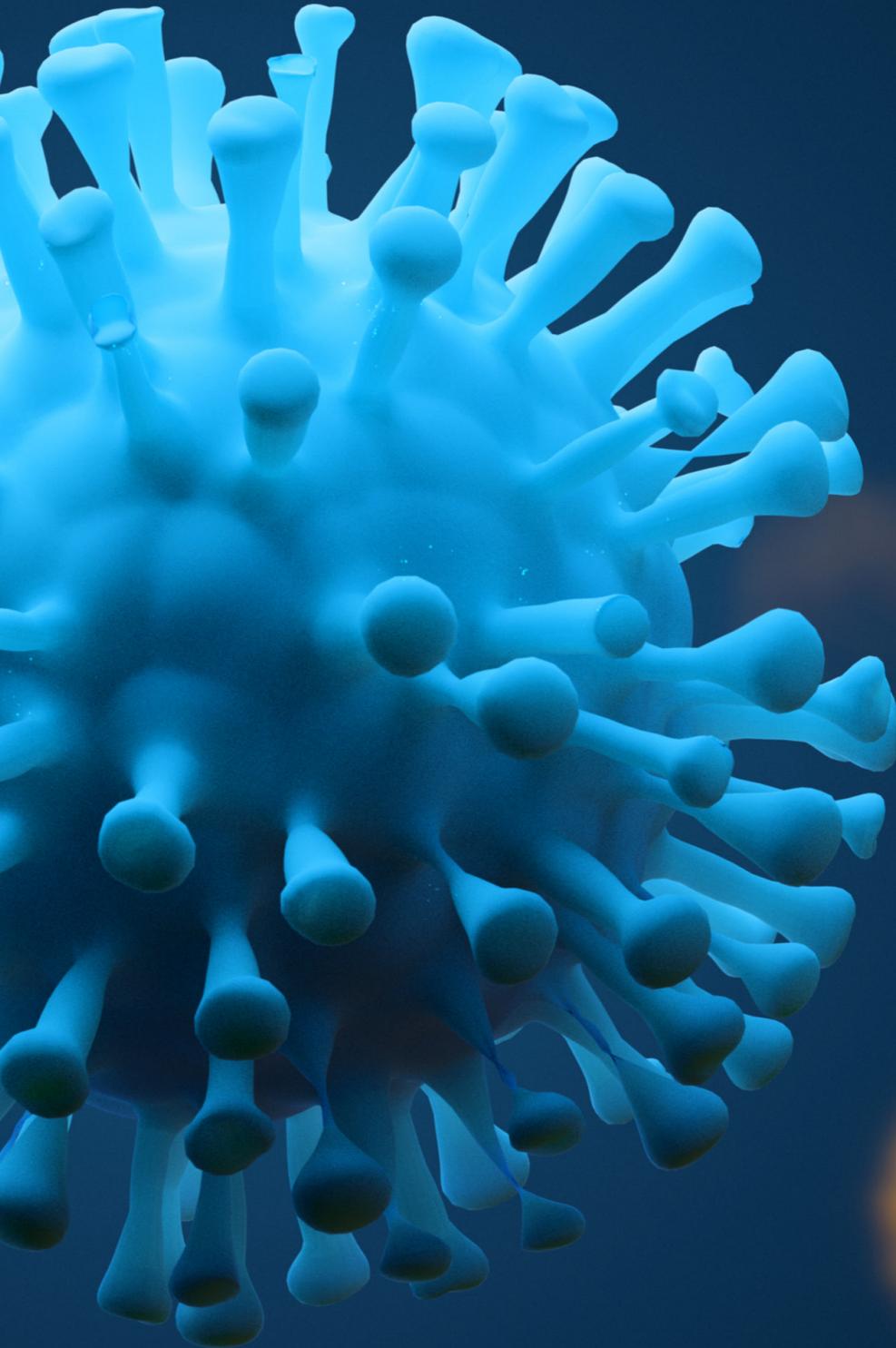


# Governance Preparedness: Initial Lessons from COVID-19

Background report commissioned by the Global Preparedness Monitoring Board

Center for Global Health Science & Security  
Georgetown University  
July 2020



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# CONTENTS

ABBREVIATIONS	4
EXECUTIVE SUMMARY	5
1. INTRODUCTION	6
2. DEFINING GOVERNANCE FOR PANDEMIC PREPAREDNESS	6
3. INITIAL GOVERNANCE ISSUES ARISING DURING COVID-19	9
3.1. DISCREPANCIES BETWEEN ASSESSED & ACTUAL PREPAREDNESS	9
3.2. FAILURES OF GOVERNANCE: CO-ORDINATION & COLLECTIVE ACTION THROUGH MULTILATERALISM	11
3.2.1 Global health governance: World Health Organization	12
3.2.2 Global governance for health: other international institutions	13
<i>The United Nations Security Council</i>	13
<i>World Trade Organization</i>	14
<i>Public Private Partnerships for Diagnostics, Treatments &amp; Vaccines</i>	16
3.2.3 Governance for global health: gaps in national decision-making	17
3.3. GOVERNANCE & FINANCING	19
3.3.1 Financing Global Health Governance Preparedness: World Health Organization	19
<i>Accountability for payment &amp; increases of Member State assessed contributions</i>	20
<i>Accountability for IHR International Collaboration &amp; Assistance Obligations</i>	20
3.3.2 Governance of Financing for Global Health Preparedness	21
4. REFORM FOR PANDEMIC PREPAREDNESS	23
4.1. AMENDMENTS TO THE IHR	23
4.1.1 Review Conferences	23
4.1.2 Sharing of Clinical, Epidemiological and Sequence Data and Pathogen Samples	25
4.1.3 Research & Development	27
4.1.4 Declaration processes	27
<i>PHEIC v "Pandemic" Declarations</i>	29
<i>Intermediate Level Declaration</i>	30

4.2.	REFORM TO OPERATIONALIZE THE IHR	31
4.2.1	Enforcement mechanisms	31
	<i>Suspending Membership</i>	31
	<i>Dispute resolution</i>	32
4.2.2	Investigations	33
	<i>Investigations of compliance with preparedness obligations</i>	33
	<i>Investigations of outbreaks</i>	33
4.2.3	Addressing measures exceeding WHO recommendations: travel and trade restrictions	34
4.2.4	Measuring Governance – Metrics & Simulations	36
4.3.	Improving global governance for health: other multilateral bodies	37
5.	Conclusions	38
	Appendix 1 – Existing Dispute Settlement Processes for IHR Obligations	39
	Appendix 2 – United Nations Secretary General’s Mechanism for Investigations	43

## ABBREVIATIONS

<b>ACT Accelerator</b>	Access to COVID-19 Tools Accelerator
<b>BWC</b>	Convention on the Prohibition of the Development, Production, and Stockpiling of Bacteriological (Biological) and Toxin Weapons (1975)
<b>CEPI</b>	Coalition for Epidemic Preparedness Innovations
<b>CFE</b>	Contingency Fund for Emergencies
<b>COVAX</b>	COVID-19 Vaccines pillar of the ACT Accelerator
<b>FIND</b>	Foundation for Innovative New Diagnostics
<b>GAVI</b>	Global Alliance for Vaccines and Immunizations
<b>GHS Index</b>	Global Health Security Index
<b>GPMB</b>	Global Preparedness Monitoring Board
<b>ICJ</b>	International Court of Justice
<b>ICJ Statute</b>	Statute of the International Court of Justice
<b>IHR</b>	International Health Regulations (2005)
<b>JEE</b>	Joint External Evaluation Tool
<b>MPIA</b>	Multi-Party Interim Appeal Arrangement
<b>Nagoya Protocol</b>	Nagoya Protocol on Access to Genetic Resources and the Fair and Equitable Sharing of Benefits Arising from their Use (2014)
<b>OIE</b>	World Organization for Animal Health
<b>PCA</b>	Permanent Court of Arbitration
<b>PHEIC</b>	Public Health Emergency of International Concern
<b>PIP Framework</b>	Pandemic Influenza Preparedness Framework
<b>PPE</b>	Personal Protective Equipment
<b>SPAR</b>	IHR State Parties Self-Assessment Annual Reporting Tool
<b>TRIPS Agreement</b>	Agreement on Trade-Related Aspects of Intellectual Property Rights
<b>UN</b>	United Nations
<b>UN Charter</b>	Charter of the United Nations
<b>UNGA</b>	United Nations General Assembly
<b>UNODA</b>	United Nations Office of Disarmament Affairs
<b>UNSC</b>	United Nations Security Council
<b>UNSGM</b>	United Nations Secretary-General's Mechanism for Investigation of Alleged Use of Chemical and Biological Weapons
<b>WHA</b>	World Health Assembly
<b>WHO</b>	World Health Organization
<b>WTO</b>	World Trade Organization

## EXECUTIVE SUMMARY

COVID-19 has demonstrated how failure to adequately consider the importance of governance globally and nationally has undermined pandemic preparedness. The success of any efforts to redress this failure, including reform of existing governance arrangements, will be contingent on an effective multilateral order that is committed to providing sufficient financial and political support to global institutions, laws, and norms.

To improve governance preparedness, states should rapidly:

1. Re-establish global norms of solidarity and multilateral cooperation, including through critical reforms of the International Health Regulations, implementation of regular review conferences and consideration of new international instruments or mechanisms to support data sharing, research and development, and equitable access to diagnostics, treatments, vaccines, and medical goods;
2. Immediately address funding constraints on the World Health Organization through increases in assessed contributions and multilateral prioritization of investment in strengthening available, accessible, acceptable and quality health systems;
3. Develop frameworks and processes for more cohesive and responsive coordination between international institutions and instilling pandemic preparedness in all policies at the international level; and
4. Actively incorporate principles of good governance into international and national decision-making bodies and processes, in particular processes to ensure accountability, transparency, equity, participation, and the rule of law.

## 1. INTRODUCTION

The 2019 novel coronavirus (COVID-19) pandemic has revealed that global and national governance is a neglected element of preparedness. Most pre-COVID-19 forms of assessing public health emergency preparedness failed to adequately capture the impact and dimensions of governance on outbreak response; focusing on crucial technical capacities but masking accurate representation of national and global capacities to respond to a pandemic like COVID-19. The COVID-19 pandemic has revealed a failure in preparedness arising from a failure of governance in global collective action, including coordination and engagement with multilateral systems, and financing, including chronic underinvestment in preparedness as well as states withdrawing financial support. This report examines pathways for strengthening governance in these two preparedness gaps by improving accountability, transparency, equity, participation, and the rule of law: elements of good governance and demonstrated challenges in COVID-19 preparedness. Using lessons from governance of other global challenges, this report proposes how accountability, transparency, equity, participation and the rule of law can be improved for ensuring better preparedness for collective action and financing in the medium- and long-term future.

## 2. DEFINING GOVERNANCE FOR PANDEMIC PREPAREDNESS

Governance is relevant to pandemic preparedness at both the process and substantive levels. Procedurally, good governance of the preparedness process itself is crucial for ensuring global and national systems are best equipped to respond to a pandemic. Substantively, entrenching elements of good governance within the different facets of pandemic preparedness may contribute to more rapid, effective, and resilient pandemic response systems.

There are a range of definitions and permutations for governance and global health, depending on the institutions involved and whether health is their primary mandate. Global health governance may be broadly defined as “the use of formal and informal institutions, rules and processes by states, inter-governmental organizations and nonstate actors to deal with challenges to health that require cross-border collective action to address effectively”,<sup>1</sup> or narrowly defined as the “institutions and processes of governance which are related to an explicit health mandate”.<sup>2</sup> For the purposes of this report, this primarily involves the World Health Organization (WHO) and how states and other actors engage

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<sup>1</sup> Fidler, David P. *The Challenges of Global Health Governance*. Council on Foreign Relations, Inc. 2010. [https://cdn.cfr.org/sites/default/files/pdf/2010/05/IIGG\\_WorkingPaper4\\_GlobalHealth.pdf](https://cdn.cfr.org/sites/default/files/pdf/2010/05/IIGG_WorkingPaper4_GlobalHealth.pdf), 3.

<sup>2</sup> Kickbusch, Ilona, and Martina Marianna Cassar Szabo. “A New Governance Space for Health.” *Glob Health Action* 7 (April 13, 2014). <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3925805/>, 2.

with preparedness in forums like the World Health Assembly (**WHA**) and with international agreements including the International Health Regulations (2005) (**IHR**). In addition to global health governance, the all-encompassing nature of pandemics engages institutions and actors at the global level that do not have express health mandates, including broader matters of global governance affecting health through institutions such as the United Nations Security Council (**UNSC**) and the World Trade Organization (**WTO**), as well as at the national level, engaging questions governance for global health.<sup>3</sup>

For pandemic preparedness, global health governance and institutions with express health mandates like the WHO are likely to be subject to the most scrutiny. However, other global institutions and actors, as well as at the national level, play a role in the governance of preparedness. This is particularly relevant given the risk of politicization of investigations and reviews into governance preparedness. Such assessments should be also carried out in a manner consistent with principles of good governance to ensure confidence in and motivation to implement any findings that would ensure a more prepared world. Furthermore, assessing and improving how these organizations work together, and the governance arrangements for their engagement and the distribution of financing, are crucial parts of preparedness. This also needs to include non-governmental organizations, particularly those disproportionately building local capacities and providing rapid outbreak response.

Similar to definitions, there are a range of frameworks that propose elements for implementing and assessing governance.<sup>4</sup> Based on these frameworks and the preparedness challenges that have arisen with COVID-19, there are five common elements of good governance of particular consideration: accountability, transparency, equity, participation, and rule of law (Figure 1).

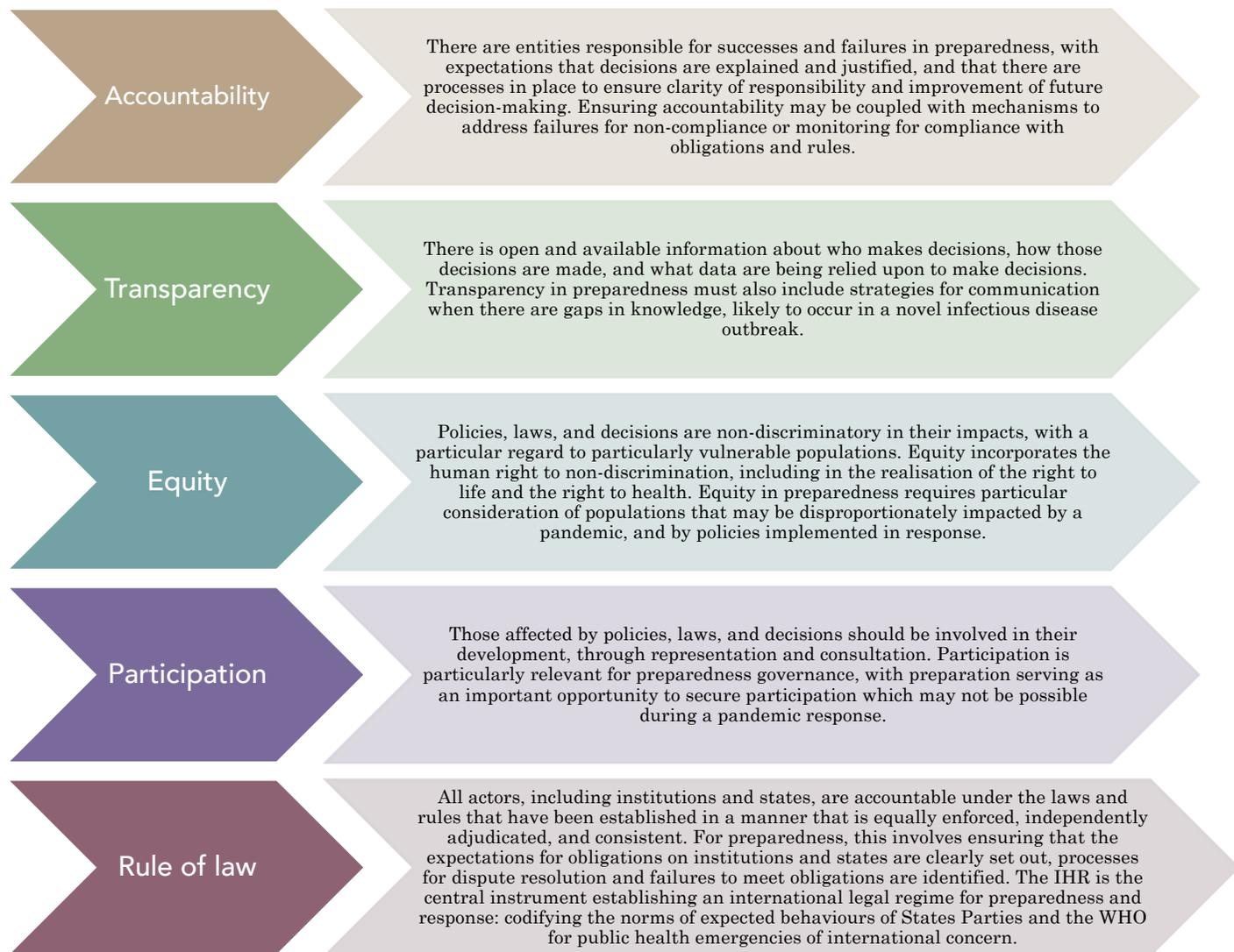
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<sup>3</sup> Kickbusch, Ilona, and Martina Marianna Cassar Szabo. "A New Governance Space for Health." *Glob Health Action* 7 (April 13, 2014). <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3925805/>, 2–3.

<sup>4</sup> See for example, United Nations Development Program, *Governance for sustainable human development: a UNDP policy document*. New York. (1997).

<https://www.undp.org/content/dam/undp/library/Democratic%20Governance/Discussion-Paper--Governance-for-Sustainable-Development.pdf>; World Health Organization. *Advancing the right to health: the vital role of law* (2016). <https://apps.who.int/iris/handle/10665/252815>, 75–77; Lee, Kelley, and Adam Kamradt-Scott. "The Multiple Meanings of Global Health Governance: A Call for Conceptual Clarity." *Globalization and Health* 10, no. 1 (April 28, 2014): 28.

FIGURE 1 – ELEMENTS OF GOVERNANCE FOR ANALYZING PREPAREDNESS



These common elements also engender trust in decision-makers, contributing to necessary compliance with and engagement in public health measures. At the international level, the relevant actors in this framework are states, international institutions, as well as civil society and, where appropriate, industry. At the national level, these principles apply to the relationship between governments at all levels, and the individuals and groups of individuals policies, laws, and decisions affect.

### 3. INITIAL GOVERNANCE ISSUES ARISING DURING COVID-19

The first six months of the COVID-19 pandemic have demonstrated how failures to consider governance in preparedness have been some of the most significant barriers to effective pandemic response, protecting human health, and saving lives. In particular, this is demonstrated across three main areas of governance. Firstly, disconnection between the most devastating COVID-19 case and death rates in the pandemic to date, and states that were assessed as being the most prepared in leading metrics for assessing pandemic preparedness demonstrates an underestimation or devaluing of governance in the pandemic preparedness process; secondly, weakened multilateral governance resulting in significant failures of global co-ordination and collective action; and thirdly, failures in the governance of preparedness financing.

#### 3.1. DISCREPANCIES BETWEEN ASSESSED & ACTUAL PREPAREDNESS

The failure to consider governance sufficiently in preparedness has left the world underprepared for COVID-19. This has been highlighted in states with the most devastating COVID-19 case and death rates in the pandemic to date, and their assessments as being the most prepared states in leading metrics for assessing pandemic preparedness. The reason for this is two-fold. Firstly, the IHR, the primary international governance instrument for health emergencies, do not fully capture the range of national capacities necessary to assess preparedness, including research and development, and the multisectoral impacts of outbreaks that become pandemics. The IHR also do not sufficiently address international cooperation, collaboration, or the preparedness of multilateral organizations. Secondly, our existing assessment metrics measure preparedness narrowly, and are largely static.

Under the IHR, States Parties have obligations to meet core capacity requirements to prevent, detect, and respond to potential public health emergencies of international concern. Historically, States Parties have self-reported compliance with these obligations, most recently using the State Parties Self-Assessment Annual Reporting Tool (**SPAR**), while many have participated in the independent external monitoring process, using the Joint External Evaluation Tool (**JEE**). Governance is not an express indicator in either the SPAR or JEE, while the SPAR's legislation and financing core capacity, and the JEE's national legislation indicators do not assess whether or how governance principles are incorporated into other preparedness capabilities. However, self-assessment under the SPAR and participation in the JEE process contributes to preparedness governance: providing transparency and facilitating accountability. This was recognized in the 2019 Global Health Security (**GHS**) Index, which assessed metrics relevant to aspects of governance preparedness. The GHS Index incorporates assessment of political and security risks to assess the effectiveness of governance, political systems, and public trust of countries. Only 15% of countries scored in the highest tier of confidence in

government, and while countries with effective governance and political systems also had higher overall scores, only 23% of countries scored in the top tier for political system and government effectiveness.<sup>5</sup> Similarly, the GHS Index examined compliance with international norms. These measures focused largely on compliance with reporting under the IHR and a number of metrics related to normative obligations of the Convention on the Prohibition of the Development, Production, and Stockpiling of Bacteriological (Biological) and Toxin Weapons (1975). However, COVID-19 has revealed potential under-weighting of the importance of governance in assessing overall pandemic preparedness. In the GHS Index, the United States was ranked as the most prepared country at 83.5 out of 100, however it was ranked poorly in governance metrics, including 59<sup>th</sup> in political and security risks, and a score of zero for public confidence.<sup>6</sup> Given the centrality of public confidence and trust in the effectiveness of public health measures,<sup>7</sup> assessments should consider how to give greater weight to the role of governance in preparedness. In addition, there is an opportunity for any governance metrics to be revised to include further normative considerations, such as participation in non-security multilateral institutions, such as human rights and global trade, contributions to international collaboration and assistance for health, and independence and authority of scientific and public health advisors.

In essence, measures of preparedness governance at the national levels underestimated the impact of delayed decision-making (substantively and on public trust) and on population adherence to government decrees. At the international level, measures underestimated the weakening of global health norms. This in turn resulted in failures of governance in coordination and collective action through multilateral institutions and in financing. Redressing governance gaps – by improving accountability, transparency, participation, equity, and the rule of law – is therefore a critical pathway for pandemic preparedness.

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<sup>5</sup> Nuclear Threat Initiative & Johns Hopkins Center for Health Security. Global Health Security Index: Building Collective Action and Accountability (2019). [https://www.nti.byfi.io/wp-content/uploads/2019/10/GHS-Index-Report\\_FINAL\\_Oct2019.pdf](https://www.nti.byfi.io/wp-content/uploads/2019/10/GHS-Index-Report_FINAL_Oct2019.pdf)

<sup>6</sup> GHS Index. “United States.” *GHS Index*. accessed May 30, 2020 <https://www.ghsindex.org/country/united-states/>.

<sup>7</sup> See, for example: Larson, Heidi J., and David L. Heymann. “Public Health Response to Influenza A(H1N1) as an Opportunity to Build Public Trust.” *JAMA* 303, no. 3 (January 20, 2010): 271–72; Blair, Robert A., Benjamin S. Morse, and Lily L. Tsai. “Public Health and Public Trust: Survey Evidence from the Ebola Virus Disease Epidemic in Liberia.” *Social Science & Medicine* 172 (January 1, 2017): 89–97.

### 3.2. FAILURES OF GOVERNANCE: CO-ORDINATION & COLLECTIVE ACTION THROUGH MULTILATERALISM

The COVID-19 pandemic has placed pressure on global health norms and institutions, weakened by inadequate international responses to past pandemics, and failure to commit to preparedness outside of a cycle of panic and neglect. One of the more insidious, but unexamined aspects, of this cycle is not simply the consequences of neglect, but the damage done to norms and institutions during the panic stage. Recommendations from independent expert and Member State critiques of the WHO and the IHR during crises are not only not implemented or addressed during periods of neglect, but serve as rationales for not following temporary recommendations, technical advice, or legal obligations during the next crisis.

This has been accelerated by the global re-emergence of nationalism, with some countries expressly rejecting commitments to the multilateral system, scientific expertise, and undermining international institutions, even when collaboration is in national best interests. The rapid pace of these geopolitical shifts has meant that many approaches to preparedness have failed to factor in or address the significant consequences of these changes to pandemic preparedness: for the WHO, for the broader international community, and for national readiness.

In addition to these challenges, COVID-19 demonstrated a general lack of preparedness in the multilateral system to function cooperatively and cohesively. Upon the declaration of a public health emergency of international concern (**PHEIC**), and even as COVID-19 became a pandemic, international institutions did not move fully into a response mode sufficient to provide support to WHO and national governments and facilitate cross-organizational cooperation. As a matter of preparedness, procedures and mechanisms for rapid and comprehensive global cooperation and collective action were absent, inadequate or unused, including protecting and ensuring global supply chains for personal protective equipment (**PPE**) and other essential items including food, and the governance of research and development for – and equitable distribution of – diagnostics, treatments, and vaccines. The potential strengths of multilateral institutions – their subject matter expertise, legal obligations on states, and norms – were not rapidly mobilized or engaged in the coordinated or collective manner. In addition, while existing cluster-based coordination exists within the United Nations (**UN**) system, the pandemic has demonstrated how pandemic preparedness requires collective action mechanisms cognizant of the critical role non-UN international institutions, such as the WTO, and public-private partnerships play. Addressing this fragmentation as a matter of preparedness through governance may be necessary to facilitate and ensure greater coordination for collective action.

### 3.2.1 Global health governance: World Health Organization

The role of the WHO in global health governance has become a flashpoint in the COVID-19 pandemic for tensions between expectations of WHO and the limits of powers Member States have granted it. This has been exacerbated by existing geopolitical tensions and Member States' willingness to engage in multilateralism. This has highlighted preparedness gaps in governance expectations, inherent limits on the WHO as an international organization, and legal limits imposed by international instruments drafted by States Parties. For preparedness, WHO plays a critical role in establishing technical guidance and shaping norms, such as those contained in the IHR. The WHO also plays a critical leadership role in pandemic preparedness and response, with its capacity to convene member states, other international organizations, non-governmental organizations, civil society, and industry.<sup>8</sup>

Despite this, WHO has come under intense scrutiny in its handling of the response, particularly in relation to the first two months of the epidemic while the epidemic was believed to be still predominantly limited to China. Limited by the powers granted to it under the IHR by States Parties, the WHO was constrained in its practical and legal ability to seek full epidemiological and genetic sequence data, necessary for understanding the novel pathogen, conducting risk assessments, and developing countermeasures, such as vaccines. The timing and process for declaring a public health emergency of international concern, and subsequently the use of the term pandemic, has been criticized, echoing existing critiques that were foreseeable. However, the rapid break down of established norms for control measures, such as non-pharmaceutical interventions of various restrictiveness and international travel bans, revealed gaps in governance preparedness in relation to international obligations and reliance on WHO expertise and technical guidance.

Future global health governance preparedness gaps persist for COVID-19. In particular, the role of the WHO in facilitating the global equitable distribution of personal protective equipment, diagnostics, treatments, and vaccines. Given the significant accountability, transparency, and equity issues this is likely to raise, establishing governance of this process, such as through an international instrument or framework, should be a priority.

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<sup>8</sup> Held, David, Ilona Kickbusch, Kyle McNally, Dario Piselli, and Michaela Told. "Gridlock, Innovation and Resilience in Global Health Governance." *Global Policy* 10 (February 14, 2019): 161–77.

### 3.2.2 Global governance for health: other international institutions

The broader global governance for health involves a range of international institutions that have an impact on collaboration, cooperation and international engagement in multilateral systems. COVID-19 has highlighted preparedness governance challenges for two bodies in particular: the United Nations Security Council and the World Trade Organization.

#### *The United Nations Security Council*

In April, the United Nations General Assembly (UNGA) adopted Resolution 74/270 “Global solidarity to fight the coronavirus disease 2019 (COVID-19)”, calling for intensified international cooperation, applying recommendations from the WHO, and calling upon the UN system to mobilize a coordinated global response to the pandemic and its adverse impacts.<sup>9</sup> The scale of the pandemic, the compounding risk of transmission and vulnerability of displaced or conflict-affected populations, and the threat COVID-19 poses to international peace and security led UN Secretary-General António Guterres to appeal for a UNSC resolution calling for a global ceasefire.<sup>10</sup> While an unprecedented moment for global peace and security, escalating tensions between two UNSC permanent members, the United States and China, purportedly over the origins of COVID-19, compliance with IHR obligations, and the role of the WHO delayed adoption of the resolution.<sup>11</sup> On July 1, 2020, the UNSC unanimously adopted Resolution 2532 (2020), expressing grave concern about the devastating impact of COVID-19 globally, particularly in states affected by armed conflicts, post-conflict states, and humanitarian crises, demanding a general and immediate cessation of all hostilities, and acknowledging the disproportionate socio-economic impact of COVID-19 on women and girls, children, refugees, internally displaced persons, older persons, and persons with disabilities.<sup>12</sup>

While the role of the UNSC in public health emergencies has been limited, precedent from the Ebola outbreak in West Africa, demonstrated the UNSC’s recognition of the risk outbreaks pose to global

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<sup>9</sup> United Nations General Assembly, Resolution 74/270 Global solidarity to fight the coronavirus disease 2019 (COVID-19). UN Doc A/RES/74/270 (April 3, 2020).

<sup>10</sup> “Secretary-General Reiterates Appeal for Global Ceasefire, Warns ‘Worst Is Yet to Come’ as COVID-19 Threatens Conflict Zones | Meetings Coverage and Press Releases.” *United Nations*, April 3, 2020. <https://www.un.org/press/en/2020/sgsm20032.doc.htm>.

<sup>11</sup> “How COVID-19 Gave Peace a Chance, and Nobody Took It.” *The Economist*. accessed May 22, 2020 <https://www.economist.com/international/2020/05/05/how-covid-19-gave-peace-a-chance-and-nobody-took-it>

<sup>12</sup> United Nations Security Council, Resolution 2532 (2020). UN Doc S/RES/2532(2020) (July 1, 2020).

peace and security and the founding objectives of the United Nations.<sup>13</sup> This demonstrates the UNSC's inability to act as a result of the permanent member veto powers, despite the significant threat the COVID-19 pandemic poses to stability and security. This removes one of the most powerful multilateral forums under international law from global pandemic preparedness governance.

### *World Trade Organization*

COVID-19 has resulted in unprecedented disruption of global trade and economies, with international travel bans limiting movement of people and goods, and reduced consumption and shifting production needs. Countries have introduced a suite of international trade and trade-related measures in response to COVID-19. Approximately 57% of measures have sought to eliminate tariffs and expedite customs procedures, however governments have also moved to restrict exports, disrupting critical access to food and medical goods through the implementation of 109 trade restrictive measures.<sup>14</sup> For the global trade system, lack of clarity over export restrictions, tariffs and new customs regulations implemented in response to COVID-19 can cause unnecessary disruptions through uncertainty and error, including blocking medical goods at borders or interrupted during transit.

The WTO has been criticized for not reacting sufficiently quickly or vocally to respond to measures imposed by Members to guarantee the global movement of essential goods during the early months of the pandemic. In response to measures, the WTO has called for increased transparency and information sharing, with transparency mechanisms incorporated into a number of agreements and processes within the WTO system. Under these agreements, Members have notification obligations, with the WTO receiving 219 notifications as of August 4, 2020.<sup>15</sup> However, the WTO has also established a non-exhaustive repositories to track trade and trade-related measures for goods,<sup>16</sup>

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<sup>13</sup> Burci, Gian Luca. "Ebola, the Security Council and the Securitization of Public Health." *QIL QDI*, December 23, 2014. <http://www.qil-qdi.org/ebola-security-council-securitization-public-health/>.

<sup>14</sup> Director General Remarks, Informal Trade Policy Review Board meeting – trade monitoring reports. (July 24, 2020). Available at: [https://www.wto.org/english/news\\_e/spra\\_e/spra305\\_e.htm](https://www.wto.org/english/news_e/spra_e/spra305_e.htm).

<sup>15</sup> WTO, WTO Members' notifications on COVID-19. Available at: [https://www.wto.org/english/tratop\\_e/covid19\\_e/notifications\\_e.htm](https://www.wto.org/english/tratop_e/covid19_e/notifications_e.htm)

<sup>16</sup>WTO, COVID-19: Trade and trade-related measures (goods). Available at: [https://www.wto.org/english/tratop\\_e/covid19\\_e/trade\\_related\\_goods\\_measure\\_e.htm](https://www.wto.org/english/tratop_e/covid19_e/trade_related_goods_measure_e.htm)

services,<sup>17</sup> and intellectual property,<sup>18</sup> collected from official sources and verified by the WTO Secretariat on an ad hoc basis.

The WTO is a Member-driven organization. As a result, a number of COVID-19 responses have been driven by WTO Members, including a joint ministerial statement calling for “intensified cooperation between the WTO and other international organizations in support of a coherent response to this and future health crises”, the role of WTO in monitoring trade-related measures implemented, and further concrete actions by the WTO “aimed at facilitating cross-border flows of vital medical supplies and other essential goods and services”.<sup>19</sup> In addition, the WTO dispute resolution system is dependent on Members bringing disputes against other Members alleged to have for trade barriers for settlement through the dispute settlement process. However, the operation of this process has been stymied by the United States’ refusal to approve new members for to the system’s Appellate Body necessary for it to operate, while indicating an intention to withdraw from the WTO dispute resolution system.<sup>20</sup> In the interim, a 16 Members have established a new dispute settlement regime consistent with existing international laws, known as the Multi-party Interim Appeal (**MPIA**) Arrangement. As the European Union noted in its announcement of the initiation of the MPIA, wider reform of trade, including dispute resolution processes, “is even more important now that the public health situation has re-emphasised the need for a functioning, multilateral, rules-based global trading system”.<sup>21</sup>

The WTO also conducts periodic reviews of Members through its Trade Policy Review Mechanism, as well as the biannual production is of a trade policy review. These processes serve to not only improve transparency but also accountability and the rule of law within the WTO system.

Pandemic preparedness relies upon commitment and support of multilateral and global institutions beyond those with a health mandate. However, the fragmentation of global institutions across fields of international law highlights potential preparedness gaps. At the World Health Assembly, Member States adopted Resolution WHA73.1 on COVID-19 response, which included a call on international

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<sup>17</sup> WTO, COVID-19: Measures affecting trade in services. Available at: [https://www.wto.org/english/tratop\\_e/covid19\\_e/trade\\_related\\_services\\_measure\\_e.htm](https://www.wto.org/english/tratop_e/covid19_e/trade_related_services_measure_e.htm)

<sup>18</sup> WTO, COVID-19: Measures regarding trade-related intellectual property rights. Available at: [https://www.wto.org/english/tratop\\_e/covid19\\_e/trade\\_related\\_ip\\_measure\\_e.htm](https://www.wto.org/english/tratop_e/covid19_e/trade_related_ip_measure_e.htm)

<sup>19</sup> Joint Ministerial Statement on COVID-19 and the Multilateral Trading System by Ministers Responsible for the WTO. (May 5, 2020. Revised 30 July 2020). WT/GC/212/Rev.2.

<sup>20</sup> Johnson, Keith. “U.S. Effort to Depart WTO Gathers Momentum.” *Foreign Policy*. accessed June 3, 2020 <https://foreignpolicy.com/2020/05/27/world-trade-organization-united-states-departure-china/>.

<sup>21</sup> European Commission. The WTO multi-party interim appeal arrangement gets operational (August 3, 2020). Available at: <https://trade.ec.europa.eu/doclib/press/index.cfm?id=2176>

organizations to facilitate timely, equitable and affordable access to diagnostics, therapeutics and vaccines, consistent with the Agreement on Trade-Related Aspects of Intellectual Property Rights (**TRIPS Agreement**) and the flexibilities within the Doha Declaration on the TRIPS Agreement and Public Health. However, from a preparedness perspective, the inclusion of this consideration in the WHA resolution is unlikely to preempt potential disputes that arise under the TRIPS Agreement. Despite seeking to withdraw membership from both the WHO and WTO systems, the United States has lodged its objection to this provision.<sup>22</sup> This reflects ongoing and future challenges with global trade, its impacts on health, and the role of the WTO in supporting WHO and global health governance. However, while the transferability may be limited given the incentives for participation and underpinning philosophies, there may be lessons in the normative and legal context of the WTO given Members' commitments to transparency, accountability, and the rule of law for global governance for health.

#### *Public Private Partnerships for Diagnostics, Treatments & Vaccines*

The COVID-19 pandemic has demonstrated significant gaps in existing global governance for research, development, and equitable distribution of diagnostics, treatments, and vaccines for a range of diseases, including COVID-19. In April 2020, a number of States and a suite of global health organizations – WHO, the Bill and Melinda Gates Foundation, the Coalition for Epidemic Preparedness Innovations (**CEPI**), the Global Alliance for Vaccines and Immunizations (**GAVI**), the Global Fund to Fight AIDS, Tuberculosis, and Malaria, UNITAID, The Foundation for Innovative New Diagnostics (**FIND**), The Wellcome Trust, the World Bank Group, and WHO – launched the Access to COVID-19 Tools (**ACT**) Accelerator. The ACT Accelerator is a governance framework for collaboration for the development and equitable distribution of COVID-19 diagnostics, treatments and vaccines (**COVAX**) and strengthening of health systems.

While not a formalized decision-making body, the need for the ACT Accelerator demonstrates States' failures in ensuring adequate governance frameworks for the rapid cooperation and facilitation of research and development into pandemic preparedness and response. While individual international institutions responded sooner, the collaboration took a number of months before publicly announced which may have been reduced if States developed governance frameworks for pandemic collaboration prior to COVID-19. For example, the threat of pandemic influenza, and concerns regarding equitable

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<sup>22</sup> “U.S. Explanation of Position ‘COVID-19 Response’ Resolution.” *U.S. Mission to International Organizations in Geneva*, May 19, 2020. <https://geneva.usmission.gov/2020/05/19/explanation-of-position-covid-19-response-resolution/>.

access to diagnostics, therapeutics, and vaccines previously led to the WHA's negotiation and adoption of the Pandemic Influenza Preparedness (PIP) Framework in 2011. The absence of a similar governance framework for non-pandemic influenza has been noted in reviews of the PIP Framework,<sup>23</sup> as well as in regard to other international law developments such as the impact of access and benefit sharing regimes.<sup>24</sup>

Cooperation across public and private sectors is critical in the research and development of diagnostics, therapeutics, and vaccines, and requires careful consideration of good governance, including clear rules for transparency, accountability, participation, and equity, particularly given decisions around the distribution of diagnostics, treatments, and vaccines which rely heavily on trust for effective pandemic response.

### 3.2.3 Governance for global health: gaps in national decision-making

In the absence of approved treatments or vaccines, national government efforts to limit transmission of COVID-19 have relied upon the use of non-pharmaceutical interventions, such as physical distancing requirements, mass gathering bans, and closures of non-essential businesses. These measures have been vital to interrupting transmission and ensuring health care systems are not overwhelmed, while implementing established public health measures of testing, contact tracing, quarantining contacts, and isolating and supporting the ill. However, many countries failed to act rapidly despite the WHO Director-General's declaration of a PHEIC or conduct appropriate national risk assessments. As a result, national decision-making regarding the timing, scope, and purpose of non-pharmaceutical interventions in many instances has been contrary to public health or WHO recommendations. This has included tensions arising due to the scientific uncertainty inherent to a novel pathogen (e.g. mask requirements), false perceptions of a public health versus economy dichotomy (e.g. delaying imposing of physical distancing restrictions) and the scale of the pandemic challenging previously accepted norms (e.g. international travel bans, used generally or country-specific). In addition, government responses, particularly early in the pandemic, failed to take into

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<sup>23</sup> World Health Assembly. Review of the Pandemic Influenza Preparedness Framework. WHA70(10). (May 29, 2017). Annex A70/17. Report of the 2016 PIP Framework Review Group.

<sup>24</sup> World Health Organization. *Implementation of the Nagoya Protocol and Pathogen Sharing: Public Health Implications. Study by the Secretariat.* (2016). Available at: [https://www.who.int/docs/default-source/documents/nagoya-protocol/nagoya-full-study-english.pdf?sfvrsn=ec2ab49d\\_12](https://www.who.int/docs/default-source/documents/nagoya-protocol/nagoya-full-study-english.pdf?sfvrsn=ec2ab49d_12)

consideration the unique vulnerabilities and needs of certain population groups, and the disproportionate impact of COVID-19 and measures on different population groups.

Ensuring accountability is dependent upon transparency in decision-making, while good governance requires appropriate inclusivity in participation in advisory bodies. In Australia and the United Kingdom, national scientific advisory bodies have been criticized for a lack of transparency about membership or the specific nature of advice given to government.<sup>25</sup> Preparedness involves pre-determining the composition (including representation requirements), scope of issues and limitations of power of advisory bodies. Analysis of governance bodies expressly activated to give scientific advice on COVID-19 to 24 nations' decision-makers found a lack of transparency on who is responsible for making decisions, how they are selected, how decisions are made (procedurally and in the substance considered), the exact positions of advisors, and the breadth and nature of expertise consulted.<sup>26</sup> This further raises questions about the level of participation in national advisory bodies. For preparedness, appropriately representative participation may be established prior to an outbreak in the terms of reference for decision-making bodies, including multi-disciplinary expertise for a whole-of-society consideration of response measures and their impacts.

Analysis of national advisory bodies also demonstrated stark gender disparity in representation, where that information was available, with women a minority in advisory bodies, or not represented at all.<sup>27</sup> Further study into the participation of individuals across race, ethnicity, disability, and religion in advisory bodies will also be relevant to determine participation in decision-making relating to the disproportionate and differing impacts of measures and associated policy-responses on vulnerable populations.

For democratic countries, accountability is also achieved through the election process. However, there is a risk that governments will use the pandemic to legitimately or illegitimately justify election delays or failure to provide safe alternatives (such as postal voting). In the first four months of the pandemic, at least 62 countries and territories globally have postponed national and subnational elections due to

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<sup>25</sup> See for example, the United Kingdom: Landler, Mark, and Stephen Castle. "The Secretive Group Guiding the U.K. on Coronavirus." *The New York Times*, April 23, 2020, sec. World. <https://www.nytimes.com/2020/04/23/world/europe/uk-coronavirus-sage-secret.html>; Australia: "Who Advises the Man Who Advises the Nation on COVID-19?" *Crikey*, April 17, 2020. <https://www.crikey.com.au/2020/04/17/health-protection-committee-coronavirus-murphy/>.

<sup>26</sup> Rajan, Dheepa, Kira Koch, Katja Rohrer, Csongor Bajnoczki, Anna Socha, Maike Voss, Marjolaine Nicod, Valery Ridde, and Justin Koonin. "Governance of the COVID-19 Response: A Call for More Inclusive and Transparent Decision-Making." *BMJ Global Health* 5, no. 5 (May 1, 2020): e002655, 5.

<sup>27</sup> *Ibid*, 2-4.

COVID-19, including 18 countries postponing national elections and referenda.<sup>28</sup> There is a significant risk that opportunities for accountability for national decision-making during COVID-19 will be undermined or lost with governments unable or unwilling to impose the least restrictive measures necessary to protect health, such as providing safe alternative voting methods that fulfill international obligations under international human rights law to protect civil and political rights, as well as the right to health.

### 3.3. GOVERNANCE & FINANCING

The effectiveness of governance for pandemic preparedness has been stymied by long-term underfunding of global health governance, donor-directed prioritization, and inappropriate funding mechanisms for global governance for health.

#### 3.3.1 Financing Global Health Governance Preparedness: World Health Organization

The COVID-19 pandemic has highlighted the chronic underfunding of the WHO. Member States continue to fail to meet assessed contributions in a timely manner, while ear-marked voluntary contributions skew the prioritization of global health and preparedness activities. In some cases, the fragmentation of funding into vertical programs for preparedness activities has potential broader global health preparedness benefits.<sup>29</sup> For decades though, failure to not only meet but increase assessed contributions has put significant financial stress on the organization, limiting the WHO's capacity to prioritize activities on a public health needs basis, undermining autonomy in directing global public health resources, while also resulting in mismatched expectations about the organization's capacity and role, particular in responding to infectious disease emergencies.<sup>30</sup> This in turn poses governance risks two-fold: firstly, undermining equity and participation in directing WHO

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<sup>28</sup> International Institute for Democracy and Electoral Assistance. Global overview of COVID-19: Impact on elections. Available at: <https://www.idea.int/news-media/multimedia-reports/global-overview-covid-19-impact-elections> (accessed May 28, 2020)

<sup>29</sup> See, for example: The Lancet Infectious Diseases. "Lessons from Polio to Ebola." *The Lancet Infectious Diseases* 15, no. 8 (August 1, 2015): 863; Boyce, Matt R., Attal-Juncqua, Aurelia, Lin, Jessica, McKay, Stephanie and Katz, Rebecca, Global Fund Contributions to Health Security: Mapping Synergies between Vertical Disease Programs and Capacities for Preventing, Detecting, and Responding to Public Health Emergencies (February 28, 2020) (preprint): <http://dx.doi.org/10.2139/ssrn.3546037>.

<sup>30</sup> Reddy, Srikanth K., Sumaira Mazhar, and Raphael Lencucha. 2018. "The Financial Sustainability of the World Health Organization and the Political Economy of Global Health Governance: A Review of Funding Proposals." *Globalization and Health* 14(1): 119; Gostin, Lawrence O. 2015. "The Future of the World Health Organization: Lessons Learned From Ebola." *The Milbank Quarterly* 93(3): 475–79.

priorities, particularly from the needs of the Global South which must be addressed; and, secondly feeding into a cycle of critique against the organization for failing to function as a global health leader while financially, politically, (and in some cases, legally) constrained. As COVID-19 has demonstrated, this in turn undermines preparedness and response during a pandemic.

#### *Accountability for payment & increases of Member State assessed contributions*

Under article 7 of the WHO Constitution, the WHA may suspend the voting privileges and services of WHO Member States who fail to meet their financial obligations. Suspension of voting rights is one of the few punitive powers the WHA possesses and has regularly been used to suspend voting rights for Member States that have remained in arrears for assessed contributions. However this power could be used to exclude resource constrained Member States, rather than as an accountability mechanism for unjustifiable withholding of dues.

Failures to pay assessed contributions detract from more significant discussions about increasing Member States' assessed contributions. Despite the increasing number of mandates and functions of the WHO, and independent recommendations,<sup>31</sup> many Member States have been generally unwilling to significantly increase assessed contributions.

In May 2020, the WHO Foundation was established, seeking to broaden the WHO's funding sources to include the general public, individual donors and corporate partners.<sup>32</sup> The diversification of WHO funding sources may address the constraints on WHO. Ultimately, however, increasing Member States' assessed contributions, untied to donor-specific demands, while strengthening transparency and accountability, will be a critical facet of preparedness for the next pandemic.

#### *Accountability for IHR International Collaboration & Assistance Obligations*

Under article 44 of the IHR, States have obligations to provide international collaboration and assistance to each other for pandemic preparedness. However, international provision of funds has been largely in response to crises and separate from IHR international collaboration and assistance obligations. For example, the WHO's Contingency Fund for Emergencies (CFE) activates response

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<sup>31</sup> See, e.g. United Nations High Level Panel on the Global Response to Health Crises (2016) UNGA Doc A/70/723. Available at: <https://digitallibrary.un.org/record/822489>, recommendation 18, which recommended that Member States "increase their assessed contributions to the WHO budget by at least 10 per cent".

<sup>32</sup> World Health Organization. "WHO Foundation Established to Support Critical Global Health Needs." accessed May 29, 2020 <https://www.who.int/news-room/detail/27-05-2020-who-foundation-established-to-support-critical-global-health-needs>.

when a disease outbreak or humanitarian crisis with health consequences occurs. During COVID-19, the WHO has released funds from the CFE to support preparedness in countries with weak health systems, however this is coupled with the imminence of response in the pandemic.

There is significant scope for clarity of the content, and advocacy for commitment to, State obligations under article 44. This provides an opportunity for States to develop clear processes for how States may provide and obtain international assistance to meet IHR core capacities, and equitably distribute the costs of capacity-building activities that benefit all States.<sup>33</sup>

### 3.3.2 Governance of Financing for Global Health Preparedness

Despite significant warnings from experts and advocates of the impacts of a pandemic, the dearth of global financing pandemic preparedness – beyond dedicated global health institutions – demonstrates the global failure to recognize the complete dependence of our societies and economies on our health. Six months into the COVID-19 pandemic, the consequences of this failure are evident.

As the ACT Accelerator has demonstrated, global financial investment in research and development necessary for pandemic preparedness is significantly lacking. While international organization advance purchase agreements may help rectify market failures, they are typically disease specific and do not address the range of other pathogens of concern or threats to health we face now and in the future.

Pandemic specific financing, including financing based on strict outbreak criteria, is also inherently unsuitable for preventing and preparing for pandemics. The World Bank Group’s Pandemic Emergency Fund insurance window was controversially not triggered during the 2018-2020 Ebola in Democratic Republic of Congo PHEIC and was not triggered for COVID-19 until March 31, 2020.<sup>34</sup>

The G20 has implemented a debt service suspension initiative in response to the COVID-19 pandemic.<sup>35</sup> Under this initiative, 77 low income countries can apply for postponement of principal debt and interest payments for 2020. However, debts will not be cancelled and will fall due between

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<sup>33</sup> Phelan, Alexandra. “Human Rights Implications of Pathogen Sharing and Technology Transfer.” In *Viral Sovereignty and Technology Transfer*, edited by Sam F. Halabi and Rebecca Katz. Cambridge University Press. 2020, 125–126.

<sup>34</sup> World Bank Group, Fact Sheet: Pandemic Emergency Financing Facility (April 27, 2020). Available at: <https://www.worldbank.org/en/topic/pandemics/brief/fact-sheet-pandemic-emergency-financing-facility>.

<sup>35</sup> G20 Finance Ministers and Central Bank Governors Meeting (April 15, 2020), Communiqué. Available at: [https://g20.org/en/media/Documents/G20\\_FMCBG\\_Communique\\_EN%20\(2\).pdf](https://g20.org/en/media/Documents/G20_FMCBG_Communique_EN%20(2).pdf).

2022 and 2024 under current arrangements, with adjustments to recoup any creditor losses over the period as well as conditionality on government budget allocation decisions. Conditionality has previously been demonstrated to negatively impact government health expenditure, impeding progress towards universal health coverage.<sup>36</sup> For COVID-19, this approach has been critiqued as penalizing countries in the expected post-pandemic period when strengthening and investing in health systems will be critical for both the countries affected and future global pandemic preparedness.<sup>37</sup> G20 members have committed to building on existing efforts to increase resilience of infrastructure against risks including pandemics through better preparedness and investment in health systems.<sup>38</sup> Recovery out of a post-pandemic world, and preparedness for the next pandemic, will need to reframe existing debt obligations, and consideration of how not only the impacts of COVID-19 but pre-pandemic financing, undermines global health preparedness.

Governance of financing for global health preparedness must be grounded in investment in scientific research, strengthening health systems, and addressing inequalities within and between societies, otherwise the next pandemic will repeat the effects of COVID-19.

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<sup>36</sup> Stubbs, Thomas et al. 2017. “The Impact of IMF Conditionality on Government Health Expenditure: A Cross-National Analysis of 16 West African Nations.” *Social Science & Medicine* 174: 220–27.

<sup>37</sup> Khan, Mishal, and Sarah Shanks. 2020. “Decolonising COVID-19: Delaying External Debt Repayments.” *The Lancet Global Health* 0(0). [https://www.thelancet.com/journals/langlo/article/PIIS2214-109X\(20\)30253-9/abstract](https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(20)30253-9/abstract) (June 3, 2020).

<sup>38</sup> G20 Finance Ministers and Central Bank Governors Meeting (April 15, 2020), Communiqué. Available at: [https://g20.org/en/media/Documents/G20\\_FMCBG\\_Communique\\_EN%20\(2\).pdf](https://g20.org/en/media/Documents/G20_FMCBG_Communique_EN%20(2).pdf).

## 4. REFORM FOR PANDEMIC PREPAREDNESS

Addressing the initial preparedness gaps of COVID-19 will likely require reform of existing global health governance mechanisms. This may include reforms to the WHO and the laws that it and Member States are responsible for administering, including the International Health Regulations (2005). In addition to reforms proposed following past outbreaks (that have not been adopted) there may be further lessons from other areas of global governance to improve accountability, transparency, equity, participation, and the rule of law for preparedness.

### 4.1. AMENDMENTS TO THE IHR

Given the weakening of global norms over time and as a result of COVID-19, ensuring future pandemic preparedness is likely to require revision of existing international legal obligations under the IHR. The law reform process, in of itself, will also contribute to strengthening norms for international cooperation and collaboration. However, this is predicated on the law reform process itself integrating principles of accountability, participation, transparency, equity, and rule of law.

#### 4.1.1 Review Conferences

The COVID-19 pandemic has demonstrated the fragility of the norms underpinning States' legal obligations under the IHR. This fragility is not an inevitable feature of international treaties: reflecting failures in preparedness to reinforce State commitments and address potential emerging concerns, including those identified in multiple review panels following the 2014-2016 Ebola PHEIC in West Africa. Part of this can be attributed to broad historical (and anecdotal) hesitation to reopen the IHR for renegotiation, despite disputes arising related to WHO powers. These have included debates over the WHO's investigatory powers, confidentiality duties, the PHEIC declaration process, and a mandate to avoid international travel and trade restrictions in recommendations. However, failing to address conflicting expectations on the exercise of WHO powers and State compliance with the IHR was a factor that may have eroded the normative weight of the revised IHR.<sup>39</sup> This has been accelerated with the global retreat from multilateralism in recent years. This rapidly changing international landscape may have further contributed to the historical hesitation to reopen negotiations.

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<sup>39</sup> Fidler, David P. "To Declare Or Not To Declare: The Controversy Over Declaring A Public Health Emergency Of International Concern For The Ebola Outbreak In The Democratic Republic Of The Congo." *Asian Journal of WTO and International Health Law and Policy* 14 (2019): 287–330.

The reluctance to revise the IHR sits in contrast to the intentions of States when drafting the WHO Constitution. The IHR are a legally binding treaty, but unique under international law with states “opting-out”, rather than going through a signing and ratification process. This is as the IHR were adopted under articles 21 and 22 of the WHO Constitution which States expressly drafted to enable rapid revision and updates of sanitary regulations given the fast pace of technological and health developments, without the traditional time consuming and costly classical treaty-making process, while also ensuring broad uptake and compliance. Perhaps given its uniqueness in international law, States have not embraced the rapid update aspect of these powers, focusing rather on their opt-out nature as the primary mechanism for achieving global consensus. There may be scope for the original intentions of the drafters to be explored further for rapid revision of the IHR, and an opportunity for States to recommit (by omission) to IHR norms which have not been revisited in substance for 15 years.

Other international governance regimes may also provide more proactive opportunities for States to reassert commitment to IHR norms and agree to interpretations of existing provisions under the IHR without requiring renegotiation of the treaty. The Convention on the Prohibition of the Development, Production, and Stockpiling of Bacteriological (Biological) and Toxin Weapons (1975) (**BWC**) is an international treaty that broadly bans an entire category of weapons. Given the rapid pace of technological developments and political debates about limits and practices, the BWC governance regime incorporates annual political meetings of states parties, with formal review conferences every five years. As former US representative to the BWC Charles Flowerree has written, treaties “cannot be simply left to fend for themselves”, as the “means by which these agreements survive and adapt to changing conditions after they enter into force deserve as much attention as the negotiations that produced them in the first place”.<sup>40</sup> The adoption of regular review conferences for the IHR would provide an opportunity for States to discuss scientific and technological developments, the implications of emerging health threats, the status of preparedness efforts, expectations on the WHO, and addressing potential conflicts of IHR interpretation.<sup>41</sup> From a governance perspective, review conferences can directly facilitate more global and representative participation in the creation and acceptance of norms, provide opportunities for accountability, and be a mechanisms for transparency and upholding the rule of law. Even if the IHR are subject to formal review following COVID-19, any new obligations or reiteration of international cooperation cannot be left untended, with review

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<sup>40</sup> Flowerree, Charles. “On Tending Arms Control Agreements.” In *U.S. Security in an Uncertain Era*, edited by Brad Roberts. MIT Press. 1993, 403.

<sup>41</sup> Katz, Rebecca. “Pandemic Policy Can Learn from Arms Control.” no. 7782. *Nature* 575, no. 7782 (November 12, 2019): 259–259.

conferences helping to reinforce norms and contribute to preparedness, dismantling periods of normative neglect. A review conference in 2021 or 2022 may assist in building in accountability, transparency, participation, equity, and rule of law into any future IHR review process while repairing preparedness gaps that have arisen prior to and during COVID-19. Further, participation in review conferences provide an opportunity to develop metrics around governance, similar to the metrics examined in the GHS Index for the BWC.

#### 4.1.2 Sharing of Clinical, Epidemiological and Sequence Data and Pathogen Samples

Immediate outbreak response saves lives and relies upon the rapid and comprehensive sharing of epidemiological and clinical data to conduct risk assessments and formulate responses. Similarly, the rapid and comprehensive sharing of genetic sequence data and pathogen samples (perhaps less critically with advancements in viral synthesis and global transmission) is critical. During the early stages of COVID-19, the sharing of all three – clinical and epidemiological data, sequences, and samples – was reportedly delayed.<sup>42</sup> This issue highlights a general issue of compliance with existing IHR obligations, partly due to differing interpretations on the scope of state obligations, the scope of WHO powers to request information, as well as a persisting gap in data governance and preparedness.

Under the IHR, States Parties have a binding obligation to share clinical and epidemiological data for a potential PHEIC.<sup>43</sup> However, the COVID-19 pandemic has demonstrated that compliance with information sharing obligations under the IHR is highly dependent on both a States Party's willingness as well as capacity to share data, and the strength of the WHO's power to request verification of information through non-State sources. States Parties may be hesitant to share data due to concerns about the economic impacts of retaliatory travel and trade restrictions, undermining of global political standing, or domestic legal or bureaucratic impediments, such as national security laws, biosecurity restrictions, and verification requirements. However, the IHR intend to address these issues such as requiring WHO to keep information confidential unless the States Party consents or there is a public health threat to other countries, a prohibition on unnecessary interference with international travel and trade without scientific justification, compliance with WHO recommendations, notification timeliness obligations, and implementation of the IHR and core capacities into domestic law. However, as successive outbreaks have shown, this normative balance is delicate, and States

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<sup>42</sup> "China Delayed Releasing Coronavirus Info, Frustrating WHO." *AP NEWS*, June 2, 2020. <https://apnews.com/3c061794970661042b18d5aeaed9fae>.

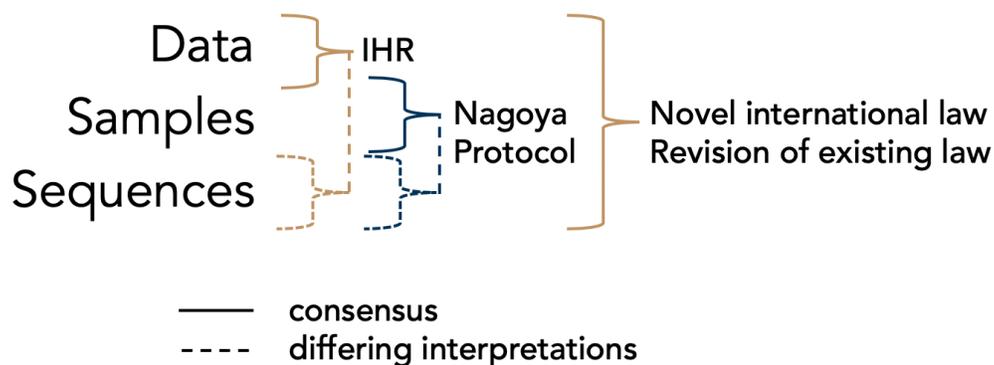
<sup>43</sup> Article 6, IHR.

Parties have not been dissuaded from engaging in response measures contrary to WHO recommendations that risk undermining timely and comprehensive notification.

Some States Parties interpret the obligation to share clinical and epidemiological data to also include pathogen genetic sequence data, however this is not an express or universally agreed interpretation. There is also currently no obligation to share pathogen samples under the under the IHR. Depending on national legislation, the sharing of pathogen samples may be governed by the Nagoya Protocol on Access to Genetic Resources and the Fair and Equitable Sharing of Benefits Arising from their Use (2014) (**Nagoya Protocol**). There is an increasing push for the provisions of the Nagoya Protocol to be expanded to include genetic sequence data (digital sequence information), however this debate is ongoing, and in the absence of a legally binding obligation to share genetic sequence data, countries are free to adopt domestic legislation incorporation such data into their Nagoya Protocol implementing legislation.

Whether real or perceived, these differing interpretations in the application of international legal requirements to data, sample, or sequence sharing has the potential to exacerbate existing geopolitical tensions, undermining global cooperation, as well as, if actualized, hamper pandemic response. This highlights a gap in preparedness for the governance of samples and sequences, as well as clarity regarding the scope of, and compliance with, data sharing obligations (see Figure 2).<sup>44</sup>

FIGURE 2 – GAPS IN INTERNATIONAL LAW FOR PREPAREDNESS & SHARING



<sup>44</sup> Rourke, Michelle, Mark Eccleston-Turner, Alexandra Phelan, and Lawrence Gostin. “Policy Opportunities to Enhance Sharing for Pandemic Research.” *Science* 368, no. 6492 (May 15, 2020): 716.

### 4.1.3 Research & Development

The IHR do not currently provide a framework for WHO-directed investment or States Parties' obligations to invest in research and development for diagnostics, therapeutics, or vaccines. In addition, the IHR do not provide guidance to the WHO or obligations on States Parties with regard to ensuring access to and the equitable distribution of diagnostics, vaccines, treatments and other critical goods such as PPE. Coupled with the data and pathogen sharing gaps, there is a clear gap in the current legal regime for the prevention, detection, and response to PHEICs like COVID-19 reflecting the existing fragmentation in the international legal governance of diagnostics, medicines, and goods.

This also highlights a potential additional preparedness risk with a future COVID-19 vaccine. While global efforts for vaccine development have been denationalized, there is a non-zero risk that geopolitical tensions will play out if vaccines have been developed using particular sequence data or samples in the absence or contrary to contracts negotiated with the transfers. Revisions to the IHR, or the development of a novel international instrument, will likely be needed to address these governance gaps.<sup>45</sup>

### 4.1.4 Declaration processes

COVID-19 has added to existing critiques of decision-making processes and the use of declaration powers under the IHR. This has included governance issues related to accountability of States, transparency of the WHO Director-General and Emergency Committee's decision-making, participation and equity in Emergency Committee composition, and the limits and scope of the IHR text as it relates to the rule of law. In addition, COVID-19 has revealed a disconnect between declarations and how States interpret signals to prepare response activities.

The WHO Director-General is empowered under article 12 of the IHR to declare an event a public health emergency of international concern (**PHEIC**). This decision is to be based on a number of factors, including the advice of the Emergency Committee which is tasked with advising whether an event constitutes a PHEIC by assessing if it is extraordinary, constitutes a public health risk to other states through the international spread of disease, and potentially requires an international response.<sup>46</sup>

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<sup>45</sup> Ibid.

<sup>46</sup> Articles 1 and 48, IHR (2005).

In recent years, the PHEIC declaration process has been subject to increasing scrutiny and critique; partly as a result of normative shifts in how the text of the IHR are interpreted and applied. As a governance tool, the incorporation of the PHEIC process into the revised IHR was a balance between state sovereignty and the powers Member States granted to the WHO, the Director-General, and the Emergency Committee. The initial inclusion of the PHEIC power in the revised IHR was a significant grant of institutional authority, reflecting WHO Member States' desire to increase the WHO's powers in responding to global public health threats.<sup>47</sup> At the same time, Member States incorporated safeguards into the IHR to balance the use of the PHEIC power, including confidentiality requirements on the WHO, limits on travel and trade restrictions, and clear criteria to be used before declaring a PHEIC. Disputes arising with these safeguards have tested the efficacy of the declarations to incentivize or trigger preparedness.

Global health legal and international relations experts have raised concerns a number of concerns with how the PHEIC process has been used (or not used). Firstly, that the Emergency Committee has considered factors that are inconsistent with the strict criteria set out in the IHR and States Parties' intentions, including whether declarations are beneficial or the risk that States will impose retaliatory travel measures or have not advised against a PHEIC even when the criteria are met.<sup>48</sup> Experts argue that this exceeds the legal limit of powers delegated to the Emergency Committee, weakening the normative legitimacy of PHEIC declarations.<sup>49</sup> Secondly, the procedure for the Emergency Committee process has been criticized for not being transparent, weakening the legitimacy, in perception and reality, of the decision-making process.<sup>50</sup> Failure to follow the IHR, whether by States Parties, the WHO, or the Emergency Committee, weakens the IHR's governance, and undermines the rule of law.

The lack of normative weight of the PHEIC declaration has been especially evident during COVID-19. On January 30, 2020, the WHO Director-General declared COVID-19 a PHEIC, following the advice

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<sup>47</sup> Burci, Gian Luca, "Shifting Norms in International Health Law", 98 *American Society of International Law Proceedings* 16 (2004) at 18; Phelan, Alexandra. "Climate Change: a Public Health Emergency of International Concern? The Scope of WHO Institutional Authority" [forthcoming] 2020.

<sup>48</sup> Phelan, Alexandra L., Rebecca Katz, and Lawrence O. Gostin. "The Novel Coronavirus Originating in Wuhan, China: Challenges for Global Health Governance." *JAMA*, January 30, 2020. <https://jamanetwork.com/journals/jama/fullarticle/2760500>; Gostin, Lawrence, Alexandra Phelan, Alex Godwin Coutinho, Mark Eccleston-Turner, Ngozi Erondu, Oyebanji Filani, Tom Inglesby, et al. "Ebola in the Democratic Republic of the Congo: Time to Sound a Global Alert?" *The Lancet*, February 4, 2019. [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(19\)30243-0](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(19)30243-0).

<sup>49</sup> Fidler, David P. "To Declare Or Not To Declare: The Controversy Over Declaring A Public Health Emergency Of International Concern For The Ebola Outbreak In The Democratic Republic Of The Congo." *Asian Journal of WTO and International Health Law and Policy* 14 (2019): 287–330.

<sup>50</sup> Eccleston-Turner, Mark, and Adam Kamradt-Scott. "Transparency in IHR Emergency Committee Decision Making: The Case for Reform." *BMJ Global Health* 4, no. 2 (April 1, 2019): e001618.

of the second meeting of the Emergency Committee convened under the IHR.<sup>51</sup> The first meeting, on January 23, 2020, was split “[a]lmost 50/50” on whether the events constituted a PHEIC.<sup>52</sup> In accordance with article 15 of the IHR, temporary recommendations were issued with the declaration, including advice that “all countries should be prepared for containment, including active surveillance, early detection, isolation and case management, contact tracing and prevention of onward spread of 2019-nCoV infection [sic], and to share full data with WHO” and expressly did not recommend any travel or trade restriction on available information.<sup>53</sup> Despite this declaration, States largely failed to initiate national preparedness, and even response, activities, and largely failed to meet international collaboration and assistance obligations to assist preparedness activities in States with weaker health systems.

### *PHEIC v “Pandemic” Declarations*

Instead, significant international political focus has been on the WHO’s hesitation to use the term “pandemic” to describe COVID-19. On March 11, 2020, the WHO Director-General described COVID-19 as a pandemic for the first time.<sup>54</sup> Unlike a PHEIC declaration, there is no distinct legal power for a declaration of a pandemic. Rather, it is a descriptive term, to describe the spread of a disease worldwide or over a significant portion of the world, such as over two or more continents. Current WHO guidance for pandemics is specifically limited to influenza, where it is relevant for the distribution of vaccines and antivirals under the PIP Framework.<sup>55</sup> While there was apparently

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<sup>51</sup> World Health Organization. “Statement on the Second Meeting of the International Health Regulations (2005) Emergency Committee Regarding the Outbreak of Novel Coronavirus (2019-nCoV).” accessed January 30, 2020 [https://www.who.int/news-room/detail/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-room/detail/30-01-2020-statement-on-the-second-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-outbreak-of-novel-coronavirus-(2019-ncov)).

<sup>52</sup> World Health Organization. “Transcript: International Health Regulations Emergency Committee on Novel Coronavirus in China,” January 23, 2020. Available at: [https://www.who.int/docs/default-source/coronavirus/transcripts/ihr-emergency-committee-for-pneumonia-due-to-the-novel-coronavirus-2019-ncov-press-briefing-transcript-23012020.pdf?sfvrsn=c1fd337e\\_2](https://www.who.int/docs/default-source/coronavirus/transcripts/ihr-emergency-committee-for-pneumonia-due-to-the-novel-coronavirus-2019-ncov-press-briefing-transcript-23012020.pdf?sfvrsn=c1fd337e_2)

<sup>53</sup> World Health Organization. “Statement on the Second Meeting of the International Health Regulations (2005) Emergency Committee Regarding the Outbreak of Novel Coronavirus (2019-nCoV).” accessed January 30, 2020 [https://www.who.int/news-room/detail/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-room/detail/30-01-2020-statement-on-the-second-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-outbreak-of-novel-coronavirus-(2019-ncov)).

<sup>54</sup> World Health Organization. “WHO Director-General’s Opening Remarks at the Media Briefing on COVID-19,” March 11, 2020. <https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19--11-march-2020>.

<sup>55</sup> World Health Organization. “Pandemic Influenza Risk Management. A WHO Guide to Inform & Harmonize National & International Pandemic Preparedness and Response. WHO/WHE/IHM/GIP/2017.1.” WHO. World Health Organization. 2017. [http://www.who.int/influenza/preparedness/pandemic/influenza\\_risk\\_management/en/](http://www.who.int/influenza/preparedness/pandemic/influenza_risk_management/en/).

hesitation to use the term pandemic in case it dissuaded countries from continuing to use containment measures, not using the term was interpreted erroneously by some States that there was not a global threat and potentially eroded trust in the WHO. This disconnect poses a particular challenge for governance and preparedness of future public health risks. Revisions to the PHEIC declaration process may also be opportunities to revise the IHR to match State expectations or reaffirm norms about the global declaration system.

### *Intermediate Level Declaration*

In its COVID-19 temporary recommendations, the Emergency Committee advised the WHO to “continue to explore the advisability of creating an intermediate level of alert between the binary possibilities of PHEIC or no PHEIC, in a way that does not require reopening negotiations on the text of the IHR(2005).” It is not clear how this would be possible without creating parallel, non-binding processes that are likely inconsistent with the mandate States have granted the WHO under IHR, which could cause further disputes or undermine the integrity of the IHR. If States pursue reform, an intermediate level of alert could signal differences in geographic risk, such as a “public health emergency of regional concern”. However, there is a risk that an intermediate level of alert could simply replicate the same issues seen with PHEIC decisions to a more granular level without substantively resolving the governance challenges. It could further lead to confusion with severity, as seen with the PHEIC and pandemic distinction, of inadvertently communicate a difference in risk that may not reflect the realities of pre-pandemic levels of global travel.

To ensure future pandemic preparedness, the PHEIC declaration process likely requires reform. The declaration has insufficiently signaled both preparedness and response activities for States. At the same time, States have responded to the declaration by implementing measures contrary to recommendations, which risk delays in future outbreak notifications and undermining pandemic preparedness.

## 4.2. REFORM TO OPERATIONALIZE THE IHR

Beyond amendments to the text of the IHR, preparedness is dependent on reforms to how compliance with IHR obligations are governed and measured. States may choose to incorporate such measures into potential IHR reform or efforts to better operationalize the IHR may exist separately to the treaty.

### 4.2.1 Enforcement mechanisms

Preparedness relies on actors fulfilling their obligations under international agreements. Enforcement mechanisms may be one way to ensure accountability and the rule of law. There are a number of existing mechanisms under WHO legal instruments for enforcement of States' collective cooperation and financing obligations, however they have been underutilized and there is limited advocacy for their use. Furthermore, many enforcement mechanisms may be punitive, subject to politicization, and have disproportionate impacts on States most dependent on WHO assistance. Use of these mechanisms without appropriate legal or normative protections may therefore undermine critical governance principles, including equity, participation, transparency and the rule of law for the sake of accountability. The primary enforcement mechanisms under the IHR are normative, encouraging mutual compliance with obligations and WHO recommendations. If the IHR are opened to reform, States may consider the inclusion of more explicit enforcement mechanisms, however more punitive measures may not result in improved global public health preparedness.

#### *Suspending Membership*

Under article 7 of the WHO Constitution, the WHA may suspend access to WHO services and voting privileges of Members that fail to meet their financial obligations. This power may also be used in other exceptional circumstances.<sup>56</sup> There is also precedent to set further limits on membership. In 1965, Member States sought to amend article 7 to revoke membership from States deliberately practicing a policy of racial discrimination, however it has not received sufficient support to come into effect.<sup>57</sup> While limiting access to membership is an accountability mechanism, and could assist in enforcement of compliance with legal or normative obligations, in comparison with other global governance regimes, such as the WTO, States have already undervalued the benefit of cooperation and the technical and normative benefits of WHO membership. For some States, suspension of membership may not be seen as having sufficiently punitive impacts for failing to pay dues. Such

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<sup>56</sup> Further research is required to determine any relevant precedent for the use of article 7.

<sup>57</sup> World Health Assembly, 18. (1965). WHA Res 18.8. Amendments to article 7 of the Constitution.

measures would also run counter to the importance of global cooperation and collaboration and may, as a result, undermine global preparedness.

### *Dispute resolution*

Mechanisms for resolving disputes or conflicts that arise between States provide avenues of accountability for the enforcement of obligations. Similarly, advisory opinions can clarify treaty interpretations and prevent disputes from arising. This certainty can assist further in entrenching the accountability, equity, and the rule of law: contributing to preparedness and good governance. While the WHO does not have a formalized, institutional dispute resolution body like the WTO Appellate Body, the IHR contains dispute settlement mechanisms under article 56. If a dispute arises between two or more States Parties regarding the interpretation or application of the IHR, States Parties must first seek to resolve the dispute through negotiation or other peaceful means, and if unsuccessful, the States Parties may agree to refer the dispute to the WHO Director-General. However, COVID-19 has demonstrated the risk that State to State disputes may arise in connection with WHO response in a manner that could result in actual or perceived bias in the Director-General as an arbiter. It is therefore possible that disputes will not be resolvable through these steps, including where a State Party disagrees with the conclusions or remedies the Director-General determines. Under the IHR, States Parties can escalate disputes that are not resolvable to arbitration, and potentially, the International Court of Justice. This forum could also provide advisory opinions on points of IHR interpretation if requested by WHO. Further information on the dispute resolution processes under the IHR are contained in *Appendix 1 – Existing Dispute Settlement Processes for IHR Obligations*.

Despite these provisions, the IHR does not have a framework for penalties, compensation, or other retaliatory measures for non-compliance. The existing dispute settlement processes are underused, and do not provide sufficiently detailed processes to ensure accountability, transparency, equity and the rule of law. In contrast, the WTO dispute settlement system is highly formalized and is a regime that can directly quantify costs and compensatory measures beyond specific performance of obligations. This is partly due to significant differences between the fields of trade and health, reflecting different values on formalizing the role of law and lawyers, the weight of norms and precedent, the ethics and simplicity of quantifying costs, and States' perceptions of the value of participation. However, like the IHR, the WTO is also facing significant governance and operational challenges in light of members' retreat from multilateralism. The impact of this on the operation of the WTO Appellate Body has been significant, while the establishment of the Multi-party Interim Appeal Arrangement demonstrates the importance of continued forums for dispute resolution and resolution of broader hesitations against international accountability.

## 4.2.2 Investigations

The utility of investigations can be differentiated based on their purpose and timing. Routine investigations into compliance with preparedness obligations – such as IHR core capacities – versus outbreak-specific investigations to determine whether notification obligations were complied with, accuracy of data, or the source of an outbreak.

### *Investigations of compliance with preparedness obligations*

Independent expert investigations into compliance with IHR obligations to build core capacities are unlikely to incentivize preparedness. Currently, the JEE process actively engages countries in the core capacity assessment process and are aimed at providing an expert evaluation that can inform country prioritization and resources. While there is scope for the relevant metrics used to be revised and updated, particularly as understandings of preparedness shift as a result of COVID-19, the JEE already achieves many of the intended outcomes of an investigation into preparedness. Further, moving to an investigatory model, which indicates a less participatory, educative, and collaborative approach and a more punitive one, risks undermining country compliance, willingness, and transparency, undermining the accuracy of assessments. If so, this could leave the world less, rather than more, prepared.

### *Investigations of outbreaks*

Based on models from the various weapons regimes, Australia has called for WHO to be granted investigatory powers to send in inspectors to assess an outbreak.<sup>58</sup> The proposal for investigations has been framed through a response lens, rather than preparedness, to assess States' responses to outbreaks, being based on regimes that examine the alleged use of chemical or biological weapons, namely the United Nations Secretary-General's Mechanism (UNSGM). Given that this proposal was raised in response to COVID-19 events, this proposal seeks a greater level of investigatory independence than the WHO-China Joint Mission conducted in February 2020. For preparedness, inspections might be implemented similar to that used in the nuclear proliferation regime to ensure compliance. However, it is not clear whether such inspections would increase compliance or reveal further information for preparedness beyond that provided by existing assessments of preparedness, like the JEE.

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<sup>58</sup> "Australia to Pursue Coronavirus Investigation at World Health Assembly." *Reuters*, April 23, 2020. <https://www.reuters.com/article/us-health-coronavirus-australia-china-idUSKCN2251G7>.

Given the sensitivity of investigations and inspections, as well as the potentially significant trade implications, the political practicality of this proposal may be limited. States may reject the proposal completely or require prior consent for any investigations. Alternatively, as with the UNSGM, States may request that any such investigations must be run through the UNSC to ensure access to veto powers. *Further background to the UNSGM is provided in Appendix 2 – the United Nations Secretary General’s Mechanism for Investigations.*

#### 4.2.3 Addressing measures exceeding WHO recommendations: travel and trade restrictions

The IHR seek to balance the protection with public health and unnecessary interference with travel and trade. This reflects over 150 years of history of the international diplomacy for the precursors to the IHR, when economic considerations were a driving force behind establishing rules for outbreak notification and limits on control measures, balanced with overly restrictive travel or trade restrictions. This balance has been reflected in subsequent versions of the IHR, and following the first SARS outbreak in 2002-2003, was incorporated into the revised IHR with the objectives and operative provisions of the instrument proactive in attempting to protect against unnecessary interference with travel and trade (see Box 1).<sup>59</sup>

##### BOX 1 – THE NORM AGAINST INTERNATIONAL TRAVEL & TRADE RESTRICTIONS

The prohibition against unnecessary interference with travel and trade has underpinned international cooperation for preventing the spread of infectious disease for more than a century and a half. In past PHEICs, the WHO has advised against travel and trade bans generally as they:

- (1) can impede the flow of medical goods and services to affected areas;
- (2) are typically insufficiently tailored to prevent transmission given the scale of global travel;
- (3) give a false sense of security and effective government preparedness;
- (4) can be bypassed by travelers in many ways, not only losing an opportunity to provide and obtain important public health information but also discouraging engagement with authorities after arrival; and
- (5) risk disincentivizing countries’ disclosure in future outbreaks.

<sup>59</sup> See, e.g. IHR, arts 2, 17, 43, and Annex 2.

However, over successive PHEICs, some States Parties ignored these norms but were criticized and there was consensus that these actions violated IHR obligations. The COVID-19 pandemic has pushed this further, with more than 194 countries adopting some form of cross-border restriction, including border closures, travel bans, and visa restrictions.<sup>60</sup> This revealed not only the rapidity and scale at which States Parties disregarded or actively disagreed with WHO recommendations and advice,<sup>61</sup> but also a potential shift in international consensus regarding the effectiveness of travel restrictions (although not trade restrictions) as a method to delay, rather than prevent, the spread of a pandemic.<sup>62</sup>

As the UN specialized agency for health, the WHO has the most appropriate scientific and technical capacity to make assessments on whether control measures that impact travel and trade are necessary to protect public health. However, the impact of the scale of travel and trade restrictions means that this authority has been weakened. In addition, the central norms underpinning the IHR have been potentially undermined, incentivizing States Parties to delay reporting future outbreaks. As a result, failure to reassert consensus regarding the norm (whether in its current form or in a revised version of the IHR) is a risk for future pandemic preparedness. Any revision to the IHR however should be carefully considered in light of the available evidence, possible pathways for accountability and transparency, and potential nuance between types of permissible restrictions and their timing.

These help guide the potential paths forward. Firstly, more data and nuanced analysis is needed to determine the actual public health evidence base for travel restrictions, depending on the pathogen and the objectives of the restriction (e.g. containment versus suppression). Secondly, similar to the WTO repository of trade restrictions discussed above, WHO could develop and make publicly available a register of travel and trade restrictions countries impose above WHO recommendations in response to a PHEIC to improve accountability, transparency, and compliance with the rule of law. As States Parties are required to provide to the WHO the public health rationale of control measures which significantly interfere with international traffic, such a register could incorporate this information,

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<sup>60</sup> WHO. Weekly update on COVID-19, April 8–15, 2020. Health Emergencies Programme. Geneva: World Health Organization, 2020. Available at: <https://www.who.int/publications/m/item/weekly-update-on-covid-19---15-april-2020>

<sup>61</sup> Devi, Sharmila. 2020. “Travel Restrictions Hampering COVID-19 Response.” *The Lancet* 395(10233): 1331–32.

<sup>62</sup> Tigerstrom, Barbara von, and Kumanan Wilson. “COVID-19 Travel Restrictions and the International Health Regulations (2005).” *BMJ Global Health* 5, no. 5 (May 1, 2020): e002629.

fulfilling WHO's obligation to share this information, and information about excessive control measures, with other States Parties.<sup>63</sup>

Thirdly, potential reform of the IHR may include incorporating distinctions for when restrictions are legitimate based on the pathogen, whether a PHEIC has been declared, or between travel restrictions, affecting travelers, and trade restrictions, affecting the flow of goods. This latter option could be facilitated by stronger coordination and formalized cooperation between the WHO and the WTO on these issues. However, these distinctions are also possible through the existing WHO recommendation process. Any reform of the IHR, or even the decision not to reform, will require agreement between the States Parties as to when such measures are and are not legitimate. Given the public health benefits of avoiding unnecessary interference with travel and trade, the norms and binding obligations against restrictions should not be abandoned without careful consideration.<sup>64</sup>

#### 4.2.4 Measuring Governance – Metrics & Simulations

Existing metrics for assessing pandemic preparedness do not adequately consider or weigh the importance of governance in national and global capacities to respond to pandemics. As a result, even with disclaimers as to their interpretation, these assessments risk providing highly-ranked States with a false sense of security, while inaccurately assessing other States as being underprepared. While this may result in more funding to strengthen metrics that a State ranks low in, it also risks undervaluing or not measuring possible lessons and advantages for preparedness, including positive deviants. As what gets measured gets done, failure to identify the elements of good governance that makes for better prepared health systems means that these metrics are not measured, capacities not developed, and nations are less prepared.

Using the lessons of COVID-19 and past outbreaks, there is scope for the WHO, States or third parties to develop new metrics for governance that contribute to pandemic preparedness. These metrics would go beyond securitized concepts of stability, to capture measures of governance that contribute to public trust, institutional integrity, and informed response, including accountability, transparency, participation, equity, and the rule of law. Governance metrics must themselves meet uphold principles of good governance, ensuring that any metrics are not driven by donor-based needs or work to entrench

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<sup>63</sup> IHR, Art 43(3).

<sup>64</sup> Lee, Kelley, Catherine Z. Worsnop, Karen A. Grépin, and Adam Kamradt-Scott. 2020. "Global Coordination on Cross-Border Travel and Trade Measures Crucial to COVID-19 Response." *The Lancet* 395(10237): 1593–95.

existing inequitable power dynamics in global health between the global north and global south.<sup>65</sup> The development of metrics should therefore be transparent (in both process and data) and facilitate inclusive and equitable geographic, economic, and cultural participation.

Beyond metrics, governance capacity for preparedness may be strengthened through the use of simulations.<sup>66</sup> Simulations have been used for assessing IHR core capacities, and while focused on technical areas, the process of conducting simulations also help evaluate, train, and advocate for strengthening governance capacities.<sup>67</sup> Appropriately tailored simulations must go beyond simply testing different public health capacities and challenges, and must include different governance challenges, including trust in government, misinformation, willingness to comply with health measures, government willingness to engage in multilateralism and evidence-based measures, legal barriers and enablers to preparedness and response, as well as consideration of the human rights implications of imposing or failing to impose measures. Similar to decision-making itself, our metrics and assessments of capacities of preparedness will be more accurate if they involve considered multidisciplinary expertise.

#### 4.3. IMPROVING GLOBAL GOVERNANCE FOR HEALTH: OTHER MULTILATERAL BODIES

Multilateralism broadly faces significant challenges. The mid- and post-pandemic period may be the greatest test of multilateralism in the post-war period and of modern global governance institutions since their inception. Pandemics are inextricable with all facets of human society and our environment. The only path forward during this pandemic, through recovery, all while preparing for the next pandemic is through cooperation and collective action. The entire multilateral system must be actively involved, and engage in, pandemic preparedness activities, including investment in health systems and addressing a range of inequalities that entrench health injustice. The movement for health in all policies, the realization of our global right to health, and solidarity must drive multilateral recovery

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<sup>65</sup> Shiffman, Jeremy, and Yusra Ribhi Shawar. “Strengthening Accountability of the Global Health Metrics Enterprise.” *The Lancet* 395, no. 10234 (May 2, 2020): 1452–56.

<sup>66</sup> See, for example, South Korea’s initial successful response to COVID-19, which has been anecdotally partly attributed to recent simulations: Breen, Michael. “What’s Fueling Korea’s Coronavirus Success — and Relapse.” *POLITICO*, May 15, 2020. <https://www.politico.eu/article/whats-fueling-south-korea-coronavirus-covid19-success-and-relapse/>.

<sup>67</sup> WHO, “Concept note: Development, monitoring and evaluation of functional core capacity for implementing the International Health Regulations (2005)”, p. 3. [http://www.who.int/ihr/publications/concept\\_note\\_201407.pdf?ua=1](http://www.who.int/ihr/publications/concept_note_201407.pdf?ua=1); WHO, “WHO Simulation Exercise Manual” (2017), p. 1. <https://apps.who.int/iris/bitstream/handle/10665/254741/WHO-WHE-CPI-2017.10-eng.pdf?sequence=1>; WHA, A69/20, “Annual Report on the Implementation of the International Health Regulations (2005). Report by the Director-General” (18 May 2016). [http://apps.who.int/gb/ebwha/pdf\\_files/WHA69/A69\\_20-en.pdf](http://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_20-en.pdf).

and preparedness efforts. This will require a rethinking of coordination – and how it is governed – between states, UN agencies, non-UN international institutions, civil society, and the private sector. Global governance for health will require ensuring accountability, transparency, equity, participation, and the rule of law across the multilateral system.

## 5. CONCLUSIONS

COVID-19 has brought into stark relief how failures to adequately consider the importance of governance – globally and nationally – have undermined pandemic preparedness. There are a number of reforms that may recentre governance in pandemic preparedness. However, the success of any reforms to existing preparedness governance mechanisms will be contingent on an effective multilateral order committed to providing the financial and political support to global institutions, laws, and norms. This is itself a profound governance challenge and, in the absence of commitment from both traditional and emerging international powers driven by national interest, will require substantive and immediate commitment from financially and politically influential countries committed to the global order.

To improve governance preparedness, states should rapidly seek to:

1. Re-establish global norms of solidarity and multilateral cooperation, including through critical reforms of the IHR, implementation of regular review conferences and consideration of new international instruments or mechanisms to support data sharing, research and development, and equitable access to diagnostics, treatments, vaccines, and medical goods;
2. Immediately address funding constraints on WHO through increases in assessed contributions and multilateral prioritization of investment in strengthening available, accessible, acceptable and quality health systems;
3. Develop frameworks and processes for more cohesive and responsive coordination between international institutions and instilling pandemic preparedness in all policies at the international level; and
4. Actively incorporate principles of good governance into international and national decision-making bodies and processes, in particular processes to ensure accountability, transparency, equity, participation, and the rule of law.

## Appendix 1 – Existing Dispute Settlement Processes for IHR Obligations

*Extracted: Phelan A, Katz R et al ILIAID White Paper: The International Health Regulations and Dispute Resolution: Ensuring Infectious Disease Information Sharing [forthcoming]*

### *WHO Director-General as arbiter*

The IHR 2005 provides a dispute settlement process under Article 56. If a dispute arises between two or more States Parties regarding the interpretation or application of the IHR 2005, the States Parties must first seek to resolve the dispute through negotiation or other peaceful means, and if unsuccessful, the States Parties may agree to refer the dispute to the WHO Director-General. These initial dispute resolution stages are likely the furthest that disagreements will progress in many cases and is largely the appropriate forum for the resolution of conflicts arising under the IHR 2005.

### *Escalation to Arbitration*

However, it is possible that disputes will not be resolvable through these steps if a State Party disagrees with the conclusions or remedies the WHO Director-General determines. Under the IHR 2005, States Parties can escalate disputes that are not resolvable through these steps. At any time, States Parties have the standing ability to declare to the Director-General that it accepts arbitration as a compulsory process for disputes arising under the IHR 2005, or for a specific dispute. Any arbitration conducted under this provision is conducted per the Permanent Court of Arbitration (PCA) Optional Rules for Arbitrating Disputes between Two States, which establish the rules of procedure for how the arbitration is conducted. The PCA is an intergovernmental organization separate to the United Nations and established in 1899 by the Convention for the Pacific Settlement of International Disputes. The PCA Optional Rules set out how an arbitration to resolve disputes between States is to be conducted, including composition of arbitration panels and rules of procedure. Under these rules, the parties are involved in the selection of the arbitrators and the hearings and final award is only made public with the consent of the parties. While parties agree to carry out the award of the tribunal without delay, tribunals established under the PCA Optional

Rules have no specific enforcement mechanism. The PCA has been used in territorial, maritime boundary, and sovereignty claims, human rights disputes, commercial investment and trade matters, but has not been used to resolve disputes arising under the IHR 2005.

#### *International Court of Justice – Dispute Settlement*

Article 56 also notes that the IHR 2005 dispute resolution provisions do not prevent States Parties from resorting to other dispute settlement mechanisms established under other international agreements or of other intergovernmental organizations, while Article 57 notes that the IHR 2005 should be interpreted so as to be compatible with other international agreements. These dispute settlement provisions differ to those under the IHR 1969, which expressly provided under Article 93(3) that a State Party could refer any disputes or questions of interpretation or application of the regulations to the International Court of Justice (ICJ).

In contrast, the ICJ is the principal judicial organ of the United Nations. In 1945, the Charter of the United Nations (Charter) was signed and entered into force, establishing the United Nations and a system of international peace and collective security. Under Article 1(1) of the Charter, one of the primary purposes of the United Nations is to “bring about by peaceful means, and in conformity with the principles of justice and international law, adjustment or settlement of international disputes or situations which might lead to a breach of the peace”. As the constituent treaty of the United Nations, all United Nations Member States are bound by the Charter and agree to settle their international disputes by peaceful means. The Charter contains the governing document of the ICJ, the Statute of the International Court of Justice (ICJ Statute). Like the rest of the Charter, United Nations Member States are bound to fulfill in good faith their obligations under the ICJ Statute and are ipso facto members of the ICJ.

Typically, matters referred to the ICJ are to resolve a dispute between States concerning the operation of international law (contentious cases) or to provide a specialized legal opinion on matters

of uncertainty for certain international organizations (advisory opinion). For the ICJ to consider a contentious case, the States involved must consent, or have consented to the ICJ's jurisdiction. States can give their consent in four recognized ways: (1) prior agreement to the Court's jurisdiction under a bilateral or multilateral treaty, (2) through a declaration of the Court's compulsory jurisdiction over legal disputes, (3) by a special agreement between the parties for the ICJ to provide a statement on the relevant principles of international law, or in rare cases, (4) the ICJ concluding that the respondent has consented to a matter that has been unilaterally brought by another State through formal agreement, informal agreement, or inferred from conduct.

Once a State has consented to a case in one of the above four ways, it is bound to comply with the decision made by the ICJ, and such decisions can be enforced by the United Nations Security Council. In addition, United Nations Member States' obligations under the Charter prevail over any other obligations under any other international agreement. The ICJ has settled legal disputes between States involving claims of territorial and maritime boundaries, breaches of treaty obligations regarding whaling, state responsibility for damage at sea, acts of genocide and violations of human rights. In addition to making declarations of non-compliance with the relevant international law, while rare, the ICJ can also determine that a party is owed compensation for violations of international law found by the court. The ICJ has not yet been used for the settlement of a dispute arising under either the IHR 1961 or IHR 2005. While the IHR 2005 removed the express reference to the ICJ for the peaceful settlement of disputes, under Article 36 of the ICJ Statute, IHR 2005 States parties could voluntarily accept the jurisdiction of the ICJ for disputes concerning the IHR 2005.

#### *International Court of Justice – Advisory Opinions*

International organizations can also request the ICJ provides advisory opinions on legal questions within the scope of their activities. Advisory opinions are not legally binding, and the ICJ can refuse to grant the request. The WHO has previously sought two advisory opinions from the ICJ: on the

legality of the use of nuclear weapons by a State in armed conflict, where the ICJ denied that the subject matter was within the scope of the WHO's activities, but addressed the issue in a subsequent request from the United Nations General Assembly; and in a matter involving a request by a group of States for relocation of the WHO regional office from Egypt. Despite the limitations of Advisory Opinions, and the requirement that the WHO put disputes to the WHA under Article 56 of the IHR, the WHO could potentially seek an Advisory Opinion on legal questions arising under the IHR 2005. For example, the WHO could request that the ICJ provide an advisory opinion on whether a State's failure to provide timely public health information or genetic sequence data, where it is available, during a public health event would violate its obligations to provide information to the WHO under Articles 6 and 7 of the IHR 2005.

## Appendix 2 – United Nations Secretary General’s Mechanism for Investigations

Extracted from Rourke M., Phelan A, Katz R. [Access and Benefit-Sharing: Implications for Accessing Biological Samples for United Nations Secretary-General Mechanism Investigations](#). ILIAID White Paper (December 2019).

The United Nations Secretary-General’s Mechanism (UNSGM) empowers the Secretary-General to conduct investigations into alleged uses of biological, chemical, or toxin weapons. The UNSGM is the only tool that is currently available to the United Nations Security Council for the investigation of alleged biological weapons use, and as a result, the only currently available mechanism for Biological Weapons and Toxins Convention (1975) (BWC) States Parties. Article VI of the BWC provides that:

- (1) Any State Party to this Convention which finds that any other State Party is acting in breach of obligations deriving from the provisions of the Convention may lodge a complaint with the Security Council of the United Nations. Such a complaint should include all possible evidence confirming its validity, as well as a request for its consideration by the Security Council.
- (2) Each State Party to this Convention undertakes to co-operate in carrying out any investigation which the Security Council may initiate, in accordance with the provisions of the Charter of the United Nations, on the basis of the complaint received by the Council. The Security Council shall inform the States Parties to the Convention of the results of the investigation.

Shortly after the BWC entered into force, allegations of toxin weapons use in Southeast Asia and Afghanistan in the late 1970s led to the first ad hoc investigation ordered by the Secretary General. A resolution to create a formal investigative mechanism was passed by the UN General Assembly in 1987 (A/RES/42/37C) and endorsed by the Security Council in 1988 (UNSCR 620). In 1989, a set of Guidelines and Procedures were produced, that included logistical considerations such as personnel, equipment, transport, interview procedures, as well as the types of samples required for investigations.

To date, the UN has been involved in 13 investigations into alleged chemical or toxin weapons use, ten of which were conclusive (either finding chemical weapons or not) and three were inconclusive (Southeast Asia, Afghanistan and Mozambique). Starting in 2010 the UN Office for Disarmament Affairs (UNODA) entered into a series of Memoranda of Understanding, including with the World Health Organization (WHO) and the World Organization for Animal Health (OIE) to, in part, facilitate timely access to biological samples.

The background of the image is a dark blue gradient. On the right side, there is a large, detailed 3D rendering of a virus particle, likely a coronavirus, shown in a light blue color. It has a spherical core and numerous spike-like protrusions extending from its surface. On the left side, there are several smaller, out-of-focus virus particles in a golden-yellow color, scattered across the frame.

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