



# **THE ROLE OF THE WORLD HEALTH ORGANIZATION IN THE COVID-19 PANDEMIC**

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## EXECUTIVE SUMMARY

The COVID-19 pandemic has exposed deep interconnections and strong interdependencies between countries and peoples on our planet. Globalized trade and supply chains, unrestricted travel and technological advancements in transport and communication have all resulted in human beings being bound by a shared fate. The novel Coronavirus, a respiratory pathogen invisible to the human eye, spread globally in a matter of months from East Asia to the Americas and from Europe to Antarctica. Asymptomatic at first (and sometimes even remaining so), but potentially deadly and often requiring hospitalisation of infected individuals in intensive care units, COVID-19 has put immense pressure on the health systems of even the most economically developed countries. Initially unprepared, entire societies had to adapt to a public health emergency context. To different degrees, they have adopted practices to slow down the spread of a highly transmissible virus. Such practices took the shape of social ‘isolation’ and handwashing at first, then social ‘distancing’ and mask wearing, and now ventilation and vaccination. Nevertheless, the COVID-19 pandemic has also exposed how difficult it can be to foster cooperation among countries and governments in the current global order. Mistrust and unilateral policies have often taken precedence in relation to international solidarity and a more effective global response.

The World Health Organization (WHO) is the cornerstone of global health governance, taking the lead in international responses to public health emergencies such as the COVID-19 outbreak. Created in 1948 as part of the United Nations system, the WHO is an intergovernmental organization with the ambitious goal of attaining the highest level of health for all peoples. Throughout history, the organization has served as a depository of scientific knowledge and good practices for health policies. In parallel, it has also developed into an organization that coordinates the actions of its individual Members and non-state actors, taking decisions in the health sector and implementing them. In the course of time, misalignment resulting from the WHO’s dual nature – a knowledge-based and a policy-oriented organization – has negatively impacted its ability to prevent, prepare for, and respond to, the outbreak of infectious diseases like COVID-19 based on the legal instruments it has at its disposal. As an authoritative source of scientific information and recommendations, the WHO relies heavily on perceptions regarding its impartiality and unbiased assessments. The inherent political nature of its governance and decision-making processes, however, can negatively impact such perceptions as well as the national and local adoption of WHO input.

Drawing from a series of interviews conducted with experts, stakeholders and decision-makers at various levels of governance (national, regional and global), the Research Report sets out a political and legal analysis of the WHO as the focal multilateral institution active in health matters. Importantly, it identifies key issues and challenges faced by the WHO in its response to the COVID-19 pandemic, from initial reactions to the outbreak of the disease in late 2019 to current efforts in global immunization. This summary distils the key problems and issues in respect of the WHO that need to be addressed in order to enhance its position vis-à-vis future health emergencies. At the same time, the summary enumerates twenty-four policy recommendations formulated in the Research Report, which are aimed at improving the WHO’s

standing, functioning and overall response to future health emergencies. The in-depth analysis of the WHO's response to COVID-19, coupled with a description of its legal framework and functioning, are available in the more extensive Research Report.

Fundamentally, the WHO-led response aiming to address the health emergency suffered from obstacles inherent to a deeply interconnected world while suffering simultaneously from the organization being obligated to rely on intergovernmental, sovereignty-based decision-making and implementation structures. The first major lesson is that the WHO, as an intergovernmental organization, shares responsibility with its **Members**, many of whom failed to (i) properly prepare and equip their health systems to face outbreaks and emergencies, (ii) be fully transparent and keep other Members and the WHO informed, and (iii) show *de facto* solidarity in their efforts to prevent, treat, and immunize against COVID-19. National governments also fell short in adequately equipping the WHO itself with funds, personnel, and legal instruments necessary for the organization to fulfil all its tasks, both in terms of preparedness and response.

Secondly, **global geopolitical and normative contexts** are also a cause of suboptimal responses to the COVID-19 pandemic. The ongoing rivalry between the United States and China has disempowered the WHO and has contributed significantly to the politicization of policy responses, delays in investigating the origin of the virus, and threats to the sustainability and predictability of the WHO's budget. With structural economic inequalities, many countries are unable to build national core capacities in order to deal with health emergencies properly and sustainably. In addition, the current normative context leads to stigmatization rather than encouraging states intent on being fully transparent and readily reporting on their disease outbreaks. In an uncooperative environment, disclosure of an outbreak risks leading – in the first instance – to economic and travel disruptions rather than short and long-term assistance. Such a context, in turn, delays the response and impacts the early warning instruments. All these factors contribute to an overall crisis in the leadership and reputation of the WHO. As a result, national governments risk ignoring or altering the WHO's technical guidelines or risk using the organization's guidelines and actions as a scapegoat for their own domestic failures.

A third group of challenges in the response to global outbreaks relates to the **WHO governance structures and financial means**. While the locally specific expertise of regional and national offices is highly desirable, the multi-level governance system of the WHO has the potential to lead to incoherent policies and decisions if autonomous regional offices are not properly coordinated. Furthermore, the WHO's response has been impacted by insufficient funds and overreliance on voluntary contributions. This financial situation diminishes the organization's in-house expertise, its efforts to enhance preparedness, and its initiatives for research and development of health tools with equitable access.

Finally, the WHO has underperformed in its use of the **International Health Regulations (IHR)**. The IHR are the key normative instrument for preventing, protecting against, controlling, and providing a public health response to the international spread of disease. As a legal instrument, however, the IHR do not place the WHO and its individual Members in an optimal position to face unknown, contagious, and long-lasting disease outbreaks of a large scale, such as COVID-19. The IHR are characterized by a certain rigidity in their procedures,

thereby preventing flexible and swift action in the face of an emerging outbreak. In addition, the IHR incorporate several checks and balances that allow Members to maintain crucial control over critical decisions and processes in health emergency situations. Notably, the IHR also primarily focus on preventing and controlling disease outbreaks and their international spread, rather than foreseeing a myriad of tools to respond to long-lasting and wide-scale outbreaks.

Looking closer at specific IHR provisions, one observes shortcomings in their design and implementation, which hamper the WHO's ability to efficiently respond to outbreaks and/or negatively impact its overall credibility to do so. Broadly considered, several flaws are apparent in the IHR that warrant amendment if the international community wishes to be better positioned to respond swiftly and effectively to contagious disease outbreaks in the future. The actions of the WHO within the framework of the IHR have been significantly impacted by issues that are inherent in global governance, such as high levels of politicization of decision-making and excessive attachment to national sovereignty. As a result, the organization was unable to raise sufficient levels of alarm in the early days of the pandemic. Nor was it able to coordinate an optimal global response.

It is undeniable that the WHO and its personnel have contributed decisively to mitigating the adverse consequences of the COVID-19 pandemic, playing an irreplaceable role in the provision of scientific guidance, and coordinating international efforts to ensure reliable and expeditious research as well as equitable access to various health tools. At the same time, the same WHO-led response faced various obstacles, endogenous and exogenous to the organization, many of which can be addressed by sincere reform efforts and effective international commitment. Based on the identification of these key issues and challenges faced by the WHO in its COVID-19 response, the Research Report offer a number of insights, in the form of recommendations, on how the organization can be strengthened to provide a stronger emergency preparedness and response in the future. Before summarizing these recommendations, it is worth pointing to the guiding principles that underlie their formulation. First, WHO reform should follow the 'one health approach', as consolidated by the international community, and put human rights above any other consideration. Secondly, reforms should also prioritize strengthening the WHO's authority rather than opting for the creation of new mechanisms and institutions in an already overcrowded global governance landscape. A principled but realistic approach should be followed for a reform of WHO governance, financing, preparedness, emergency, and communication.

## **Reform Recommendations**

### ***Overall approach***

1. Forthcoming global health governance reforms should aim to improve and enhance prevention, preparedness, and response capabilities for a wide range of health emergencies that might arise in the future.
2. WHO actions, guidelines, and health policies should aim at enhancing the positive legacies of the fight against COVID-19.
3. There is a need to find a working consensus on what can be expected from the WHO in a health emergency and then to clarify this consensus to the broader public by way of publication and education.
4. The WHO and its Members must strive for clear separation and an effective balance between the organisation's political and techno-scientific functions.
5. It is recommended that the WHO proactively prepare for a future crisis to mitigate its potential ramifications. This recommendation is made despite uncertainty concerning the actual occurrence of a future crisis. Nevertheless, and considering scarcity of resources, a proactive approach should not attempt to tackle all potential ramifications simultaneously; instead, prioritisation of proactive efforts is recommended.
6. There should be a strong link between future reform to enhance preparedness for and responses to health crises on the one hand and climate emergencies on the other.

### ***WHO governance***

7. WHO reform should establish a clear and efficient division of labour between global WHO headquarters and WHO regional offices, avoiding duplication and incoherence.
8. The mandate of senior positions of leadership active in WHO headquarters and regional offices should be extended in time, but limited to one term.
9. The WHO should have access to broad, additional, and more representative expertise, including health scientists, but also health workers, doctors, and social scientists.
10. The World Health Assembly should establish a special Committee, with reduced membership, to periodically assess and peer-review the actions of WHO Members relating to pandemic preparedness, response, and IHR-related obligations.
11. The WHO should commit to the principles of transparency and accountability in its governance system through standardisation of procedures.

### ***Financing***

12. The WHO urgently requires increased financing to operate efficiently and effectively. Such financing must be readily available, sufficient to cover institutional activities, and extended in a flexible manner.
13. The WHO should lead efforts to establish a Global Health Fund focused on sustained pandemic preparedness in the developing world.

### ***Pandemic preparedness***

14. The swift and accurate identification of sick or infected individuals is required, through the adoption of adaptable and flexible standards for the testing, tracking, and reporting of cases.
15. The WHO should ramp up readily available resources to prepare sufficiently for swift reactions to health emergencies and to enable such responses.
16. The WHO should create more sustainable links – including a senior liaison position – with health-related industries and with non-governmental actors for preparedness, response, research and development, and financing purposes.

### ***International Health Regulations***

17. To ensure Members' compliance and best efforts in respect of prevention and preparedness measures, further precision, in terms of the minimum requirements for IHR core capacities, should be provided; moreover, a periodic and critical peer-review system should be established to encourage and monitor Member progress in their meeting of these IHR core capacities.
18. The instrument of temporary recommendations issued by the WHO Director-General should be strengthened to enhance effective and coordinated international public health responses.
19. The lack of accountability for Members, in the event that they choose to implement additional health measures in response to specific public health emergencies pursuant to Article 43 IHR, needs to be addressed.

### ***Emergency***

20. The PHEIC declaration (Public Health Emergency of International Concern), which is the highest level of alert available to the WHO, should be maintained in the future, albeit with a number of adjustments and specifications.
21. A pandemic declaration should be introduced as an official concept within the purview of the WHO. More specifically, it should be placed under the authority of the WHO Director-General pursuant to a predetermined definition and process.
22. There should be a timely transition from an emergency situation and response to a long-term and sustainable programme to address a disease outbreak with prolonged implications.

### ***Communication***

23. The WHO should foster a global environment in which individual Members are encouraged to raise an alert regarding a (potential) health emergency.
24. The WHO should propose a digital and social media communication strategy to be approved by the World Health Assembly.

The present report concludes that these reform recommendations should enhance the WHO's ability to coordinate and direct international cooperation to better prevent, prepare for, and respond to future health emergencies.



## GLOSSARY

COVID-19	Coronavirus Disease 2019
DG	WHO Director-General
EIOS	Epidemic Intelligence from Open Sources
ERF	Emergency Response Framework
FAO	Food and Agriculture Organization
GISRS	Global Influenza Surveillance and Response System
GOARN	Global Outbreak and Response Network
GPMB	Global Preparedness Monitoring Board
HOLN	Health Organization of the League of Nations
IHR	International Health Regulations
IMS	Incident Management System
IPPPR or Panel	Independent Panel for Pandemic Preparedness and Response
ISC	International Sanitary Conventions
ISR	International Sanitary Regulations
OIHP	Office International d'Hygiène Publique
PAHO	Pan-American Health Organization
PHEIC	Public health emergency of international concern
PIP Framework	Pandemic Influenza Preparedness Framework
ProMED	Program for Monitoring Emerging Diseases
Review Committee or Committee	Review Committee on the functioning of the IHR (2005) during the COVID-19 response
SARS	Severe acute respiratory syndrome
State Parties	States party to the IHR
UN	United Nations
UNGA	United Nations General Assembly
WPRO	Western Pacific Regional Office
WHA or Health Assembly	World Health Assembly
WHO	World Health Organization
WHO Constitution	Constitution of the World Health Organization
WIPO	World Intellectual Property Organization
WTO	World Trade Organization

## OVERVIEW OF CONDUCTED INTERVIEWS

<b>Interview</b>	<b>Date and time</b>	<b>Function</b>
<b>1.</b>	25 February 2021 11h00 CET	Legal Officer, WHO
<b>2.</b>	25 February 2021 11h00 CET	Legal Officer, WHO
<b>3.</b>	26 February 2021 17h00 CET	Professor of International Law
<b>4.</b>	5 April 2021 9h00 CET	Senior Official, WHO/Europe
<b>5.</b>	21 April 2021 12h15 CET	Expert, GEMS (Groep van Experts voor Managementstrategie van COVID-19, Belgium)
<b>6.</b>	4 May 2021 20h00 CET	Senior Official, PAHO
<b>7.</b>	12 May 2021 17h00 CET	Professor of Global Health and Medicine
<b>8.</b>	20 May 2021 16h00 CET	Professor of Global Health
<b>9.</b>	21 May 2021 16h00 CET	Strategic Advisor, Belgian Federal Public Service Health
<b>10.</b>	21 May 2021 16h00 CET	Diplomatic Advisor, Belgian Minister of Health and Social Affairs
<b>11.</b>	26 May 2021 14h00 CET	Advisor COVID-19, WHO/Europe
<b>12.</b>	3 June 2021 15h00 CET	Technical Officer IHR Secretariat, WHO

*COVID-19 is taking so much from us. But it is also giving us something:  
the opportunity to come together as one against a common threat, and to build  
a common future.*

Tedros Adhanom Ghebreyesus<sup>1</sup>

## INTRODUCTION

More than one year and a half into a global pandemic, it is safe to say that a new normal has befallen persons of all nationalities. For many, the wearing of face masks in public spaces and the practicing of social distancing is nothing short of normal. Despite vaccination roll-outs and campaigns that have fostered significant progress in some States, the fact that other States do not have the same access to vaccines and the influence of new variants of the coronavirus are causing a resurgence in COVID-19 cases globally. An end to the COVID-19 pandemic does not yet loom on the horizon.

With the world having fallen victim to such a long-lasting and broad-scale public health emergency, which has resulted in indescribable human suffering, leadership and guidance has naturally been sought from the organisation at the centre of global health governance: the World Health Organization (WHO or Organization). Attention has been directed at the WHO ever since information began to spread about the outbreak of a novel coronavirus in December 2019. The Organization's actions have been put under the microscope by individual Members and by the international community at large. Unquestionably, attention towards and examinations of the WHO's response to the COVID-19 pandemic and its actions during the ongoing health emergency have proven to be very critical.

In light of such strong criticism, which has been voiced from various angles, the present report aims to provide a case study of the role of the WHO during the COVID-19 pandemic. It is highly relevant to clarify and objectively discern the extent to which the WHO is (and was) able to respond in the event of an infectious disease outbreak, such as COVID-19, so as to put myriad criticisms into perspective. As such, the case study will provide a political and legal analysis of the WHO and its role as the focal multilateral institution in the fight against COVID-19. Ultimately, the aims of the case study are to adopt a forward-looking approach and to analyse the WHO's actions since the onset of the COVID-19 outbreak. These objectives are pursued to guide the formulation of policy recommendations, which will enhance the WHO's ability to coordinate and direct international cooperation to better prevent, prepare for, and respond to future health emergencies.

The multiple dimensions of the COVID-19 crisis have exposed a global environment marked by interconnectedness and interdependency: indeed, as a result of close global ties, the new

infectious disease took only a couple of months to spread to all corners of our planet. COVID-19 has deeply impacted societies even in States that held high scores relating to the capacity of their health systems to prevent, monitor, and treat infectious diseases.<sup>2</sup> Despite global interconnectedness, the pandemic has also shed light on cracks in the international system that have significantly limited cooperation during the various stages of the response to the pandemic. The *central question* of the present report lies at the intersection between this interdependent environment and a system of global health governance in which States are still reluctant to give up autonomy and sovereignty: how can the WHO enhance international cooperation to better prevent, prepare for, and respond to an outbreak of an infectious disease like COVID-19? And how can it slow the spread and reduce the impact of such an event?

The present report, and particularly its recommendations, draw from a series of interviews conducted with experts, stakeholders, and decision-makers at various levels of governance: national, regional and global. In total, 10 in-depth interviews have been conducted with 12 people who hold senior positions in government and in academia. Each interview lasted between 40 minutes and 1 hour and was conducted via a videoconference system during the first semester of 2021. To make the best use of the insights derived from the interviews and given the contested nature of some topics discussed, the interviews have been anonymised. Information on the interviews, including a numerical reference system, is available on page 5. We thank all interviewees for their time and willingness to contribute to this report, particularly given their busy agendas in challenging times. The insights from the interviews are complemented by academic literature on the politics, historical background, and legal framework of the WHO and global health governance as well as by specialised reports and assessments concerning international organisations.

*Part 1* will provide a general overview of the WHO as the focal multilateral institution covering health matters. The WHO's functions, in the event of a public health emergency, will be explained as will the powers it has been entrusted with to perform such functions. Subsequently, *Part 2* will provide a critical assessment of the normative and political framework that the WHO has available to it. This will objectively demonstrate the extent to which the WHO is actually able to act in the face of a public health threat. Special attention will be paid to evaluating the key global instrument for protection against the international spread of disease, the International Health Regulations, which bestows significant authority upon the WHO to act in the event of a

(threat of a) public health emergency. Lastly, *Part 3* will provide some insights into how the WHO can be strengthened so as to provide a stronger emergency response in the future. After providing a high-level overview of some findings and recommendations formulated by prominent international review committees and panels, the present report will conclude with policy recommendations.

## PART 1. THE WORLD HEALTH ORGANIZATION

Before delving into the analysis and critical assessment of the WHO's actions during the ongoing COVID-19 pandemic, a clear understanding is required about the WHO and its status as the world's designated global health leader. Indeed, to fully grasp the extent to which the WHO was able to react to the COVID-19 outbreak as well as the limitations it faced, one must first have a comprehensive notion of the organisation that existed at the time it was confronted with the novel coronavirus. This Organization grew, in part, out of historical developments, but also through continuous reform initiatives, which have proliferated right from its establishment more than 70 years ago.

In Part 1, the WHO will be placed in perspective, by providing an overview of how it came into existence and how it operates. Special attention will be paid to the powers and functions it has been entrusted with by its Members, and some key examples of the Organization's successes and failures will be recounted (Section 1). Thereafter, a brief description will be given about the important reforms the WHO has undergone throughout its existence. Furthermore, a summary account will be given of its actions during three previous public health emergencies: SARS, H1N1 and Ebola. This section will detail the lessons learned by the WHO during these emergencies (Section 2). Finally, a detailed description will be given of the WHO and its operations and programmes during the decade prior to the COVID-19 pandemic. Special attention will be given to the last pre-COVID-19 year, namely 2019 (Section 3).

### 1. The WHO in perspective

#### A. Establishment

The WHO is a specialised agency of the United Nations (UN) and was established on 7 April 1948.<sup>3</sup> However, the first steps towards international health cooperation, which ultimately led to the WHO's creation, date back to a century earlier, to the mid-1800s. It was at this time that willingness grew amongst mostly European States to adopt uniform quarantine measures across borders so as to protect international trade.<sup>4</sup> International cooperation on health issues crystallised across the following decades at various International Sanitary Conferences and within numerous International Sanitary Conventions, which predominantly covered infectious diseases, such as cholera, plague, and yellow fever, all the while minimising impediments to

international travel and trade.<sup>5</sup> In 1903, the International Sanitary Conference resulted in the amalgamation of the prior conventions into a single document: the International Sanitary Convention (ISC) of 1903.<sup>6</sup>

The ISC also authorised the establishment of a permanent international health body, a previously floated idea, which likely gained traction again at this time due to the recent establishment of the International Sanitary Bureau for the Americas (later: Pan American Sanitary Bureau and now: Pan-American Health Organization (PAHO)) in 1902.<sup>7</sup> In 1907, the *Office International d'Hygiène Publique* (OIHP) was created to protect European States by compiling and disseminating factual health information of public interest.<sup>8</sup> Despite unsuccessful discussions after World War I to absorb the OHIP and establish a new international health agency under the recently created League of Nations<sup>9</sup>, an additional health agency, the Health Organization of the League of Nations (HOLN), was created in 1922.<sup>10</sup> The HOLN's mandate was an innovative change from previous practice, which dealt largely with the creation of sanitary barriers, as it also encompassed the provision of technical cooperation with Members and would be active in international standard setting for health.<sup>11</sup> The OIHP and HOLN remained in contemporaneous operation due, amongst other things, to differences in membership.<sup>12</sup>

It was not until after World War II that the idea of creating a truly international health organisation with a global reach was once again raised, this time successfully.<sup>13</sup> The idea of creating one international health organisation was reiterated in 1945, by representatives of Brazil and China during the San Francisco Conference that set up the UN.<sup>14</sup> Following this proposal, on 15 February 1946, the Economic and Social Council of the UN called upon the Secretary-General to convene a conference aimed at drafting the constitution of the new health organisation.<sup>15</sup> In response to this call, between 18 March and 5 April 1946, a Technical Preparatory Committee convened in Paris and prepared the framework for such a constitution.<sup>16</sup> Its suggestions were presented to the International Health Conference in New York, between 19 June and 22 July 1946, and resulted in the drafting and adoption of the WHO's Constitution.<sup>17</sup> The newly established organisation absorbed both the OIHP and the HOLN, leading to their dissolution.<sup>18</sup> The WHO Constitution was signed on 22 July 1946 and entered into force on 7 April 1948 after 26 UN Members had ratified it.<sup>19</sup> The Organization's membership is global, consisting of all UN Member States, except Liechtenstein, and two non-



UN Member States, Niue and the Cook Islands.

**B. Mandate and functions**

The WHO Constitution specifies the Organization’s functions, which exist to achieve its overall objective of “attaining the highest level of health for all.”<sup>20</sup> Article 2 provides an enumeration of twenty-two functions; the final of these confers upon the WHO “general authority to take all necessary action to attain the objective of the Organization.”<sup>21</sup> Overall, the Organization’s core functions can be divided into three categories: (i) normative functions, (ii) directing and coordinating functions (including information dissemination), and (iii) research and technical cooperation functions.<sup>22</sup>

<b>Functions of the World Health Organization</b>	
<b>Normative</b>	To propose conventions, agreements and regulations, and make recommendations with respect to international health matters; <sup>23</sup>
	To develop, establish and promote international standards with respect to food, biological, pharmaceutical and similar products; <sup>24</sup>
	[...]
<b>Directing and coordinating</b>	To act as the directing and coordinating authority on international health work; <sup>25</sup>
	To establish and maintain effective collaboration with the UN, specialized agencies, governmental health administrations, professional groups and such other organizations as may be deemed appropriate; <sup>26</sup>
	To promote cooperation among scientific and professional groups which contribute to the advancement of health; <sup>27</sup>
	[...]
<b>Research and technical cooperation</b>	To furnish appropriate technical assistance and, in emergencies, necessary aid upon the request or acceptance of Members; <sup>28</sup>
	To establish and maintain such administrative and technical services as may be required, including epidemiological and statistical services; <sup>29</sup>
	To stimulate and advance work to eradicate epidemic, endemic and other diseases; <sup>30</sup>
	To promote and conduct research in the field of health; <sup>31</sup>
	[...]

### C. Governing bodies

To accomplish its overall objective and perform the aforementioned functions, the WHO Constitution sets out the governance structure of the Organization. Article 9 stipulates that the WHO's work shall be carried out by three organs: the World Health Assembly, the Executive Board, and the Secretariat.<sup>32</sup> The World Health Assembly (WHA or Health Assembly) is the supreme decision-making body of the WHO, and it is supported in its work by the Executive Board.<sup>33</sup> Amongst its functions specified in the WHO Constitution, the Health Assembly has the authority to determine the WHO's policies, appoint its Director-General (DG), approve its budget, and adopt documents that are legally binding *vis-à-vis* WHO Members.<sup>34</sup> In addition, the Health Assembly is the organ that most often interacts with and reports to UN principal organs<sup>35</sup> and other health actors.<sup>36</sup> The Health Assembly comprises delegates representing each WHO Member, and each Member has one vote.<sup>37</sup> Voting rules depend on the type of decision: decisions on important questions are made by a two-thirds majority of Members present and voting; decisions on other questions are made by a majority of Members present and voting.<sup>38</sup> Important competences include, amongst others listed in Article 60 of the WHO Constitution, the adoption of conventions or agreements and the approval of agreements that bring the WHO into relations with the UN or other intergovernmental organisations.<sup>39</sup>

The Executive Board consists of thirty-four persons, who technically qualified in the field of health. They are appointed by as many Members as are elected for that purpose by the Health Assembly according to equitable geographical distribution.<sup>40</sup> Broadly speaking, the Executive Board executes the Health Assembly's decisions and policies, provides advice or proposals to the Health Assembly, and takes emergency measures that require immediate action.<sup>41</sup> Finally, the Secretariat comprises the DG, who is the WHO's chief technical and administrative officer, and other scientific, technical, and administrative staff.<sup>42</sup>

Besides these principal organs, the Executive Board may also establish committees, and either the Executive Board or Health Assembly may also convene local, general, technical, or special conferences to consider matters within the WHO's competences.<sup>43</sup> A unique aspect of the WHO's governance structure is its regional organisations: each consists of a regional committee and a regional office and is tasked with formulating regional policies, recommending regional activities, and approving the relevant regional budget.<sup>44</sup> Besides its organisational headquarters located in Geneva, Switzerland, the WHO has six regional offices; each has its own Regional

Director.<sup>45</sup> Since the Regional Directors hold these leadership positions, the WHO DG does not have direct control at the regional level.<sup>46</sup>

#### D. Budget

The WHO obtains its funding from two main sources: assessed contributions and voluntary contributions.<sup>47</sup> The former are membership dues that are paid by WHO Members and calculated as a percentage of a Member's Gross Domestic Product.<sup>48</sup> The latter are contributions that are voluntarily paid by Members, other UN organisations (e.g., OCHA), intergovernmental organisations (e.g., the World Bank), philanthropic foundations (e.g., the Bill and Melinda Gates Foundation, Rotary International, etc.) or other sources (e.g., Gavi, the European Commission, etc.).<sup>49</sup> Over the years, assessed contributions have declined: they currently account for less than one-fifth of the Organization's financing.<sup>50</sup> As at June 2020, almost 40% of voluntary contributions were directed towards emergency operations and appeals, with another 20% allocated to increased health coverage and 19% to polio eradication.<sup>51</sup> The WHO's current approved biennium budget for 2020-2021 stands at USD 5.84 billion.<sup>52</sup>

#### E. Legal instruments

The WHO Constitution is the Organization's principal governing document. It sets out the WHO's overall objective of "*the attainment by all peoples of the highest possible level of health.*"<sup>53</sup> Similar to other constituent documents of international organisations, the WHO Constitution determines the body's membership; purpose and functions; governance structure; legal capacity; and provides rules concerning amendment, interpretation, and the entry into force of the Constitution.

Articles 19 to 22 of the WHO Constitution bestow normative authority upon the Health Assembly.<sup>54</sup> Pursuant to Article 19, the Health Assembly has the "*authority to adopt conventions or agreements with respect to any matter within the competence of the Organization.*"<sup>55</sup> In addition, it has the authority to adopt regulations concerning five well-specified subjects, which are listed in Article 21.<sup>56</sup> One such subject relates to "*sanitary and quarantine requirements and other procedures designed to prevent the international spread of disease.*"<sup>57</sup>

The Health Assembly has used its normative authority on prior occasions. With respect to its treaty-making powers pursuant to Article 19, the Health Assembly previously adopted the Framework Convention on Tobacco Control, in 2003, which aims to tackle tobacco-related deaths and disease.<sup>58</sup> It is the first and only treaty yet negotiated under the auspices of the WHO.<sup>59</sup> With regard to international disease control, the Health Assembly adopted the International Sanitary Regulations (ISR) in 1951.<sup>60</sup> The ISR was largely a substantive continuation of pre-existing International Sanitary Conventions. It reflected earlier international agreements, concluded since the mid-1800's, which lay out how to respond to the international spread of infectious diseases.<sup>61</sup> In 1969, the ISR was revised and renamed as the International Health Regulations.<sup>62</sup> These regulations have undergone minor revisions over subsequent years, mostly concerning the removal of particular diseases from the list of notifiable diseases: by 1981 the list applied to only three diseases.<sup>63</sup> Faced by the threat of outbreaks of both old and new diseases, the Health Assembly requested a substantial revision of the International Health Regulations in 1995.<sup>64</sup> This was not completed until 2005, when the Health Assembly adopted the International Health Regulations (2005) (IHR) on 23 May 2005, by way of resolution WHA58. The IHR entered into force on 15 June 2007. They are an instrument of international law and are legally binding on 196 States, including all WHO Members.

#### F. The WHO's relations with other organisations

As mentioned above, the WHO was established under the auspices of the UN and constitutes one of its specialised agencies.<sup>65</sup> Given the multitude of provisions in the WHO Constitution that refer to the UN,<sup>66</sup> and the fact that its functions require significant collaboration between the organisations, strong WHO and UN-system interaction and co-dependency was envisioned from the very beginning.<sup>67</sup> To maintain effective collaboration, provide assistance, or consider recommendations that bear on health, the WHO Office at the United Nations was established to represent the WHO at the UN.<sup>68</sup>

Notwithstanding the WHO's broad authority, it is not the only organisation within the UN system that has a mandate covering health-related matters:<sup>69</sup> within the UN, one can point to the Food and Agriculture Organization of the UN (FAO), the World Intellectual Property Organization (WIPO) and the World Bank Group; outside the 'UN family', one can mention the World Trade Organization (WTO).<sup>70</sup> The WHO interacts with these organisations and with

other UN specialised agencies through co-sponsored programmes, joint meetings, high-level fora, exchanges of information, and other modes of interaction in the health domain.<sup>71</sup>

Importantly, as the designated directing and coordinating authority on international health work, the WHO also partners with countries, international organisations, civil society, foundations, academia, research institutes, and others to improve health outcomes for people and communities.<sup>72</sup> The significant importance of the WHO's collaboration and partnerships with other international organisations – both in and outside the UN system – is emphasised by the inclusion of a separate chapter in its Constitution entitled “*Chapter XVI – Relations with Other Organizations*”. While Article 69 prompts relations between the WHO and the UN, Articles 70 and 71 provide for collaboration and partnership between the WHO and other intergovernmental organisations, non-governmental organisations and national governmental or non-governmental organisations.<sup>73</sup>

#### G. Successes and failures

It is worth considering some key WHO successes and failures, which are identifiable in activities across its roughly 70-year history. The eradication of smallpox in the 1970s and strong global efforts to end polio are notable achievements of the Organization. The WHO was also widely commended for its strong and decisive leadership in 2003 when it facilitated the containment of the SARS epidemic, which was also caused by a respiratory coronavirus.

Besides these and other success stories, the WHO has also been subject to widespread criticism. By way of illustration, the WHO's actions during the H1N1 influenza outbreak in 2009 caused a stir. At this time the Organization gave the impression of aligning itself with big pharmaceutical companies instead of remaining independent. Another example of a failure was the WHO's delayed declaration of the 2014 Ebola outbreak in West Africa as a public health emergency of international concern (PHEIC). While it might be too early to definitively assess whether the WHO's COVID-19 pandemic response constitutes a success or a failure, its actions have left it vulnerable to criticism.

## 2. The WHO under reform

In its initial years, the WHO's activities mostly involved the application of technical and medical expertise for the purpose of controlling infectious diseases.<sup>74</sup> Since the mid-1970s, however, the WHO started to undergo various reforms in light of the ever-changing international economic and political environments.<sup>75</sup> This Section provides a bird's eye overview of a number of WHO reforms. It provides a better understanding of the type and extent of the reforms it has actually undertaken as well as those it has endeavoured to carry out, albeit unsuccessfully (Title A). It pays special attention to specific reform ideas that have emerged following relatively recent public health emergencies (Title B).

### A. A bird's eye view of WHO reforms

An important milestone in the WHO's history occurred in 1978 with the adoption of the Alma-Ata Declaration.<sup>76</sup> Pursuant to the declaration and under the leadership of WHO DG Halfdan Mahler, the WHO took on a more activist and holistic approach, by promoting primary health care access for all: better known as the Health for All by 2000 programme.<sup>77</sup> Despite the lofty goals of the Alma-Ata Declaration, the WHO largely failed in its implementation, due to a lack of international support.<sup>78</sup> The WHO's international standing continued to diminish across subsequent years, as individual States deemed health to be a low priority and, moreover, a national responsibility.<sup>79</sup> In the 1990s, negative attention was also directed at the WHO when it became the subject of criticism for its failures to respond to emerging health issues.<sup>80</sup> Since then, the Organization has been in a continuous state of reform. By way of illustration, a number of critical junctures and significant reform plans are detailed below.

In 1993, international pressure to reform existing institutions, including the WHO, was mounting.<sup>81</sup> Notwithstanding the identification of several operational issues, such as management deficiencies, inadequate financing practices, and an overly-strong autonomy of WHO regional offices, limited change occurred at the time.<sup>82</sup> The WHO did, however, undergo significant reforms when Dr Gro Harlem Brundtland became DG in 1998.<sup>83</sup> DG Brundtland was successful in pushing health onto the international development agenda and her efforts improved the WHO's overall reputation.<sup>84</sup> Notably, she envisioned the creation of "*one WHO*":<sup>85</sup> in her view, the WHO could not be perceived as being subdivided, in the first instance due to its dual financing sources (through the regular budget and contributions) and in the

second instance due to its seven different bodies (one in Geneva and the six semi-independent regional offices).<sup>86</sup> In the end, the realisation of “*one WHO*” was not fully achieved: close cooperation with regional offices and an increase in the regular budget did not materialise.<sup>87</sup> Her tenure is noteworthy, however, for the development of the WHO’s outbreak response capabilities. In 2000, the WHO established the Global Outbreak and Response Network (GOARN), which brings together technical partners and other institutions that are ready to participate in international coordinated responses to outbreaks.<sup>88</sup> As from 2010, the WHO underwent further notable reforms, under the leadership of DG Margaret Chan. These reforms were initially aimed at tackling problems with the WHO’s financing; however, consultations went even further and eventually addressed other fundamental issues.<sup>89</sup> Moreover, the ‘next steps’ for WHO reform were discussed and divided into three priority areas: programmes and priority setting, governance, and management.<sup>90</sup>

#### B. WHO reforms after previous public health emergencies: lessons learned?

Since its establishment in 1948, the WHO has faced many epidemic, endemic, and other diseases. Pursuant to its mission to stimulate and advance the eradication of diseases and address health emergencies,<sup>91</sup> the Organization has actively directed and coordinated international health work whenever outbreaks have occurred in the past. Recent health emergencies, of the 21<sup>st</sup> century, have required a particularly strong response. These include the outbreaks of SARS, in 2003; the H1N1 influenza virus, in 2010; the Zika virus, in 2015; Ebola, in 2014; and Ebola again, in 2018.

Over the following sub-sections, a more detailed report will be given of the outbreaks of and WHO responses to SARS, H1N1 influenza, and, more recently, Ebola. We choose to take a closer look at these particular health emergencies as: (i) the SARS outbreak resulted in the adoption of the concept of ‘public health emergency of international concern (PHEIC)’, within the revised IHR, agreed upon in 2005, post-SARS; (ii) the H1N1 influenza was coined as the first PHEIC, after the concept was introduced in the revised IHR; and (iii) Ebola was the most recent PHEIC before the emergence of COVID-19.<sup>92</sup> Each of these outbreaks resulted in a strong push – originating either from within the WHO itself and/or from the international community – to reform the WHO’s global preparedness and response capacities in cases of public health emergencies. Important lessons were learned from these outbreaks, and this has impacted the workings of the WHO.

*a. SARS epidemic (2003)*

Severe acute respiratory syndrome (SARS) was the first readily transmissible new disease of the 21<sup>st</sup> century, and its origins can be traced back to an outbreak in Guangdong Province in China in February of 2003.<sup>93</sup> On 10 and 11 February 2003, the WHO received reports, from the Chinese Ministry of Health, amongst others, of an outbreak of an acute respiratory disease in Guangdong Province that had already caused several deaths.<sup>94</sup> Due to its swift and effective outbreak response, the WHO was already able to announce the end of the epidemic on 5 July 2003 as the final chain of human transmission had been broken.<sup>95</sup>

The WHO's overall response to the SARS outbreak was evaluated positively.<sup>96</sup> The Organization acknowledged, from the outset, that this atypical pneumonia ran the risk of spreading rapidly and internationally.<sup>97</sup> Early on, it alerted the international community and GOARN of the health emergency, it assisted in investigating the novel disease, and provided support on the ground by sending volunteers.<sup>98</sup> In addition, the WHO extended guidance and adopted policies with the aim of containing the disease:<sup>99</sup> it issued travel recommendations and encouraged widespread information dissemination.<sup>100</sup> The Organization also recommended effective control measures, such as the early identification and isolation of patients, contact tracing, and the limiting of close contacts.<sup>101</sup> Moreover, the WHO had its experts assist in identifying the origin of the outbreak in Guangdong Province and coordinated international efforts to develop diagnostic tests.<sup>102</sup> Through its rapid mobilisation of resources and cooperative stance towards other international and national agents, the Organization successfully supported the containment of the SARS outbreak within six months.

These effective measures were made possible by the strong and decisive leadership of DG Brundtland.<sup>103</sup> Interestingly, DG Brundtland acted without authority when she confronted China regarding its lack of transparency during the initial outbreak. There was also no legal basis for the recommendations issued by the WHO against travel to SARS-affected locations.<sup>104</sup> While discussions regarding the revision of the IHR had been ongoing since 1995, the SARS pandemic propelled the international community into action, resulting in the adoption of the significantly revised IHR in 2005.<sup>105</sup>

The basic purpose of the IHR is to assist in the prevention of and response to public health threats that run the risk of spreading internationally.<sup>106</sup> The major revisions of 2005 relate to the



IHR's scope of application, the extent of the powers granted to the WHO, the inclusion of human rights principles, and the obligations for Members.<sup>107</sup> Importantly, unlike the old IHR, which focused on a small number of known and specific infectious diseases, the revised IHR covers all public health risks.<sup>108</sup> Other innovations that are worth mentioning are the obligations of Members to develop minimal core public health capacities (known as the 'core capacities') and notify the WHO of events that (threaten to) constitute a PHEIC.<sup>109</sup> In addition, the revised IHR bestow far-reaching powers upon the WHO: i.e., the DG has the authority to declare a PHEIC and to issue temporary recommendations that could have repercussions for international traffic and trade.<sup>110</sup>

*b. H1N1 influenza pandemic (2009)*

The first public health emergency of international concern – i.e., the concept that was newly introduced by the 2005 IHR revisions - was the influenza A (H1N1) pandemic that emerged in April 2009.<sup>111</sup> In August 2010, DG Chan announced that the pandemic was over and that the world was moving into the post-pandemic period.<sup>112</sup> An IHR Review Committee had already been convened in January 2010, while the pandemic was ongoing.<sup>113</sup> It had the mandate to assess the pandemic response and review the overall functioning of the IHR in order to modify, where appropriate, the ongoing response and strengthen preparedness for future pandemics.<sup>114</sup>

Following its investigation of the IHR's functionality and the WHO's response to H1N1, the IHR Review Committee drew up a report with summary conclusions and recommendations.<sup>115</sup> DG Chan transmitted it to the Health Assembly on 5 May 2011.<sup>116</sup>

The report articulated three summary conclusions. First, on the part of Members, while the IHR did render the world better prepared to respond in the wake of a health emergency, the report indicated that the core national and local capacities demanded by the IHR were not yet fully operational during the H1N1 pandemic and that timely implementation thereof would likely not occur.<sup>117</sup> Second, on the part of the WHO, the Review Committee concluded that the WHO's response during the pandemic displayed shortcomings but no wrongdoing.<sup>118</sup> Third and looking towards the future, the Review Committee reported that the world was ill-prepared for the outbreak of any future severe influenza pandemics or other global public health emergencies.<sup>119</sup>

Alongside the three summary conclusions, the IHR Review Committee included fifteen recommendations, which aimed strengthening the WHO's future pandemic preparedness and response capabilities.<sup>120</sup> These recommendations highlighted, amongst other things, the need to accelerate core capacity-building and ensure the availability of resources; encourage enhanced transparency and communication and information dissemination; pursue comprehensive research; and reach advance agreements related to vaccine development and virus sharing.<sup>121</sup> These recommendations formulated by the IHR Review Committee were, however, not implemented extensively.<sup>122</sup> Members' general lack of interest in the recommendations was a consequence of the economic turmoil that was raging at the time, caused by the financial crisis.<sup>123</sup> Many of the recommendations formulated in the wake of the H1N1 influenza pandemic reappeared in reviews after the subsequent Ebola outbreaks.

*c. Ebola outbreaks (West Africa: 2013-2015; Democratic Republic of Congo: 2018-2020)*

While States were not actively engaged in implementing recommendations after the H1N1 pandemic, international attention to reform the WHO and IHR gained significant traction after the Ebola outbreak of 2014 in West Africa.<sup>124</sup> The WHO was regarded as having failed tremendously in its emergency response during the outbreak.<sup>125</sup> Criticism voiced against the WHO focused on its slow declaration of a PHEIC in relation to the Ebola outbreak:<sup>126</sup> while *Médecins sans frontières* had warned the international community about the magnitude of the outbreak as early as March 2014, DG Chan did not declare the outbreak a PHEIC until 8 August 2014.<sup>127</sup> It has been said that the WHO declined to declare a PHEIC earlier because it feared that an announcement would hurt the Organization's relations with affected States and could result in negative economic and political ramifications.<sup>128</sup> The Organization was also criticized in the months preceding the PHEIC declaration, because it failed to act upon information from non-state sources and did not reprimand governments for their minimisations of the seriousness of the disease.<sup>129</sup> When the WHO finally declared a PHEIC, the declaration was not accompanied by travel or trade recommendations nor was a call for further international support included.<sup>130</sup>

Numerous review committees and independent panels were convened to consider the WHO's perceived inadequate response to the Ebola outbreak.<sup>131</sup> It had been made quite clear that the WHO's institutional framework was not up to par in terms of preventing, responding to, or controlling an emergency outbreak in a timely or efficient manner. Each of the review panels,

therefore, provided recommendations for reforming the WHO. In one of his books on global health governance, internationally recognised global health politics expert JEREMY YOUDE, has identified commonalities found in the recommendations of the two most prominent independent review panels: the independent Ebola Interim Assessment Panel and the Harvard Global Health Institute – London School of Hygiene and Tropical Medicine Independent Panel on the Global Response to Ebola:<sup>132</sup>

*“[b]oth [panels] recognize that an assessment of [the] WHO’s mandate reveals significant underfunding and call for changes in its funding structure. Both place an emphasis on WHO’s central role as an information provider and distributor for the international community. Both argue for the need to introduce changes within WHO’s bureaucracy, calling for the creation of new coordinating offices and additional politically insulated advisement bodies. Finally, both recognize that the operational expectations of what WHO can and should do outstrip its mandate and that the organization should focus on its areas of core competency.”<sup>133</sup>*

In the years following the Ebola pandemic in West Africa, various reform actions were taken regarding the ambit of the WHO: these targeted areas that had been identified during the earlier reviews as needing reform. The 68<sup>th</sup> Health Assembly of May 2015 resulted in agreement on a number of major reforms.<sup>134</sup> One was the May 2015 establishment of the WHO Contingency Fund for Emergencies, which aims to enable swift action during health emergencies by providing rapid funding to the WHO and its partners.<sup>135</sup> Pursuant to a call during the 68<sup>th</sup> Health Assembly to accelerate research and development of diagnostics, vaccines, and therapeutics relating to emerging pathogens that lack medical solutions, the WHO R&D Blueprint was created;<sup>136</sup> it aims to improve coordination between scientists and health professionals and develop new norms and standards to enhance the global response and ensure that R&D activities are rapidly activated during outbreaks.<sup>137</sup> The same Health Assembly also requested the DG to launch a Review Committee to look into revisions of the IHR.<sup>138</sup> A further example of innovative reform post-Ebola was the creation of the WHO Health Emergencies Programme in 2016. This programme aims to enable the WHO to respond more effectively to outbreaks and emergencies by promoting collective action and assisting in rapid detection, response, and recovery activities.<sup>139</sup> A final reform example was the May 2016 launch of the Global Health Emergency Workforce.<sup>140</sup> The workforce is a global registry of emergency medical teams, which facilitates the rapid mobilisation of emergency personnel during a health crisis.<sup>141</sup>

The above analysis reveals that the WHO did respond to numerous calls for reform following

the 2014 Ebola outbreak; moreover, the reforms touched upon various functional issues facing the Organization and further enhanced its emergency prevention, preparedness, and response capabilities.

Another Ebola crisis occurred in the Democratic Republic of the Congo in 2018.<sup>142</sup> While the Emergency Committee convened several times in the months following the initial outbreak, it repeatedly failed to conclude that the health crisis constituted a PHEIC.<sup>143</sup> Consequently, DG Tedros Ghebreyesus did not declare a PHEIC until 17 July 2019, after the Emergency Committee had finally advised him to do so.<sup>144</sup> This protracted delay sparked significant criticism, even though the WHO's support on the ground did result in the control of the outbreak in 2019.<sup>145</sup> Importantly, strong calls were voiced in favour of providing the DG with more options, beyond the mere binary approach of declaring or, alternatively, not declaring a PHEIC.<sup>146</sup>

As the Ebola pandemic continued, the WHO unveiled, in March 2019, its intention to implement significant reforms at all three levels of the Organization: headquarters, regional offices, and country offices.<sup>147</sup> The process of fully implementing these operational reforms, with more clearly-defined roles for country offices, regional offices, and headquarters, was underway when the world was confronted with the COVID-19 pandemic.

### **3. The pre-COVID-19 decade**

The WHO, as well as global health governance in general, were intensively impacted by and assessed according to the experiences of responding to the epidemic outbreak of Ebola in West Central Africa, beginning in December 2013. Both the “*WHO's ability to play a coordinating role in the global response to the epidemic*”<sup>148</sup> as well as its legitimacy as the international health agency were questioned and criticised. The 2017 appointment of a DG from Africa, Dr Tedros Ghebreyesus, can be seen within this context: as part of an institutional quest for renewed leadership and authority.

In addition, the WHO's experiences with health emergencies, epidemics, and disease outbreaks earlier in the century (e.g., Ebola, Zika, and H1N1) meant that the Organization, and its emergency response structures, were placed on review and reform mode across the second half

of the 2010s. While many reform efforts moved to equip the WHO, in itself, with operational capacity, there exists a commonly held perception that the Organization has as its main goal the enhancement of the positions and capacities of its Members. Reforms and actions at both global and regional levels focused on ensuring support for WHO Members: in terms of their preparedness and readiness for and responses to emergency and pandemic-like situations.

By 2019, the WHO was the centre-piece of a large and complex global health structure that both monitored the global health situation and stood ready to be activated in response to a health emergency. By this time, the Organization's specific responsibilities were and continue to include: acting as the focal point for health within the UN Inter-Agency Standing Committee for humanitarian assistance; leadership of the Global Health Cluster; and coordination of the Emergency Medical Team. Regarding infectious hazards, such as COVID-19, the WHO was, and remains, the custodian of the IHR; moreover, by 2019, the Organization had positioned itself to offer technical guidance and leadership as well as operational capacity, thereby supplementing the actions of its Members. Since 2005, the work of the WHO and its six regional offices has been underpinned by the updated and legally binding International Health Regulations, while the State Party Self-Assessment Annual Reporting (SPAR) mechanism has aimed at monitoring and ensuring that States' obligations to develop and maintain core capacities are actually met.

The creation of the WHO Health Emergencies Programme in 2016, mentioned previously, aimed at enhancing the Organization's management of health emergency cycles (i.e., management relating to preparedness, alert, response, recovery, and prevention). These reforms aimed at answering Member and public expectations relating to the WHO's "*leadership, support and expertise*"<sup>149</sup> in emergency situations. The WHO Health Emergencies Programme was established at the request of the Health Assembly: it originated in a recommendation of the Advisory Group on Reform of WHO's Work in Outbreaks and Emergencies with Health and Humanitarian Consequences, itself put together by WHO DG Margaret Chan in July 2015. In November 2015, the Advisory Group's first report underlined that technical assistance and aid in emergencies are "*core component(s)*"<sup>150</sup> of the WHO's general goal of attainment by all peoples of the highest possible level of health.

In January 2016, the Advisory Group's final report recommended that the WHO should

establish “*a single Programme for its work in outbreaks and emergencies, with a single budget, a single workforce, a single line of authority, a single operations support system, and a single set of business processes, while remaining flexible and adaptable to the multi-faceted nature of health and humanitarian emergencies.*”<sup>151</sup> Both of the Advisory Group’s reports recalled the importance of impartiality and independence at all organisational levels in order to offer credible leadership with special care towards vulnerable populations. The reports also stressed that WHO Members should keep their commitments and ensure “*steady-state financing*” for the WHO Health Emergencies Programme and the WHO as a whole.

The Advisory Group recommended a major escalation of operational capacity, but not at the expense of technical expertise. It set the benchmarks for future outbreaks as follows:

*“The Advisory Group recommends that WHO position itself as an operational organization while maintaining its leadership in technical expertise. As an operational organization, WHO will need to be present in outbreaks and emergencies; be capable of leading, coordinating and implementing key public health functions; be equipped with adequate capacity; be ready to engage quickly and openly with other actors for health and be consistent in reflecting humanitarian principles. This means recognizing that as an operational actor, WHO will not be the default actor to implement all needed interventions in an outbreak or emergency. In most instances, the national government will be the principal actor, supplemented by other national and international partner organizations. WHO’s principal operational role will be to work in partnership with others to facilitate and ensure that critical operational requirements are covered and gaps are filled, with WHO itself serving as an implementer when appropriate.”*<sup>152</sup>

In 2017, the WHO published the second edition of its Emergency Response Framework (ERF),<sup>153</sup> updating its first, 2013, document by incorporating lessons from previous outbreaks. The new ERF established a roadmap for, on the one hand, early detection and risk assessment of public health events and, on the other hand, the WHO’s operational response. It established a grading system for health emergencies, from ungraded monitoring to grade 3 emergency requiring maximal WHO response. The assessment of an emergency triggers the Incident Management System (IMS), mobilising resources according to the threat level. Within the IMS the Organization has the following functions: leadership, coordination, information and planning, health operation and technical expertise, operations support and logistics, and finance and administration.<sup>154</sup> The grading system, however, largely remains as a WHO internal affair and as a public awareness tool it pales in comparison to the potential awareness that can be

raised by the IHR's PHEIC declaration.

In addition to the IHR and the WHO Health Emergencies Programme, the WHO also plays a core role within the Pandemic Influenza Preparedness (PIP) Framework, which was approved by the Health Assembly in 2011. The PIP Framework, as developed by WHO Members, works towards improving the sharing of influenza virus samples and increasing access to vaccines and pandemic related supplies. In sum, it works to facilitate goals that are very similar to those objectives sought within COVID-19 pandemic responses. The PIP Framework also set up partnerships with industry, ensuring sustainable flows of resources: in exchange for access to the WHO Global Influenza Surveillance and Response System (GISRS), manufacturers of pharmaceuticals and vaccines contribute to the Framework budget. To access GISRS data (e.g., biological material, virus with pandemic potential), entities, such as biotech firms and manufacturers, also must commit to provide in kind contributions of vaccines, pharmaceuticals, technical assistance, and necessary equipment, according to legally binding Standard Material Transfer Agreements 2.<sup>155</sup>

## PART 2. THE WHO DURING THE COVID-19 PANDEMIC

Part 1 clarifies that over its more than 70-year history the WHO has been given functions and corresponding powers to better position the international community to prevent, prepare for, control, and respond to disease outbreaks. It has continuously drawn lessons from previous outbreaks, by convening review committees and listening to independent panels that have been concerned with the various ways the Organization might adjust its approach in the future: i.e., by negotiating innovative legal instruments (e.g., the IHR in 2005), by introducing new programmes (e.g., the WHO Health Emergencies Programme in 2016), or by improving its governance mechanisms (e.g., the operational reform in March 2019). This was illustrated in the previous part of the report through the lens of the lessons learnt by the WHO after its confrontations with SARS, H1N1, and Ebola.

Despite the various reforms implemented throughout the years, which have extended the WHO's normative, technical, and operational capabilities relating to public health threats, the emergence of COVID-19 has demonstrated that the WHO was not in a position to prevent the pandemic's international spread. The Organization has faced a strong backlash over its pandemic response. Severe criticism has been voiced against the WHO and has called into question its efficiency, legitimacy, and modes of governance. At the time of the initial outbreak, as well as later on, the Organization was blamed for responding too slowly, for being overly deferential to China, and for providing inadequate advice and guidance, amongst other things.

This criticism has raised the question as to whether the WHO has performed its functions during the COVID-19 pandemic to the extent envisioned by its Members. In what follows, a critical assessment of the WHO's powers and authority will be performed, based on the normative and political framework available to the Organization. We will first recall the facts surrounding the WHO's early response to the COVID-19 outbreak (Section 1). Thereafter, a critical evaluation will be made concerning the design of the IHR and its provisions, on the one hand, and the respective implementations of IHR provisions during the COVID-19 pandemic, by the WHO and its Members, on the other (Section 2).<sup>156</sup> We will then proceed by discussing the broader global health governance system, i.e., beyond the IHR, and evaluate how the WHO interacted with other actors within that system in response to COVID-19 (Section 3). Finally, the findings from the aforementioned evaluations will be brought together to distil key problems and issues in respect of the WHO; all must be addressed to enhance the Organization's position *vis-à-vis*



future health emergencies (Section 4).

The analyses in this Part will shed light on shortcomings in the IHR's design and/or its implementation as well as failings in the interactions between the WHO and other global health governance actors. Both have negatively impacted the WHO's ability to efficiently respond to the COVID-19 outbreak and/or have negatively impacted its overall credibility.

## 1. The early response

In the years preceding the COVID-19 pandemic, institutions and leaders in global health governance were aware of the dangers posed by a fast-spreading respiratory disease in a interdependent and interconnected world. In 2019, a report by the Global Preparedness Monitoring Board (GPMB), co-convened by the WHO and the World Bank, warned about the possibility of a pandemic spreading due to a lethal respiratory pathogen: highlighting in particular high-impact pathogens, such as deadly strains of influenza. Even though the report did not refer to the coronavirus in particular, it warned that “*respiratory droplets can infect a large number of people very quickly and with today's transportation infrastructure, move rapidly across multiple geographies.*”<sup>157</sup> Governmental organisations, the scientific community, and a variety of stakeholders also warned about the deadly consequences of fast-spreading diseases<sup>158</sup> and previously unknown pathogens,<sup>159</sup> including coronaviruses of zoonotic origins.<sup>160</sup>

On 31 December 2019, the WHO became aware of an outbreak of cases of pneumonia with an unknown cause in Wuhan, China. On that same day, three different sources provided the information that led to such awareness:<sup>161</sup> the WHO Western Pacific Regional Office (WPRO) was informed by the WHO Representative Office in the People's Republic of China, which had taken note of a public bulletin from the local authorities; the Centre for Disease Control in Taiwan had contacted the WHO via the IHR; and the WHO Epidemic Intelligence from Open Sources (EIOS) had uncovered information on the website of the Program for Monitoring Emerging Diseases (ProMED).<sup>162</sup> Over the following days, the WHO responded to these signals on multiple fronts. Following the IHR, WHO/WPRO requested additional information and verification from China, while the WHO Country Office met with the Chinese National Health Commission on 3 January 2020. In addition, the WHO asked the Chinese Centre for Disease Control for further and updated information on the outbreak, the virus, and the disease.<sup>163</sup>

Initial WHO communication and responses to the outbreak were marked by contradicting information regarding sustained or limited human-to-human transmission of the novel coronavirus. The WHO informed all Members about the outbreak on 5 January 2020, through the IHR Event Information System. On the same day, it released a Disease Outbreak News bulletin noting the absence of evidence for human-to-human transmission and that no healthcare worker infection was known. The bulletin placed emphasis on a cluster originating at the Huanan Seafood market in Wuhan. While stating that the situation should be “*handled prudently*”, the WHO positioned itself “*against the application of any travel or trade restrictions on China.*”<sup>164</sup>

On 15 January 2020, the WHO Country Office arrived at an agreement with Chinese authorities to visit Wuhan, and the first WHO mission took place on 20-21 January 2020. This first mission concluded that data indicated human-to-human transmission, but the extent of transmission remained unknown.<sup>165</sup> Days earlier, exportation of the virus had already been confirmed: with cases in Thailand and Japan on 8 and 16 January 2020 respectively. By late January 2020, the building of a completely new 1,000-bed hospital was underway in Wuhan,<sup>166</sup> and a strict lockdown had been declared in the city, which would eventually lead to significant local reduction of cases. These policies in China contributed<sup>167</sup> to the decision of an official in the Pan-American Health Organization to issue an Epidemiological Alert about the novel coronavirus with the aim of raising awareness and preparedness.<sup>168</sup> PAHO did not recommend travel and trade restrictions.

The first meeting of the IHR Emergency Committee was convened by the WHO DG on 22-23 January 2020 to discuss the outbreak of the novel coronavirus. Several members of the Committee considered that it was “*still too early to declare a PHEIC, given its restrictive and binary nature*”,<sup>169</sup> but nevertheless warned about the possibility of further cases being exported to any country. Following the meeting, the WHO did not recommend any traffic restrictions nor specific health measures for travellers as “*entry screening offers little benefit, while requiring considerable resources.*”<sup>170</sup> Reviewing the events of January 2020, the Independent Panel for Pandemic Preparedness and Response (IPPPR) concluded that the Wuhan outbreak likely already met the criteria for declaration as a PHEIC on 22 January 2020 when the Emergency Committee met for the first time.<sup>171</sup>

The IHR Committee met again a week later, by which time the WHO DG had declared that the outbreak constituted a PHEIC. By this stage, virus exportations numbered roughly 100 cases in 18 countries outside China, including cases in North America, Europe, and South and South-East Asia. The PHEIC declaration of 30 January 2020 led to the issuance of temporary recommendations according to the IHR. Emphasis was put on early detection, containment, contact tracing, isolation, and prevention. It was warned that countries should expect further exportation of the virus and should prepare themselves, while also contributing to the global response through multisectoral communication and collaboration aimed at increased knowledge about the virus and the disease. While stating that it was “*still possible to interrupt virus spread*”,<sup>172</sup> the Committee did not recommend travel or trade restrictions. Countries implementing additional health measures that interfered with international traffic were asked to inform and justify their actions. By the end of January 2020, however, individual countries, including the United States and Austria, were already taking action to restrict travel, initially targeting travellers who had been in China in the previous weeks.

Despite constituting the loudest possible alarm under the IHR, there is now a consensus that the PHEIC declaration of 30 January 2020 did not convey a sufficient sense of urgency and seriousness regarding the threat.<sup>173</sup> It did not lead to a coordinated global response that matched the scale of the outbreak. Furthermore, it was not followed by necessary measures and emergency actions by States, many of which did not have the core capacities to slow the spread and mitigate the consequences of COVID-19. When presenting the rationale behind the PHEIC declaration, the WHO DG stated that the greatest concern was not the situation in China, but “*the potential for the virus to spread to countries with weaker health systems, and which are ill-prepared to deal with it.*”<sup>174</sup>

In February and March 2020, two louder, but unofficial, alarms came to complement the PHEIC declaration. The first came from the WHO, which announced that the situation constituted a pandemic on 11 March 2020. This new label did not usher in any official change in terms of the required or actual actions of the WHO and States; instead, the main purpose of the declaration was to raise awareness about the fast spread and severity of COVID-19 and to denounce inaction: “(the) *WHO has been assessing this outbreak around the clock and we are deeply concerned both by the alarming levels of spread and severity and by the alarming levels of inaction. We have called every day for countries to take urgent and aggressive action. We*

*have rung the alarm bell loud and clear.”*

The second, louder alarm resulted from the weight of reports and data from around the world, which indicated the reality of a fast and often uncontrolled spread of the virus. The images of lockdown in northern Italy, declared on 21 February 2020, and information about the dire situation in the country’s hospitals rapidly travelled the world. On 7 March 2020, a state of emergency was declared in the State of New York, United States, following a spike in the number of cases. By mid-March 2020, cases of COVID-19 had been confirmed in over 100 countries, many with community transmission. Europe had become the epicentre of the pandemic, and European governments had introduced lockdown and travel restriction measures.

The picture of the early response to the outbreak, from the awareness of cases in Wuhan to the declaration of the pandemic, is mixed. On the one hand, the official response did not succeed in creating the necessary sense of urgency regarding the impact of the outbreak in Wuhan: additional steps taken by States after the PHEIC declaration on 30 January 2020 were insufficient, leading to February 2020 being considered a “*lost month*” in the overall response;<sup>175</sup> on 4 February 2020, the WHO DG called States to action, stating “*(w)e have a window of opportunity. While 99% of cases are in China, in the rest of the world we only have 176 cases;*”<sup>176</sup> a month later, on 4 March 2020, over 90% of new confirmed cases were outside of China, with cases being confirmed in 4 to 5 new countries each day.<sup>177</sup> The Organization has also been criticized for its default position against travel bans and for praising China excessively in the initial weeks of the pandemic.<sup>178</sup>

On the other hand, it has been argued that COVID-19 presented unique characteristics: i.e., a combination of high rates of human-to-human and asymptomatic transmission, asymptomatic infections, a 4-day period of virus incubation on average, and mortality rates correlating with age and pre-existing conditions.<sup>179</sup> Observers have pointed out that these factors could not be clearly anticipated and were unconfirmed at the beginning of the outbreak. Even with the information available by mid-January 2020, experts did not urge for travel to China or even the city of Wuhan to be avoided; instead, it put emphasis on “*good hand and personal hygiene.*”<sup>180</sup> By late January, a Financial Times editorial still downplayed the potential threat of the novel coronavirus,<sup>181</sup> emphasising its lower mortality rate compared to SARS and calling attention to

flu epidemics. This uncertainty led WHO experts to attempt a balance between an effective response and reasonable restrictions to trade and travel.

## **2. The International Health Regulations during COVID-19**

As seen above, the IHR are the normative instrument that were negotiated for the purpose of preventing, protecting against, controlling, and providing a public health response to the international spread of disease.<sup>182</sup> Therefore, in light of the importance of the IHR, this Section will zoom in on the Regulations to assess the WHO's actions and the extent to which it could act during the COVID-19 pandemic. We will describe the WHO's actions, after it was informed of the atypical pneumonia cases in Wuhan at the end of 2019, and will analyse such actions based on the procedures set out in the IHR. Based on our research and interviews, we submit that there are several design flaws in the IHR, which put into perspective the limited extent to which the WHO can act in the face of a public health emergency such as the COVID-19 pandemic. Further, we observe that there have also been implementation flaws relating to the use of IHR provisions during the pandemic, these relate to the actions of both the WHO and individual Members and have exacerbated ill-preparedness for and inefficient responses to the pandemic. We will both critically review the IHR from a holistic perspective (Title A) and evaluate specific IHR provisions (Title B) so as to better understand the extent to which the WHO was positioned to respond, based on the tools it was entrusted with by its Members, to the novel disease outbreak in December 2019.

### **A. Holistic evaluation of the IHR**

The IHR aim to assist in prevention of and responses to public health threats that run the risk of spreading internationally.<sup>183</sup> Despite having been significantly revised in 2005, to further enhance the international community's preparedness for disease outbreaks, the prolonged nature of the COVID-19 pandemic has raised the question as to whether the IHR is sufficiently tailored to and capable of providing the tools required for addressing a pandemic.<sup>184</sup> In the following sections, a number of limitations, inherent within the IHR, will be discussed to clarify difficulties encountered by the WHO during a disease outbreak.

*a. Narrow purpose of the IHR*

Article 2 IHR sets out the purpose and scope of the legal instrument: “*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*”.<sup>185</sup> While this provision gives the impression that the legal instrument will provide a comprehensive toolbox to address (threats of) public health emergencies, an inquiry into the IHR negotiators’ intentions adds some illuminating perspective.

As discussed, revision of the IHR was agreed upon in 2005, to address the recent major crisis that had faced the international community: namely the SARS outbreak of 2003.<sup>186</sup> SARS is known as a disease that presents with an acute and sudden onset; however, it does not last long.<sup>187</sup> The IHR, crafted to respond to similar situations, were not envisioned to guide an international response to a sustained, long-term pandemic, i.e., a situation extending beyond a few months.<sup>188</sup> Moreover, the IHR was conceived by negotiators and drafters with a pandemic of limited scale, such as SARS, in mind.<sup>189</sup> As such, the IHR were not geared towards addressing and responding to a pandemic with the magnitude and complexity of COVID-19.<sup>190</sup>

With respect to COVID-19, GIAN LUCA BURCI, Adjunct Professor of International Law at the Graduate Institute of International and Development Studies in Geneva and former WHO Legal Counsel, summarises that the IHR “*were actually meant to prevent events of this magnitude and reduce the risk of uncontrolled spread with the related collapse of multilateral governance*” (emphasis added).<sup>191</sup> In other words, the purpose of the IHR is relatively narrow in that it regulates surveillance, alerts, guidance, and coordination to prevent and control the international spread of disease.<sup>192</sup> One can think in this regard of the notification and surveillance obligations of WHO Members, which serve to provide an early alert system to curb the spread of a disease. Coordinating or regulating a *response* during a pandemic, once a disease has spread internationally, is not necessarily within the ambit of the IHR.<sup>193</sup>

*b. Rigidity of the IHR*

Regarding pandemic response, the IHR do not contain many provisions that provide WHO or individual Members with tools or procedures for the formulation or coordination of an

international response to a pandemic, at a time when prevention and control measures have failed to curb the international spread of a disease.<sup>194</sup>

One tool that is provided by the IHR and which assists in responses during a pandemic is the ability of the DG to issue temporary recommendations.<sup>195</sup> However, this mechanism does not provide the right recipe for a long-term and uncertain pandemic like COVID-19.<sup>196</sup> When scientific knowledge changes almost every week, the time-consuming issuance of temporary recommendations cannot keep up with events, especially due to the mechanisms relative procedural rigidity.<sup>197</sup> Once the process has been completed, culminating in the issuance of tailored temporary recommendations, the scientific knowledge upon which they are based might already be outdated.<sup>198</sup> What is more, the procedure can also become highly politicised, as temporary recommendations may have a significant impact on economic, social, and other aspects that lean towards the national purview.<sup>199</sup>

The DG issued a limited number of temporary recommendations on the same day as the PHEIC declaration. Over the following months, however, use of the instrument of temporary recommendations largely fell away, except at the time of their mandatory review.<sup>200</sup> Instead, the WHO chose to provide general WHO advice during press conferences and by way of publications on its website and through social media. While the Organization should be commended for sharing its scientific and technical expertise and providing ample guidance through its general advice, such advice is less forceful and less compelling for Members to follow than temporary recommendations. On the other hand, the process to issue temporary recommendations is time-consuming and can become highly politicised, which slows down decision-making and guidance at critical times. This trade-off between the swift publication of general WHO advice and slower but more compelling temporary recommendations needs addressing.<sup>201</sup>

### *c. Constraints inherent in the IHR*

Besides its narrow purpose and rigidity, the constraints inherent in the IHR are another aspect that hampers the IHR from operating as an efficient and effective framework for addressing large-scale global pandemics like COVID-19.<sup>202</sup> The IHR are a product of negotiations wherein individual Members had significant input. As in any international organisation, power and control are only transferred to the international organisation upon consent of individual States,

which make up the membership of the organisation. While WHO Members were incentivised after SARS to revise and strengthen the IHR, it remains clearly discernible within the revised IHR of 2005 that Members wanted to retain sufficient degrees of control and sovereignty.<sup>203</sup>

Several provisions clearly demonstrate that a balance was struck between Members wanting to extend more elaborate powers and authority to the WHO to manage health threats while, at the same time, other Members wanted to maintain control and sovereignty.<sup>204</sup> One example, as elaborated upon below, is the possibility for the Organization to obtain information about health threats from sources other than Member governments (Article 9 and 10 IHR). While this has given the WHO more elaborate powers, the IHR requires the Organization to first verify such information with the Member concerned before acting upon it. This demonstrates the balance struck – or rather tension established – between authority granted to the WHO and control maintained by Members. Another example is the non-binding nature of temporary recommendations issued by the DG. On the one hand, the DG has been vested with significant authority, as temporary recommendations can have substantial political, economic, and social impacts;<sup>205</sup> however, as these recommendations are not legally binding in nature and because Members are allowed to implement additional health measures, pursuant to Article 43 IHR, Members are able to maintain their control and sovereignty, if they are so inclined, by not following these recommendations.

The aforementioned characteristics of the IHR make it a legal instrument that is ill-suited for a global pandemic of a large scale, such as COVID-19.<sup>206</sup> The control and sovereignty that Members have maintained undermine the WHO's ability to take efficient and effective action in the event of a public health emergency, especially in a global political climate within which some individual States choose to go at it alone, foregoing global solidarity initiatives. The verification procedure of non-governmental reports, whereby the WHO must first reach out to the Member concerned, results in an unnecessary delay during the crucial early days of an outbreak. The non-binding nature of temporary recommendations also indicates that Members have leeway to pursue national measures that run counter to a coordinated international response to an outbreak.

#### *d. Interim conclusion*

Holistically, when considering the purpose of the IHR and the intentions of its drafters, it is



clear that, as a legal instrument, the IHR does not place the WHO or its individual Members in the strongest position to face unknown, contagious, and long-lasting disease outbreaks of a large scale. The IHR was not drafted in a way that provides the WHO with the necessary tools or, and especially, sufficient flexibility to act in such circumstances. The IHR are characterised by rigidity and constraints that allow Members to retain crucial control. What is more, while the IHR sets out provisions on preventing and controlling disease outbreaks and their international spread, long-lasting and wide-scale response measures are almost lacking. There are temporary recommendations that the DG can issue but the protracted procedure for their issuance and their non-binding nature curb their effectiveness – and that of the WHO – to respond swiftly to major outbreaks.

## B. Evaluation of specific IHR provisions

To better understand the WHO's actions during the COVID-19 pandemic, it is of the utmost importance to clarify the extent of its powers and authority as provided for by the IHR. Hereafter, the design of particular IHR provisions and their respective implementation during the COVID-19 pandemic will be evaluated. Our analysis will mainly focus on the IHR provisions that have attracted international criticism during the COVID-19 pandemic. This will allow us to better put such criticism into perspective and to understand whether the alleged shortcomings derive from the design of the IHR provisions and/or from their implementation. Specifically, our analysis will focus on the IHR provisions in respect of: (a) Members' obligation to notify the WHO of events that may constitute a PHEIC, (b) the Organization's authority to take into consideration unofficial reports of public health events and to obtain verification thereof from Members, (c) Members' obligation to continue to communicate to the WHO timely, accurate, and sufficiently detailed public health information, where available, and (d) the procedure for the determination by the DG of a PHEIC and the issuance of corresponding temporary recommendations.

### *a. Members' obligation to notify the WHO of events that may constitute a PHEIC*

#### *i. Procedure under the IHR*

Pursuant to Article 6 IHR, WHO Members are obliged to assess whether events occurring in their territory run the risk of constituting a PHEIC. As indicated above, a PHEIC constitutes an

extraordinary event which is determined to constitute a public health risk to other States through the international spread of disease and which potentially requires a coordinated international response.<sup>207</sup> To assist individual States in assessing whether events may constitute such a PHEIC, the IHR provides for a decision instrument in Annex 2.<sup>208</sup> By considering specific questions, provided for by the decision instrument, there is a structured and pre-defined assessment that Members can perform to decide whether an event may constitute a PHEIC.<sup>209</sup> In the affirmative, the Member has a duty to notify the WHO “*by the most efficient means of communication available, by way of the National IHR Focal Point, and within 24 hours of assessment of public health information*”.<sup>210</sup>

**IHR – Article 6**

“1. Each State Party shall assess events occurring within its territory by using the decision instrument in Annex 2. Each State Party shall notify WHO, by the most efficient means of communication available, by way of the National IHR Focal Point, and within 24 hours of assessment of public health information, of all events which may constitute a public health emergency of international concern within its territory in accordance with the decision instrument, as well as any health measure implemented in response to those events. [...]

2. [...] (emphasis added).”

ii. Observations

The WHO first became aware of the atypical pneumonia cases in Wuhan on 31 December 2019. As indicated above, the Organization learned of the cases by way of three different sources on that day: the WHO Representative Office in China learned about the cases through a public bulletin from local authorities, the Taiwanese Centre for Disease Control reached out to the Organization regarding the cases, and the WHO Epidemic Intelligence from Open Sources (EIOS) received information on the cases from ProMED. China did not notify the WHO on its own initiative about the cluster of cases of an atypical pneumonia of unknown cause in Wuhan pursuant to Article 6 IHR.

iii. Evaluation of the design and implementation of the IHR provision

When analysing Article 6 IHR more closely, it appears that the WHO is strongly dependent on individual States becoming aware of and obtaining information about novel disease outbreaks. It is an obligation of Members to assess events occurring in their territory, but the IHR does not provide much incentive or pressure for States to notify the WHO early on and as soon as they

discover a public health threat. LAWRENCE GOSTIN and REBECCA KATZ even go so far as to note that there is “*a disincentive to transparency and information sharing*” in the IHR.<sup>211</sup> The extent to which individual Members lack an incentive to notify the WHO “*within 24 hours of assessment of public health information*” should, therefore, not be underestimated.<sup>212</sup>

For one, individual Members are often not inclined to be as forthcoming as is necessary out of a fear of negative economic repercussions or reputational damage once they notify the WHO of a public health threat.<sup>213</sup> Furthermore, the international environment currently borders on hostility towards citizens from the States where public health risks originate. As witnessed during the COVID-19 pandemic, there has been an increase in xenophobia and racism towards Chinese citizens and citizens from States with similar characteristics. Instead of blaming or punishing States that warn the international community, such warnings should go hand in hand with assistance to address the public health risk.<sup>214</sup> It is important to not punish States that raise an alarm; instead, they should be provided with more support.<sup>215</sup> The COVID-19 pandemic has clearly demonstrated that this is not yet done internationally. There is a clear need to foster a different global environment, in which emergencies are dealt with in such a way as to ensure that States are not discriminated against and Members are encouraged rather than disincentivised to sound the alarm.<sup>216</sup>

Another factor that diminishes pressure on Members to promptly notify the WHO of health emergencies is the absence of enforcement measures in the IHR.<sup>217</sup> Several interviewees emphasised that the IHR does not provide for any sort of enforcement authority allowing the WHO to obtain information.<sup>218</sup> The question therefore arises whether enforcement or sanctioning measures could be an option within the ambit of the WHO to incentivise Members to swiftly meet their notification obligation. It may be observed in this respect that the WHO is not a sanctioning body, but is rather built around its aims to cooperate with and assist Members.<sup>219</sup> For the WHO to sanction individual Members for not meeting their notification or other IHR obligations, it would first need a constitutional basis to do so, which is currently lacking.<sup>220</sup> Article 7 WHO Constitution allows the Health Assembly to suspend the voting rights of a Member if it “*fails to meet its financial obligations to the Organization or in other exceptional circumstances*”. The latter expression seems to leave the door open for the WHO to suspend voting rights if a Member fails to meet its notification obligation; nevertheless, there

is no precedent for this action and it can be questioned whether the threat of a sanction would sufficiently compel Members to comply with their notification obligations.

Apart from the aforementioned factors explaining the lack of incentive for/pressure on Members to notify the WHO promptly, the way in which Article 6 IHR is drafted gives Members some leeway to delay notifications. While the provision clearly stipulates the time period within which a notification must occur, namely “*within 24 hours of assessment of public health information*”, it does not stipulate the time period within which the assessment of public health information must be performed.<sup>221</sup>

*b. The WHO’s authority to take into consideration unofficial reports of public health events and obligation to obtain verification thereof from Members*

i. Procedure under the IHR

Since the IHR’s revision in 2005, the WHO’s scope of participation in the global surveillance process has expanded: in the sense that the WHO may consider reports other than those provided by Members.<sup>222</sup> This revision has alleviated some of the Organization’s dependency on individual States when seeking to become aware of health threats. The WHO does not need to wait for Members’ notifications of events that may constitute a PHEIC, as it can now become aware of such events from other sources. Specifically, pursuant to Article 9 IHR, the WHO may also take into account reports from non-governmental sources. The WHO can receive such reports from independent non-state actors, systems, or individuals, or through monitoring systems that the WHO is itself a part of, e.g., the Epidemic Intelligence from Open Sources (EIOS) initiative.

**IHR – Article 9**

*“1. WHO may take into account reports from sources other than notifications or consultations and shall assess these reports according to established epidemiological principles and then communicate information on the event to the State Party in whose territory the event is allegedly occurring. Before taking any action based on such reports, WHO shall consult with and attempt to obtain verification from the State Party in whose territory the event is allegedly occurring in accordance with the procedure set forth in Article 10. To this end, WHO shall make the information received available to the States Parties and only where it is duly justified may WHO maintain the confidentiality of the source. [...]*

2. [...] (emphasis added)”

However, before acting upon non-governmental reports the WHO must meet an additional requirement. Article 9 IHR stipulates that the Organization “*shall consult with and attempt to obtain verification from the State Party in whose territory the event is allegedly occurring in accordance with the procedure set forth in Article 10*”. Article 10 IHR sets out the procedure for verification of these other reports. Upon receiving a request for verification by the WHO, the Member concerned is obliged to verify the report(s). It must provide an initial reply to the WHO’s request, or at least an acknowledgment of the request, within 24 hours and must also provide the WHO with further information within 24 hours.

When the WHO receives reports on an event that may constitute a PHEIC, it must offer to collaborate with the Member concerned in “*assessing the potential for international disease spread, possible interference with international traffic and the adequacy of control measures*”. Significantly, if the Member concerned does not accept the WHO’s offer of collaboration, the Organization has been given the authority to share the available information with other States, but only if this is justified by the magnitude of the public health risk.

**IHR – Article 10**

“1. [...]

2. Pursuant to the foregoing paragraph and to Article 9, each State Party, when requested by WHO, shall verify and provide:

(a) within 24 hours, an initial reply to, or acknowledgement of, the request from WHO;

(b) within 24 hours, available public health information on the status of events referred to in WHO’s request; and

(c) information to WHO in the context of an assessment under Article 6, including relevant information as described in that Article.

3. [...]

4. [...] (emphasis added)”

ii. Observations

The WHO learnt of the atypical pneumonia cases on 31 December 2019. On 1 January 2020, it contacted the Chinese authorities to request information about the reported cluster of atypical pneumonia cases in Wuhan. This request for information was repeated on 2 January 2020 by the WHO Representative in China, who also offered WHO support. On 3 January 2020, Chinese

officials replied and provided the WHO with available information on the cluster of cases of ‘viral pneumonia of unknown cause’ identified in Wuhan. Immediately afterwards, on 4 January 2020, the WHO issued its first international alert by tweet. On 5 January 2020, the WHO reported information about the number of cases and their clinical status to the scientific and public health communities, as well as to the global media. It also provided details about the Wuhan national authority’s response measures and the WHO’s risk assessment and advice on public health measures.

As indicated above, the WHO learned of the public health risk in Wuhan by way of non-governmental reports on 31 December 2019. In accordance with its verification obligation in Article 10 IHR, the WHO requested further information from the Chinese authorities on 1 January 2020. China replied on 3 January 2020 and provided the WHO with available information on the cluster of cases.

### iii. Evaluation of the design and implementation of the IHR provision

While Article 9 IHR empowers the WHO to consider more reports on public health threats and thereby reduces its dependency on individual States’ notifications, the provision still curbs the Organization’s ability to act to an undesirable degree. Specifically, it strongly limits the WHO’s ability to act swiftly and efficiently in the face of a developing public health risk: it is obliged to first verify the relevant non-governmental reports with the Member concerned before it is able to act on them.

This limitation can be traced back to Members’ refusal to transfer more authority to the WHO. The January 2004 draft text of the IHR (2004 Draft IHR) provided the WHO with more powers to use non-governmental sources of information in its global surveillance: that version stipulated that the Organization “*may validate these reports*” through verification procedures included in the IHR.<sup>223</sup> This draft provision was ultimately revised due to sovereignty concerns. What resulted was the WHO’s obligation requiring it to attempt to obtain verification of non-governmental reports from relevant Members before acting upon the information contained therein.<sup>224</sup>

Notwithstanding the verification duty, the aforementioned provision can speed up the process through which an individual State shares information about public health risks. Consider, for example, a Member that is aware of a disease outbreak within its territory, but which delays notifying the WHO due to reputational or economic concerns. If the WHO learns about the outbreak through non-governmental reports, it must reach out to the Member concerned, which, pursuant to Article 10 IHR, has a duty to reply and provide the Organization with available public health information within 24 hours. Even if the Member refuses to collaborate with the WHO, the Organization may share the information with other Members “*when justified by the magnitude of the public health risk*”. Thus, while the Organization remains heavily dependent on individual Members, to provide it with information about public health threats before it can act, its ability to consider other reports does allow it to receive information sooner. If the WHO had not been granted the authority to consider other reports, an individual Member would have the leeway – albeit in violation of its IHR obligation to notify – to sit on important public health information longer, because it would not be compelled to respond to WHO verification requests. Nonetheless, the fact remains that the verification requirement, as a precondition for the WHO to act on other reports, constitutes a limitation for swift and efficient WHO action.

One caveat is worth considering here: while Article 9 IHR should, in theory, enable the WHO to learn about public health threats early on, the Organization might not always be able to accomplish that aim in practice, due to the vast number of ‘other reports’ it receives and must evaluate within the limited scope of its resources. Given the substantial number of non-governmental reports it receives, the WHO must perform a filtering exercise; this is done only in part by machines.<sup>225</sup> The Organization’s filtering capacity, including its further digitalisation, is a matter that requires addressing in future reform. This will enable the WHO to gain awareness of and act on public health threats as soon as possible.<sup>226</sup>

Regrettably, there is another flaw in the design of this particular IHR provision that runs the risk of preventing the WHO from receiving such other, non-governmental reports.<sup>227</sup> One sentence in Article 9 IHR generates the risk of hindering the WHO, in that it could scare off non-state actors from reporting on events in certain States.<sup>228</sup> Article 9 IHR stipulates that the “*WHO shall make the information received available to the States Parties and only where it is duly justified may WHO maintain the confidentiality of the source*”. This means that the WHO must share with concerned Members the identity of non-governmental actors reporting on

public health threats within their territory. Such actors could, therefore, face retribution, which may be a considerable risk in the case of authoritarian or repressive regimes.<sup>229</sup> As a consequence, non-governmental actors – individuals or organisations alike – could be more hesitant to share information with the WHO, knowing that the Organization must inform the Member concerned regarding their identity.<sup>230</sup>

*c. Members' obligation to continue to communicate to the WHO timely, accurate and sufficiently detailed public health information available to it*

i. Procedure under the IHR

To enable the WHO to respond effectively, it is not enough for it to become aware of a public health threat that runs the risk of spreading internationally: either by way of a notification by a Member (Article 6 IHR) or after verification by a Member of other reports obtained by the WHO (Articles 9 and 10 IHR). The Organization also needs to (continue to) receive public health information about the event in a timely and continuous manner. The IHR sets out obligations that Members concerned must provide the WHO with such information.

Articles 6 and 10 IHR require a Member to provide public health information to the WHO after notification of events that may constitute a PHEIC or upon verification of reports from non-governmental sources. Furthermore, Article 7 requires a Member to provide all relevant public health information to the WHO if an unexpected or unusual public health event occurs within its territory and could constitute a PHEIC. The aforementioned provisions, which include an information-sharing obligation if and when a particular event occurs, all refer back to Article 6 IHR, which requires a Member to *continue* to communicate public health information to the WHO in a timely, accurate and sufficiently detailed manner. Article 6 IHR is clear about the information that must be disclosed: it should include, where possible, case definitions, laboratory results, the source and type of the risk, the number of cases and deaths, conditions affecting the spread of the disease, and the health measures employed.



**IHR – Article 6**

“1. [...]

2. *Following a notification, a State Party shall continue to communicate to WHO timely, accurate and sufficiently detailed public health information available to it on the notified event, where possible including case definitions, laboratory results, source and type of the risk, number of cases and deaths, conditions affecting the spread of the disease and the health measures employed; and report, when necessary, the difficulties faced and support needed in responding to the potential public health emergency of international concern (emphasis added).”*

**IHR – Article 7**

*“If a State Party has evidence of an unexpected or unusual public health event within its territory, irrespective of origin or source, which may constitute a public health emergency of international concern, it shall provide to WHO all relevant public health information. In such a case, the provisions of Article 6 shall apply in full (emphasis added).”*

**IHR – Article 10**

*“Pursuant to the foregoing paragraph and to Article 9, each State Party, when requested by WHO, shall verify and provide:*

[...]

*(c) information to WHO in the context of an assessment under Article 6, including relevant information as described in that Article (emphasis added).”*

ii. Observations

This information-sharing obligation has proven to be quite controversial during the on-going pandemic. During the first month of the COVID-19 outbreak, questions emerged about the level of information-sharing by China. Such questions arose in light of reports from inside the country that, *inter alia*, the government was not fully transparent about all deaths, held off on sharing the genome sequence once it was decoded, and repeatedly refused assistance from outside experts.<sup>231</sup> Nevertheless, the WHO actively praised China for its outbreak response and transparency.<sup>232</sup> In the same statement in which he declared that the COVID-19 outbreak constituted a PHEIC, the DG stated: “(t)he speed with which China detected the outbreak, isolated the virus, sequenced the genome and shared it with WHO and the world are very impressive, and beyond words. So is China’s commitment to transparency and to supporting other countries. In many ways, China is actually setting a new standard for outbreak response. It’s not an exaggeration”.<sup>233</sup> This praise has given rise to criticism that the Organization was overly deferential to China, thereby severely damaging the WHO’s credibility and legitimacy.<sup>234</sup>

### iii. Evaluation of design and implementation of the IHR provision

While the WHO can become aware of public health events that may constitute a PHEIC by way of a Member's notification or through other reports, an alert is not enough to enable the Organization to respond effectively. A disease outbreak or other event that runs the risk of constituting a PHEIC requires the WHO to obtain all relevant information as soon as possible so it can be in the position to respond immediately and effectively. By way of illustration, decoding of the genomic sequence and the sharing of it internationally act to assist processes that are seeking to detect and recognise the spread of the genome to other States.<sup>235</sup> In addition, the sharing of genome information allows international development of diagnostic tests and vaccines to commence for previously unknown genomes.<sup>236</sup> Furthermore, the provision of detailed patient data assists in determining how fast the virus is spreading.<sup>237</sup>

The information-sharing obligations included in the IHR, again, show that the WHO is overly dependent on Members' goodwill and their willingness to share available information early on. The Member concerned needs to be fully cooperative and willing to share public health information in accordance with its IHR obligation; however, if the Member concerned falls short in its information-sharing obligation, the WHO has no way to force the State into being more forthcoming. As mentioned previously, the WHO has no enforcement measures available to it that could compel an individual State to become more transparent or cooperative. Moreover, the WHO does not have the authority to conduct in-country visits to obtain the information itself. Expert missions are only possible with the consent of the Member concerned. Referring to these limitations, an interviewee described the situation by emphasising that "*the World Health Organization is not the world health inspectorate*".<sup>238</sup>

What is more, while the WHO does not have the authority to compel Members to meet their information-sharing obligations under the IHR and is therefore dependent on their goodwill, IHR provisions even provide Members with leeway in how to meet these obligations.<sup>239</sup> For example, Article 6.2 IHR requires Members to provide information to the WHO, but with the important caveat "*where possible*".<sup>240</sup> This offers Members room for delayed action or even failures to share particular public health information.

**IHR – Article 6**

“1. [...]

2. *Following a notification, a State Party shall continue to communicate to WHO timely, accurate and sufficiently detailed public health information available to it on the notified event, where possible including case definitions, laboratory results, source and type of the risk, number of cases and deaths, conditions affecting the spread of the disease and the health measures employed; and report, when necessary, the difficulties faced and support needed in responding to the potential public health emergency of international concern (emphasis added).”*

The information-sharing obligations included in the IHR show, yet again, the tension between, on the one hand, Members wanting to provide the WHO – its Secretariat and the DG – with greater flexibility and authority in the event of health threats, and, on the other, Members preferring to maintain control and sovereignty.<sup>241</sup> Illustrative of this point is the way in which the WHO uses the information it receives and how it further shares that information, in the first instance with Members and only subsequently to the public.<sup>242</sup> As the IHR does not confer authority upon the DG or the WHO Secretariat to compel Members to share public health information, it solely allows the WHO to try to persuade Members to meet their IHR obligations to provide information.<sup>243</sup>

*d. The procedure for the determination by the DG of a PHEIC and issuance of corresponding temporary recommendations*

**i. Procedure under the IHR**

As mentioned above, a PHEIC refers to an extraordinary event which is determined to constitute a public health risk to other States through the international spread of a disease and which potentially requires a coordinated international response.<sup>244</sup> The DG of the WHO has the sole authority to declare whether an event constitutes a PHEIC, which is the highest alert known to the WHO. By declaring a PHEIC, the DG unlocks the power to issue temporary recommendations pursuant to Article 15 IHR.<sup>245</sup> The purpose of such temporary recommendations is to guide national measures, in a coordinated manner, in response to a specific PHEIC.<sup>246</sup>

The procedure to declare a PHEIC is set out in Articles 12, 48, and 49 IHR. Article 12 specifies that the DG has the authority to determine whether an event constitutes a PHEIC. It provides further details on how the DG should make this determination. Specifically, the provision sets out the elements that the DG must consider and the procedure to be followed. In determining whether an event constitutes a PHEIC, the DG must consider five elements, as set out in the box below.

**IHR – Article 12**

*[...]*

*4. In determining whether an event constitutes a public health emergency of international concern, the Director-General shall consider:*

*(a) information provided by the State Party;*

*(b) the decision instrument contained in Annex 2;*

*(c) the advice of the Emergency Committee;*

*(d) scientific principles as well as the available scientific evidence and other relevant information; and*

*(e) an assessment of the risk to human health, of the risk of international spread of disease and of the risk of interference with international traffic.*

*[...] (emphasis added)*

An important element of the DG’s consideration is the advice given by an Emergency Committee. Each specific public health threat which the DG must consider (as to whether it constitutes a PHEIC) generates the establishment of an Emergency Committee, which is likely to have a different composition every time it is convened. This is due to the procedure set out in Articles 48 and 49 IHR, which stipulate that the DG will select experts from a predetermined list of independent experts (the IHR Expert Roster) and based on the expertise and experience required by the particular public health threat. Once established, the Emergency Committee can provide advice upon the request of the DG on three particular matters, as indicated in the box below, including whether an event constitutes a PHEIC.

**IHR – Article 48**

*“1. The Director-General shall establish an Emergency Committee that at the request of the Director-General shall provide its views on:*

- (a) whether an event constitutes a public health emergency of international concern;*
- (b) the termination of a public health emergency of international concern; and*
- (c) the proposed issuance, modification, extension or termination of temporary recommendations.*

*[...] (emphasis added)”*

The DG needs to consider the advice given by the *ad hoc* Emergency Committee, but he or she is in no way bound by the advice: Article 49 IHR stipulates that “[t]he views of the Emergency Committee shall be forwarded to the Director-General for consideration. The Director-General shall make the final determination on these matters”.<sup>247</sup>

**IHR – Article 17**

*“When issuing, modifying or terminating temporary or standing recommendations, the Director-General shall consider:*

- (a) the views of the States Parties directly concerned;*
- (b) the advice of the Emergency Committee or the Review Committee, as the case may be;*
- (c) scientific principles as well as available scientific evidence and information;*
- (d) health measures that, on the basis of a risk assessment appropriate to the circumstances, are not more restrictive of international traffic and trade and are not more intrusive to persons than reasonably available alternatives that would achieve the appropriate level of health protection;*
- (e) relevant international standards and instruments;*
- (f) activities undertaken by other relevant intergovernmental organizations and international bodies; and*
- (g) other appropriate and specific information relevant to the event.*

*With respect to temporary recommendations, the consideration by the Director-General of subparagraphs (e) and (f) of this Article may be subject to limitations imposed by urgent circumstances (emphasis added).”*

Once the DG has determined that a PHEIC is occurring, he or she has the power to issue temporary recommendations pursuant to Article 15 IHR: to prevent or reduce the international spread of disease and avoid unnecessary interference with international traffic. As indicated

above, such temporary recommendations can have quite a significant impact, as they can guide political, economic, social, and diplomatic responses by Members.<sup>248</sup> Before issuing temporary recommendations, the DG must consider various elements as set out in Article 17 IHR. As is the case with the determination of a PHEIC, the DG must also consider advice of the Emergency Committee.

## ii. Observations

DG Tedros Ghebreyesus convened an Emergency Committee for the first time on 22 January 2020 to advise him as to whether the COVID-19 outbreak constituted a PHEIC. That day, the Committee did not reach a conclusion because of the limited information available to it: the members were split;<sup>249</sup> however, they did agree on the urgency of the situation and advised the DG to call another meeting very soon.<sup>250</sup>

On 23 January 2020, the Emergency Committee reconvened at the request of the DG to examine the situation further: also in light of the most recent epidemiological evolution and the new containment measures adopted in Wuhan on 22 January 2020.<sup>251</sup> Several of the fifteen independent experts still found it to be too early to declare a PHEIC that day, given the restrictive and binary nature of such a declaration.<sup>252</sup> While they did not yet advise the DG that the event constituted a PHEIC, they indicated their availability to reconvene in approximately ten days.<sup>253</sup> At the same time, the Committee formulated further advice to the WHO, to China, to other States, and to the global community.<sup>254</sup> The DG followed the advice given by the Committee and held off on declaring a PHEIC.

On 29 January 2020, the DG decided to reconvene the Emergency Committee on the following day: in light of the increase in cases and evidence of human-to-human transmission outside China.<sup>255</sup> On 30 January 2020, the Emergency Committee advised the DG that the COVID-19 outbreak met the criteria for a PHEIC, and the DG accepted the advice and declared a PHEIC.<sup>256</sup> That same day, the WHO issued temporary recommendations and highlighted that “*there is no reason for measures that unnecessarily interfere with international travel and trade*”. Six weeks later, on 11 March 2020, the WHO characterized COVID-19 as a pandemic.

### iii. Evaluation of design and implementation of the IHR provision

Strong criticism has been voiced against the WHO, and in particular its DG, for having been too slow in alerting the international community about the novel coronavirus.<sup>257</sup> DG Tedros Ghebreyesus has been criticised for being too slow to use the WHO's highest level of alarm, namely a PHEIC declaration. It took the DG approximately one month after the WHO became aware of the cluster of atypical pneumonia cases in Wuhan to declare a PHEIC, on 30 January 2020. We do not purport to evaluate whether the PHEIC declaration by the DG relating to COVID-19 was done in a timely manner; however, we do aim to shed light on the shortcomings of the related IHR provisions – both in their design and implementation – that have a negative impact on the WHO's ability to efficiently respond to an outbreak.

As explained above, the DG has the ultimate power to declare a PHEIC after having considered various elements, including the advice of the Emergency Committee. The DG can therefore decide to declare a PHEIC despite a negative advice of the Emergency Committee. Nevertheless, there is discernible practice on the part of WHO DGs to not declare a PHEIC until they receive positive advice from an Emergency Committee. As observed by GIAN LUCA BURCI, *“the DG until now has always “rubber-stamped” the [Emergency Committee]’s conclusions, thus seeking political cover [...]”*.<sup>258</sup> By awaiting the positive advice of the Emergency Committee, the DG can deflect accountability later on. This practice shows that, despite the DG having been entrusted with an important responsibility to alert the international community in case of a (threat of a) public health emergency of international concern, the raising of the alarm by the DG might not occur in as agile and swift a manner as is needed.

One may consider the lack of a genuine mechanism for the accountability of the DG as a notable shortcoming in connection with the PHEIC-related IHR provisions. Due to the lack of an accountability mechanism, the DG finds him- or herself in a position where they can await a positive advice by an Emergency Committee. Moreover, there is a risk that a DG may be subjected to undue influence by external actors or might take political considerations into account when deciding whether to declare a PHEIC. This risk must be viewed in light of the highly political nature of the DG election process, which is all the more relevant given the DG's ability to be re-elected for a second mandate.<sup>259</sup> In this way, questions can arise regarding political influence and support by individual Members and also whether these factors play a

role in the DG's decision-making.

By awaiting positive advice from the Emergency Committee, the DG is “*also shifting in practice decision-making power to what is formally an advisory body*”.<sup>260</sup> This raises concerns about legitimacy and transparency, as the Emergency Committee convenes in private and only publishes reports, which lack in their details, shortly after its meetings.<sup>261</sup> While these concerns have been raised in the past – notably during the Ebola crisis in the Democratic Republic of the Congo, when there was a protracted delay in declaring a PHEIC<sup>262</sup> – measures improving transparency have not materialised, except for the publication of the names of IHR Emergency Committee members, following an earlier policy change in 2011.<sup>263</sup> ECCLESTON-TURNER and KAMRADT-SCOTT have summarised the issue accurately: “*Given the crucial role the [Emergency Committee] plays in determining whether a PHEIC ought to be declared, coupled with the central importance of the PHEIC declaration for responding to health crises (including pandemics), we argue any concerns regarding the transparency of IHR [Emergency Committee] processes undermines the decisions reached, the legitimacy of those decisions and their processes and, by association, the IHR 2005 and the treaty’s custodian, the WHO*”.<sup>264</sup> Public trust in the PHEIC decision-making process and the WHO’s overall legitimacy is, thus, put at risk, as “*irrelevant considerations, undue influence and political interference*” cannot be ruled out.<sup>265</sup>

Beside the need to improve the accountability of the DG and the transparency of the Emergency Committee, it would serve well to provide a more precise and clear assessment of the process to declare a PHEIC. This point was also raised during several interviews.<sup>266</sup> Pursuant to Article 1 IHR, a PHEIC is defined by the presence of several predetermined criteria, namely an extraordinary event which constitutes a public health risk to other States through international spread of disease and potentially requires a coordinated international response. It has been critically observed that, in the past, considerable inconsistencies in the application of the criteria for a PHEIC were wielded during the decision-making process, sometimes even contrary to the criteria defined by the IHR.<sup>267</sup>

Besides the aforementioned procedural shortcomings, shortcomings are also apparent in relation to implementation. One cannot fail to observe that once the PHEIC was declared in respect of COVID-19, on 30 January 2020, the international community did not react in the



way envisioned by the IHR. As mentioned repeatedly, a PHEIC declaration is the highest level of alert known by the WHO and the idea behind the alert is to propel the international community into action to reduce and control the further spread of the disease.

A first implementation flaw can be observed by the limited international action following the PHEIC declaration by the DG. This stands in stark contrast to the national responses that followed the WHO's characterisation of COVID-19 as a pandemic on 11 March 2020. The PHEIC declaration, an official and legally defined act, had much less impact than the unofficial description of the COVID-19-outbreak as a pandemic.<sup>268</sup> The latter announcement kick-started the international community into action. Paradoxically, the term 'pandemic' is not defined by the WHO and is not included in the IHR, while a 'public health emergency of international concern' is and constitutes the highest level of alert available to the WHO. In future, the international community should act more rapidly after the WHO sounds the alarm so that the international spread of a disease can be prevented or at least better controlled.

Another implementation flaw can be found in the large-scale non-compliance with the temporary recommendations issued by the DG. Such non-compliance could be observed after the PHEIC declaration. The WHO indicated that there was no need for Members to impose measures that unnecessarily interfered with international travel and trade; nevertheless, a large number of States went on to impose such restrictions throughout the COVID-19 pandemic. These restrictions ran counter to the issued temporary recommendations. Moreover, many Members did not follow the procedure to impose additional health measures pursuant to Article 43 IHR. Whatever the pertinency of the WHO's initial recommendations, coordinated international action and responses fell short in the early months of COVID-19: individual Members were acting alone in emergency mode. This implementation flaw is a consequence of the tool of temporary recommendations not having the weight or authority they were intended to have.<sup>269</sup> It is also a consequence of the lack of repercussions where a Member chooses to impose additional health measures without following the procedure in Article 43 IHR.<sup>270</sup>

### C. Interim conclusion

This Section has evidenced that there are several flaws apparent in the IHR. All call for amendments if the international community wishes to be better positioned to respond swiftly and effectively to contagious disease outbreaks in the future.<sup>271</sup> The flaws which need

addressing both relate to design and implementation. In light of the way in which the IHR have been designed and drafted, however, the question arises as to whether such shortcomings will be effectively addressed in practice. For one thing, it is unlikely that Members will agree to reduce the control and sovereignty aspects they held on to during the previous IHR revision process. What is more, several interviewees noted that there is – and has continuously been – a strong hesitation on the part of Members to re-open the IHR and change the *status quo*.<sup>272</sup> Thus, while various design flaws could benefit from revision, it remains unclear whether it is feasible that the IHR will undergo renegotiation in the future.

Nevertheless, it is worth highlighting that the IHR were negotiated and agreed upon with the inclusion of some core obligations.<sup>273</sup> Specifically, these core obligations refer to good faith, transparency, and cooperation on the part of Members.<sup>274</sup> Indeed, the previously discussed Articles 6, 7, 9, and 10 IHR demonstrate the need for individual Members to adhere to these core obligations. The specific obligations to notify, verify, and share information under the IHR will lack implementation if Members do not adhere to the overarching core obligations of good faith and transparency. These obligations are also inherent in other IHR provisions. The IHR were negotiated whilst keeping in mind the premise that Members would act in accordance with the core obligations. Practice has shown that this might not always be the case when individual States face a public health threat with potentially damaging repercussions for its national reputation, economy, etc; nevertheless, if the international community wishes to better position itself in the event of future pandemics, stronger adherence to the core obligations inherent to the IHR will be required.

### **3. The global health governance of the COVID-19 pandemic**

The declaration of a pandemic on 11 March 2020 was followed by the intensification of WHO actions on multiple fronts and with various partners in the global health governance system. These actions included information sharing, guidelines, facilitation and coordination of science cooperation, private-public partnerships, and deployment of missions to particularly affected countries and territories. By March 2020, lockdown actions, domestic and international traffic restrictions, and other sanitary measures had put a heavy toll on the global economy, with even stronger effects on the most vulnerable countries and social groups. Broadly speaking, the WHO has two major responsibilities in outbreaks and emergencies such as COVID-19: enabling States to deal with the emergency themselves and maintaining leadership and support

to other actors in health governance via “*strategic direction, reliable information, coordination and technical guidance.*”<sup>275</sup>

States are major players in global health governance. Under the IHR, they are obliged to maintain core capacities to effectively respond to emergency situations. In May 2020, the Health Assembly emphasised “*the primary responsibility of governments for adopting and implementing responses to the COVID-19 pandemic that are specific to their national context, as well as for mobilizing the necessary resources to do so*” and called governments to “*to put in place a whole-of-government and whole-of-society response including through implementing a national, cross-sectoral COVID-19 action plan.*”<sup>276</sup> Nevertheless, most States lack such core capacities<sup>277</sup> and “*health systems and health workers were not prepared for a prolonged crisis.*”<sup>278</sup> Pre-existing economic and other structural conditions meant that many States did not have the capacity to properly respond to COVID-19 with necessary measures for prevention, contact-tracing, and treatment. At the same time, States that took the outbreak threat seriously and proactively from the early stages fared better. Inequalities in terms of prevention and treatment are visible among States, but also within States’ geographical spaces and population groups.

As the virus spread globally, WHO actions moved “*from short-term response towards a sustainable response*”<sup>279</sup> with continuous calls for whole-of-government and whole-of-society approaches to tackle the pandemic and its consequences. At the same time, the period saw increased critiques of the WHO’s actions in response to the pandemic and of its credibility as the world’s leading health organisation.<sup>280</sup> Critics point to the Organization’s ponderous procedures and decision-making, its lack of authority beyond the IHR, and its slow speed in adapting public health guidance to scientific insights: “*it is sometimes too cautious when it lacks scientific evidence that meets the highest standards, even in cases where that is hard to obtain and where there are few if any health downsides to endorsing a course of action*”.<sup>281</sup> It took too long, for example, to acknowledge the importance of ventilation to avoid the spread of the virus.<sup>282</sup>

Particularly challenging was the task of balancing the need for traffic restrictions to slow the infection rate and the need for efficient supply chains. The inability to travel presented a “*huge impact*” on the deployment of staff and provisions of supplies.<sup>283</sup> A Joint Statement of the WHO

with the International Chamber of Commerce called for public-private cooperation for “*effective action to protect their workers, customers and local communities and contribute to the production and distribution of essential supplies.*”<sup>284</sup> Together with the UN, the WHO launched the United Nations COVID-19 Supply Chain System, which played a significant role in channelling essential supply towards low and middle-income countries.<sup>285</sup> Finally, the WHO has also worked together with the WTO to improve supply chains and avoid barriers to the trade of health technologies, such as protective equipment and testing tools.<sup>286</sup>

As health systems across the world suffered pressures, due to high numbers of hospitalisations, the WHO turned its efforts to the search for effective COVID-19 treatments. Together with partners, the WHO launched the Global Solidarity Trial (GST) on 18 March 2020. A large international randomised trial, the GST aimed at evaluating: the effects of treatment drugs on mortality rates, the need for assisted ventilation, and hospitalisation. Its report of October 2020 found that all four treatments (remdesivir, hydroxychloroquine, lopinavir/ritonavir, and interferon) had little to no effect in terms of treating COVID-19.<sup>287</sup> The GST accelerated the arrival at such conclusions; however, it did so as global attention and strategies were shifting away from treatment and “herd immunity strategies” towards vaccines as the viable sustained response. In August 2021, a new round of the GST began testing three different therapeutics (artesunate, imatinib and infliximab).<sup>288</sup>

In April 2020, the WHO and partners launched the Access to COVID-19 Tools Accelerator (ACT). Funded by donations, the ACT aims at accelerating the production and deployment of tests, treatments, and vaccines to ensure equitable access. Via the COVAX Facility – the ACT vaccine pillar – the WHO works with GAVI Vaccine Alliance, the Coalition for Epidemic Preparedness Innovations (CEPI), and UNICEF to accelerate development and production of vaccines and ensure equitable access to inoculation. Its mechanism pools together procurement, thereby reducing costs and risks by diversifying the portfolio of vaccines available to participating countries.

By and large, the COVAX Facility has proven to be necessary, but insufficient.<sup>289</sup> As of 23 July 2021, COVAX counted 136 participants and the vaccine roll-out had reached 136 million doses. However, the initiative had proven unable to beat vaccine nationalism - rich countries privileged their own nationals and residents and signed direct bilateral deals with pharmaceutical

companies to ensure faster supply.<sup>290</sup> In January 2021, the WHO DG warned that rich countries were jumping in front of the queue and driving prices up.<sup>291</sup> Pharmaceutical companies, for their part, privileged countries that invested in R&D earlier and more substantially and committed to purchases prior to efficacy tests: a risk investment that developing countries could not and cannot afford.<sup>292</sup> Companies also prioritised vaccine approval by national regulatory agencies instead of seeking WHO approval.<sup>293</sup> Furthermore, the effort was not fully multilateral; it excluded key countries and presented a reduced portfolio of vaccines compared to those available in the market.<sup>294</sup>

More robust and readily available funding at the early stages of COVAX would have ensured a faster and more reliable supply of vaccines; thus, helping to mitigate successive outbreaks and virus mutation.<sup>295</sup> It was only as vaccination rates in the developing world reached higher numbers, that upper-income countries became more willing to contribute to the COVAX facility and other cooperative efforts.<sup>296</sup> More recently, in July 2021, the World Bank joined the COVAX effort in order to ensure a more reliable cost-sharing arrangement.<sup>297</sup> Regional organisations, such as the Africa Union, have also intervened to procure vaccines for its member countries.<sup>298</sup>

On 1 June 2020, the WHO DG joined the President of Costa Rica and dozens of other States in a Solidarity Call to Action.<sup>299</sup> Aiming at equitable access to health technologies, the Costa Rica Initiative called upon multiple stakeholders – governments, holders of knowledge such as intellectual property and data, researchers, and civil society – to contribute to a joint effort to halt the COVID-19 transmission. Stakeholders were encouraged to remove barriers to cooperation, increase available funding, and share knowledge on the disease under the umbrella of the COVID-19 Technology Access Pool (C-Tap), itself launched in May 2020. The facility, however, suffered from a lack of engagement from companies, which have proven reluctant to share knowledge and intellectual property.<sup>300</sup>

A year after the launch of C-Tap, the WHO signed a trilateral agreement with the WTO and the World Intellectual Property Organization (WIPO) to ensure equitable access to COVID-19 technology by increasing the flow of technologies and enable countries to properly leverage them. The agreement came after a months-long international discussion on intellectual property

waivers and became possible only once developed countries changed positions towards favouring waivers.<sup>301</sup>

Throughout the pandemic, the WHO has also remained active in providing updated information on scientific output regarding prevention, treatment, and other aspects of the disease and the virus. In April 2020, it cautioned States that the so-called immunity passports – granting travel facilitation to individuals with prior contamination – were not advisable given the uncertainty about natural immunity and its duration.<sup>302</sup> It also routinely updated information on potential treatments,<sup>303</sup> contact tracing, and virus transmission, even if this was sometimes done at a slower than optimal speed.<sup>304</sup>

A particularly contentious field in global health governance, with significant political ramifications, concerns the origins of the coronavirus and how it began to infect humans.<sup>305</sup> An early formed consensus sustained a zoonotic origin via an intermediate animal host. For many scientists, this is still the most likely cause and the prevailing theory.<sup>306</sup> Counter hypotheses, such as a laboratory accident, have often been branded as conspiracy theories,<sup>307</sup> but have received growing support.<sup>308</sup> At the same time, China has sustained that the origins of the coronavirus may lie outside of the country and has consistently pushed for a broader investigation that includes other states.<sup>309</sup> In the midst of this politicised debate, the WHO has been leading the inquiry regarding the origins of the coronavirus. Most notably, it has facilitated a number of expert team visits to China and the Wuhan province. In August 2020, a two-person WHO team tasked with investigating the origins of Sars-Cov-2 spent three weeks in China, but faced restricted access to key locations, such as the city of Wuhan itself.

Six months later, in January 2021, a larger investigative team of experts reached Wuhan and visited the Wuhan Institute of Virology as well as the city’s seafood market. After the visit, the team reported that the introduction of the virus through a laboratory incident was an “*extremely unlikely pathway*”<sup>310</sup> and stated that the coronavirus most likely originated from bats and spilled over to humans via an as yet unknown intermediate animal between mid-November and early December 2019.<sup>311</sup> At the same time, the report mentions that the visit to Wuhan did not provide definitive proof.

The WHO DG was also clear to keep divergent theories alive, stating that “*further data and studies will be needed to reach more robust conclusions*”. In addition, 14 countries issued a joint statement expressing concern that “*the international expert study on the source of the SARS-CoV-2 virus was significantly delayed and lacked access to complete, original data and samples.*”<sup>312</sup> The same statement calls for transparency and respect for privacy and scientific integrity in future inquiries, which is in line with calls by the scientific community for a more robust investigation.<sup>313</sup> The WHO is willing to send additional missions and to continue the probe,<sup>314</sup> but opposition from China persists.<sup>315</sup>

#### 4. Problems and issues to be addressed

The table below presents the main issues and problems facing the WHO. All are linked to its actions in response to health emergency situations. It draws from the account of the WHO’s actions in response to the COVID-19 pandemic, lessons from previous health crises, and from different insights taken from the interviews conducted for this report.

	Challenge	Description	Potential Consequence	COVID-19 (non-exhaustive illustrations)
Health Emergency				
1	Preparedness	The current IHR system does not offer sufficient incentives and oversight for States to build core capacities and better prepare for health emergencies	Most States do not adequately prepare for health emergencies and do not have the required core health system capacity	States lacked PPE, track and tracing, and test capacity; health emergency protocols; and established channels of communication and decision-making
2	Enforcement	Obligations deriving from the IHR (e.g., information sharing) are lacking in enforcement	States are not fully transparent and do not share all information in due time	Crucial information is withheld in the early months of the pandemic. WHO expert missions face restricted access to outbreak sites
3	Checks and Balances	IHR decision-making is heavily dependent on Members, which have maintained significant control and sovereignty to the detriment of swift and independent WHO and WHO DG decision-making	Politicisation and delays in the assessment of public health events and information and related decision-making	PHEIC declaration is delayed, negatively impacting the early international response
4	Alert	The highest level of alert provided for by the IHR is the PHEIC declaration	PHEIC does not convey a sufficient level of threat and alert to the international community	The PHEIC declaration in late January 2020 did not lead to sufficient (coordinated) action by States

Science				
5	Bias	Composition of expert groups reflects expertise related to WHO's day-to-day practices and corresponding to previous emergencies	Scientific advice is delayed and/or there is a higher burden of proof demanded in respect of unprecedented or rare events	There was a crucial delay in seriously considering human-to-human and asymptomatic transmission of the novel coronavirus
6	Temporal Gaps	Temporal gap between advancements in science and WHO's policy decisions	Effectiveness of guidelines is diminished due to obstacles in information flow	There was inconsistency in the guidelines for face mask wearing
7	Communication	Ineffective communication of crucial scientific information and its implications	Scientific information is not properly assessed, understood, or followed	Misinformation on potential treatments. Risk of vaccine side-effects not properly understood
WHO Governance				
8	Regional Autonomy	Regional directors are not accountable to WHO Headquarters, their appointment is dependent on regional selection processes	Incoherence in the assessment of and responses to health emergencies between different regions and between regions and the WHO HQ	Policy decisions were made at the level of Headquarters, but, due to the time-consuming nature for approval, Regional Offices chose to inform Headquarters of their actionable policy frameworks instead of awaiting normative guidance
9	Budget	The WHO's budget is too small and largely dependent on voluntary contributions	Lack of broad spectrum of in-house expertise. Delay in response due to funding restrictions. Absence of long-term investment in preparedness	Inability to offer early funding to vaccine R&D led to unequal and inequitable distribution of vaccines
10	Intergovernmentalism	The World Health Assembly is a large intergovernmental body made up of representatives of 194 States	Decisions within the WHA follow minimum common denominator. Little to no binding decisions or obligations materialise	The WHA73 (May 2020) and WHA74 (May/June 2021) covered too many agenda items and pandemic-related decisions made were insufficient
11	Reputation	WHO suffers from a crisis of reputation	WHO does not receive proper support for its actions and its guidelines are not followed	Governments ignore WHO guidelines and requests. Governments scapegoat the Organization <sup>316</sup>
Global Politics				
12	Power Struggle	Global competition between global powers	Necessary cooperation is not possible due to rivalry between powerful States. Agreement on new international instruments is not possible	Little cooperation between rival camps despite interdependency during the health crisis. Regional initiatives to address a global pandemic



13	Inequalities	Structural economic and social inequalities amongst States	States are unable to build national core capacities to properly and sustainably respond to health emergencies	Higher levels of virus mutation in countries and regions lacking core capacity. Vaccines do not reach poorer countries
14	Stigma	Stigmatisation of States and social groups due to pattern of recurring health emergencies	Marginalisation of States or social groups linked to the spread and mutation of the virus	States delay information sharing or policy responses due to fear of negative trade and tourism impact
15	Momentum	Momentum for reform and improvement of global health governance and emergency preparedness	Loss of political momentum for reform due to improvement of conditions and return to pre-emergency normality	Calls for a new international instrument on pandemic preparedness have run into strong push-back and further discussions have been postponed until a Special Session of the World Health Assembly in November 2021

This is not a list of mistakes made by the WHO, but of challenges and issues it faces, given its goals as the leading global health organisation tasked with responding to health emergencies. While some challenges are closely linked to WHO’s structure and functioning, others are linked to global governance and international legal systems that struggle to balance the requirements for effective global action in the face of health emergencies and power imbalances and state sovereignty.

While the Organization has responded to these challenges to various degrees of success, these issues remain relevant for the future. The policy recommendations in Part 3 will be linked to the challenges presented above.

## PART 3. LOOKING TO THE FUTURE

Having identified challenges and issues that the WHO faces when confronted with public health emergencies in Part 2, we provide some insights in this Part as to how the Organization can be strengthened to provide a stronger emergency preparedness and response in the future, specifically in light of the challenges and issues it faces. After providing a high-level overview of some recent findings and recommendations formulated by prominent international review committees and panels established or convened during the COVID-19 pandemic, we conclude with policy recommendations.

### 1. Reflections and promises

Discussions on the actions of the WHO in response to the COVID-19 pandemic and debate over possible reforms of global health governance began almost as soon as the virus was spreading and while the first lockdowns and restrictive measures were still in place. During the Health Assembly of 18-19 May 2020 health ministers from WHO Members requested that the WHO DG take steps towards a “*impartial, independent and comprehensive evaluation*”<sup>317</sup> of the WHO-coordinated international health response to COVID-19. The DG established an Independent Panel for Pandemic Preparedness and Response (IPPPR or Panel).

The IPPPR worked on establishing the facts and producing an authoritative chronology of events.<sup>318</sup> Its final report, presented in May 2021, stated that the WHO was too slow in declaring a PHEIC and that the declaration did not convey a sufficient level of alert. Delays in the actions of the WHO and Members, coupled with States’ ill-prepared health systems, led to February 2020, a crucial period in the fight against the virus’ spread, which was considered a “*lost month*”. Overall, the final report paints a harsh picture of global preparedness and response: “*(p)reparation was inconsistent and underfunded. The alert system was too slow—and too meek. The World Health Organization was under-powered.*”<sup>319</sup>

With this assessment, the Panel recommended the establishment of a high-level Global Health Threats Council led by Heads of State and Government. Such a Council would allocate funds from an International Pandemic Financing Facility that would, in turn, finance preparedness and provide fast disbursement in the case of a health emergency. The Panel also recommended the strengthening of the international legal framework, with the adoption of a Pandemic

Framework Convention to “to address gaps in the international response, clarify responsibilities between States and international organizations, and establish and reinforce legal obligations and norms.”<sup>320</sup>

Regarding political learnership, and with an eye at de-politicisation, the Panel suggested empowering the WHO DG, but also limiting his or her position to a single term, with the same rule applied to regional offices. As for WHO priorities, the Panel recommended a focus on “normative, policy and technical guidance” together with a coordinating role in operational aspects, but without responsibility for procurement and supplies in most cases.

Altogether, the Panel’s report presents a comprehensive assessment of the WHO response mechanisms and its shortcomings, including those of broader global health governance and of States. It pays less attention, however, to the constraints of the international system and its challenges for future reform. The report itself acknowledges that the “*tendency for nationalism and protectionism rather than cooperation and multilateralism has been much wider* [than systemic great power competition].”<sup>321</sup> It is important to note that as a consequence many of the bold policy recommendations, such as those requiring additional financial and political commitments from States and those leading to additional international institutions, will not find fertile ground in the upcoming intergovernmental negotiations.

Following the WHA73 instructions, the WHO DG convened the WHO Review Committee on the functioning of the IHR (2005) during the COVID-19 response (Review Committee or Committee). The Review Committee<sup>322</sup> noted an overall lack of compliance by States with IHR obligations, in particular with preparedness, which should be addressed with a strong mechanism for accountability. The Committee also noted the importance of an early alert system with the application of the precautionary principle for travel-related measures in the early stages of an outbreak. Finally, the Committee report called attention to the need for predictable and sustainable funding for effective implementation of the IHR.

The Review Committee aimed to formulate recommendations that are “*comprehensive and practical rather than aspirational.*”<sup>323</sup> With an initial focus on the responsibilities of the States that are subject to the IHR (State Parties or one State Party), the Committee recommended the empowerment of National IHR Focal Points and of core capacities for surveillance and

response, the continuous improvement of domestic legal frameworks for health emergency response, and enhanced information sharing capacities. If a State Party fails at sharing information and/or does not appropriately respond to verification requests, the Committee suggested that the WHO “*should provide that publicly available unverified information about the event, while protecting the source of that information.*”<sup>324</sup> To ensure compliance with IHR requirements, the report recommended the development and implementation of a periodical review mechanism.

Regarding the alert system of the IHR, the Committee did not offer a direct path for a legal instrument or definition of *pandemics* as a possible higher level of alarm. Its report did, however, emphasise the need for more transparency concerning WHO Emergency Committee deliberations and for better communication of WHO decisions, including on the distinction between a PHEIC and “*the characterization of a pandemic*”.<sup>325</sup> Furthermore, the WHO should actively alert the world community even when criteria for a PHEIC are not met, but the events require urgent escalated action.

When looking at international cooperation, the Committee sustains that “*a new era of international cooperation is required to better support IHR implementation.*”<sup>326</sup> This enhanced support would include adequate budget and human resources at all levels, a clear WHO mandate to proactively support States Parties in cases of health emergencies, and clear procedures to interact with GOARN, Emergency Medical Teams, and the Global Health Cluster. In similar fashion to the findings of the Independent Panel, the Committee encouraged States Parties to “*consider the benefits of developing a global convention on pandemic preparedness and response*”. Such a convention would go beyond the current IHR to establish provisions for rapid deployment of WHO teams for investigation and response, for the maintenance of global supply chains, and for the prevention of zoonotic risks. It would also establish strategies for the sharing of information on pathogens as well as provisions for equitable access to benefits arising from the sharing of information.

Finally, the IHR Review Committee recommended stronger use of digitalisation in communication and on other fronts. These recommendations included a digital International Certificate of Vaccination and Prophylaxis, norms and standards for technology for international travel with safeguards for privacy, better technology for communication amongst

NFPs, and a generally enhanced strategy for public communication that would increase the public's trust in science. Interestingly, the Committee suggested that the acronym PHEMIC should be used in lieu of PHEIC, to avoid the frequent pronunciation [feik] (“fake”) in English.<sup>327</sup>

A third major exercise in reflection and assessment relating to health governance and the pandemic was convened by the WHO/Europe Regional Director in September 2020. The Pan-European Commission on Health and Sustainable Development (Monti Commission or Commission), chaired by former Italian Prime Minister Mario Monti, was set up to rethink policy priorities in the light of pandemics. In contrast to the IPPPR and the IHR Review Committee, the Commission's work focused on drawing lessons from the responses of national health systems to the COVID-19 pandemic and the ways in which systems can improve their resilience.<sup>328</sup> It also aimed at linking, politically and in practice, sustainable development and social cohesion to healthcare.

In its final report, published on 10 September 2021, the Monti Commission called for a full operationalisation of the concept of one health and highlighted the need to support innovation and increase international support for health investments.<sup>329</sup> Regionally, the report recommended the establishment of a Pan-European Health Threats Council that would promote political commitment to health threat preparedness and responses and ensure collective action and cooperation across the pan-European space.<sup>330</sup> The Commission also recommended further cooperation with international financial institutions, such as the IMF and the World Bank, and suggested the creation of a Global Health Board, under the auspices of the G20, modelled on the Financial Stability Board.<sup>331</sup> The latter would stand in for effective coordination of health, economic, and financial policies both within governments and internationally.<sup>332</sup> In addition, it would identify gaps in the provision of global public health goods and rally support to address them.<sup>333</sup> Finally, the report also encouraged innovative changes in healthcare systems, with enhanced and more transparent public-private partnerships.<sup>334</sup> As such, while missing a detailed assessment of pandemic preparedness, the Monti Commission's work had the advantage of encouraging broader reforms of healthcare and creating resilient societies by increasing their overall health conditions. Positively, the Commission also provided an overview within its report to assist in the implementation of its recommendations.<sup>335</sup>

The global response to the COVID-19 pandemic has also been a topic considered in various international meetings since early 2020. Various pledges were made to reform and reinforce the WHO, its mandate, and its financing within these contexts. On 26 March 2020, a G20 extraordinary Summit highlighted the necessity of and committed to a “*transparent, robust, coordinated, large-scale and science-based global response in the spirit of solidarity.*”<sup>336</sup> G20 leaders called for the strengthening of the WHO’s mandate and for the full implementation of the IHR. As a leading economic forum, the G20 commits to preserving financial stability, minimising disruptions to trade and supply chains and coordinating financial matters along with the IMF, the World Bank Group, and the WHO. Leaders committed resources, on a voluntary basis, to the WHO’s COVID-19 Solidarity Response Fund, Gavi, and CEPI.

The 2020 UN General Assembly approved a resolution<sup>337</sup> – 169 votes in favour, 2 against (Israel, United States), and 2 abstentions (Hungary, Ukraine) – that reinforced the WHO’s leadership role in coordinating and catalysing the international response to COVID-19: with an eye on the recovery phase, the resolution called for effort to “*build better back*”, taking into account sustainable development and broad understandings of health and wellbeing.

In May 2021, at the Global Health Summit, organised by the Italian G20 presidency and the European Commission, leaders of the G20 and other States spoke of the “*the urgent need to scale up efforts, including through synergies between the public and private sectors and multilateral efforts, to enhance timely, global and equitable access to safe, effective and affordable COVID-19 tools.*”<sup>338</sup> Leaders reaffirmed “*the leading and coordinating role of the WHO in the COVID-19 response and the broader global health agenda.*”<sup>339</sup>

The Rome Declaration also pointed to COVID-19 vaccination as a global public good, highlighting the importance of filling the ACT-A funding gap; however, it also made clear that global sharing of vaccines should be done “*when domestic situations permit*”.<sup>340</sup> The Rome Declaration also included commitments on various principles of action, most of which require enhanced financial investment, from appropriate funding for the WHO to compliance with the IHR, to the development of regional manufacturing capacity. The Declaration also noted the vital role of the WTO in the multilateral trading system and that it would ensure reliable global supply chains. In order to fund its commitments, the G20 calls for various financing mechanisms, such as: “*blended finance, innovative mechanisms, public, private, and*

*philanthropic sources, and international financial institution funds.*”<sup>341</sup>

The US-EU Summit of 15 June 2021 echoed pledges to reform the WHO, “*including advancing sustainable financing and improving its internal operation*”<sup>342</sup>. The meeting also encouraged the assessment of benefits of a possible international instrument of pandemic preparedness and response and pointed to the need for swift and independent means for investigating outbreaks in the future. In the same week, the G7 leaders committed to “*effective multilateral action and a strengthened global health system, with the [WHO] at its centre*”<sup>343</sup>, building on the recommendations of the IPPPR. The G7 also emphasised the need for more transparency, collaboration, and accountability in global health governance. The Carbis Bay Health Declaration also highlighted the need for a more nuanced and clear early warning system and the importance of holding States accountable with respect to the IHR. In parallel, the G7 committed to providing one billion vaccine doses over the coming year; this has been considered to be below the required number of doses needed to slow down the pace of the pandemic.<sup>344</sup>

Calls for an enhanced WHO from experts, journalists, and academics also date back to the early days of the COVID-19 pandemic. General discourse on WHO reform has pointed to more transparency and accountability, which is seen as necessary to equip the Organization with the credibility it needs to provide authoritative guidance. “*A separation of WHO’s technical and implementation functions from its political functions*”<sup>345</sup> would be a step in this direction. Another focus has been the action of States, as the WHO requires cooperation and support from its Members as much as any UN agency.<sup>346</sup>

Other commentators have gone further, suggesting that reform of global health governance should go beyond reinforcing the WHO’s mandate and its funding and should, instead, include the creation of new mechanisms or institutions. The creation of a Financial Stability Board<sup>347</sup> – with a focus on the financial aspects of health governance, but with many of its functions, such as risk assessment and recommendations, overlapping considerably with the WHO’s mandate – and even a brand “*new COVID-19-specific alternative based on neutrality, transparency and shared values about data privacy*”<sup>348</sup> have both been suggested.

## 2. Reform recommendations

### A. Guiding principles underlying reform recommendations

The 24 reform recommendations set out below build on the analysis of the WHO's history and functioning, the assessment of its actions and policies in response to the current COVID-19 pandemic, the current international context, and the insights derived from the interviews conducted for this report. There is a degree of overlap between the recommendations formulated in this report and recommendations published by other international review committees and panels. In particular, one can find similarities with the reports drawn up by the Independent Panel for Pandemic Preparedness and Response, the WHO Review Committee on the functioning of the IHR (2005) during the COVID-19 response, and the Pan-European Commission on Health and Sustainable Development. Such similarities touch upon, *inter alia*, the monitoring of compliance with core capacities, the key functions of the WHO, the term limit of senior WHO officials, and the future of the PHEIC declaration. Nevertheless, this report has aimed to formulate its own policy recommendations to add to the on-going reform debate by offering limited and relatively feasible recommendations, mostly targeting the WHO as the focal multilateral institution in the fight against health emergencies.

The reform recommendations aim at addressing the challenges presented in Part 2 Section 4 above. Before describing these reform recommendations in detail, it is worth reflecting on the guiding principles that underly the formulation of these recommendations.

The reform recommendations are anchored in **two transversal principles**, which should guide their interpretation and implementation. First of all, reform of the WHO and its future actions should always take a **human rights first** approach, safeguarding life, privacy, and the wellbeing of individuals and social groups. The Organization should pay particular attention to the negative and sometimes unintended consequences of its policies *vis-à-vis* vulnerable groups. The WHO should also work towards avoiding that its own measures, guidelines, and discourse end up legitimising human rights violations committed by other actors.

Secondly, the Organization should continue to emphasise and further enhance its principle of **one health**. While the recommendations below focus on preparedness and response to emergency disease outbreaks, the COVID-19 pandemic has demonstrated that populations in



good health, with fewer underlying conditions, are less likely to suffer from high mortality rates, hospitalisation, and stress in health systems.<sup>349</sup> As such, it is crucial to constantly promote an overall good level of health and wellbeing across the global population, including the promotion of sanitation, access to clean water, food security and nutrition, prevention of endemic diseases, access to health services for all, preservation of the natural environment, development of robust mental health, and other aspects. Any reform or action aimed at better preparing the WHO and the world for future pandemics should be implemented in addition to, and not in lieu of, actions that promote general wellbeing. This principle of one health has also been placed front and centre within the recent final report of the Monti Commission.<sup>350</sup>

In addition to the principles of human rights first and one health, reform of global health governance, and of the WHO specifically, should follow **four basic guidelines**. Firstly, it should **build on the current momentum for reform** in order to lock in sustainable and far-reaching commitments from States. Politicians and decisionmakers have very little to no incentive to commit resources to prevent rare but impactful events such as a global pandemic; however, the current pandemic creates new, albeit temporary, incentives to pursue reform. Public support is at hand for bolder action and for financial investment that must be made permanent in the long-run via legal instruments and institutionalisation.

Secondly, reform of the WHO and global health governance should better **prepare the system against a broad variety of health emergencies**. The COVID-19 pandemic has particular characteristics regarding the origin of the pathogen, its transmission, prevention, treatment, and various other aspects. It is unlikely that the next health emergency will follow similar characteristics. Policies, guidelines and tools that work effectively in the current COVID-19 response might not work properly against future health emergencies and vice-versa. Therefore, preparation must be guided by the assumption that the health system may face very different challenges.

Thirdly, improvement of the **WHO as the centre-piece of global health governance** should be preferred to the creation of new institutions and organisations that are not properly resourced or experienced. It is preferable to reform current structures, build on their expertise and experience, and clarify the division of labour between different actors than to create overlaps in global health governance. Furthermore, the creation of new institutions runs the risk of

putting further pressure on the already busy international agenda and creating confusion and incoherence.

Lastly, it is of paramount importance to **restore the credibility and reputation of the WHO** at the centre of global health governance. Reforms of the WHO, and possibly the IHR, should aim at restoring the Organization’s leadership and authority. This is especially important in a health governance system that relies on voluntary actions and contributions by States.

Basis for the formulation of reform recommendations	Transversal Principles	
	1.	Human rights first approach
	2.	Principle of one health
	Basic Guidelines	
	1.	Build on current momentum for reform
	2.	Prepare against a broad variety of health emergencies
	3.	Position the WHO as the centre-piece of global health governance
	4.	Restore the credibility and reputation of the WHO

**B. Specific reform recommendations**

*a. Overall approach for reform*

The COVID-19 pandemic has and continues to expose vulnerabilities in national healthcare systems and international preparedness and response efforts *vis-à-vis* major health emergencies. As was the case during and after the outbreaks of SARS, H1N1, and Ebola, the international community has already drawn lessons from the ongoing pandemic. As a result, calls for reform, on the domestic and, perhaps most importantly, on the international level have been raised since the early days of the COVID-19 outbreak. Importantly, such calls must be placed in perspective. The international community will be better able to prevent, prepare for, and respond to future health emergencies if it draws broadscale lessons from the COVID-19 pandemic: in the sense that it should not focus too narrowly on its particularities (i.e., transmission, infection, mortality, treatment, vaccines). In addition, while ideas for reform have been formulated in vast numbers, prioritisation and selectiveness should be encouraged in their adoption to ensure robust, lasting, and strong reforms of the global health governance system. Caution must be exercised to avoid

making hasty decisions that will result in mere superficial reforms that are not suitable for addressing a broad range of potential health emergencies which the world may face in the future. The following recommendations keep these notions in mind and aim to provide guidance on how the overall reform movement should be approached.

### **Recommendation 1**

**Forthcoming global health governance reforms should aim to improve and enhance prevention, preparedness, and response in the event of a wide-range of health emergencies that may arise in the future (e.g., diseases, climate change repercussions, bio-threats, etc.).**

To prepare for other pandemics, reforms born out of the COVID-19 pandemic should not only be formulated based on the specific characteristics of the coronavirus (i.e., asymptomatic transmission, relatively long period of incubation, airborne transmission, higher death rate in elderly populations and for persons with underlying health conditions, etc.).

The COVID-19 pandemic has proven educational in respect of tools and instruments and rules and regulations potentially equipped to deal with myriad diseases. While many tools and rules did not prove highly effective to curb the spread of COVID-19, such as temperature checks at transportation hubs and hand hygiene practices, they could be extremely valuable in responding to other, future diseases. In this respect, measures and responses to the current pandemic should not be discarded *a priori* in future responses. At the same time, resources that were necessary to combat COVID-19 (e.g., respiratory equipment, intensive care units, intubation, oxygen tanks, etc.) may not be effective or suitable against other viruses or diseases.

The global response to the COVID-19 pandemic has relied heavily on mass vaccination as a preventive measure to increase population immunity and reduce transmission and hospitalisation. The rapid development and efficacy of mRNA vaccines have proven to be a crucial scientific breakthrough, which has had real world benefits. Nevertheless, the next pandemic might see a different ratio between prevention and treatment. It is therefore important to continue R&D efforts for a broad spectrum of treatments, such as antivirals. At the same time, availability of traditional and cheaper vaccines remains important, as they are easier to produce and may show good results against new viruses in the future.

## **Recommendation 2**

**WHO actions, guidelines, and health policies should aim at enhancing the positive legacies of the fight against COVID-19.**

In the past, the fight against pandemics and infectious diseases has left positive legacies, often contributing to better living conditions and an increase in life expectancy. The transition into the 20<sup>th</sup> century saw significant improvement of sanitary conditions, especially through the provision of clean water. Water supplies had been a source of multiple diseases, chief among them cholera. The current COVID-19 pandemic points to innovations and behavioural change in relation to ventilation, including measures to increase air quality and circulation and techniques to measure it. Buildings often receive greenlights from fire departments and events measure noise levels; it is logical to expect similar standards for air quality and how to measure it moving forward.

Policy implementation, guidelines, and behavioural change often lag behind innovation and new processes provided by science. The gap between the discovery of pasteurisation and its widespread use, for example, was 50 years.<sup>351</sup> The WHO can play a significant role in education and can provide guidelines which promote sustainable benefits from scientific achievements and direct behaviour in a positive direction.

Technical and digital innovations are also potential positive legacies, which includes a broad social and political debate on the management of private data for public health purposes. There should be continuous discussion on the best balance between public health and privacy (e.g., personal medical data, freedom of movement, etc.).

## **Recommendation 3**

**There is a need to find a working consensus on what can be expected from the WHO in a health emergency and then to clarify this consensus to the broader public by way of publication and education.**

The WHO's expansive objective - of attaining the highest level of health for all - results in significant but unattainable expectations by its Members regarding the Organization's functions. The flawed perception of the IHR, wherein Members have chosen to maintain a substantial grip on control and sovereignty, results in a distorted view of what the WHO can accomplish in the face of an emerging health threat.

As witnessed during the COVID-19 pandemic, these unrealistic expectations go hand in hand with criticisms directed towards the WHO. Therefore, to enhance the WHO's credibility and legitimacy as an international organisation that can lead an international response in the event of a public health threat, realistic expectations regarding its capabilities should be ensured. Consensus amongst WHO Members should lead to a clear delineation of the Organization's functions. Emphasis should be placed on the functions that the WHO is best placed to perform, such as providing technical and scientific guidelines and advice. Educating all levels of Member governments and the wider public on these functions will then assist in international support for and adherence to WHO guidance.

#### **Recommendation 4**

**The WHO and its Members must strive for a clear separation and for an effective balance between the Organization's political and techno-scientific functions.**

As part of the UN system, the WHO is not estranged from politics: it is impacted by geopolitical imperatives, power asymmetries, and interstate rivalries. At the same time, a certain degree of politicisation is useful, because it underpins the Organization's leadership and its cooperation with other actors.

In order to address its reputational crisis and to avoid States and other political actors shifting the blame for failures onto the WHO, the Organization must isolate its critical tasks from politics. The Organization's priorities should be to offer base-level guidelines, based on broad science inputs, which can, in turn, be tailored by regional and local officers and politicians according to their own political environments.

The WHO's function *vis-à-vis* the IHR, such as the decision to declare a PHEIC, are inherently political. Its declaration can disrupt trade, travel, and tourism and lead to the stigmatisation of States that are seen as the origin of outbreaks and diseases. As such, the Organization must aim at transparent and accountable decision-making, based on timely scientific inputs.

#### **Recommendation 5**

**Proactive preparation relating to a future crisis is recommended. Despite uncertainty concerning the actual occurrence of a future crisis, the recommendation is made in the interests of mitigating the ramifications of a future outbreak. Nevertheless, and considering scarcity of resources, such an approach should not tackle potential ramifications on all fronts simultaneously. Prioritisation of proactive efforts is recommended.**

Most national health systems, especially in the developing world, have to prioritise their actions and responses because of resource scarcities. Communication to the public should be based on the prioritisation of actions and policies. While the adoption of better standards and habits in hand hygiene, for example, is a step forward in healthcare, it becomes a problem if it comes at the expense of or in lieu of ventilation and mask use.

At the same time, in the event of health emergencies with a risk of spreading internationally, the WHO should take on a precautionary approach; whereby, it responds swiftly and strongly to mitigate the further spread or any negative repercussions to health. Based on the no-regrets principle, it is advisable to take tough action early to address and counter a health threat.

#### **Recommendation 6**

**There should be a strong link between future reform to enhance preparedness and response to health crises, on the one hand, and climate emergencies, on the other.**

In order to maintain momentum, the interconnected elements of global health and global environment must be fully acknowledged. There must be strong links between the preparedness

and response to future pandemics and health emergencies and evolving global environmental governance.

The current rate of vaccination in the developed world indicates a much faster exit process and strategy to move away from the pandemic situation than in the developing world. Thus, there is a non-negligible risk that interest, energy, and momentum for reforming global health governance will diminish with the current pandemic under control.

This issue linkage between global health emergencies and climate change can be enhanced both institutionally and discursively. Institutionally, the creation and reform of instruments aimed at fighting climate change and ensuring environmental protection should be linked to prevention of zoonotic spill-overs of human diseases that are likely to spread and/or originate due to environmental degradation, intensive livestock farming, and increased human intervention in wild spaces. Attention paid to preservation of environment and wild species contributes to mitigating the rise of zoonotic diseases in humans and can, overall, have positive spill-over effects on the prevention of diseases via better sanitary conditions. Discursively, investments in preparedness for climate change mitigation and environmental education must be linked to behaviour and habits that reduce the risks of emergence of new pathogens.

#### *b. WHO Governance*

The Governance system of the WHO has undergone a series of reforms since the creation of the Organization in the 1940s. Nevertheless, these reforms were not able to sustainably address the inherent tensions between the various facets and roles of the WHO – political leadership, scientific guidance, and implementation and coordination. There are also imbalances due to different levels of global health governance – global, regional, and local – and over politicisation of mostly technical decisions and policies. These tensions potentially lead to reputational damage, lack of credibility, incoherence, delays, and other negative consequences in the face of health emergencies. As the fundamental aspects of the WHO system are unlikely to change, especially given the current geopolitical environment, recommendations must circumvent these tensions in order to ensure a better working arrangement between levels of governance, less politicisation of key decisions, more transparency and accountability, a broad range of expertise, etc.

## **Recommendation 7**

**WHO reforms should establish a clear and efficient division of labour between the global WHO Headquarters and WHO regional offices, avoiding duplication and incoherence.**

The interplay between the WHO Headquarters and WHO regional offices should be anchored in both complementarity of action and coherence over time. There is a balance to be set between the efficiency of decentralised policy-making and the efficacy of centralisation. Because centralisation favours efficacy, it should be preferred in situations of health emergencies that require immediate decisions and reactions regardless of costs: financial or otherwise. Health emergencies, especially of contagious pathogens, should be considered to present a global threat until proven to be restricted to local or regional levels and decisive measures should be taken accordingly at the global level.

Decentralisation towards regional offices and local authorities is preferable in the sustained response, which privileges efficiency and tailored approaches. Given their expertise and knowhow, regional and local levels are able to sustain long-term responses at lower costs, which is extremely relevant given scarcities of financial resources, tools, and personnel. WHO Headquarters' broad guidelines and decisions can be translated by regional and local officers and politicians according to their own political environments. Adaptations of broad guidelines by local and regional levels should help to reduce politicisation of decisions at WHO Headquarters.

WHO Headquarters should play an enhanced role in continuous communication and interaction between regional offices. Regular meetings of a "College of Directors", presided over by the WHO DG, and with the membership of Regional Directors should be institutionalised in addition to extant and more informal weekly exchanges.<sup>352</sup> Senior officials directing and overseeing emergency programmes and efforts should also be present, such as the Executive Director of the WHO Health Emergencies Programme and Regional Emergency Directors. Regional offices should regularly report on their activities, both in terms of preparedness and response to health emergencies, sharing best practices. The World Health Assembly should institutionalise and give voice to Regional Directors and their periodic reports.



## **Recommendation 8**

**The mandate of senior positions of leadership active in WHO Headquarters and the regional offices should be extended in time, but limited to one term.<sup>353</sup>**

Appointments or elections of senior positions of leadership in WHO Headquarters and in the regional offices should be limited to a single term, longer than currently established, without the possibility of re-election or re-appointment. This rule should apply to the positions of the WHO DG and Regional Directors, but also other senior positions, such as (regional) health emergency directors.

Appointment and election of senior officers should be finalised well ahead of transition times, preferably one year ahead, to ensure efficient sharing of best practices and expertise and continuation of long-term actions. This one-term rule with an extended period of transition should enhance the authority, credibility, and independence of action of the WHO and its regional offices.

## **Recommendation 9**

**The WHO should have access to broad, additional, and more representative expertise, including health scientists but also health workers, doctors, and social scientists.**

While the WHO cannot maintain a diverse and sufficiently broad in-house group of experts, it should have mechanisms in place to call upon a wide variety of expertise for emergency situations that require sustained responses. This diverse expertise should be present in various meetings, such as the Emergency Committee and the Executive Council, and should be able to give input on-demand or proactively during various moments of the decision-making process and the issuance of guidelines.

In order to avoid unknown biases in critical moments of the international response, such as IHR-related decisions and temporary recommendations, dissenting scientific opinions should be encouraged, given voice to, and institutionalised.<sup>354</sup>

## **Recommendation 10**

**The World Health Assembly should establish a special Committee, with reduced membership, to periodically assess and peer-review actions of WHO Members in preparedness, response and IHR-related obligations.**

The IHR establish the obligation of States to create and maintain core capacities in their health sectors. Nevertheless, enforcement of such obligations is currently insufficient: the current political and economic incentives do not ensure compliance. The Health Assembly should establish a peer-review system, anchored in a special Committee, for reporting, discussion, and assessment of the Members' steps towards enhanced compliance with IHR core capacities in the health system (see recommendation 17).

The Health Assembly's special Committee would have a smaller and limited membership of 50 State Parties, which would rotate every 2 years. The two-year period would correspond to the peer-review cycle, including presentation of a report, written peer-assessment, discussion on necessary improvements and means to achieve them, and a second report on measures taken to address shortcomings. Each State Party shall join the Committee at least once every 8 years. Committee meetings should be attended by the highest level of State leadership, preferably Ministers of Health or equivalent.

The Committee-based peer-review system would create incentives for compliance with IHR core capacity obligations, but would also foster exchanges of best practices. Its work should be based on principles of good faith and sincere cooperation, working towards linking reported deficiencies to clear means of addressing them politically and financially (see recommendation 13). The WHO global peer-review system shall be complementary to existing and future review processes at the local level.

## **Recommendation 11**

**The WHO should commit to the principles of transparency and accountability in its governance system through the standardisation of procedures.**

The WHO governance system, including its decision-making procedures, must be as transparent as possible in order to reinforce its credibility as a science-led organisation. As such, composition of and decision-making in key organs, such as the Emergency Committee, should be readily publicised and substantiated by relevant expertise or evidence. Meetings should always produce detailed reports, including dissenting opinions, to enable oversight on crucial assessment and decision-making processes. If necessary, the publication of dissenting opinions can follow Chatham House rules.

The WHO DG should be held to the same high standards. Given the significant repercussions that a PHEIC declaration can have in the event of a (potential) health emergency, timely publication of the WHO DG's assessment, evaluation, and decision-making, regarding whether or not to declare a PHEIC, is highly necessary for purposes of transparency and accountability and, in turn, the credibility and legitimacy of WHO action.

*c. Financing*

There is currently a consensus that the WHO's budget structure and different funding schemes are largely insufficient and ill-adapted to the requirements of a global organisation which is leading world-wide efforts concerning preparedness and response against disease outbreaks. The WHO's annual budget of assessed contributions is comparable to that of a large hospital facility and pales in comparison to the budget of national health systems.<sup>355</sup> A better funding system requires structural change within the WHO's own budget as well as the availability of larger sums through extra-budgetary funds linked to areas beyond health.

<b>Recommendation 12</b>
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**The WHO urgently requires more financing to operate efficiently and effectively. Such financing must be readily available, in sufficient degrees and extended in a flexible manner (i.e., not earmarked for specific projects or purposes by donors).**

Despite previously unanswered petitions for a budgetary increase, a call for an increase in the WHO's budget remains a pertinent and urgent priority. Besides requiring a higher budget for daily operations, many of the proposed or envisioned reforms cannot succeed if additional

funding is not supplied. Importantly, a budget increase will assist in avoiding dependency on individual Members during emergencies.

### **Recommendation 13**

**The WHO should lead efforts to establish a Global Health Fund focused on sustained preparedness in the developing world.**

Middle and low-income countries face structural challenges to create and maintain core capacities in their health systems, making them particularly vulnerable to disease outbreaks. Deficiencies in their or any health system can prolong pandemic situations. The WHO should direct efforts in the Health Assembly and in the UN General Assembly towards the creation of a Global Health Fund that focuses on enhancing the preparedness and core capacities of the developing world.

The Global Health Fund should be financed by both regular and voluntary State contributions as well as private donations. It should also be linked to other development funds and programmes. The Fund shall be managed by the WHO and expenditure should be based on the outcome of the peer-review process in the special committee of the Health Assembly (see recommendation 10). States accessing the Fund shall properly report on their use of funds. The WHO regional offices can also have access to such funds in accordance with their own review system, but with valuable reporting to the Health Assembly.

#### *d. Preparedness*

Current political and financial structures make it difficult to prepare for low probability but high impact events, such as the COVID-19 pandemic. The decision to prepare for such occurrences (i.e., investing time, money, and resources) is very costly and can hurt decision-makers if the event fails to take place. Nevertheless, the COVID-19 pandemic has showcased that preparedness for health emergencies should be of the highest priority for national and international decision-makers. The following recommendations address aspects that can assist in heightened preparedness.

#### **Recommendation 14**

**Swift and accurate identification of sick or infected patients will be required through the adoption of adaptable and flexible standards for testing, tracking, and reporting cases.**

For contagious diseases, the swift identification of patients is extremely important to curb the further spread of the disease. The WHO should therefore adopt standards for testing, tracking, and reporting cases so that swift identification procedures are implemented early during an outbreak. Members should be informed about the appropriate methods through pre-established channels of communication. As viruses or diseases can differ strongly, such standards should be adaptable and flexible.

#### **Recommendation 15**

**The WHO should ramp up readily available resources to sufficiently prepare for and enable swift reaction to health emergencies.**

Such readily available resources should support a variety of actions, such as surveillance and detection, but also R&D, mass testing, contact tracing, etc. Regarding preparedness in the form of surveillance and detection, the WHO should enhance its digital capacities. One WHO action that could undergo strong improvement, if increasingly performed through digital means, is the filtering exercise of non-governmental reports regarding potential public health emergencies of international concern.<sup>356</sup>

From a reactive perspective, health emergencies require the mobilisation of significant resources in what is often as rapid a fashion as possible. As demonstrated during the COVID-19 pandemic, during the early months of outbreak responses States faced significant shortages in, amongst other things, protective gear, medical equipment, and medicine. There were only a select group of States with strong manufacturing capabilities that had resources at their disposal and could then choose to distribute materials globally. The lack of available resources and the dependency on just a handful of strong manufacturing States resulted, arguably, in unnecessary and costly delays in responding to the COVID-19 outbreak and its international spread: both on the part of the WHO and individual States. Having its own resources at its disposal would allow

the WHO to play its envisioned directing and coordinating role by extending rapid assistance on the ground. In addition, it would support independent decision-making on the part of the WHO without the risk of (perceived) undue influence from individual States.

#### **Recommendation 16**

**The WHO should create more sustainable links – including a senior liaison position – with health-related industries and with non-governmental actors for preparedness, response, research and development, and financing.**

The WHO, as an international organisation charged with fostering interstate cooperation, must also ensure constant interaction with non-state actors, both private and organised civil society. Various health-related industries, such as the pharmaceutical industry and producers of personal protective equipment, are an essential part of a functioning health governance. At the same time, industry actors gain access to public databases and information they would not otherwise have access to without the coordinating role of the WHO and the IHR. This information, such as DNA/RNA sequences of virus or large-scale testing capacity, is essential for research and the development of vaccines, treatments, and prevention tools. As such, the WHO should work together with industries to ensure that the latter contribute appropriately in return for access to global public goods. Constant communication and interplay with other international organisations and fora focused on the economic domain, such as the OECD, the WTO, G7, and G20, should be maintained at the highest level.

WHO efforts on the ground can also rely on the expertise, knowledge, and capacity of organised civil society. Civil society can constitute a reliable source of information where states do not comply with the IHR and their obligations to share information. Finally, civil society organisations are an essential component of effective communication to the broader public. Empowering civil society and enhancing their role in national health systems is a step forward in the preparation for future health emergencies.

Optimal preparedness and response are dependent on successful interaction with all stakeholders. The WHO should consider the creation of a permanent senior position, with

adequate staff support and in close contact with the WHO DG, to liaise with non-state actors at the highest level and report to the Health Assembly and other appropriate organs.

*e. International Health Regulations*

The IHR require reform to enable the WHO – and the international community – to better prevent, prepare for, and respond to disease outbreaks. Importantly, the IHR now focuses on prevention and detection measures, but it does not provide for adequate instruments or mechanisms to provide a swift and coherent response to disease outbreaks.<sup>357</sup> Almost the only reactionary instrument available to the WHO is that of temporary recommendations,<sup>358</sup> which have their own shortcomings that warrant strengthening to render them effective.<sup>359</sup> In addition, the prevention and detection measures that are provided for by the IHR have both design and implementation flaws. These leave the international community vulnerable to disease outbreaks and their subsequent spread. The following recommendations touch upon these aspects for improvement or enhancement.

<b>Recommendation 17</b>
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**To ensure Members’ compliance and best efforts in respect of prevention and preparedness measures, further precision of minimum requirements for IHR core capacities should be provided and a periodic and critical peer-review system should be established to encourage and monitor Members’ progress on meeting these IHR core capacities.**

To better position individual Members to meet their core capacity requirements, a better understanding is urgently required of which measures would meet the minimum requirements for Members’ core capacities.<sup>360</sup> Further quantitative and qualitative precision, through standardisation, is necessary and must be provided by the WHO to assist Members in understanding how to meet their core capacity obligations under the IHR.<sup>361</sup> Importantly, existing standards and guidelines and subsequent standards need to be compiled and aligned with each other so that a single uniform approach can be adopted by Members to facilitate adherence to their core capacity requirements.<sup>362</sup>

Accompanying this, stronger encouragement, pressure, and oversight is needed to guarantee that individual Members meet their IHR core capacity requirements. DG Tedros Ghebreyesus has already proposed a new voluntary mechanism of peer-to-peer review, namely the Universal Health and Preparedness Review.<sup>363</sup> It should be strongly considered to negotiate and implement a mandatory, periodic peer-review mechanism that, besides being Member-driven, is also independently verified by experts.<sup>364</sup> This peer-review system should adopt best practices from other peer-review systems, such as the Joint External Evaluation (JEE) mechanism. Special consideration should be taken in respect of PAHO's specific JEE system, which incentivises Members to participate now that PAHO aims to resolve shortcomings raised in national review reports and in a short time period after detection (see recommendation 10).<sup>365</sup>

To assist low- and middle-income countries in meeting their core capacity requirements and to allow the WHO to swiftly address shortcomings identified in review reports in respect of preparedness, innovative financing arrangements and additional funds should be committed to and made available to the WHO (see recommendation 13).

### **Recommendation 18**

**The instrument of temporary recommendations issued by the DG should be strengthened to enhance effective and coordinated international public health responses.**

A monitoring mechanism should be adopted to oversee compliance with and implementation of temporary recommendations by individual Members. This could be done through self-reporting of Members and/or through a peer-review system.<sup>366</sup> Better compliance with temporary recommendations issued by the DG should provide the WHO with the ability to coordinate the international response to health emergencies.<sup>367</sup> A monitoring mechanism will also hold individual States accountable for their obligations under the IHR.

Another way to strengthen the instrument of temporary recommendations is by improving their content. Temporary recommendations should be crafted in a more concise manner and should be operational.<sup>368</sup> Recommendations that can be operationalised by individual Members based on their specific circumstances and needs during a health emergency will allow the WHO to play a more significant role in national governance.<sup>369</sup> More specifically, framework



recommendations will be coherent across borders; however, precise application and implementation of these framework recommendations needs to be decided at a more national and local level. Note that some level of standardisation could also be adopted in respect of temporary recommendations.<sup>370</sup>

### **Recommendation 19**

**The lack of accountability of Members, in the event that they choose to implement additional health measures in response to specific public health emergencies pursuant to Article 43 IHR, needs addressing.**

When choosing to make use of their authority under Article 43 IHR, Members are obliged to inform the WHO within 48 hours. In the past, Members have often failed to inform the WHO of additional health measures taken, which results in a serious lack of accountability.<sup>371</sup> What is more, in the critical first period of a health emergency, it could also obstruct resources from reaching affected areas, delay the international public health response, and stigmatise populations.<sup>372</sup>

To resolve this lack of accountability and avoid the negative repercussions that go with it, a peer review system could generate the necessary incentive for individual Members to report the additional health measures they are implementing nationally.<sup>373</sup> A peer review system would thus serve as a more formalised system of naming and shaming, which is needed to drive individual Members' reporting obligations.<sup>374</sup>

#### *f. Emergency*

To induce proper and sufficient reactions to health emergencies or threats thereof, the system of alert stands as an extremely important mechanism. Crucially, it must be understandable, transparent, timely, and reaction-inducing. A clear distinction between different conceptual notions of alert is also required to avoid confusion within the international community and provide clarity as to when swift emergency responses are necessary.

## Recommendation 20

**The PHEIC declaration, which is the highest level of alert available to the WHO, should be maintained in the future, albeit with a number of adjustments and precisions.**

There is a need to change the acronym: PHEIC is an unclear, confusing, and difficult to pronounce acronym that requires revision.<sup>375</sup> The acronym should be revised to increase visibility and understanding within the wider public following a declaration by the DG. One suggestion is to change PHEIC to PHEMIC, which stands for ‘Public Health EMergency of International Concern’.<sup>376</sup> Once amended, public awareness of the meaning of the acronym needs to be promoted.

There is a need for a clearer and more transparent process to declare a PHEIC: a more precise and clear assessment of the process to declare a PHEIC is needed. In the past, there has been inconsistent application of the criteria for a PHEIC, which harms the credibility and legitimacy of the WHO to address and respond to health emergencies.<sup>377</sup> Therefore, a clear and coherent application of the criteria stipulated in the IHR is necessary, without taking, for example, policy considerations into account.

There is a need for Members to better understand the consequences of a PHEIC declaration: the meaning and consequences of a PHEIC declaration need to be clearly communicated to Members and to the wider public. In particular, Members require increased awareness of the powers that a PHEIC declaration unlocks for the WHO and which corresponding obligations fall upon them as states.<sup>378</sup> Most importantly, a PHEIC declaration unlocks the power for the DG to issue temporary recommendations and its purpose is to generate swift, broadscale, and coordinated international action. Better education and communication regarding these aspects will assist the international community in its ability to formulate a strong and coordinated response to health emergencies.

### **Recommendation 21**

**A pandemic declaration should be introduced as an official concept in the purview of the WHO and, specifically, under the authority of the DG pursuant to a predetermined definition and process.**

The pandemic declaration should not be perceived as an additional level of alert. The PHEIC declaration remains the highest level of alert available to the DG. In the event that a pandemic is declared, either the surveillance and detection measures of Members and the WHO have failed to alert the international community regarding a PHEIC or, if a PHEIC was declared, then the measures taken to prevent and control the international spread of a disease characterised as a PHEIC have fallen short.

The benefit of a pandemic declaration lies in the awareness of the international community that a disease is affecting several countries and populations over a wide area and that individual Members can no longer remain on the sidelines. Furthermore, from a legal perspective, a pandemic declaration generates specific legal consequences now that, for example, pandemic is included as a *force majeure* event in many contractual relations.

### **Recommendation 22**

**There should be a timely transition from an emergency situation and response to a long-term, sustainable programme to address a disease outbreak with prolonged implications.**

The WHO should adopt a review mechanism that, in the event of a PHEIC of a prolonged nature, provides for a reflection process regarding whether the PHEIC still warrants an emergency response and framework or whether a more sustainable approach to the particular disease needs to be adopted.

If a public health emergency takes on a more prolonged nature, the WHO should consider how to transplant its international actions into a well-structured, well-organised and stable framework to alleviate the burden and high-intensity nature that emergency responses require. Amongst other things, emergency measures, funds, and workforces should be applied and

employed to respond to serious and unexpected situations that require immediate action. They must be handled with care so that they are not overextended, which could make them unable to be deployed during a subsequent emergency. The expiration dates stipulated in Article 15 IHR in respect of temporary recommendations could serve as guidance for the timing considerations in such a review mechanism.

*g. Communication*

Clear and coherent communication is of vital importance to prevent, prepare for, and respond to health threats. Not only the initial alert that heralds a health threat but also the response measures and coordination actions which address it require strong communication channels with global reach. The following recommendations touch upon aspects of communication that should be improved upon, enhanced, or newly installed.

**Recommendation 23**

**The WHO should foster a global environment in which individual Members are encouraged to raise an alert regarding a (potential) health emergency.**

Underlying discourse in global health governance needs to move from stigma to encouragement, especially when it comes to crucial information-sharing in the event of emergencies and disease outbreaks. The international community and individual States must avoid stigmatising and blaming Members that encounter a health threat. Instead, these Members should receive support and assistance as soon as an alert is shared. Such an environment will serve to encourage alerts early on, which, in turn, can improve the chances of swiftly addressing health threats.

**Recommendation 24**

**The WHO should propose a digital and social media communication strategy to be approved by the World Health Assembly.**

Social media channels like Twitter, Facebook, or YouTube present challenges that are different from official communications with governments as well as information that is tailored and

filtered by traditional media. There is an enormous gap in numbers between the direct audience of WHO's official social media channels (i.e., number of views and followers) and the people who should receive information. This gap is traditionally filled by other actors, such as national governments and media outlets, which communicate guidelines and relevant information.

Social media and direct communication without a clear strategy might contribute to misinformation and the spreading of fake news. National and international actors might also misuse the WHO's own communications on social media to discredit it or shift political blame. As such, the WHO DG should present to the Health Assembly a comprehensive digital and social media communication strategy. Within this strategy, the WHO must reflect on its social media engagement and communication priorities, including clear definitions of goals and targeted audience(s). Direct communication with all populations affected by a health emergency (i.e., billions of people in the case of COVID-19) is virtually impossible, therefore a strategy of prioritisation is required.

WHO social media engagement should prioritise direct communication and advice to healthcare providers in the developing world, which are often in pressing need of reliable information and guidelines. This audience includes a broad spectrum of healthcare providers and public health officials without medical degrees. Civil society organisations, especially those with a presence on the ground, should constitute an essential part of the WHO communication strategy so as to improve informational dissemination and sharing and to enhance the credibility of information.

The proposed communication strategy should also take into account the importance of general education about health policies, individual behaviour and risk assessment. Vaccine hesitancy supported by very minor risks of inoculation should be addressed through a clear strategy aimed at providing education on risks and trade-offs.

## CONCLUDING REMARKS

In light of the significant criticism voiced against the WHO since the early days of the COVID-19 outbreak, this report aimed to address how the WHO can enhance international cooperation to better prevent, prepare for, and respond to an outbreak of an infectious disease, such as COVID-19, slow its spread, and reduce its impact in the future. Importantly, despite a strong focus on the WHO in this report, international actors need to remain aware that broader reform, beyond the WHO, will be necessary to enhance health efforts globally.

This report has analysed and assessed the WHO's actions in response to the COVID-19 pandemic, reviewed lessons learned from previous health crises, and included insights derived from various interviews with senior WHO officials and other global health professionals. On this basis, it has identified particular issues and problems regarding the WHO's structure and actions in response to health emergency situations that warrant addressing for more stable and robust global health governance in the future. Taking on a forward-looking approach, the report culminated in 24 policy recommendations, which aim to tackle challenges linked to the WHO's structure and functioning, but also to global governance, existing power imbalances, and the strong grip maintained by States upon sovereignty.

The recommendations follow the “one health approach”, as consolidated by the international community, and put human rights first. The recommendations also prioritise reform of the WHO and the strengthening of its authority rather than opting for the creation of new mechanisms and institutions. As such, the policy recommendations provide principled but realistic guidance for an overall and holistic approach to reform and touch upon aspects of WHO governance, financing, preparedness, emergency, and communication.

Strong emphasis is placed, throughout the report and in the recommendations, on shortcomings relating to the International Health Regulations as well as the core capacities obligation which is imposed on States therein. Action must be undertaken to reform particular design and implementation shortcomings inherent in the IHR. Importantly, national healthcare systems also require urgent improvements to prepare for and respond to health emergencies that will arise in the future. International leadership and coordination by the WHO or other international actors will be in vain if implementation on the ground – nationally and locally – is inadequate.

As was accurately summarised by the IHR Review Committee convened during the COVID-19 response:

*“It is clear that sustainable national health systems, accessible to all, are an essential basis for global health emergency preparedness and response, and that the foundation of productive international collaboration is trust and transparency. Neither can be achieved without the other: they are two sides of the same coin. The world must be prepared to respond better to the next public health emergency of international concern, especially if it has the potential to become a pandemic. The changes necessary to enable effective implementation of the IHR require urgent action, not years of political negotiations.”<sup>379</sup>*

While numerous reports have been drawn up in recent months to contribute towards the improvement and/or enhancement of the global health governance system, this report aspires to add to this debate by offering a small number of relatively feasible policy recommendations which mostly target the WHO as the focal multilateral institution in the fight against health emergencies. Importantly and as noted by the UN Secretary-General in his recently published ‘*Our Common Agenda*’, “[w]hen we all face the same threat, cooperation and solidarity are the only solutions, within societies and between nations”.<sup>380</sup> The recommendations formulated in this report, thus, aim to enhance the WHO’s particular ability to coordinate and direct international cooperation to better prevent, prepare for, and respond to future health emergencies.

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- <sup>56</sup> Article 21 Constitution of the World Health Organization, 22 July 1946, Off. Rec. Wld Hlth Org., vol. 2, 100.
- <sup>57</sup> Article 21(a) Constitution of the World Health Organization, 22 July 1946, Off. Rec. Wld Hlth Org., vol. 2, 100.
- <sup>58</sup> ‘World Health Assembly Adopts Historic Tobacco Control Pact’ (*World Health Organization*) <<https://www.who.int/mediacentre/news/releases/2003/prwha1/en/>> accessed 1 February 2021.
- <sup>59</sup> The Conference of the Parties to the WHO FCTC, *WHO Framework Convention on Tobacco Control* (World Health Organization 2003).
- <sup>60</sup> ‘International Health Regulations. Working Paper for Regional Consultations’ 2 <[https://www.who.int/csr/resources/publications/IGWG\\_IHR\\_WP12\\_03-en.pdf](https://www.who.int/csr/resources/publications/IGWG_IHR_WP12_03-en.pdf)> accessed 1 February 2021; Fidler, ‘From International Sanitary Conventions to Global Health Security’ (n 4) 330.
- <sup>61</sup> Fidler, ‘From International Sanitary Conventions to Global Health Security’ (n 4) 327–30.
- <sup>62</sup> ‘International Health Regulations. Working Paper for Regional Consultations’ (n 60) 2; Fidler, ‘From International Sanitary Conventions to Global Health Security’ (n 4) 333.
- <sup>63</sup> Namely cholera, yellow fever and plague. See J Youde, *Global Health Governance in International Society* (Oxford University Press 2018) 65; ‘International Health Regulations. Working Paper for Regional Consultations’ (n 60) 2.
- <sup>64</sup> ‘International Health Regulations. Working Paper for Regional Consultations’ (n 60) 2.
- <sup>65</sup> Preamble and Article 69 Constitution of the World Health Organization, 22 July 1946, Off. Rec. Wld Hlth Org., vol. 2, 100.
- <sup>66</sup> Amongst its functions, the WHO must establish and maintain effective collaboration with the UN and provide or assist in providing, upon request of the UN, health services and facilities to special groups. Moreover, the WHA must consider recommendations bearing on health made by the UN General Assembly, the UN Economic and Social Council, the UN Security Council or the Trusteeship Council of the UN and report on how it has given effect to these recommendations. See Articles 2(b), 2(e) and 18(i) Constitution of the World Health Organization, 22 July 1946, Off. Rec. Wld Hlth Org., vol. 2, 100; Kirton (n 4) 49–50.
- <sup>67</sup> *ibid.* 50. Kirton accurately notes that “it is the intent of all these provisions that WHO shall function as one of the ‘planets’ in the ‘solar’ system of the United Nations.”
- <sup>68</sup> ‘About WHO. Collaborations and Partnerships. Office at the United Nations’ (*World Health Organization*) <<https://www.who.int/about/collaborations-and-partnerships/who-office-at-the-united-nations>> accessed 3 February 2021.
- <sup>69</sup> OECD and WHO, ‘International Regulatory Co-Operation and International Organisations: The Case of the World Health Organization (WHO)’ (OECD and WHO 2016) 14–15 <[https://www.oecd-ilibrary.org/governance/international-regulatory-co-operation-and-international-organisations\\_9789264225756-en](https://www.oecd-ilibrary.org/governance/international-regulatory-co-operation-and-international-organisations_9789264225756-en)> accessed 1 February 2021.
- <sup>70</sup> *ibid.* 15.
- <sup>71</sup> Some examples of cooperation through these means are the UN Programme on HIV/AIDS (UNAIDS) and the FAO/WHO Joint Food Standards Programme, which are both co-sponsored by the WHO; the trilateral cooperation between WHO, WIPO and WTO, which regularly organises Joint Technical Symposia; the UN Sustainable Development Group, in which the WHO and various other UN entities participate to formulate joint policy and decisions; and the Global Preparedness Monitoring Board, which was created by the WHO and the World Bank Group. See *ibid.* 14–15; For other examples of inter-agency cooperation, see ‘Inter-Agency Collaboration’ (*World Health Organization*) <<https://www.who.int/emergencies/partners/inter-agency>> accessed 3 February 2021.

- <sup>72</sup> ‘About WHO. Collaborations and Partnerships’ (*World Health Organization*) <<http://www.who.int/about/collaborations/en/>> accessed 3 February 2021.
- <sup>73</sup> Articles 69-71 Constitution of the World Health Organization, 22 July 1946, Off. Rec. Wld Hlth Org., vol. 2, 100.
- <sup>74</sup> Clift (n 44) 7; Youde, *Global Health Governance* (n 4) 36.
- <sup>75</sup> Clift (n 44) 7; Youde, *Global Health Governance* (n 4) 36–39.
- <sup>76</sup> Youde, *Global Health Governance* (n 4) 37–39; Cueto, Brown and Fee (n 4) 175–178.
- <sup>77</sup> Clift (n 44) 7; Youde, *Global Health Governance* (n 4) 39; Cueto, Brown and Fee (n 4) 178.
- <sup>78</sup> Youde, *Global Health Governance* (n 4) 39; Cueto, Brown and Fee (n 4) 178–180.
- <sup>79</sup> Youde, *Global Health Governance* (n 4) 40.
- <sup>80</sup> *ibid.*
- <sup>81</sup> Concerns about the WHO’s operations were raised in a report of the UN Joint Inspection Unit and a working group on the WHO Response to Global Change. Gavin Yamey, ‘Have the Latest Reforms Reversed WHO’s Decline?’ (2002) 325 *BMJ* : British Medical Journal 1107; Clift (n 44) 7–8; ‘Report of the Executive Board Working Group on the WHO Response to Global Change’ <[https://apps.who.int/iris/bitstream/handle/10665/171623/EB92\\_4\\_eng.pdf?sequence=1&isAllowed=y](https://apps.who.int/iris/bitstream/handle/10665/171623/EB92_4_eng.pdf?sequence=1&isAllowed=y)> accessed 1 February 2021.
- <sup>82</sup> Clift (n 44) 8.
- <sup>83</sup> *ibid.*; Yamey (n 81) 1107.
- <sup>84</sup> Clift (n 44) 8; Yamey (n 81) 1111.
- <sup>85</sup> Clift (n 44) 8; Yamey (n 81) 1109.
- <sup>86</sup> Clift (n 44) 8; World Health Assembly, ‘Dr Gro Harlem Brundtland. Director-General Elect. The World Health Organization. Speech to the Fifty-First World Health Assembly’ (World Health Organization 1998) A51/DIV/6 <<http://doi.wiley.com/10.1046/j.1600-0528.2003.00124.x>> accessed 1 February 2021; Yamey (n 81) 1109.
- <sup>87</sup> Clift (n 44) 9; Yamey (n 81) 1110.
- <sup>88</sup> John S Mackenzie and ors., ‘The Global Outbreak Alert and Response Network’ (2014) 9 *Global Public Health* 1023, 1023–1024; Fidler, ‘From International Sanitary Conventions to Global Health Security’ (n 4) 347.
- <sup>89</sup> ‘Ten Years of Transformation: Making WHO Fit for Purpose in the 21st Century’ 9 <<https://apps.who.int/iris/bitstream/handle/10665/272451/9789241512565-eng.pdf?sequence=1&isAllowed=y>> accessed 1 February 2021; Clift (n 44) 9.
- <sup>90</sup> Clift (n 44) 9; OECD and WHO (n 69) 19.
- <sup>91</sup> Article 2 Constitution of the World Health Organization, 22 July 1946, Off. Rec. Wld Hlth Org., vol. 2, 100.
- <sup>92</sup> Annelies Wilder-Smith and Sarah Osman, ‘Public Health Emergencies of International Concern: A Historic Overview’ (2020) 27 *Journal of Travel Medicine* <<https://academic.oup.com/jtm/article/doi/10.1093/jtm/taaa227/6025447>> accessed 14 July 2021.
- <sup>93</sup> ‘Severe Acute Respiratory Syndrome (SARS)’ (*World Health Organization*) <<https://www.who.int/westernpacific/health-topics/severe-acute-respiratory-syndrome>> accessed 1 February 2021; ‘Update 95 - SARS: Chronology of a Serial Killer’ (*World Health Organization*) <[https://www.who.int/csr/don/2003\\_07\\_04/en/](https://www.who.int/csr/don/2003_07_04/en/)> accessed 1 February 2021; JS Mackenzie and others, ‘The WHO Response to SARS and Preparations for the Future’, *Learning from SARS: Preparing for the Next Disease Outbreak -- Workshop Summary* (National Academies Press 2004) 41–42 <<http://www.nap.edu/catalog/10915>> accessed 1 February 2021.
- <sup>94</sup> ‘Update 95 - SARS: Chronology of a Serial Killer’ (n 93).
- <sup>95</sup> *ibid.*; ‘WHO SARS International Reference and Verification Laboratory Network: Policy and Procedures in the Inter-Epidemic Period’ <<https://www.who.int/csr/sars/guidelines/en/WHOSARSReferenceLab.pdf>> accessed 1 February 2021.
- <sup>96</sup> Youde, *Global Health Governance* (n 4) 122–123.
- <sup>97</sup> James W LeDuc and M Anita Barry, ‘SARS, the First Pandemic of the 21st Century’ (2004) 10 *Emerging Infectious Diseases* e26.
- <sup>98</sup> ‘Update 95 - SARS: Chronology of a Serial Killer’ (n 93); LeDuc and Barry (n 97).
- <sup>99</sup> LeDuc and Barry (n 97).
- <sup>100</sup> ‘Update 95 - SARS: Chronology of a Serial Killer’ (n 93).
- <sup>101</sup> *ibid.*
- <sup>102</sup> *ibid.*
- <sup>103</sup> David P Fidler, ‘The World Health Organization and Pandemic Politics’ [2020] *Think Global Health* <<https://www.thinkglobalhealth.org/article/world-health-organization-and-pandemic-politics>> accessed 4 February 2021.
- <sup>104</sup> *ibid.*; Youde, *Global Health Governance* (n 4) 123.
- <sup>105</sup> Fidler, ‘From International Sanitary Conventions to Global Health Security’ (n 4); Youde, *Global Health Governance* (n 4) 122.
- <sup>106</sup> Sixty-Fourth World Health Assembly, ‘Implementation of the International Health Regulations (2005). Report of the Review Committee on the Functioning of the International Health Regulations (2005) in Relation to Pandemic (H1N1) 2009. Report by the Director-General’ (World Health Organization 2011) A64/10 8.
- <sup>107</sup> David P Fidler and Lawrence O Gostin, ‘The New International Health Regulations: An Historic Development for International Law and Public Health’ (2006) 34 *Journal of Law, Medicine & Ethics* 85, 86; ‘International Health Regulations (2005). Third Edition’ Foreword <<https://apps.who.int/iris/bitstream/handle/10665/246107/9789241580496-eng.pdf;jsessionid=1FD446DFBDAC5C7E37C780DE387C0574?sequence=1>> accessed 1 February 2021.
- <sup>108</sup> ‘International Health Regulations (2005). Third Edition’ (n 107) Foreword; Fidler and Gostin (n 107) 86–87.
- <sup>109</sup> ‘International Health Regulations (2005). Third Edition’ (n 107) Foreword; Fidler, ‘From International Sanitary Conventions to Global Health Security’ (n 4) 88.
- <sup>110</sup> ‘International Health Regulations (2005). Third Edition’ (n 107) Foreword; Fidler, ‘From International Sanitary Conventions to Global Health Security’ (n 4) 90.

- <sup>111</sup> Sixty-Fourth World Health Assembly (n 106) 6 and 8.
- <sup>112</sup> ‘H1N1 in Post-Pandemic Period. Director-General’s Opening Statement at Virtual Press Conference’ (*World Health Organization*, 10 August 2010) 1 <[https://www.who.int/mediacentre/news/statements/2010/h1n1\\_vpc\\_20100810/en/](https://www.who.int/mediacentre/news/statements/2010/h1n1_vpc_20100810/en/)> accessed 5 February 2021.
- <sup>113</sup> The IHR provides the DG with the authority to establish such a Review Committee in Chapter III of Part IX; Sixty-Fourth World Health Assembly (n 106).
- <sup>114</sup> *ibid* 8; Fidler, ‘The World Health Organization and Pandemic Politics’ (n 103).
- <sup>115</sup> See Sixty-Fourth World Health Assembly (n 106).
- <sup>116</sup> *ibid*.
- <sup>117</sup> *ibid* 11.
- <sup>118</sup> *ibid*.
- <sup>119</sup> *ibid* 12.
- <sup>120</sup> Review Committee on the Functioning of the International Health Regulations (2005) and during the COVID-19 Response, ‘WHO’s Work in Health Emergencies Strengthening Preparedness for Health Emergencies: Implementation of the International Health Regulations (2005)’ (2021) 8 <[https://cdn.who.int/media/docs/default-source/documents/emergencies/a74\\_9add1-en.pdf?sfvrsn=d5d22fdf\\_1&download=true](https://cdn.who.int/media/docs/default-source/documents/emergencies/a74_9add1-en.pdf?sfvrsn=d5d22fdf_1&download=true)>.
- <sup>121</sup> Sixty-Fourth World Health Assembly (n 106) 13–23.
- <sup>122</sup> Fidler, ‘The World Health Organization and Pandemic Politics’ (n 103).
- <sup>123</sup> *ibid*.
- <sup>124</sup> Sanjana J Ravi, Michael R Snyder and Caitlin Rivers, ‘Review of International Efforts to Strengthen the Global Outbreak Response System since the 2014–16 West Africa Ebola Epidemic’ (2019) 34 *Health Policy and Planning* 47, 47.
- <sup>125</sup> Fidler, ‘The World Health Organization and Pandemic Politics’ (n 103).
- <sup>126</sup> *ibid*; Youde, *Global Health Governance in International Society* (n 63) 122.
- <sup>127</sup> Ravi, Snyder and Rivers (n 124) 47; ‘UN Declares Ebola Outbreak Global “International Public Health Emergency”’ (*UN News*, 8 August 2014) <<https://news.un.org/en/story/2014/08/474732-un-declares-ebola-outbreak-global-international-public-health-emergency>> accessed 5 February 2021; ‘Statement on the 1st Meeting of the IHR Emergency Committee on the 2014 Ebola Outbreak in West Africa’ (*World Health Organization*, 8 August 2014) <<https://www.who.int/mediacentre/news/statements/2014/ebola-20140808/en/>> accessed 5 February 2021; Jeremy Youde, ‘Chapter 6. International Society Confronts Ebola’, *Global Health Governance in International Society* (1st edn., Oxford University Press 2018) 120–122 <<https://oxford.universitypressscholarship.com/view/10.1093/oso/9780198813057.001.0001/oso-9780198813057-chapter-7>> accessed 4 February 2021; LO Gostin, D Sridhar and D Hougendobler, ‘The Normative Authority of the World Health Organization’ (2015) 129 *Public Health* 854, 857.
- <sup>128</sup> Ten countries were connected to this Ebola epidemic but Guinea, Liberia and Sierra Leone were hit the hardest. See Youde, *Global Health Governance in International Society* (n 63) 122.
- <sup>129</sup> Fidler, ‘The World Health Organization and Pandemic Politics’ (n 103).
- <sup>130</sup> Youde, *Global Health Governance in International Society* (n 63) 122; Gostin, Sridhar and Hougendobler (n 127) 857.
- <sup>131</sup> For an overview of the different review bodies, see ‘About WHO. Ebola Lessons Learned’ (*World Health Organization*) <<http://www.who.int/about/evaluation/evaluation/en/>> accessed 5 February 2021. See also Suerie Moon and others, ‘Post-Ebola Reforms: Ample Analysis, Inadequate Action’ [2017] *BMJ* j280, 6.
- <sup>132</sup> Youde, *Global Health Governance in International Society* (n 63) 127 and 129–130. For another article commenting on commonalities in seven major reports, see Moon and others (n 131).
- <sup>133</sup> Youde, *Global Health Governance in International Society* (n 63) 129–130.
- <sup>134</sup> ‘World Health Assembly Gives WHO Green Light to Reform Emergency and Response Programme’ (*World Health Organization*, 23 May 2015) <<https://www.who.int/mediacentre/news/releases/2015/wha-23-may-2015/en/>> accessed 5 February 2021; Gostin, Sridhar and Hougendobler (n 127) 857.
- <sup>135</sup> ‘WHO Contingency Fund for Emergencies: Annual Report 2019’ (*World Health Organization*) <<https://www.who.int/publications-detail-redirect/who-CFE-annual-report-2019>> accessed 3 February 2021; Ravi, Snyder and Rivers (n 124) 51; ‘World Health Assembly Gives WHO Green Light to Reform Emergency and Response Programme’ (n 134); Moon and others (n 131) 3; Geneva Global Health Hub (G2H2) (n 50) 2–3.
- <sup>136</sup> Ravi, Snyder and Rivers (n 124) 51; ‘World Health Assembly Gives WHO Green Light to Reform Emergency and Response Programme’ (n 134).
- <sup>137</sup> Ravi, Snyder and Rivers (n 124) 51; ‘WHO R&D Blueprint’ (*World Health Organization*) <[http://www.who.int/research-observatory/analyses/rd\\_blueprint/en/](http://www.who.int/research-observatory/analyses/rd_blueprint/en/)> accessed 5 February 2021; ‘R&D Blueprint and COVID-19’ (*World Health Organization*) <<https://www.who.int/teams/blueprint/covid-19>> accessed 26 February 2021.
- <sup>138</sup> ‘World Health Assembly Gives WHO Green Light to Reform Emergency and Response Programme’ (n 134); Gostin, Sridhar and Hougendobler (n 127) 857.
- <sup>139</sup> ‘Update. WHO Health Emergencies Programme: Progress and Priorities’ <<https://www.who.int/about/finances-accountability/funding/financing-dialogue/whe-update.pdf>> accessed 3 February 2021; OECD and WHO (n 69); ‘WHO Health Emergencies Programme’ (*World Health Organization*) <<https://www.who.int/westernpacific/about/how-we-work/programmes/who-health-emergencies-programme>> accessed 3 February 2021; Sanjana J Ravi, Michael R Snyder and Caitlin Rivers, ‘Review of International Efforts to Strengthen the Global Outbreak Response System since the 2014–16 West Africa Ebola Epidemic’ (2019) 34 *Health Policy and Planning* 47, 51; Moon and others (n 131) 3; Geneva Global Health Hub (G2H2) (n 50) 2–3.
- <sup>140</sup> Ravi, Snyder and Rivers (n 124) 51.
- <sup>141</sup> *ibid*.
- <sup>142</sup> Fidler, ‘The World Health Organization and Pandemic Politics’ (n 103).

- <sup>143</sup> World Health Organization, ‘Statement on the Meeting of the International Health Regulations (2005) Emergency Committee for Ebola Virus Disease in the Democratic Republic of the Congo on 17 July 2019’ (World Health Organization 2019) <<https://www.who.int/ihr/procedures/statement-emergency-committee-ebola-drc-july-2019.pdf>>; Fidler, ‘The World Health Organization and Pandemic Politics’ (n 103).
- <sup>144</sup> World Health Organization, ‘Statement on the Meeting of the International Health Regulations (2005) Emergency Committee for Ebola Virus Disease in the Democratic Republic of the Congo on 17 July 2019’ (n 143).
- <sup>145</sup> Fidler, ‘The World Health Organization and Pandemic Politics’ (n 103).
- <sup>146</sup> *ibid.*
- <sup>147</sup> ‘Transforming for Impact. Speech by WHO Director-General’ (*World Health Organization*, 6 March 2019) <<https://www.who.int/director-general/speeches/detail/transforming-for-impact>> accessed 5 February 2021.
- <sup>148</sup> Cueto, Brown and Fee (n 4) 320.
- <sup>149</sup> Advisory Group on Reform of WHO’s Work in Outbreaks and Emergencies, ‘Second Report of the Advisory Group on Reform of WHO’s Work in Outbreaks and Emergencies’ (World Health Organization 2016).
- <sup>150</sup> Advisory Group on Reform of WHO’s Work in Outbreaks and Emergencies with Health and Humanitarian Consequences, ‘First Report of the Advisory Group on Reform of WHO’s Work in Outbreaks and Emergencies with Health and Humanitarian Consequences’ (World Health Organization 2015).
- <sup>151</sup> Advisory Group on Reform of WHO’s Work in Outbreaks and Emergencies (n 149).
- <sup>152</sup> Advisory Group on Reform of WHO’s Work in Outbreaks and Emergencies, ‘Second Report of the Advisory Group on Reform of WHO’s Work in Outbreaks and Emergencies’ (World Health Organization 2016).07/12/2021 14:46:00
- <sup>153</sup> World Health Organization, ‘Emergency Reponse Framework’.
- <sup>154</sup> *ibid.* 10.
- <sup>155</sup> Advisory Group on Reform of WHO’s Work in Outbreaks and Emergencies with Health and Humanitarian Consequences, ‘First Report of the Advisory Group on Reform of WHO’s Work in Outbreaks and Emergencies with Health and Humanitarian Consequences’ (World Health Organization 2015).
- <sup>156</sup> Interviewee No. 3 used this concept of “*design and implementation flaws*” to reference shortcomings in the IHR.
- <sup>157</sup> Global Preparedness Monitoring Board, ‘A World at Risk: Annual Report on Global Preparedness for Health Emergencies’ (World Health Organization 2019).
- <sup>158</sup> Kevin Loria, ‘Bill Gates Thinks a Coming Disease Could Kill 30 Million People within 6 Months — and Says We Should Prepare for It as We Do for War’ (*Business Insider*) <<https://www.businessinsider.com/bill-gates-warns-the-next-pandemic-disease-is-coming-2018-4>> accessed 16 April 2021.
- <sup>159</sup> Pandemic Prediction and Forecasting Science and Technology Working Group, ‘Towards Epidemic Prediction: FEderal Efforts and Opportunities in Outbreak Modeling’ (Executive Office of the President of the United States 2016).
- <sup>160</sup> Jie Cui, Fang Li and Zheng-Li Shi, ‘Origin and Evolution of Pathogenic Coronaviruses’ (2019) 17 *Nature Reviews Microbiology* 181.
- <sup>161</sup> The Independent Panel For Pandemic Preparedness and Response, ‘COVID-19: Make It the Last Pandemic’ (2021) 23.
- <sup>162</sup> Such signs of outbreaks are not uncommon and interviewees report dozens per day. The challenge is to process them efficiently and to ensure an appropriate response to each sign.
- <sup>163</sup> For a detailed chronology of early events, see: The Independent Panel For Pandemic Preparedness and Response, ‘COVID-19: The Authoritative Chronology, December 2019–March 2020’ 48.
- <sup>164</sup> ‘Pneumonia of Unknown Cause – China’ (2020) <<https://www.who.int/emergencies/emergency-events/item/2020-DON229>> accessed 30 June 2021.
- <sup>165</sup> World Health Organization, ‘Press Briefing on WHO Mission to China and Novel Coronavirus Outbreak’ (29 January 2020) <<https://www.who.int/director-general/speeches/detail/press-briefing-on-who-mission-to-china-and-novel-coronavirus-outbreak>> accessed 8 April 2021.
- <sup>166</sup> ‘Chinese City Plans to Build Coronavirus Hospital in Days’ (*the Guardian*, 24 January 2020) <<http://www.theguardian.com/science/2020/jan/24/chinese-city-wuhan-plans-to-build-coronavirus-hospital-in-six-days>> accessed 30 June 2021.
- <sup>167</sup> Interview No. 6.
- <sup>168</sup> Interview No. 6.
- <sup>169</sup> World Health Organization, ‘Statement on the Meeting of the International Health Regulations (2005) Emergency Committee Regarding the Outbreak of Novel Coronavirus 2019 (n-CoV) on 23 January 2020’ (23 January 2020) <[https://www.who.int/news/item/23-01-2020-statement-on-the-meeting-of-the-international-health-regulations-\(2005\)-emergency-committee-regarding-the-outbreak-of-novel-coronavirus-\(2019-ncov\)](https://www.who.int/news/item/23-01-2020-statement-on-the-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-outbreak-of-novel-coronavirus-(2019-ncov))> accessed 8 April 2021.
- <sup>170</sup> ‘WHO Advice for International Travel and Trade in Relation to the Outbreak of Pneumonia Caused by a New Coronavirus in China’ (2020) <<https://www.who.int/news-room/articles-detail/who-advice-for-international-travel-and-trade-in-relation-to-the-outbreak-of-pneumonia-caused-by-a-new-coronavirus-in-china>> accessed 30 June 2021.
- <sup>171</sup> The Independent Panel For Pandemic Preparedness and Response, ‘COVID-19: Make It the Last Pandemic’ (n 160) 25.
- <sup>172</sup> ‘Statement on the Second Meeting of the International Health Regulations (2005) Emergency Committee Regarding the Outbreak of Novel Coronavirus (2019-NCov)’ (*World Health Organization*, 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-\(2019-ncov\)](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 14 April 2021.
- <sup>173</sup> The Independent Panel For Pandemic Preparedness and Response, ‘COVID-19: Make It the Last Pandemic’ (n 160) 28–30. Interview No. 1. Interview No. 9.
- <sup>174</sup> Clive Cookson, ‘WHO Declares International Emergency over Coronavirus’ *Financial Times* (31 January 2020) <<https://www.ft.com/content/b8d6f0a8-439d-11ea-abea-0c7a29cd66fe>> accessed 1 July 2021; Stephanie Nebehay and Emma Farge, ‘WHO Lauds Chinese Response to Virus, Says World “at Important Juncture”’ *Reuters* (29 January 2020) <<https://www.reuters.com/article/us-china-health-who-idUSKBN1ZS2EE>> accessed 28 July 2021.

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- <sup>176</sup> ‘WHO Director-General’s Opening Remarks at the Technical Briefing on 2019 Novel Coronavirus’ <<https://www.who.int/director-general/speeches/detail/who-director-general-s-opening-remarks-at-the-technical-briefing-on-2019-novel-coronavirus>> accessed 1 July 2021.
- <sup>177</sup> World Health Organization, ‘Coronavirus Disease 2019 (COVID-19) Situation Report - 44’ (2020) 44 <[https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200304-sitrep-44-covid-19.pdf?sfvrsn=783b4c9d\\_2](https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200304-sitrep-44-covid-19.pdf?sfvrsn=783b4c9d_2)>.
- <sup>178</sup> David Pilling, ‘The WHO Has Become a Scapegoat’ *Financial Times* (14 October 2020) <<https://www.ft.com/content/e7b89b60-4e9f-4c16-87f0-7995654cb90a>> accessed 28 July 2021; Michael Collins, ‘The WHO and China: Dereliction of Duty’ (*Council on Foreign Relations*, 27 February 2020) <<https://www.cfr.org/blog/who-and-china-dereliction-duty>> accessed 28 July 2021.
- <sup>179</sup> Interview No. 8.
- <sup>180</sup> Tom Hancock and Clive Cookson, ‘How Dangerous Is China’s Latest Viral Outbreak?’ *Financial Times* (15 January 2020) <<https://www.ft.com/content/7a80b8c6-362c-11ea-a6d3-9a26f8c3cba4>> accessed 1 July 2021.
- <sup>181</sup> The editorial board, ‘Coronavirus Is the Latest Round in an Age-Old Struggle’ *Financial Times* (24 January 2020) <<https://www.ft.com/content/bd6cad34-3eab-11ea-b232-000f4477fbca>> accessed 1 July 2021.
- <sup>182</sup> ‘International Health Regulations (2005). Third Edition’ (n 107) Foreword.
- <sup>183</sup> Sixty-Fourth World Health Assembly (n 106) 8.
- <sup>184</sup> Interview No. 1; Interview No. 3.
- <sup>185</sup> Article 2 ‘International Health Regulations (2005). Third Edition’ (n 107).
- <sup>186</sup> Interview No. 3; Gian Luca Burci, ‘The Legal Response to Pandemics: The Strengths and Weaknesses of the International Health Regulations’ (2020) 11 *Journal of International Humanitarian Legal Studies* 204, 206.
- <sup>187</sup> Interview No. 3.
- <sup>188</sup> Interview No. 3; Burci, ‘The Legal Response to Pandemics’ (n 186) 216.
- <sup>189</sup> Interview No. 1.
- <sup>190</sup> Burci, ‘The Legal Response to Pandemics’ (n 186) 216.
- <sup>191</sup> *ibid.*
- <sup>192</sup> *ibid* 207.
- <sup>193</sup> Interview No. 12. Note that the IHR do not aim to regulate the domestic response to outbreaks except for national core capacities that function as a tool to prevent international spread. See *ibid.*
- <sup>194</sup> Interview No. 12.
- <sup>195</sup> Interview No. 12.
- <sup>196</sup> Interview No. 3.
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