The Outbreak of COVID-19 Coronavirus: are the International Health Regulations fit for purpose?

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The outbreak of coronavirus first detected in December 2019 in Wuhan, China (COVID-19 in WHO's parlance) has taken the world by surprise and confirmed our shared global vulnerability to the appearance of new pathogens, in particular airborne viruses that spread easily through travel and social proximity. As of 25 February 2020, China had reported more than 77 000 cases with more than 2600 deaths, and the figures keep increasing every day. As of the same date, about 2500 cases have also been reported from 33 countries, with 34 reported deaths (see the links to WHO's situation reports here). There is still a high degree of scientific uncertainty on crucial aspects of the disease, from its likely animal source to the route of transmission, clinical management and infection control protocols.

In contrast to the 2003 SARS outbreak, China has shown greater transparency in communicating on a daily basis its epidemiological situation, shared an at early date the genomic sequence of the virus on an open-access database, accepted the presence of a WHO support team, and taken draconian control measures including the quarantine of millions in Wuhan and other cities. Even though there are not yet clear empirical data, strong measures from China and better preparedness from other countries may have helped contain the rate of international spread and related mortality. As in past cases, however, third countries and economic operators (especially airlines) have been taking precautionary measures and restricted travel from China, suspended air links or quarantining returning nationals. International media have given wide coverage to the unprecedented refusal by five countries to let the passengers of the Westerdam cruise ship disembark, as well as to the ordeal of the 3600 passengers quarantined aboard the Diamond Princess cruise boat in the port of Yokohama. Such restrictive measures have raised questions about the extent of national emergency powers and the relevance of human rights considerations to ensure a measure of due process, proportionality of the measures to the actual risk as well as to generate domestic and international accountability.

WHO has positioned itself as the central institutional hub in this situation, providing guidance and assistance, coordinating research on vaccines, diagnostics and antivirals, and framing the international response in normative terms under the International Health Regulations. The secretariat has been using the WHO web site as the main tool for guidance, awareness raising and information update. It has also convened or coordinated a significant number of technical meetings that aim to generate scientific clarity and consensus, thus fighting the disinformation or deliberate manipulations that have been increasing anxiety and irrational reactions worldwide.

The role of the International Health Regulations 2005

The International Health Regulations (2005) (IHR 2005), adopted by the World Health Assembly in 2005 and in force for 196 states since June 2007, are the sole binding global legal instrument dedicated to the prevention and control of the international spread of disease (see the text of the IHR 2005 here). The IHR 2005 represent a radical change from previous versions as well as pre-WHO regulations; they shift from a passive approach relying on a list of diseases and rigid maximum national measures to a dynamic and open-ended approach based on the cooperation and good faith of states parties, where WHO plays a central role in surveillance, risk assessment and response and aims at ensuring an effective but proportional public health response to avoid unnecessary interference with traffic and trade. States parties are under an obligation to cooperate in good faith with WHO and one another by assessing health events occurring on their territory, notifying to WHO those which reach a certain threshold of gravity, providing detailed information and taking a range of measures depending on the nature of the health event. Most importantly, states parties must achieve and maintain a set of core capacities in their respective national health systems (rather than only at points of entry such as ports and airports as was the case for the previous IHR) in order to promptly detect, notify and respond to public health risks and emergencies. This has proved to be one of the major challenges in implementation, with the IHR lacking a both a dedicated funding mechanism and a formal mechanism for compliance monitoring. In part due to these shortcomings, many countries are still far from achieving the required capacities.

The international alert system

The most dramatic action under the IHR 2005 is the declaration by the WHO Director-General (DG), on the advice of an "emergency committee" (EC) composed of individual experts, of a "public health emergency of international concern" (PHEIC) and the consequential adoption of time-limited "temporary recommendations" of urgent measures to contain the outbreak domestically and control international spread. After some hesitations that commentators criticized as excessively deferential towards China, the Director-General declared the coronavirus outbreak as a PHEIC on 30 January and issued rather conservative temporary recommendations excluding notably travel and trade restrictions.

The criteria for declaring a PHEIC focus on serious, unusual or unexpected events that carry implications for public health beyond the affected State's borders and may require immediate international action. As noted by Pedro Villareal in a recent post on this blog (see here), these criteria are open-ended and difficult to be framed in purely legal terms. The practice until now – with six PHEICs declared between 2009 and 2020 – has been criticized as inconsistent and prone (probably inevitably) to political considerations in contrast with WHO's ethos as a technical organization based on evidence and science. Different ECs (the DG convenes a separate EC for each event, thus membership can change) have indeed interpreted the IHR-based criteria in a flexible way that reflects more contextual considerations than the checking of predetermined boxes; in particular,

they have sometimes used policy-based arguments such as the “usefulness” of a PHEIC declaration as in the case of the 2018-2019 Ebola virus outbreak, or putting pressure on recalcitrant countries such as Pakistan in the case of poliomyelitis in 2014. The DG until now has always “rubber-stamped” the EC’s conclusions, thus seeking political cover but also shifting in practice decision-making power to what is formally an advisory body. This has raised questions about the legitimacy and transparency of the EC’s work, which is currently conducted in private (see here). The uncertainty is compounded by the relative lack of details in the EC reports, posted on WHO’s web site shortly after its meetings, on whether and how the various events fulfill the definition of a PHEIC, thus also reducing predictability about future crises. The declaration of a PHEIC has become an act of significant political symbolism and media frenzy, but its international legal implications are unclear besides unlocking WHO’s authority to issue temporary recommendations as noted below.

The current system has also been criticized for its binary approach, with the declaration of a PHEIC as the only level of alert. Complex disease outbreaks escape such a simplified categorization, and calls for introducing a more gradual alert system are increasing, including recently by the ECs responsible respectively for the COVID-19 outbreak and the current Ebola virus outbreak in the Democratic Republic of the Congo. Interestingly, and even though it is difficult to deviate from the binary approach of the IHR 2005, there is a consensus within WHO that a system of intermediate alerts should be introduced in a practical manner without amending the text of the IHR 2005.

This attitude is emblematic of the historical reluctance of WHO to engage in international law processes and the preference for voluntary and technical approaches. At the same time, the integrity and credibility of the IHR 2005 as a legal instrument will arguably suffer if such important adjustments to their functioning are established and operated outside their framework and do not correspond to what states parties agreed upon in adopting the Regulations. In my view, the concept of PHEIC should actually be reconsidered and replaced with a more context-sensitive approach that avoids altogether the fraught concept of emergency. It would be timely, in this connection, for the WHO secretariat to conduct an empirical analysis of the reactions that can be linked chronologically and causally to declarations of PHEICs thus far and to assess whether they actually helped in coordinating international response while avoiding unnecessary economic and human hardships.

International response and compliance with the IHR 2005

Problems and uncertainties also occur also with regard to the coordination of the international response to a PHEIC, and the current outbreak confirms those challenges. While the IHR 2005 contain relatively clear obligations on due diligence and cooperation as well as on general and more routine health measures, national measures in response to a specific PHEIC are supposed to be guided by WHO’s temporary recommendations. Available practice shows, however, an inconsistent level of compliance, in particular with regard to restrictions on travel and trade with affected countries.

Whereas the DG recommended against any travel and trade restrictions in the current case, for example, many states have instituted such restrictions at different levels of intensity. It was emblematic that the United States announced an almost total ban of entry for aliens traveling from China two days after the PHEIC declaration without even mentioning the PHEIC or WHO's recommendations. The United States however requested, during the recent session of WHO's Executive Board, the secretariat's guidance on travel restrictions that would complement China's control measures and reduce the risk of disease spread while ensuring compliance with the IHR 2005. Also a number of airlines have suspended or greatly reduced flights to China, apparently as autonomous corporate decisions rather than under the direction of their respective home countries. This raises yet another layer of complexity in terms of compliance with WHO's recommendations, as many states may not be legally in a position to direct private operators to either perform or suspend certain activities.

States parties may take, under Article 43, health measures diverging from WHO recommendations or that would otherwise breach a number of IHR provisions, provided they are a direct response to a PHEIC or a public health risk, are based on the available science and on a risk assessment, are proportional to the risk and are reported to WHO if they exceed a very low threshold of delaying traffic and travel for more than 24 hours. The complex formulation of Article 43 complicates determinations about whether states parties may be in breach of the IHR when implementing additional measures, and doesn't provide concrete guidance to states that decide to go beyond WHO's recommendations or to take actions in breach of certain IHR obligations. The WHO secretariat can engage with the implementing states but has limited powers to make them accountable and posts its analyses and information on a web site only open to IHR parties and inaccessible to the public.

This lack of public access, as well as the absence of "naming and shaming" in the secretariat's annual report to the Health Assembly on the implementation of the IHR, increases overall opacity about compliance and the reasons for additional national measures and has led to criticism on the deferential attitude of the secretariat vis-à-vis states parties. The dispute settlement procedures envisaged in Article 56 have also not been used so far, thus we don't have available a body of jurisprudence that could help clarify the limits of lawful behaviour. Critics have even questioned the binding legal nature of the IHR 2005 given the lack of enforcement or even compliance monitoring mechanisms and the apparent disregard of states parties for WHO's recommendations. However, if it is eventually determined (by the Health Assembly, for example, or a judicial body) that states parties may breach the IHR through Article 43 measures that exceed WHO recommendations, then consequentially those recommendations acquire a legal force that goes beyond their apparently hortatory nature. The ambiguity of the text and the absence of jurisprudence on this point leave the legal bases for the accountability mechanism in Article 43 uncertain.

WHO's role in a broader context

The design of the IHR 2005 greatly hinges on a trade-off between reliance on WHO's "soft" emergency powers as well as normative legitimacy and credibility; openness and cooperation on the part of affected countries; good faith, solidarity and self-restraint on the part of third countries; but also the retention of ultimate sovereign rights to decide on national control measures. Antagonistic behavior such as naming and shaming, or harder forms of enforcement are not part of the IHR's design or, for that matter, of WHO's culture. Greater reliance is rather placed on the legitimacy and credibility of WHO as provider of authoritative guidance and information, on its technical assistance to countries in need, and on its authority to convene experts and stakeholders from all over the world to increase the level of knowledge and aim at scientific consensus regardless of political differences. This role may serve as a positive inducement for states parties to comply with WHO's recommendations and in general avoid unnecessary or disproportionate measures, in particular if there is an element of reliance on a similar attitude by other countries.

The normative force and the effectiveness of this approach are largely predicated on the acceptance of WHO's recommendations and advice and the perception of their legitimacy and credibility. For this reason, I find the absolute tone of several temporary recommendations in the course of time problematic in particular when, as in the present case, they categorically exclude any travel or trade restrictions without any further elaboration and without apparently acknowledging the social aspect of anxiety and the need to manage uncertainties at the national level. It may be difficult for many governments, under pressure from political actors and the public and subject to relentless media scrutiny, to conform to such prescriptive guidance at times of crisis without any supporting justification on the part of WHO. Also from this perspective, therefore, changes in WHO's implementation practice may strengthen the legitimacy of its role and the effectiveness of its coordination functions.

As noted above, the secretariat has published and continues to update on WHO's web site a large number of guidance and advisory documents related to the outbreak of COVID-19; they range from repatriation and quarantine of travelers (see here), laboratory guidance (see here) and infection prevention and control (see here); to advice to the public on when and how to use masks (see here) and advice to health workers about their rights, roles and responsibility (see here). To my knowledge there has not been a systematic empirical analysis of their impact, but there is certainly much anecdotal evidence about their use and reference both by public agencies, NGOs and economic operators which confirms their practical relevance. It should be noted incidentally that such web-based guidance bypasses governments and reaches directly individuals and other non-state actors, that often adapt their behaviors accordingly and thus confirm the direct normative impact of such guidance; this defies traditional functionalist theories about the principal-agent relationship between international organizations and their member states, whereby the latter are the sole direct addressees of the organizations' activities as well as a legal buffer between their nationals and the organizations. While this is nothing new or unprecedented (suffice it to mention ILO's recommendations addressed directly to employers and employees besides

governments), it becomes very visible at times of crisis when the world needs reliable guidance from a credible centrally placed institution and strengthens the autonomous role of the secretariat.

It is unclear whether the guidance and recommendations in question fall within the scope of the IHR 2005. The text of the regulations also in this case is quite rigid, providing only for temporary recommendations in case of a PHEIC as well as standing recommendations "for routine or periodic application" (Article 17) that are issued by the DG pursuant to a formal process contained in Articles 50 to 53. Article 13 also refers to the provision by WHO of "appropriate guidance and assistance" to states parties affected or threatened by a PHEIC, but only "when requested".

Even though the formal accountability mechanism of Article 43 only applies to temporary and standing recommendations, the secretariat would have more authority to question states parties about their use of WHO's guidance or challenges in that connection, and could include that evidence in its annual report to the Health Assembly if they unquestionably fell under the IHR 2005. As it stands, the legal status of the documents in question with regard to the IHR 2005 is blurred and was never to my knowledge openly discussed within WHO. They can probably be seen as complementary to IHR-based recommendations and falling within a broader grant of authority to the secretariat to provide assistance and support to member states and other actors in the fight against communicable diseases. As noted above, they certainly play an important role, secure the credibility and legitimacy of WHO as the central hub of the response against the COVID-19 outbreak and strengthen the overall purpose of the IHR 2005. WHO's role and performance, therefore, has to be assessed taking into account the totality of its actions and functions, including notably its "soft" normative functions and their practical impact, rather than under the IHR 2005 seen in isolation.

Conclusion

In conclusion, the current COVID-19 outbreak is testing again the effectiveness and credibility of the IHR 2005 not only as a legal instrument but also as a public health tool and a framework to channel into a health narrative political challenges and tensions having to do with sovereignty, economic interests and national security considerations. As such and given the complexity and the high number of variables surrounding disease outbreaks, I think it's unrealistic to expect a foolproof system that could deliver unimpeachable public health solutions while commanding general compliance and imposing self-restraint. Still, as argued in this post, there are serious questions of design and implementation that should be seriously and urgently addressed to avoid irreversibly weakening the integrity of the IHR 2005 as the sole and indispensable legal framework for global health security.