. 326.

17 Art. 2 IHR; this resonates the scope of the 2005 IHR's predecessors but imply a wider applicability owing to the new and expended scope, cf. D. Fidler, *supra* note 16, p. 361.

18 Art. 19 ff. IHR formulate standards for points of entry, Art. 30 ff. IHR for the treatment of travellers, Art. 33 ff. IHR for cargo, and Art. 35 ff. for health documents and charges.

19 Defined in Art. 1 IHR as "the movement of persons, baggage, cargo, containers, conveyances, goods or postal parcels across an international border, including international trade".

20 Art. 15 ff. IHR.

21 Cf. A. Wilder-Smith/S. Osman, Public Health Emergencies of International Concern: A Historic Overview, in: Journal of Travel Medicine 27 (8) (2020), pp. 3 ff.

22 COVID-19 was declared a PHEIC on 30 January 2020, WHO, Statement on the second meeting of the International Health Regulations (2005) Emergency Committee regarding the outbreak of novel

constitute a PHEIC implies duties for states, such as an obligation to notify the WHO of events that could possibly be a PHEIC,[23] and rights like imposing additional health measures.[24] PHEICs also enable reactions from the WHO, like requests to verify information[25] or temporary recommendations.[26]

3 Problems of the IHR Hindering its Effective Implementation

During the COVID-19 pandemic, serious obstacles to the effective implementation and application of the IHR have once again become apparent. In this chapter, we will focus on structural and communicative shortcomings in National Focal Points (NFPs) (3.1), uncertainties surrounding an exemption clause for states to impose additional health measures (3.2), and lastly, the lack of an enforcement mechanism under the IHR (3.3).

3.1 Structural and Communicative Shortcomings in National Focal Points

Under Article 4 (1) IHR, each state party must designate or establish a NFP which includes authorities responsible for implementing health measures under the IHR in the respective member state. The IHR do not prescribe a specific form for NFPs but only their tasks. Under Article 4 (2) IHR, NFPs are tasked with communicating, for example, event-related information to WHO's Contact Points, forwarding WHO information to state parties, and consolidating input from the WHO to relevant state organs. NFPs are thus an important communicative link between states and the WHO, which previously have been called out for major structural and communicative shortcomings[27] by the WHO's IHR Review Committee.[28]

coronavirus (2019-nCov), 30 January 2020, https://www.who.int/news/item/30-01-2020-statement-on-the-second-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-outbreak-of-novel-coronavirus-(2019-ncov) (accessed on 23.04.2022).

23 Cf., e. g., Art. 6, 7 IHR.

24 Art. 43 IHR.

25 Art. 10, 13 IHR.

26 Art. 15 IHR.

27 WHO, Review Committee on the Functioning of the International Health Regulations (2005) during the COVID-19 Response, WHO's work in health emergencies – Strengthening preparedness for health emergencies: implementation of the International Health Regulations (2005), 5 May 2021, WHA A74/9 Add.1, paras. 16 ff.; C. Packer et al., A survey of International Health Regulations National Focal Points experiences in carrying out their functions, in: Globalization and Health, 2021.

28 Established by the Director-General of WHO under Art. 50 IHR. It makes technical recommendations to the Director-General regarding amendments to IHR; provides technical advice to the Director-General with respect to standing recommendations, and any modifications or terminations

The report of the Review Committee on the Functioning of the IHR during the COVID-19 Response criticised that NFPs lack the sufficient authority in the member states or resources to exercise their mandate properly.[29]

These shortcomings impede the communication within the state (3.1.1) and *vis-à-vis* the WHO (3.1.2). Subsequently, we will outline some suggested improvements with regards to the NFPs (3.1.3).

3.1.1 Communication within the State

The COVID-19 Review Committee noted that NFPs' weak authority or lack thereof leads to difficulties in engaging directly with other state agencies or sectors relevant for health law (e.g., animal health).[30] Problematically, NFPs are often not included in national emergency planning, national health committees, or comparable bodies, making it difficult for NFPs to partake in the decision-making of national health authorities.[31]

When the states self-assessed the IHR Coordination and NFP functions, the global average was 70 out of 100 points and was therefore marked green by the WHO.[32] While the WHO Europe region scored the highest with a total of 81 points, the African region scored the lowest, with an average of 54 points.[33] However, there are still some states with an assessment as low as 20 points in the indicators of NFPs, like Botswana, the Seychelles, the Dominican Republic, or Slovakia.[34]

Moreover, many NFPs have reported that compliance with their obligations to notify the WHO is dependent on the approval of other non-health-related governmental bodies, who lack understanding of the roles of the IHR and the NFPs, resulting in delayed reports.[35] Also, states' existing communication structures are often insufficient to ensure a well-functioning communication between NFPs and other non-WHO related national health authorities.[36]

thereof; and provides technical advice to the Director-General on any matter referred to it by the Director General regarding the functioning of IHR. See: WHO, International Office, https://www.who.int/teams/ihr/ihr-review-committees (accessed on 23.04.2022).

29 Review Committee, *supra* note 27, para. 17.

30 Review Committee, *supra* note 27, paras. 17, 18.

31 *Ibid.*

32 WHO, International Office, State Parties Self-Assessment Annual Reporting on the Implementation of the International Health Regulations, Score by capacity & Indicator 2020, Updated on 28 October 2021, https://extranet.who.int/sph/spar (accessed on 23.04.2022).

33 *Ibid.*

34 *Ibid.*

35 K. Wilson et al., National focal points and implementation of the International Health Regulations, Bulletin of the World Health Organization 99 (7) (2021), p. 536.

36 *Ibid.*

A 2019 study – prior to the beginning of the COVID-19 pandemic – recollecting NFPs' experiences in performing their tasks mirrors the findings of the Committee during the pandemic. For example, 41 % of the NFPs considered a lack of authority to notify the WHO as the main issue in performing their mandate.[37] Other reasons stated were political challenges (41 %) and a lack of financial resources (34 %), human resources (31 %), and surveillance capacities (31 %).[38]

3.1.2 Communication vis-à-vis the WHO

Although most NFPs are aware of their role under the IHR, the problems described in the last section cause uncertainties regarding their concrete fulfilment.[39] This leads to a deficiency in the communication between NFPs and the WHO. The resistance of states to properly notify the WHO of health events can be attributed in particular to their fear of indirect negative consequences (reported by 53 % of NFPs).[40] This fear concerns, e. g., damages to the reporting state's image, tourism industry, trade, and transport. However, a functioning reporting mechanism is necessary to identify potential PHEICs in due time. Moreover, NFPs must also report the specific measures the respective state took in response to health risks to the WHO, Article 6 (1) IHR. This enables the WHO to stay informed, make their own assessment of the situation and the necessity of multinational measures to, and distribute valuable information on health risks to other member states.

In general, the initial response of the states was deemed insufficient by the Review Committee. One example for a debated sufficient notification was the states' behaviour right at the start of the COVID-19 pandemic. The Review Committee criticised that the alarm was not raised effectively by many of the first states with COVID-19 outbreaks and that, as a result, the WHO and states did not react early and decisively enough to the outbreak.[41] Early data provided by states to the WHO were often incomplete or insufficient and there was a lack of national responses both to the WHO's first alerts, like risk assessments, and guidance on public health response.[42]

This is especially debated concerning the sufficient notification of China in the beginning of COVID-19. On the one hand, the Review Committee found that China's "response timings do not seem to be any different in scope and duration from other similar delays (beyond the 24 hours required by the IHR) reported by WHO and some of the

37 C. Packer et al., *supra* note 27, p. 5.
38 *Ibid.*
39 K. Wilson et al., *supra* note 35, p. 536.
40 C. Packer et al., *supra* note 27, p. 6, Fig. 5.
41 P. Aavitsland et al., *supra* note 2, p. 1286.
42 *Ibid.*