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## Making International Health Regulations Work: Lessons from the 2014 Ebola Outbreak

Tsung-Ling Lee

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# Making International Health Regulations Work: Lessons from the 2014 Ebola Outbreak

*Tsung-Ling Lee\**

## ABSTRACT

*Many legal scholars believe that the lack of enforcement mechanisms provided by the International Health Regulations (IHR) in part explains the slow containment of the deadly Ebola virus disease outbreak in West Africa in 2014. In contrast, some global health practitioners deem funding for global health emergencies as a key remedy to the ineffective international infectious disease control regime. Such belief underpinned the creation of the Pandemic Emergency Facility (PEF), the World Bank's new financing initiative, aiming to finance global disaster response. Some commentators hope that the establishment of the PEF will resuscitate international interest in global health security and cooperation. Although current discussion touches upon how to integrate the PEF with the existing international infectious disease control regime, much remains unclear about how the PEF will relate to the IHR operationally and normatively. Relatedly, legal scholars and global health practitioners continue to talk about IHR enforcement and global health emergency funding as two different things, without exploring how the latter can incentivize the former.*

*Starting from the IHR as a pillar of global health security, this Article focuses on strengthening the IHR enforcement*

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mechanism—thus far overlooked in the current discussion—vis-à-vis the PEF. It also argues that such linkage is important in ensuring consistent, rapid global health emergency responses. Drawing on lessons from the 2014 Ebola outbreak, the Article demonstrates that the proposal is normatively desirable and politically feasible. The Article makes a timely intervention, as the PEF has tremendous potential in shaping the international infectious disease regime, creating new opportunities and anxiety simultaneously.

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## I. INTRODUCTION

Many legal scholars believe international law is a pillar of the maintenance of global health security and cooperation. This belief is reflected in the extensive law-making power granted to the World

Health Organization (WHO),<sup>1</sup> a global public health agency. Yet, in the past decades, and most recently during the Ebola virus disease (sometimes abbreviated “EVD,” but referred to here more colloquially as “Ebola”) outbreak of 2014 in West Africa, the consistently poor performance of the WHO in the global policy realm of infectious disease control shattered that expectation markedly. Indeed, at the most recent opening of the annual World Health Assembly (WHA), German Chancellor Angela Merkel made clear that the WHO’s response to the 2014 Ebola epidemic was nothing less than catastrophic.<sup>2</sup> Chancellor Merkel’s sharp criticism reflects a widely held sentiment within the international community because the delayed WHO response to the epidemic had resulted in 11,300 deaths and 28,601 confirmed cases, as of December 1, 2015.<sup>3</sup> Many infectious disease experts believe that, had the WHO responded promptly, such human devastation could have been averted.<sup>4</sup> Likewise, many commentators noted that the International Health Regulations (IHR),<sup>5</sup> which provide the

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1. Szeming Sze, *WHO: From Small Beginnings*, 9 WORLD HEALTH FORUM, 29 29–34 (1988), [http://apps.who.int/iris/bitstream/10665/46414/1/WHF\\_1988\\_9\\_1\\_p29-34.pdf](http://apps.who.int/iris/bitstream/10665/46414/1/WHF_1988_9_1_p29-34.pdf) (last visited Sept. 18, 2016) [<https://perma.cc/KT6J-8FZM>] (archived Sept. 18, 2016).

2. Kirsten Grieshaber, *German Chancellor Merkel Tells WHO Global Catastrophe Plan Needed for Epidemic Outbreaks*, US NEWS (May 18, 2015), <http://www.usnews.com/news/world/articles/2015/05/18/merkel-global-catastrophe-plan-needed-after-ebola-crisis> [<https://perma.cc/9EEV-KUSE>] (archived Sept. 18, 2016); see also Sarah Boseley, *Plan to Reform WHO After Ebola to be Unveiled by Angela Merkel*, GUARDIAN (May 18, 2015), <http://www.theguardian.com/world/2015/may/18/angela-merkel-plan-restructure-world-health-organisation> [<https://perma.cc/AC73-SFK6>] (archived Sept. 18, 2016); Chancellor Angela Merkel, Statement at the 68th Session of the WHO World Health Assembly in Geneva (May 18, 2015) (<http://www.who.int/mediacentre/events/2015/wha68/speeches/en/>) [<https://perma.cc/4PZF-524N>] (archived Sept. 18, 2016)).

3. *Ebola Data and Statistics*, WORLD HEALTH ORG. (WHO), <http://apps.who.int/gho/data/view.Ebola-sitrep.Ebola-summary-latest?lang=en> (last visited Sept. 17, 2016) [<https://perma.cc/MW35-4VNH>] (archived Sept. 18, 2016) (totaling cases from Guinea, Liberia, and Sierra Leone).

4. See *WHO Leadership Statement on the Ebola Response and WHO Reforms*, WHO (Apr. 16, 2015), <http://www.who.int/csr/disease/ebola/joint-statement-ebola/en/> [<https://perma.cc/BQ5Z-LJAM>] (archived Sept. 18, 2016); Denise Roland, *Experts Criticize World Health Organisation’s ‘Slow’ Ebola Outbreak Response*, WALL ST. J. (May 12, 2015), <http://www.wsj.com/articles/experts-criticize-world-health-organizations-slow-ebola-outbreak-response-1431344306> (subscription required) [<https://perma.cc/2T6R-7Z3W>] (archived Sept. 18, 2016).

5. See, e.g., Lawrence O Gostin, Mary DeBartolo, & Eric Friedman, *The International Health Regulations 10 Years On: The Governing Framework for Global Health Security*, 386 THE LANCET 2222, 2222–26 (2015); Suerie Moon et al., *Will Ebola Change the Game? Ten Essential Reforms Before the Next Pandemic. The Report of the Harvard-LSHTM Independent Panel on the Global Response to Ebola*, 386 THE LANCET 2204, 2204–21 (2015). Partly in response to the agency’s widely criticized failure in the 2014 Ebola outbreak, the WHO has taken a more proactive action in declaring the recent cluster of microcephaly and neurological abnormalities found in Latin America a Public Health Emergency of International Concern (PHEIC). Press Release, WHO, WHO Statement on the First Meeting of the Int’l Health Regulations (2005) (IHR 2005)

international legal architecture for global health security, have contributed little to enhancing international cooperation. While many reasons explain why international infectious disease regimes remain ineffective,<sup>6</sup> scholars generally agree that the lack of enforcement mechanisms provided by the IHR renders the instrument, at best, symbolic.<sup>7</sup>

In response to the widely recognized WHO leadership failure, proposals outlining more responsive mechanisms both inside and outside the WHO governance framework have emerged. The World Bank, for instance, is developing a global Pandemic Emergency Facility (PEF) in collaboration with the WHO, private sector health companies, and nongovernmental organizations (NGOs).<sup>8</sup> Chancellor Merkel, in contrast, is advocating for an autonomous body with an independent budget within the WHO.<sup>9</sup> In response to the wave of universal criticism on its poor performance, the WHO announced the creation of a global health workforce reserve and a new \$100 million contingent fund, aimed to facilitate rapid deployment and mobilization of medical staff and resources during the early phase of infectious disease control.<sup>10</sup>

At a glimpse, the wave of initiatives and programs aimed at strengthening global health security is, no doubt, a welcome, if not overdue exercise. In particular, international infectious disease control tends to occupy a place low on the political priority list once the crisis is perceived to be over. However, at the governance level, the mushrooming of new financing initiatives outside of the WHO governance framework is also at risk of undermining the WHO's normative authority, which is necessary for commanding and coordinating international responses during global health crises. While the wave of proposed initiatives reflects a general discontent with the WHO, the world is also at a critical juncture where the global infectious disease regime is undergoing dramatic transformation. The emerging

Emergency Comm. on Zika Virus and Observed Increase in Neurological Disorders and Neonatal Malformations (Feb. 1, 2016)

(<http://www.who.int/mediacentre/news/statements/2016/1st-emergency-committee-zika/en/> [<https://perma.cc/X9M7-VY6J>] (archived Sept. 18, 2016)); Tikki Pang, *Is the Global Community Prepared for Future Pandemics? A Need for Solidarity, Resources and Stronger Governance*, 8 *EMO MOLECULAR MED.* 587–88 (2016).

6. *Id.*

7. *Id.*

8. *Pandemic Emergency Facility: Frequently Asked Questions*, WORLD BANK, <http://www.worldbank.org/en/topic/pandemics/brief/pandemic-emergency-facility-frequently-asked-questions> (last visited Sept. 18, 2016) [<https://perma.cc/9U9Y-AYL9>] (archived Sept. 18, 2016).

9. Boseley, *supra* note 2; Merkel, *supra* note 2; see also Regional Comm. of WHO for the Americas, Resolutions and Other Actions of Intergovernmental Organizations of Interests to PAHO, ¶4 U.N. Doc. CD54/INF/6 (Aug. 17, 2015).

10. WHO, *supra* note 3.

Zika virus outbreak again demonstrates the necessity of a robust global infectious disease control regime.<sup>11</sup> More importantly, from the viewpoint of human rights, strengthening IHR enforcement would help the most vulnerable, most in need, populations. Scholars argue that, in cases where impoverished, ineffective, or failed states face disproportionate burdens in the provision of health services, as in the 2014 Ebola outbreak, a better-coordinated WHO would, and should, help close the gap.<sup>12</sup>

Equally as many legal scholars and political scientists have noted that the extent to which the WHO fulfills its constitutional mandate is a measure of its institutional legitimacy; a more robust IHR would also empower the WHO. Yet the emerging plethora of new actors and initiatives occupying the global health landscape could complicate the current legal order, fracture the already fragmented global governance of health, and inadvertently weaken future international response to infectious disease control. On the contrary, the emerging initiatives signal a reawakening of global interest in international health security; if these initiatives are properly coordinated and integrated within the existing system, they could have an amplifying effect, minimizing potential harms on the affected population.

In this context, the PEF, which will be administrated by the World Bank—a historical rival of the WHO—is a promising financing initiative that will transform the global infectious disease regime.<sup>13</sup> The PEF builds on the notion of risk pooling, which would help create a new market for insuring global epidemic and pandemic risk.<sup>14</sup> While the PEF could channel the funds necessary to finance efforts in containing global epidemic outbreaks, if the PEF is not properly integrated with the existing infectious disease control regime, it could risk further undermining the coherence of the regime. Equally concerning is one proposal currently under consideration with the PEF that aims to link the level of insurance premium to a country's preparedness, as measured against the benchmarks set by the WHO's IHR.<sup>15</sup> While it is true that the uneven progress in strengthening public health capacities limits the effectiveness of the IHR, the proposed linkage would likely place a disproportionate burden on

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11. Daniel R. Lucey & Lawrence O. Gostin, *The Emerging Zika Pandemic Enhancing Preparedness*, 315 JAMA 865, 866 (2016).

12. Maria Merritt, *Bioethics, Philosophy and Global Health*, 7 YALE J. HEALTH POL'Y, L. & ETHICS 273, 278 (2013).

13. Scott S. Brown, Kasturi Sen & Kristof Decoster, *The Health Systems Funding Platform and World Bank Legacy: the Gap Between Rhetoric and Reality*, 9 GLOB. HEALTH 9 (2013); Kamran Abbasi, *The World Bank and World Health: Changing Sides*, 318 BRIT. MED. J., 865–69 (1999); cf. Jennifer Ruger, *The World Bank and Global Health: Time for a Renewed Focus on Health Policy* 68 J. EPIDEMIOLOGY & COMMUNITY HEALTH 1 (2014).

14. WORLD BANK, *supra* note 8.

15. *Id.*

failing or failed states, whose inability to develop the core capacities required under the IHR are often complex.

This Article is an effort to move the dialogue beyond financing global health emergencies and toward creating a more equitable international infectious disease control regime. Instead of engaging in a normative inquiry about what makes a more equitable regime, the Article engages in a policy-driven inquiry into how to bring that about and makes concrete recommendations. Specifically, the Article draws attention to the IHR as a building block of a robust, responsive, international infectious disease control regime. The Article also demonstrates why empowering the WHO with (quasi-) enforceable power over the IHR is essential in creating a more equitable international infectious disease control regime. Instead of seeing the ascending influence of the World Bank as a potential threat to the normative authority of the WHO, as a channel to perpetuate the existing asymmetrical power structure within the international legal system, or as a potential source for causing further fracturing to the global health landscape, this Article highlights the potential, and mutually beneficial roles the World Bank and the WHO could play in the realm of global health security. The Article takes a pragmatic view and proposes an informal linkage between the IHR and the PEF to strengthen the compliance of the former. Specifically, the Article draws attention to the World Bank's unique expertise in mobilizing multi-sectorial financing, and argues that the World Bank's financial clout could be used as leverage in enhancing the IHR's compliance rate, while taking into account the varying capability of state parties to comply with the IHR.

Drawing on the respective institutional strengths of both organizations, the Article demonstrates that linking the PEF with the IHR is a plausible way forward, both politically and institutionally. Although many practitioners have expressed skepticism about states agreeing to a more legally enforceable IHR the majority of participants in a World Bank survey agreed that global infectious disease control is one of the most pressing political concerns, which suggests that the issue is politically ripe.<sup>16</sup> The Article further argues that, normatively, the parametric trigger of the PEF should be determined by the WHO

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16. Press Release, World Bank, Poll: Most Not Convinced World is Prepared for Next Epidemic (June 15, 2015) (<http://www.worldbank.org/en/news/press-release/2015/07/23/poll-most-not-convinced-world-is-prepared-for-next-epidemic> [<https://perma.cc/3SGD-C577>] (archived Sept. 18, 2016)). Likewise, across the political spectrum in the United States, both political liberals and conservatives public and experts recognized that enhancing global health security also serves domestic self-interest. See, e.g., *The Future of U.S. Global Health Policy and Programs*, HENRY J. KAISER FAMILY FOUND. (Jan. 20, 2016), <http://kff.org/global-health-policy/event/the-future-of-u-s-global-health-policy-programs/> [<https://perma.cc/F2MY-MY44>] (archived Sept. 18, 2016).

Director-General instead of by the technocrats at the World Bank. There are at least five benefits to the IHR-PEF linkage: it would level the playing field, enhance IHR compliance, ensure timely and coherent global response to global health emergencies, draw attention to the distributive impact of scarce economic and health resources in an increasingly interconnected world, and, despite the widely perceived failure of the IHR during the 2014 Ebola crisis, would also rejuvenate and sustain interest in global security.

In addition to the normative benefits brought by the informal linkage, this discussion is also particularly timely for two practical reasons: First, the WHO has established a Review Committee to assess and identify the weaknesses in global preparedness and responses to international health emergencies.<sup>17</sup> One key task the Review Committee was asked to address was how to incentivize states to better prepare for international infectious disease control.<sup>18</sup> Second, the emerging Zika outbreak in Latin America will need intensive resources and an open channel of communication to effectively contain the epidemic and a robust IHR will be central to that task.

This Article consists of four parts. Starting from the viewpoint that the international control of infectious disease is essentially a coordination game, the Article first briefly describes the 2014 Ebola crisis that unfolded in West Africa, the epicenter of the outbreak. The sketch critically reveals both the practical and normative necessity of the WHO during global health emergencies. Part II describes the WHO's constitutional mandate and its normative role in promoting public health. The discussion herein paves the way for the remaining section on the IHR—the governing global legal architecture for routine

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17. In the aftermath of the 2014 Ebola crisis, WHO established a special UN International Panel, the Review Committee on the Role of International Health Regulations in the Ebola Outbreak and Response (Review Committee), to assess the performance of the IHR and the possible use of sanctions and other mechanisms to compel better compliance. Specifically, the Review Committee is asked to address notification and related incentive to strengthen preparedness and responses for future emergencies. See REPORT OF THE FIRST MEETING OF THE REVIEW COMMITTEE ON THE ROLE OF THE INTERNATIONAL HEALTH REGULATIONS (2005) IN THE EBOLA OUTBREAK AND RESPONSE, WHO (Aug. 25, 2015), [http://www.who.int/ihr/review-committee-2016/IHRReviewCommittee\\_FirstMeetingReport.pdf](http://www.who.int/ihr/review-committee-2016/IHRReviewCommittee_FirstMeetingReport.pdf) [<https://perma.cc/UY3E-R3GV>] (archived Sept. 18, 2016); *The Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response*, WHO, <http://www.who.int/ihr/review-committee-2016/en/> (last visited Aug. 28, 2016) [<https://perma.cc/2X56-KHKU>] (archived Sept. 18, 2016).

18. In May 2015, the World Health Assembly requested that the WHO establish a Review Committee to examine how the role of IHR in the Ebola outbreak, with a focus on the effectiveness of the IHR with regard to related incentives, links to the Emergency Response Framework. Press Release, WHO, World Health Assembly Gives WHO Green Light to Reform Emergency and Response Programme (May 23, 2015) (<http://www.who.int/mediacentre/news/releases/2015/wha-23-may-2015/en/>) [<https://perma.cc/53WH-UZFT>] (archived Sept. 18, 2016).



public health protection. Part III takes a step back and provides a brief historical account of the World Bank in the global domain of public health. This overview describes the historical involvement of International Financial Institutions (IFIs) in developmental aids, which adversely shaped its recipient countries' public health systems, and, at times, competed with the WHO's mission in public health. The discussion herein lays the groundwork for the IHR-PEF linkage proposal, discussed in the ensuing section. The Article takes a cautious, but not pessimistic, view of IFIs' involvement in global health. Part IV first describes the World Bank's new financial mechanism, the PEF, and then outlines the proposal of linking the PEF with the IHR. The Article demonstrates that the proposal is both a politically plausible and practically desirable solution by reference to the International Law (IL) and International Relations (IR) literature on compliance—the focus of the remainder of Part IV. The Article argues that such linkage would create a synergetic relationship between the two institutions, in addition to embedding public health norms in the international system. The final section concludes.

#### A. *Definitional Matters*

The remainder of this Section introduces the conceptual vocabulary that grounds the rest of the discussion; in particular, it focuses on three working definitions: “global governance for health,” “failed” or “failing state,” and “compliance.” The aim is to provide a preliminary definition of these terms that will add clarity to the discussion that follows.

##### 1. Global Governance for Health

Scholars generally agree that “global health” refers to transnational health issues that require collective action from a myriad of actors, but scholars use a variety of terms to describe the governance of global health, namely, “global health governance,” “governance for global health,” and “global governance for health.” Former Dean of Harvard School of Public Health, Julio Frenk, and Suerie Moon,<sup>19</sup> for instance, use the term “global health governance” to emphasize the interdependence of the global population and draw attention to the wealth of processes that shape the way in which issues of global significance are addressed collectively through formal and informal political processes.<sup>20</sup> Similarly, Professor Lawrence Gostin<sup>21</sup>

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19. Julio Frenk & Suerie Moon, *Governance Challenges in Global Health*, 368 *NEW ENG. J. MED.*, 936–37 (2013).

20. *Id.*

21. See LAWRENCE O. GOSTIN, *GLOBAL HEALTH LAW* 508 (2014).

adopts the broader perspective, but uses the working definition of “global governance for health” instead. The term “global governance for health” analytically denotes “the collection of rules, norms, institutions, and processes that shape the health of the world’s population. Governance strategies aim to organize divergent stakeholders, and manage social, economic, and political affairs, to improve global health and narrow health inequalities.”<sup>22</sup> For Professor Ilona Kickbusch,<sup>23</sup> by contrast, these three terms—global health governance, governance for global health, and global governance for health—each encapsulate a distinct political sphere, and collectively define the global public health domain.<sup>24</sup> This Article uses Professor Gostin’s working definition of “global governance for health,” which emphasizes stakeholder participation and the aspiration to improve global health and narrow health inequalities.

## 2. Failed or Failing State

While scholars disagree widely on what precisely constitutes a failed state, scholars generally characterize a failing state by its inability to provide basic political and social goods to its people.<sup>25</sup> A failed or failing state also tends to have a collapsed, or non-existent health system, making the controlling and monitoring of the spread of disease even more challenging.<sup>26</sup> A dysfunctional national health system helps perpetuate a vicious cycle of poverty and insecurity, contributing to a decline in health indicators such as mortality and life expectancy.<sup>27</sup> An outbreak in an African country where local health care is non-existent can have devastating consequences nationally and internationally. In fact, according to former WHO Director-General Dr. Gro Harlem Brundtland, not even war or famine can have an effect on societies as devastating and destabilizing as HIV/AIDS has had.<sup>28</sup>

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22. *See id.*

23. Ilona Kickbusch & Martina Marianna Cassar Szabo, *A New Governance Space for Health*, GLOBAL HEALTH ACTION (Feb. 13, 2014), <http://www.globalhealthaction.net/index.php/gha/article/view/23507/html> [<https://perma.cc/R8U2-U7BU>] (archived Sept. 18, 2016).

24. *Id.*

25. Robert I. Rotberg, *Failed and Weak States in Theory and Practice*, OXFORD BIBLIOGRAPHIES (May 4, 2015), <http://www.oxfordbibliographies.com/view/document/obo-9780199756223/obo-9780199756223-0119.xml> [<https://perma.cc/6AFM-K5G9>] (archived Sept. 18, 2016).

26. *Id.*

27. Lawrence O Gostin, *Ebola: Towards an International Health Systems Fund*, 384 THE LANCET e49–e50 (2014).

28. *New Global Challenges: Health and Security from HIV to SARS*, WHO (July 18, 2003), <http://www.who.int/dg/brundtland/speeches/2003/genevasecuritypolicy/en/> [<https://perma.cc/9P7F-364X>] (archived Sept. 18, 2016).

Under this definition, Guinea, Sierra Leona, and Liberia, with their non-existent health systems, can be qualified as failed or failing states.

### 3. Compliance

“Compliance” means different things for International Law (IL) and International Relations (IR) scholars.<sup>29</sup> For the former, “compliance” means the degree to which a state’s conduct conforms to the prescribed legal standard in an agreement.<sup>30</sup> In contrast, the latter uses the term as a proxy to gauge the extent to which institutions and their legal rules are able to change state behaviors.<sup>31</sup> How “compliance” is defined informs the intellectually divergent ways in which IL and IR scholars understand international law. The institutional effect that political scientists describe as compliance is what legal scholars distinguish as “effectiveness,” which differs conceptually from the legal notion of “compliance.” For legal scholars, compliance and effectiveness are two analytically related, but conceptually distinct terms.<sup>32</sup> That is, unlike “compliance,” “effectiveness” refers to the extent to which a given regulation solves the political problem at hand.

Legal scholars use “effectiveness” to describe how international law shapes state behavior. To gauge the effectiveness of international law, IL scholars ask what the situation would have been in the absence of that law.<sup>33</sup> The conceptual distinction between compliance and effectiveness allows a finer-grain of understanding of whether, and how, international law shapes state behavior. Distinguishing “compliance” from “effectiveness” is also particularly useful in the

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29. Lisa L. Martin, *Against Compliance*, in INTERDISCIPLINARY PERSPECTIVES ON INTERNATIONAL LAW AND INTERNATIONAL RELATIONS: THE STATE OF ART 477–501 (Jeffrey L. Dunoff & Mark A. Pollack eds., 2013); cf. Oona Hathaway & Scott J. Shapiro, *Outcasting: Enforcement in Domestic and International Law*, 121 YALE L.J. 252, 252–349 (2001) (discussing “outcasting” which denies disobedient states the benefits of social cooperation and membership). For an overview on the disciplinary divide between the IR and IL approaches toward international law see generally Jeffrey Dunoff & Mark Pollack, *Reversing Field: What can International Relations Learn from International Law?*, (Temple Univ. Legal Studies Research Paper No. 2012-14), [http://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=2037299](http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2037299) [<https://perma.cc/JF4G-J5TB>] (archived Oct. 8, 2016).

30. See, e.g., Jana von Stein, *The Engines of Compliance*, in INTERDISCIPLINARY PERSPECTIVES ON INTERNATIONAL LAW AND INTERNATIONAL RELATIONS: THE STATE OF ART 477–501 (Jeffrey Dunoff & Mark Pollack eds., 2013); Alexander Thompson, *Coercive Enforcement of International Law*, in INTERDISCIPLINARY PERSPECTIVES ON INTERNATIONAL LAW AND INTERNATIONAL RELATIONS: THE STATE OF ART 502–23 (Jeffrey Dunoff & Mark Pollack eds., 2013).

31. See, e.g., Andrew T. Guzman, *A Compliance-Based Theory of International Law*, 90 CALIF. L. REV. 1823, 1840–60 (2002).

32. Jutta Brunnée & Stephen J. Toope, *Constructivism and International Law*, in INTERDISCIPLINARY PERSPECTIVES ON INTERNATIONAL LAW AND INTERNATIONAL RELATIONS: THE STATE OF ART 119–45 (Jeffrey Dunoff & Mark Pollack eds., 2013).

33. *Id.*

examination of the role IHR plays in delivering global health security.<sup>34</sup> Strong states, for example, tend to have robust public health capability—a core IHR requirement—which they achieved independently, in spite of the obligation stipulated by the IHR. Thus, in this instance, the compliance of strong states with the core IHR requirement, at best, is an epiphenomenon to the IHR. To that effect, the Article will focus on enhancing the effectiveness of the IHR instead of focusing on the IHR's compliance rate. Likewise, legal scholar Timothy Meyer argues that over-emphasizing compliance may understate the effectiveness of international law in changing state behavior.<sup>35</sup> In the same vein, “implementation” is a concept related to compliance, but refers to the administrative process by which states internalize their international obligations. By contrast, “enforcement” refers to the existence of sanctions or material consequences.

### B. Background: The 2014 Ebola Crisis in West Africa

The Ebola outbreak of 2014 is the largest and the most complex Ebola outbreak to date.<sup>36</sup> Formally known as Ebola hemorrhagic fever, the disease is often fatal if left untreated, with an average fatality rate of 50 percent.<sup>37</sup> Ebola is transmitted through human-to-human exchange of bodily fluids, and contact with surfaces and materials (e.g., bedding, clothing, or needles) contaminated with the bodily fluids of infected individuals. Healthcare workers are particularly vulnerable to infection while treating patients with suspected or confirmed Ebola virus disease (EVD).<sup>38</sup> Precautionary infectious disease control, if strictly practiced, mitigates this risk significantly.<sup>39</sup> EVD has an

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34. Timothy Meyer, *How Compliance Understates Effectiveness*, ASIL UNBOUND (June 18, 2014), <http://www.asil.org/blogs/how-compliance-understates-effectiveness> [<https://perma.cc/RP9V-5ZRZ>] (archived Sept. 18, 2016); see also *Ebola Response Panel Studying Ways to Enforce Compliance with Key UN Legal Health Instrument*, UN NEWS (Aug. 26, 2015), <http://www.un.org/apps/news/story.asp?NewsID=51730#.VkLfniu2W3g> [<https://perma.cc/Z3KY-YNG4>] (archived Sept. 18, 2016) (stating that a panel has been established to discuss better methods of compliance).

35. Meyer, *supra* note 34.

36. *2014 Ebola Outbreak in West Africa*, CTRS FOR DISEASE CONTROL AND PREVENTION (CDC), <http://www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/index.html> (last visited Sept. 17, 2016) [<https://perma.cc/63AE-T5XC>] (archived Sept. 18, 2016).

37. *Ebola Virus Disease*, WHO, <http://www.who.int/mediacentre/factsheets/fs103/en/> (last visited Sept. 17, 2016) [<https://perma.cc/M8T3-F5ZH>] (archived Sept. 18, 2016).

38. *About Ebola Hemorrhagic Fever*, CDC, <http://www.cdc.gov/vhf/ebola/about.html> (last visited Sept. 9, 2016) [<https://perma.cc/Z4RX-GL6Z>] (archived Sept. 18, 2016).

39. See *Transmission: Ebola Hemorrhagic Fever*, CDC, <http://www.cdc.gov/vhf/ebola/transmission/> (last visited Sept. 17, 2016) [<https://perma.cc/26LB-G898>] (archived Sept. 18, 2016) (explaining how Ebola is transmitted).

incubation period of two to twenty-one days, meaning that infected individuals are not infectious until symptoms develop, but they remain infectious as long as their blood contains the virus.<sup>40</sup> Burial of an infected person also increases the transmission of the disease if mourners have direct contact with the body of the deceased.<sup>41</sup> Currently, there are no licensed Ebola vaccines available, but two potential vaccines are undergoing human safety trials.<sup>42</sup>

The 2014 Ebola outbreak first appeared in a two-year old boy who was living near Guinea's border with Liberia and Sierra Leone.<sup>43</sup> The boy fell ill on December 6, 2013, but, due to a Guinean health officials' unfamiliarity with the disease, Ebola remained undiagnosed until March 21, 2014. By then, Ebola had spread to Liberia and Liberian officials confirmed the presence of the disease two days after Guinea's confirmation. In the meantime, scientists in Sierra Leone also suspected Ebola had emerged there, which was later confirmed as linked to an unsafe burial practice of a traditional healer held in March in Guinea. The information was not picked up by Sierra Leone's surveillance system until May. By late June, Ebola was confirmed in sixty locations across Guinea, Liberia, and Sierra Leone. Overwhelmed and understaffed, Médecins Sans Frontières (MSF, also known as Doctors without Borders), the only international, independent medical humanitarian organization treating affected individuals at that point, issued a warning on June 21, 2014 that Ebola "was out of control," calling for a "massive deployment of resources" to contain the

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40. *Signs and Symptoms*, CDC, <http://www.cdc.gov/vhf/ebola/symptoms/index.html> (last visited Sept. 17, 2016) [<https://perma.cc/YJ4V-58PW>] (archived Sept. 18, 2016).

41. *New WHO Safe and Dignified Burial Protocol - Key to Reducing Ebola Transmission*, WHO, <http://www.who.int/mediacentre/news/notes/2014/ebola-burial-protocol/en/> (last visited Sept. 11, 2016) [<https://perma.cc/9RJ9-UBH9>] (archived Sept. 18, 2016).

42. *Ebola Vaccines, Therapies, and Diagnostics*, WHO, [http://www.who.int/medicines/emp\\_ebola\\_q\\_as/en/](http://www.who.int/medicines/emp_ebola_q_as/en/) (last visited Sept. 17, 2016) [<https://perma.cc/ER59-HS5H>] (archived Sept. 18, 2016); *Ebola Virus Disease (EVD) Information for Clinicians in U.S. Healthcare Settings*, CDC, <http://www.cdc.gov/vhf/ebola/healthcare-us/preparing/clinicians.html> (last visited Sept. 17, 2016) [<https://perma.cc/743Z-W5L7>] (archived Sept. 18, 2016); see also *NIAID Role in Ebola and Marburg Research*, NAT'L INST. OF ALLERGY AND INFECTIOUS DISEASE, <http://www.niaid.nih.gov/topics/ebolamarburg/research/pages/default.aspx> (last visited Sept. 11, 2016) [<https://perma.cc/9LB8-YD7J>] (archived Sept. 18, 2016) (discussing NIAID's research regarding a vaccine for Ebola).

43. See Rebecca Davis, *Ebola Epidemic 2014: Timeline*, GUARDIAN (Oct. 15, 2014), <http://www.theguardian.com/world/2014/oct/15/ebola-epidemic-2014-timeline> [<https://perma.cc/W9AB-J8D8>] (archived Sept. 18, 2016); *Ebola Features Map*, WHO, <http://www.who.int/features/ebola/storymap/en/> (last visited Sept. 10, 2016) [<https://perma.cc/WSC7-FK9H>] (archived Sept. 18, 2016) (depicting the regional area of the outbreak).

unprecedented scale and rapid spread of Ebola.<sup>44</sup> The dire situation in these three most affected countries could not be understated, and was made worse by the lack of external financial and technical support. Liberia, for instance, had fifty-two registered medical doctors for a population of 4.5 million;<sup>45</sup> MSF was forced to turn away patients because of inadequate space and staff.<sup>46</sup>

While Ebola has periodically erupted in the region since the 1970s, no outbreak had been recorded until 2014, and it would take until July of 2014 for the international community to take MSF's warning seriously. By then, Ebola had spread to Senegal, Mali, the United States, and the United Kingdom, but was controlled in those areas.<sup>47</sup> However, the virus had also spread to Nigeria and visibly crippled the worst-affected countries in West Africa: Guinea, Liberia, and Sierra Leone. On August 8, the WHO finally declared the outbreak, which had by now killed nearly one thousand people, making it a Public Health Emergency of International Concern (PHEIC) under the IHR.<sup>48</sup> Yet it was not until September, when the United Nations established its Mission for Ebola Emergency Response (UNMEER) which directly answered to UN Secretary-General Bi-Ki Moon, that the international community responded to MSF's humanitarian pleas—first made in June—with real, substantial actions.<sup>49</sup> Two of the largest contributors, the United States and the World Bank, mobilized three thousand troops, who supported logistics, trained health workers, built seventeen treatment centers, mobilized financing for training of

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44. *Ebola in West Africa: Epidemic Requires Massive Deployment of Resources*, MÉDECINS SANS FRONTIÈRES (MSF) INT'L, <http://www.msf.org/article/ebola-west-africa-epidemic-requires-massive-deployment-resources> (last visited Sept. 11, 2016) [<https://perma.cc/Q6P6-MYVS>] (archived Sept. 18, 2016).

45. LIBERIA INSTITUTE OF STATISTICS AND GEO-INFORMATION SERVICES MONROVIA, LIBERIA, LIBERIA DEMOGRAPHIC AND HEALTH SURVEY 2013 PRELIMINARY REPORT (Oct. 2013), [http://www.unicef.org/liberia/Liberia\\_DHS\\_2013\\_-\\_Preliminary\\_Report.pdf](http://www.unicef.org/liberia/Liberia_DHS_2013_-_Preliminary_Report.pdf) [<https://perma.cc/8CHL-K2TA>] (archived Sept. 18, 2016).

46. *Ebola: Pushed to the Limit and Beyond - MSF report*, MSF UK, <http://www.msf.org.uk/article/ebola-pushed-to-the-limit-and-beyond-msf-report> (last visited Sept. 17, 2016) [<https://perma.cc/U2MY-GRAA>] (archived Sept. 18, 2016); Erika Check Hayden, *Ebola Outbreak Thrusts MSF into New Roles*, NAT. NEWS & COMMENT (June 3, 2015), <http://www.nature.com/news/ebola-outbreak-thrusts-msf-into-new-roles-1.17690> [<https://perma.cc/PQ7H-ZQZY>] (archived Sept. 18, 2016).

47. Hayden, *supra* note 46.

48. *Statement on the 1<sup>st</sup> Meeting of the IHR Emergency Committee on the 2014 Ebola Outbreak in West Africa*, WHO, <http://www.who.int/mediacentre/news/statements/2014/ebola-20140808/en/> (last visited Sept. 17, 2016) [<https://perma.cc/AV8U-9WY9>] (archived Sept. 18, 2016).

49. *See UN Mission for Ebola Emergency Response (UNMEER): Lessons Learned*, GENERAL ASSEMBLY OF THE UNITED NATIONS, <http://www.un.org/pga/70/2015/10/15/un-mission-for-ebola-emergency-response-unmeer-lessons-learned/> (last visited Sept. 17, 2016) [<https://perma.cc/M96G-C7HB>] (archived Sept. 18, 2016).

healthcare workers, purchased essential supplies, and raised funds for capability building and post-Ebola recovery and reconstruction.<sup>50</sup>

In practice, EVD can be contained efficiently within a robust public health system and with an open channel of communication.<sup>51</sup> However, in post-conflict Guinea, Liberia, and Sierra Leone, fragile public health systems, low health literacy, and inadequate health and human resources accelerated the EVD transmission rate, which was made worse by the deep distrust between governments and foreign aid workers stemming from the long periods of civil conflict in these countries.<sup>52</sup> Affected countries also hesitated in notifying the WHO because of the economic and trade repercussions associated with notification.<sup>53</sup>

Increasingly isolated, the worst-affected countries in West Africa resorted to extraordinary measures that many scholars argued were in violation of international human rights.<sup>54</sup> Soon after Liberia's state of emergency declaration, President Ellen Johnson Sirleaf authorized a large-scale, military-led quarantine in West Point, Monrovia.<sup>55</sup> Instead of containing EVD efficiently, the quarantine measure provoked fear and violence in a country that had just emerged from long-term civil conflicts.<sup>56</sup> In Guinea, MSF's aid efforts were regularly

50. Dion Nissenbaum & Julian E. Barnes, *U.S. Military to End African Ebola Role*, WALL ST. J. (Feb. 11, 2015), <http://www.wsj.com/articles/u-s-to-end-african-ebola-role-1423612366> (subscription required) [<https://perma.cc/WWW6-3WTX>] (archived Sept. 18, 2016); *Fact Sheet: U.S. Response to the Ebola Epidemic in West Africa*, WHITEHOUSE.GOV, <https://www.whitehouse.gov/the-press-office/2014/09/16/fact-sheet-us-response-ebola-epidemic-west-africa> (last visited Sept. 17, 2016) [<https://perma.cc/68F2-6BVE>] (archived Sept. 18, 2016).

51. Gerald Amandu Matua, Dirk Mostert Van der Wal & Rozzano C. Locsin, *Ebola Hemorrhagic Fever Outbreaks: Strategies for Effective Epidemic Management, Containment and Control*, 19 BRAZ. J. INFECT. DIS. 308, 310–13 (2015).

52. Adia Benton & Kim Yi Dionne, *International Political Economy and the 2014 West African Ebola Outbreak*, 58 AFR. STUD. REV. 223, 223–36 (2015).

53. World Health Organization, *Ebola Interim Assessment Panel Report by the Secretariat*, ¶10 U.N. Doc. A68/25 (May 8, 2015) [hereinafter *Ebola Interim Assessment Panel Report*]; Adele Faur, *Transparency in the Time of Ebola: Encouraging the Timely Sharing of Outbreak Data*, AFR. L. & BUS. (June 23, 2015), <http://www.africanlawbusiness.com/news/5644-transparency-in-the-time-of-ebola-encouraging-the-timely-sharing-of-outbreak-data> [<https://perma.cc/Y9SN-GE83>] (archived Sept. 18, 2016).

54. James Hodge et al., *Global Emergency Legal Responses to the 2014 Ebola Outbreak: Public Health and the Law*, 42 J.L. MED. & ETHICS 595, 598–99 (2014).

55. Norimitsu Onishi, *As Ebola Grips Liberia's Capital, a Quarantine Sows Social Chaos*, N.Y. TIMES (Aug. 28, 2014), [http://www.nytimes.com/2014/08/29/world/africa/in-liberias-capital-an-ebola-outbreak-like-noother.html?rref=collection%2Ftimes%2FJohnson%20Sirleaf%2C%20Ellen&action=click&contentCollection=timestopic%2F Ebola&region=stream&module=stream\\_unit&version=latest&contentPlacement=7&pgtype=collection&r=0](http://www.nytimes.com/2014/08/29/world/africa/in-liberias-capital-an-ebola-outbreak-like-noother.html?rref=collection%2Ftimes%2FJohnson%20Sirleaf%2C%20Ellen&action=click&contentCollection=timestopic%2F Ebola&region=stream&module=stream_unit&version=latest&contentPlacement=7&pgtype=collection&r=0) [<https://perma.cc/MZ44-46H2>] (archived Sept. 18, 2016).

56. Benton & Dionne, *supra* note 52.

met with fear, and sometimes hostility, from the local community.<sup>57</sup> In Sierra Leone, loss of confidence in political leadership translated into fear about the disease; some local residents believed that the disease was a plot by the government to get humanitarian aid.<sup>58</sup> Violence against foreign aid workers also stemmed in part from the locals' unfamiliarity with the necessary EVD precautionary measures: aid workers arrived in unfamiliar, spacesuit-like protective gear and immediately removed the infected deceased bodies, further invoking fear and panic.<sup>59</sup> In addition, health workers and patients who survived Ebola were stigmatized, and treating EVD patients diverted health resources away from the already strained health systems in these countries.

With 77.9 million people in need of assistance worldwide as of September 17, 2014, the UN Secretary-General noted that the dire situation in Africa had escalated to a humanitarian crisis.<sup>60</sup> Specifically, the Security Council categorized the disease outbreak as "a threat to international peace and security,"<sup>61</sup> noting the political, social, economic, humanitarian, logistical, and security dimensions of the Ebola outbreak in West Africa. On September 18, the Security Council adopted Resolution 2177 and, a day later, Secretary-General Ban Ki-Moon announced the establishment of UNMEER, prompted

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57. *The Race to Control Ebola in Sierra Leone*, MSF USA, <http://www.doctorswithoutborders.org/news-stories/field-news/race-control-ebola-sierra-leone> (last visited Sept. 17, 2016) [<https://perma.cc/3XUX-Y8KD>] (archived Sept. 18, 2016).

58. Benton & Dionne, *supra* note 52.

59. Laurie Garrett, *Sierra Leone's Ebola Epidemic is Spiralling Out of Control*, FOREIGN POL'Y (Dec. 10, 2014), <http://foreignpolicy.com/2014/12/10/sierra-leones-ebola-epidemic-is-spiraling-out-of-control/> [<https://perma.cc/AND4-RVE5>] (archived Sept. 18, 2016).

60. See U.N. SCOR, 69th Sess., 7260th mtg., U.N. DOC. S/PV.7260 (Sept. 9, 2014); *Statement by the Secretary-General on the establishment of the United Nations Mission for Ebola Emergency Response (UNMEER)*, U.N. SECRETARY GENERAL (Sept. 19, 2014), <https://www.un.org/sg/en/content/sg/statement/2014-09-19/statement-secretary-general-establishment-united-nations-mission> [<https://perma.cc/X2CU-8ZN2>] (archived Sept. 19, 2016); Press Release, Security Council, Adopting Resolution 2176 (2014), Security Council Approves Three-Month Extension for United Nations Mission in Liberia, With Further Renewal under Review, U.N. Press Release SC/11559 (Sept. 14, 2014) ([www.un.org/News/Press/docs/2014/sc11559.doc.htm](http://www.un.org/News/Press/docs/2014/sc11559.doc.htm)) [<https://perma.cc/7YJC-QYFL>] (archived Sept. 19, 2016) (authorizing the extension for UN Mission and urging an increased international response); Press Release, Security Council, Security Council Press Statement on United Nations Office for West Africa, U.N. Press Release SC/11466-AFR/2930 (July 9, 2014) ([www.un.org/press/en/2014/sc11466.doc.htm](http://www.un.org/press/en/2014/sc11466.doc.htm)) [<https://perma.cc/2M6H-366G>] (archived Sept. 19, 2016); *UN Mission for Ebola Emergency Response*, GLOBAL EBOLA RESPONSE, <http://ebolaresponse.un.org/un-mission-ebola-emergency-response-unmeer> (last visited Sept. 18, 2016) [<https://perma.cc/TXK2-Q9SU>] (archived Sept. 19, 2016) [hereinafter *UN Mission for Ebola Emergency Response*] (discussing the first ever UN emergency health mission).

61. S.C. Res. 2177, ¶ 1 (Sept. 18, 2014).



largely by the international leadership vacuum.<sup>62</sup> Significantly, Resolution 2177 formally marked the first time that the Security Council recognized a disease outbreak as a threat to international peace and security, and the second time that the Security Council had dealt directly with a public health concern (the first being the HIV/AIDS epidemic).

Importantly, UNMEER was established to provide immediate disaster relief to affected countries in West Africa. Hence, UNMEER, an innovative UN-led emergency health mission deployed under Secretary-General Ban Ki-Moon's authority, was neither a "peacekeeping operation" nor a "political mission."<sup>63</sup> Instead, as Secretary-General Ban Ki-Moon explained, the Mission "harness[es] the capabilities and competencies of all the relevant United Nations actors under a unified operational structure to reinforce unity of purpose, effective ground-level leadership and operational direction in order to ensure a rapid, effective, efficient, and coherent response to the crisis."<sup>64</sup>

In spite of the fact that, historically, the WHO assumes the coordination function of health matters among the UN agencies, as mandated by its Constitution, the WHO was notably absent during the initial response phase of the 2014 Ebola outbreak. Several reasons explain the WHO's conspicuous absence: first, the organization lacked the necessary financial resources to lead the international response; second, it could not command authority from states and non-state actors; and, third, structurally, the WHO is not designed to carry out ground-level support work.

This leadership vacuum during the initial response phase prompted the United Nations to take over the humanitarian mission in West Africa.<sup>65</sup> Secretary-General Ban Ki-Moon solemnly observed that "[n]o one country or organization had the resources to stem the tide of the Ebola crisis."<sup>66</sup> Such a comment is even more profound in

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62. *UN Mission for Ebola Emergency Response*, *supra* note 60.

63. *Id.*

64. *Id.*

65. *Ban Launches UN Ebola Response Mission; Advance Teams to Arrive in West Africa on Monday UN News Service Section*, UN NEWS (Sept. 20, 2014), <http://www.un.org/apps/news/story.asp?NewsID=48760#.Vlulu7-2W3g> [<https://perma.cc/S9F3-KT6N>] (archived Sept. 19, 2016).

66. THE ROLE OF WHO WITHIN THE UNITED NATIONS MISSION FOR EBOLA EMERGENCY RESPONSE REPORT OF THE SECRETARIAT, WHO, ¶7 (Apr. 2015), <http://www.who.int/csr/resources/publications/ebola/who-unmeer.pdf?ua=1> [<https://perma.cc/8SHX-7CF7>] (archived Sept. 19, 2016); *see* Press Release, WHO Welcomes Decision to Establish United Nations Mission for Ebola Emergency Response (Sept. 19, 2014) ([www.who.int/mediacentre/news/releases/2014/ebola-emergency-response/en/](http://www.who.int/mediacentre/news/releases/2014/ebola-emergency-response/en/)) [<https://perma.cc/33XS-V34C>] (archived Sept. 19, 2016)) (stating the need for the UN initiative because it was a social, humanitarian, and economic crisis); *UN Mission for Ebola Emergency Response*, *supra* note 60 (discussing the need to support the governments of Guinea, Liberia and Sierra Leone).

light of the fact that a number of agencies with public health missions have appeared recently in the global health sphere. Yet, despite the fact that the global health terrain is now occupied by numerous agencies with overlapping public health mandates—local ministries of health in Liberia, Guinea, and Sierra Leone; MSF; the U.S. Centers for Disease Control and Prevention; UNICEF; bilateral aid agencies; and private philanthropies—mobilizing the relevant agencies remained challenging during the initial stage of the international response.

While the interdependency between global health and the attainment of international peace and security is strongly referenced in the WHO's Constitution and is a repeated theme in the WHO's work,<sup>67</sup> UNMEER, which answers directly to Secretary-General Ban Ki-Moon, formally converged public health and international security interests at the UN level. In theory, UNMEER complements the WHO's work by providing its expertise in humanitarian relief, but, in practice, the lack of communication among the international agencies and the local communities created confusion and further delayed the emergency response.<sup>68</sup> UNMEER, for instance, remained a disaster relief mission operationally, and transported quantities of food instead of the medical supplies needed in the worst-affected countries.<sup>69</sup> On the other hand, the WHO had little logistical experience in West Africa, and, during the initial phase of the outbreak, the Geneva-based technocrats formulating the disease control response overlooked the basic fact that medical staff at the ground-level did not have enough essential medical supplies, for example, latex gloves, protective gowns, and rehydrating fluid.<sup>70</sup> The disconnect between the local needs and the global response was devastating: the lack of protective gear for healthcare workers had resulted in 512 deaths of EVD-infected health care workers in Guinea, Liberia, and Sierra Leone as of January 14, 2016.<sup>71</sup> Moreover, the mobilization of UNMEER was also hugely

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67. See CONST. OF THE WORLD HEALTH ORGANIZATION (1946), <http://apps.who.int/gb/bd/PDF/bd48/basic-documents-48th-edition-en.pdf?#page=7> [<https://perma.cc/VJR4-HPW8>] (archived Sept. 19, 2016), reprinted in WORLD HEALTH ORGANIZATION BASIC DOCUMENTS 1 (48th ed. 2014) ("The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and States."); G.A. Res. 217 (III) A, art. 22, Universal Declaration of Human Rights (Dec. 10, 1948) (stating that everyone has a right to security through international cooperation).

68. Benton & Dionne, *supra* note 52.

69. Press Release, Security Council, With Spread of Ebola Outpacing Response, Security Council Adopts Resolution 2177 (2014) Urging Immediate Action, End to Isolation of Affected States, U.N. Press Release SC/11566 (Sept. 14, 2014) (<http://www.un.org/press/en/2014/sc11566.doc.htm> [<https://perma.cc/LSL9-7U9G>] (archived Sept. 19, 2016)).

70. S.C. Res. 2177, *supra* note 61, at 4.

71. *Ebola in Africa: The End of a Tragedy?*, ECONOMIST (Jan. 14, 2016), <http://www.economist.com/blogs/graphicdetail/2016/01/daily-chart-12> [<https://perma.cc/DFA9-SBK9>] (archived Sept. 19, 2016).

expansive, far exceeding the WHO's interventions: the estimated cost for the operation was \$19 million, with \$3.3 million unaccounted for.<sup>72</sup> Unfamiliarity with the local culture and tradition also made the implementation of standard EVD treatment difficult.<sup>73</sup>

To their credit, the three worst-affected countries activated their national emergency committees early in the outbreak, but limited experience with EVD weakened their emergency response plans significantly.<sup>74</sup> Many commentators also pointed out that most of the measures taken by these governments had little impact in containing EVD but had a huge impact on human rights.<sup>75</sup> Without a normative guide, affected West African countries implemented measures that fomented a climate of fear, which was aggravated by the lack of effective communication between the government and the affected population, further delaying effective containment of EVD. The lack of normative guidance at the ground level also impaired nongovernmental organizations' response efforts considerably, which were further complicated by inadequate coordination mechanisms between the state and non-state actors' responses.<sup>76</sup>

Additionally, the countries affected had little incentive to notify the WHO, mainly because the affected governments feared the economic and political repercussions stemming from their notification.<sup>77</sup> Such concern was not groundless. After the WHO's PHEIC declaration, Australia and Canada announced travel restrictions on entry for residents from Liberia, Sierra Leone, and Guinea,<sup>78</sup> in spite of the fact that, with robust public health systems in

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72. See Press Release, General Assembly, Fifth Committee Concerned by Top-Heavy Structure, Resource Distribution in Ebola Response Mission, Proposed Budget Cuts to Darfur Peacekeeping, U.N. Press Release GA/AB/4141 (Dec. 18, 2014) (<http://www.un.org/press/en/2014/gaab4141.doc.htm>) [<https://perma.cc/DM2M-RTRR>] (archived Sept. 19, 2016).

73. See Monica Mark, *As Ebola Epidemic Tightens Grip, West Africa Turns to Religion for Succour*, *GUARDIAN* (Oct. 17, 2015), <http://www.theguardian.com/world/2014/oct/17/ebola-epidemic-west-africa-religion-church-virus-transmission> [<https://perma.cc/8S6S-ZUEP>] (archived Sept. 19, 2016) (discussing the role of religion in Africa in regards to Ebola).

74. See, e.g., Hodge et al., *supra* note 54.

75. *West Africa: Respect Rights in Ebola Response*, *HUM. RTS. WATCH* (Sept. 15, 2014), <https://www.hrw.org/news/2014/09/15/west-africa-respect-rights-ebola-response> [<https://perma.cc/S4WP-CCEA>] (archived Sept. 19, 2016); Elizabeth Cohen et al., *Quarantined Nurse Slams State Ebola Policy*, *CNN* (Oct. 26, 2014), <http://edition.cnn.com/2014/10/26/health/new-jersey-quarantined-nurse/> [<https://perma.cc/E5MG-BU8B>] (archived Sept. 19, 2016).

76. See Jenny Lei Ravelo, *Help Row, Not Steer: Lessons from the Ebola Crisis Response*, *DEVEX* (June 30, 2015), <https://www.devex.com/news/help-row-not-steer-lessons-from-the-ebola-crisis-response-86451> [<https://perma.cc/42BU-PVXD>] (archived Sept. 19, 2016) (discussing the importance of feedback and coordination).

77. Ebola Interim Assessment Panel Report, *supra* note 53, at ¶ 32.

78. See *Australia Suspends Visas for People Travelling from Ebola-hit Countries*, *BBC NEWS* (Oct. 27, 2014), <http://www.bbc.com/news/world-australia-29783106>

place, these two countries were at extremely low risk. Furthermore, with Resolution 2177 formally marking the 2014 Ebola outbreak as an international security issue, some commentators were wary that such categorization would imply that infected EVD patients were not dissimilar to political motivated terrorists.<sup>79</sup>

## II. THE WORLD HEALTH ORGANIZATION

The 2014 Ebola outbreak critically exposed the WHO's institutional weaknesses in coordinating an international response to control the spread of transnational infectious diseases, despite the fact that such a mandate falls squarely within its constitutional and normative authority.<sup>80</sup> Prompted by the WHO's apparent leadership failure, several new institutions and initiatives outside of the WHO governance framework have emerged, most notably, UNMEER, created by the United Nations, and the PEF, which is housed in the World Bank. The United States has also taken international steps with the launch of a Global Health Security Agenda to close the gaps in global governance.<sup>81</sup> The emergence of these initiatives highlights an idiosyncratic interest in global health security, which remains one of the WHO's cardinal responsibilities, but the leadership vacuum during the initial phase of the outbreak calls the WHO's capability to address international health security into question. Equally, many commentators are concerned that the creation of new institutions could risk undermining the WHO's authority considerably, further fragmenting the global governance of health.<sup>82</sup>

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[<https://perma.cc/5JAH-3NQP>] (archived Sept. 19, 2016); *Ebola Outbreak: Canada Turned 176 People Away After Imposing Travel Ban*, CBC NEWS (Dec. 31, 2014), <http://www.cbc.ca/news/health/ebola-outbreak-canada-turned-176-people-away-after-imposing-travel-ban-1.2887673> [<https://perma.cc/4DV7-SL6P>] (archived Sept. 19, 2016); see also *UN Security Council Criticizes Discrimination Against Those from Ebola-hit Regions*, GUARDIAN (Nov. 22, 2014), <http://www.theguardian.com/world/2014/nov/22/ebola-a-threat-to-international-peace-and-security-says-julie-bishop> [<https://perma.cc/5MJA-VPKG>] (archived Sept. 19, 2016) (discussing the UN security council criticizing countries issuing travel restrictions).

79. Gian Luca Burci & Jakob Quirin, *Ebola, WHO, and the United Nations: Convergence of Global Public Health and International Peace and Security*, AM. SOC. INT'L L., <https://www.asil.org/insights/volume/18/issue/25/ebola-who-and-united-nations-convergence-global-public-health-and> (last visited Sept. 18, 2016) [<https://perma.cc/9CVR-KDAN>] (archived Sept. 19, 2016).

80. CONST. OF THE WORLD HEALTH ORGANIZATION, *supra* note 67.

81. GLOBAL HEALTH SECURITY AGENDA, <https://www.ghsagenda.org/> (last visited Sept. 17, 2016) [<https://perma.cc/LW22-6SHK>] (archived Sept. 26, 2016).

82. See generally Lawrence O. Gostin et. al, *The Joint Action and Learning Initiative on National and Global Responsibilities for Health*, (World Health Report Background Paper No. 53, 2010) (explaining that global health institutions do not coordinate and thus cause further fragmentation).

Most fundamentally, new institutions also raise a question about the proper role of the WHO in a crowded global health landscape, a question to which the Article now turns. In order to shed light on these issues, this Part outlines the WHO's normative authority, highlighting that, with an (almost) universal membership and amiable constitutional and normative authority, the WHO is uniquely positioned to lead an international response in global health emergencies. That said, the ability of the WHO to lead is also constrained by the political-economic landscape in which the agency operates. Examining the structural deficiencies that handicap the WHO's operations paves the way for later discussion on strengthening the enforcement mechanisms of the IHR.

### A. *The WHO's Normative Visions*

The WHO, established in 1948 in the aftermath of World War II, is driven by a strong, collective recognition of the need to improve health worldwide.<sup>83</sup> Despite the recent expansion of new global health actors in the global health landscape, the WHO remains the principal international organization charged with addressing the threat of emerging and re-emerging infectious diseases affecting global health security. The WHO Constitution and the UN Charter establish the organization as the specialized health agency within the UN system, bestowing upon the organization a normative and constitutional authority in global health that is unparalleled in comparison to other UN agencies involved in health.<sup>84</sup> Article 1 of the WHO Constitution explicitly recognizes that the purpose of the organization "shall be the attainment by all peoples of the highest possible level of health."<sup>85</sup> Likewise, upon its establishment, Member States granted the WHO an extensive scope of authority so that the organization could fulfill its constitutional mandate.<sup>86</sup>

This need to coordinate international response to transnational infectious disease control in part explains the granting of extensive authority to the WHO by its Member States in the establishment of the

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83. Sze, *supra* note 1; see David McCoy, Sudeep Chand & Devi Sridhar, *Global Health Funding: How Much, Where It Comes From and Where It Goes*, 24 HEALTH POL'Y PLAN. 407, 412 (2009) (discussing WHO spending on healthcare, other organizations that provide health care, and research).

84. Lawrence O. Gostin, Devi Sridhar & Daniel Hougendobler, *The Normative Authority of the World Health Organization*, 129 PUB. HEALTH 854, 854 (2015).

85. CONST. OF THE WORLD HEALTH ORGANIZATION, *supra* note 67, at art. 1.

86. GIAN LUCA BURCI & CLAUDE-HENRI VIGNES, THE WORLD HEALTH ORGANIZATION 124 (2004); Allyn Taylor, *Making the World Health Organization Work: A Legal Framework for Universal Access to the Conditions for Health*, 18 AM. J. L. & MED. 301, 328 (1992).

agency.<sup>87</sup> Prior to the creation of the WHO, public health governance was “Westphalian,” meaning that no superior authority existed over sovereign states, and each state reigned over its own people by virtue of social contract.<sup>88</sup> But countries plagued by epidemics found it difficult to contain the diseases without coordinated agreements between national governments and standardized national quarantine measures.<sup>89</sup> The first International Sanitary Conference, held in Paris in 1851, for instance, recognized the necessity of international cooperation in implementing uniform measures with minimal interference to cross-border trade activities.<sup>90</sup> International standards not only harmonize national behavior but also ensure that states can reasonably expect that other states will undertake proportionate quarantine responses. A coordinated response is critical, if not highly desirable, in controlling the international spread of infectious diseases, delivering public assurance, and ensuring minimal interruption of international traffic. An international infectious disease control regime grounded in predictability and certainty, thus, was born.

### B. *The WHO’s Constitutional Functions*

The preamble of the WHO Constitution enshrines a collective aspiration to secure the “enjoyment of the highest attainable standard of health” for all.<sup>91</sup> However, since its establishment, the grand vision of the WHO’s founders has become less and less achievable with each passing decade. Consequently, public health practitioners and scholars who are critical of the WHO tend to downplay the normative force of the Preamble.

Upon its establishment, the WHO inherited from the International Health Office in Paris and the Health Section in Geneva—both part of the League of Nations, the predecessor to the United Nations—the cardinal responsibility for the control of international spread of diseases.<sup>92</sup> Article 2 of the WHO Constitution

87. Emilya Brummer & Allyn Taylor, *Institutional Transparency in Global Health Law-making: The World Health Organization and the Implementation of the International Health Regulation*, in *TRANSPARENCY IN INTERNATIONAL LAW* 275 (Andrea Bianchi & Anne Peters eds., 2013).

88. David Fidler, *Return of the Fourth Horseman: Emerging Infectious Diseases and International Law*, 81 *MINN. L. REV.* 771 (1997) [hereinafter Fidler, *Fourth Horseman*]; see David Fidler, *The Role of International Law in the Control of Emerging Infectious Diseases*, 95 *BULLETIN DE L’INSTITUT PASTEUR* 57 (1997), reprinted in *The Politics of Emerging and Resurgent Infectious Diseases* 62–85 (Jim Whitman ed., 2000) [hereinafter, Fidler, *Role of International Law*] (arguing a need for international law to control emerging infectious diseases).

89. Fidler, *Fourth Horseman*, *supra* note 88.

90. Fidler, *Role of International Law*, *supra* note 88, at 59.

91. *CONST. OF THE WORLD HEALTH ORGANIZATION*, *supra* note 67.

92. Brummer & Taylor, *supra* note 87, at 276.

outlines a range of the organization's twenty-two core functions, chief among them is to "stimulate and advance work to eradicate epidemic, endemic and other diseases . . ." <sup>93</sup> Article 2(a) provides that the WHO will "act as the directing and co-coordinating authority on international health work."<sup>94</sup> This has been characterized as a cardinal function of the WHO in implementing the goals of the UN Charter regarding health. Article 2(b) further affirms the WHO's coordinating authority within the UN system, where the organization is tasked "to establish and maintain effective collaboration with the United Nations, specialized agencies, governmental health administrations, professional groups and such organizations as may be deemed appropriate."<sup>95</sup> Article 2(d) provides that the WHO should "furnish appropriate technical assistance and, in emergencies, necessary aid upon the request or acceptance of Governments."<sup>96</sup> Beginning in 1947, the WHO maintained a system of global epidemiological information in accordance with Article 2(f), which mandates that the organization "establish and maintain such administrative and technical services as may be required, including epidemiological and statistic services."<sup>97</sup> The WHO is given extensive power to set international health standards and to ensure their uniformity. Article 2(k), *inter alia*, provides that the WHO will "propose conventions, agreements and regulations, and make recommendations with respect to international health matters and to perform such duties as may be assigned thereby to the Organization and consistent with its objectives."<sup>98</sup>

Insofar as the WHO is a technical-oriented agency, special focus is placed on public health research and data collection. Article 2(n) instructs the WHO "to promote and conduct research in the field of health" <sup>99</sup> and Article 2(q) further obliges the WHO "to provide information, counsel and assistance in the field of health."<sup>100</sup> Given that the WHO is the largest international health organization, Article 2(u) stipulates that the WHO should "develop, establish and promote international standards with respect to food, biological, pharmaceutical and similar products."<sup>101</sup> Finally, Article 2(v) provides that the WHO should "generally . . . take all necessary action to attain the objective of the Organization."<sup>102</sup> Evidently, the diverse and varied functions of the WHO establish the organization as the leading global

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93. CONST. OF THE WORLD HEALTH ORGANIZATION, *supra* note 67, at art. 2

94. *Id.*

95. *Id.*

96. *Id.*

97. *Id.*

98. *Id.*

99. *Id.*

100. *Id.*

101. *Id.*

102. *Id.*

health agency, uniquely situated to address international public health concerns.

Importantly, the Constitution also provides that the World Health Assembly (WHA) “shall have authority to adopt regulations concerning . . . sanitary and quarantine requirements and other procedures designed to prevent the international spread of disease.”<sup>103</sup> The WHA adopted the 2005 IHR and its predecessors under Article 21 by a simple majority.<sup>104</sup> Accordingly, legal scholar Allyn Taylor concludes that the WHO’s normative power is a “fairly unique lawmaking device in the international system.”<sup>105</sup> The foundational documents of the WHO suggest that the founders intended it to replace the previous public health governance system, which was based on a Westphalian governance system. The extensive power bestowed upon the WHO to adopt conventions and regulations and set health-related standards is central to policy integration and coherence at the international level. Professor Taylor further argues that the WHO’s lawmaking power, when read together with Article 1, confers upon the organization “the legal authority to serve as a platform for . . . agreements that potentially address all aspects of national and global public health, as long as advancing human health is the primary objective.”<sup>106</sup> Hence, in the realm of global health security, the WHO’s normative power, along with its almost universal membership, places the organization in a uniquely advantageous position, which many scholars point out the WHO has yet to fully utilize in fulfilling its constitutional mandate.<sup>107</sup>

On the other hand, legal scholar David Fidler argues that the WHO governance structure that emerged after the severe acute respiratory syndrome (SARS) epidemic exhibited features of a “constitutional outline,”<sup>108</sup> which established the WHO as the highest public health authority at the international level. Putting aside this controversial claim for the moment, many scholars and practitioners would agree that the 2014 Ebola outbreak shattered the ambitious vision of the WHO that the founders envisaged.<sup>109</sup> While the WHO

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103. *Id.*

104. World Health Assembly Res. WHA58.3, U.N. Doc. WHA58/2005/REC/1 at 7 (May 16–25, 2005) <http://www.who.int/csr/ihr/WHA58-en.pdf> (last visited Sept. 18, 2016) [<https://perma.cc/E2EN-8MZ3>] (archived Sept. 19, 2016).

105. Allyn Taylor, *International Law, and Public Health Policy*, in INTERNATIONAL ENCYCLOPAEDIA OF PUBLIC HEALTH, 675 (Kris Heggenhougen & Stella Quah eds., 2008); see also Moon et al., *supra* note 5, at 2213–14 (discussing the need to develop a framework of rules).

106. Bruemmer & Taylor, *supra* note 87, at 275.

107. *See id.*

108. David Fidler, *Constitutional Outlines of Public Health's "New World Order"*, 77 TEMP. L. REV. 247, 272 (2004).

109. WHO, MEDIUM-TERM STRATEGIC PLAN 2008–2013 (AMENDED DRAFT), [http://apps.who.int/gb/ebwha/pdf\\_files/MTSP2009/MTSP3-en.pdf](http://apps.who.int/gb/ebwha/pdf_files/MTSP2009/MTSP3-en.pdf) (last visited Sept. 18,



remains a Member State-driven multilateral organization, the political-economic landscape has changed significantly since the WHO's inception. One critical feature of modern global governance is that it has become polycentric. The WHO now competes with a myriad of powerful, and often better-funded new players. States dissatisfied with the WHO tend to circumvent the agency by funding alternative institutions.<sup>110</sup> This has resulted in the creation of health-related UN organizations such as the UN Children's Fund,<sup>111</sup> the UN Population Fund,<sup>112</sup> and the UN Development Programme (UNDP).<sup>113</sup>

Beginning in the 1990s, the World Bank also became an influential player in global health through its funding of development projects.<sup>114</sup> Similarly, in the realm of specific disease management, new initiatives such as the UN Joint Programme on HIV/AIDS (UNAIDS),<sup>115</sup> the Global Alliance on Vaccines and Immunization (GAVI),<sup>116</sup> and the Global Fund to Fight HIV/ AIDS, Tuberculosis and Malaria (GFATM)<sup>117</sup> have emerged. These initiatives joined existing and new bilateral arrangements, such as the U.S. President's Emergency Plan for AIDS Relief (PEPFAR),<sup>118</sup> the UK Department for International Development,<sup>119</sup> and, most recently, the United States launched the Global Health Security Agenda, partly in response to the

2016) [<https://perma.cc/AXD4-T3W5>] (archived Sept. 19, 2016) (discussing why the WHO believed the IHR were insufficient); WHA Res. WHA63/2010/REC/1 (May 21, 2010), [http://apps.who.int/gb/ebwha/pdf\\_files/WHA63-REC1/WHA63\\_REC1-en.pdf](http://apps.who.int/gb/ebwha/pdf_files/WHA63-REC1/WHA63_REC1-en.pdf) [<https://perma.cc/AP3X-AL68>] (archived Sept. 19, 2016).

110. Declan Butler, *Revamp The WHO*, NATURE 473, 430–31 (2011).

111. CHILDREN'S RIGHTS & EMERGENCY RELIEF ORGANIZATION (UNICEF), <http://www.unicef.org/> (last visited Sept. 11, 2016) [<https://perma.cc/LB3Q-EVYZ>] (archived Sept. 19, 2016).

112. UNITED NATIONS POPULATION FUND (UNFPA), <http://www.unfpa.org/> (last visited Sept. 11, 2016) [<https://perma.cc/3KKW-D7U9>] (archived Sept. 19, 2016).

113. UNITED NATIONS DEVELOPMENT PROGRAMME (UNDP), <http://www.undp.org/> (last visited Sept. 11, 2016) [<https://perma.cc/TX7Y-XA94>] (archived Sept. 19, 2016).

114. *The Administration's Response to Ebola*, WHITEHOUSE.GOV, <https://www.whitehouse.gov/ebola-response> (last visited Sept. 16, 2016) [<https://perma.cc/HY4X-BZFU>] (archived Sept. 19, 2016).

115. UN JOINT PROGRAMME ON HIV/AIDS (UNAIDS), <http://www.unaids.org/> (last visited Sept. 11, 2016) [<https://perma.cc/8KW2-MEBF>] (archived Sept. 19, 2016).

116. GAVI, <http://www.gavi.org/> (last visited Sept. 10, 2016) [<https://perma.cc/VK4D-DBRQ>] (archived Sept. 16, 2016).

117. THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA, <http://www.theglobalfund.org/en/> (last visited Sept. 10, 2016) [<https://perma.cc/BP22-VNPG>] (archived Sept. 19, 2016).

118. U.S. PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF (PEPFAR), <http://www.pepfar.gov> (last visited Sept. 18, 2016) [<https://perma.cc/PGD3-GF3G>] (archived Sept. 19, 2016).

119. UNITED KINGDOM GOVERNMENT WEBSITE, DEPARTMENT FOR INTERNATIONAL DEVELOPMENT, <https://www.gov.uk/government/organisations/department-for-international-development> (last visited Sept. 10, 2016) [<https://perma.cc/87NB-G3ZY>] (archived Sept. 19, 2016).

WHO's diminishing influence in global health.<sup>120</sup> The emergence of new actors and agencies further undermines the WHO's ability to steer a global health agenda. Well-funded philanthropies also exert considerable influence in steering a global health agenda, most notably, the Bill and Melinda Gates Foundation, which has helped set the governance agenda for global health.<sup>121</sup>

With the plethora of actors occupying the increasingly crowded global health terrain, investment in global health development aid increased nearly eightfold from 1990–2010, going from \$5.7 billion to \$26.9 billion.<sup>122</sup> Yet financially, the WHO did not benefit from the increased global health funding. In fact, since 1993, the WHO's budget has remained nominal.<sup>123</sup> Major donors' unwillingness to increase the WHO's budget in part reflects a deep concern about the WHO and its diminishing influence in global health. For 2014–2015, the WHO's budget in infectious disease control was cut by \$72 million, forcing the WHO to reduce its personnel in the infectious disease unit.<sup>124</sup> The WHO's \$3.96 billion annual budget is hardly commensurate with the tasks that the world bestowed upon the agency.<sup>125</sup> Moreover, with the bulk—77 percent—of the WHO's budget coming from voluntary contributions of Member States and other donors, earmarked for specific projects, the WHO has little discretion to allocate its budget apace with the global burden of diseases.<sup>126</sup>

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120. GLOBAL HEALTH SECURITY AGENDA, *supra* note 81.

121. See generally BILL & MELINDA GATES FOUNDATION, <http://www.gatesfoundation.org/> (last visited Sept. 10, 2016) [<https://perma.cc/9G8G-6MZ9>] (archived Sept. 19, 2016). For criticism on the influence the philanthropies on global health agenda see for example Christopher G. Bradley, *Partner Capture in Public International Organizations*, 44 AKRON L. REV. 261 (2011); Jeremy Youde, *The Rockefeller and Gates Foundations in Global Health Governance*, 27 GLOBAL SOC'Y 2, 139–58 (2013). Recently, Facebook founder Mark Zuckerberg announced the establishment of the Chan Zuckerberg Initiative, with a focus on health. With the announcement, Mark Zuckerberg and Priscilla Chan officially joined other high-profile global health philanthropists such as Chelsea Clinton, the Vice Chair of the Bill, Hillary and Chelsea Clinton Foundation, Barbara Pierce Bush, the co-founder and President of Global Health Corps, and former New York City mayor Michael Bloomberg, of the Bloomberg Philanthropies.

122. Paolo Piva & Rebecca Dodd, *Where Did all the Aid Go? An In-depth Analysis of Increased Health Aid Flows Over the Past 10 Years*, 87 BULL. WORLD HEALTH ORG. 930 (2009).

123. R. van de Pas & L. G. van Schaik, *Democratizing the World Health Organization*, 128 PUB. HEALTH 195, 195–201 (2014).

124. World Health Assembly, Programme Budget 2014–2015, U.N. Doc. WHA 66.2 (May 24, 2013).

125. See *About the Global Burden of Disease (GBD) Project*, WHO, [http://www.who.int/healthinfo/global\\_burden\\_disease/about/en/](http://www.who.int/healthinfo/global_burden_disease/about/en/) (last visited Sept. 18, 2016) [<https://perma.cc/ZT7C-77LA>] (archived Sept. 19, 2016) (discussing the global burden of diseases).

126. Programme Budget 2014–2015, *supra* note 124.

Amid the wave of dissatisfaction with the WHO from Member States—manifested by the creation of rival institutions and the restriction of the WHO’s operational budget—the agency also suffers from an identity crisis, which further diminishes stakeholders’ confidence in the organization. In response to the universal criticism that the agency was ineffective in handling the Ebola outbreak, Director-General Margaret Chan defended the organization, arguing that the WHO is “a technical agency,” with “governments having first priority to take care of their people.”<sup>127</sup> While it is true that the WHO does not possess the necessary financial resources to undertake disease surveillance and engage in day-to-day medical activities, it is equally unreasonable to expect the worst-affected states with fragile public health systems to be able to contain EVD without external assistance (as suggested by Director-General Chan during the early response phase).<sup>128</sup> Moreover, from a moral viewpoint, the WHO, as the global public health agency, has a moral, if not legal, responsibility to provide timely assistance to the populations worst affected by an outbreak. In particular, the Director-General has the sole discretion to declare an outbreak a PHEIC under the IHR, which MSF argues would have triggered the international mechanisms necessary for mobilizing resources to contain the spread of EVD.<sup>129</sup> Yet, it would take four and half months after the first confirmed incidence of EVD for Director-General Chan to make the declaration on August 8, 2014. By then the virus had spread to Nigeria, with infected health workers and missionaries returning from West Africa to be hospitalized in their respective home countries, including the United States and Spain.<sup>130</sup>

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127. Sheri Fink, *WHO Leader Describes the Agency’s Ebola Operations*, N.Y. TIMES (Sept. 4, 2014), [http://www.nytimes.com/2014/09/04/world/africa/who-leader-describes-the-agencys-ebola-operations.html?\\_r=0](http://www.nytimes.com/2014/09/04/world/africa/who-leader-describes-the-agencys-ebola-operations.html?_r=0) [https://perma.cc/LWL2-7SCS] (archived Sept. 19, 2016).

128. Lena Sun, Brady Dennis, Lenny Bernstein & Joel Achenbach, *How Ebola Sped Out of Control*, WASH. POST (Oct. 4, 2014), <http://www.washingtonpost.com/sf/national/2014/10/04/how-ebola-sped-out-of-control/> [https://perma.cc/27H5-AMZ7] (archived Sept. 19, 2016).

129. *Ebola: the Failures of the International Outbreak Response*, MSF INT’L (Aug. 29, 2014), <http://www.msf.org/article/ebola-failures-international-outbreak-response> [https://perma.cc/6V62-UBHD] (archived Sept. 19, 2016); Maria Cheng, *UN: We Botched Response to the Ebola Outbreak*, AP NEWS (Oct. 17, 2014), <http://www.bigstory.ap.org/article/6fd22fbcca0c47318cb178596d57dc7a/un-we-botched-response-ebola-outbreak> [https://perma.cc/9YLD-WD9X] (archived Sept. 19, 2016).

130. *Cases of Ebola Diagnosed in the United States*, CDC, <http://www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/united-states-imported-case.html> (last visited Sept. 18, 2016) [https://perma.cc/RWB9-5EQ7] (archived Sept. 19, 2016); *Ebola Outbreak: Nurse Infected in Spain*, BBC NEWS (Oct. 6, 2014), <http://www.bbc.com/news/world-europe-29514920> [https://perma.cc/DPX9-U628] (archived Sept. 19, 2016) (discussing the timeline for Ebola cases in the United States); *Ebola Virus Disease – Spain*, WHO DISEASE OUTBREAK NEWS (Oct. 9, 2014), <http://www.who.int/csr/don/09-october-2014-ebola/en/> [https://perma.cc/AG4P-8ZPT] (archived Sept. 19, 2016).

The WHO's hesitancy in declaring the 2014 Ebola outbreak a PHEIC, in part, is reactionary to its H1N1 experience, where many critics claimed that the WHO had made its PHEIC declaration prematurely.<sup>131</sup> This experience made the agency extremely cautious in declaring a situation a PHEIC; the WHO is now visibly reluctant to do so unless an almost universal consensus exists.<sup>132</sup> Nonetheless, the WHO's hesitance to lead meant that MSF—the only prominent international humanitarian aid organization providing medical care and support during the initial phase of the outbreak—was left to care for infected patients in Guinea, Liberia, and Sierra Leone without international logistical, human, or medical resources.<sup>133</sup> These countries had just emerged from long periods of civil conflict, and the deep distrust of authority and foreign workers made MSF's work more difficult.<sup>134</sup>

While the 2014 Ebola outbreak occupied center stage in the recent WHA, this focus did not translate into an increased budget for the WHO.<sup>135</sup> Nonetheless, in an attempt to restore the agency's credibility and leadership, Director-General Chan announced the creation of a Contingency Fund for Emergencies and medical corps reserve.<sup>136</sup> The WHO estimates that the cost of the Ebola response, preparedness,

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131. Dr. Margaret Chan, *External Review of WHO's Response to the H1N1 Influenza Pandemic*, WHO (Sept. 28, 2010), [http://www.who.int/dg/speeches/2010/ihr\\_review\\_20100928/en/](http://www.who.int/dg/speeches/2010/ihr_review_20100928/en/) [https://perma.cc/TT3Z-BXZ7] (archived Sept. 29, 2016).

132. In contrast, WHO declared Zika virus a PHEIC on February 1, 2016, despite that the casual link between the virus and microcephaly was yet then to be scientifically established. In this context, it is reasonable to consider WHO's relatively prompt declaration of Zika virus in Latin America as a political reaction to its widely criticized response and leadership failure during the 2014 Ebola outbreak. Legal scholar Lawrence Gostin further points out that WHO was right to sound the global alert on Zika virus, but the agency still fell short in announcing an action plan and mobilizing the necessary resources which should follow the declaration. Hence the agency's laudable attempt to salvage its reputation contributed little to alleviate the situation on the ground. Donald G. McNeil Jr., *Proof of Zika's Role in Birth Defects Still Months Away*, *W.H.O. Says*, N.Y. TIMES (Feb. 19, 2016), [http://www.nytimes.com/2016/02/20/health/zika-virus-microcephaly-birth-defects-proof-who.html?\\_r=0](http://www.nytimes.com/2016/02/20/health/zika-virus-microcephaly-birth-defects-proof-who.html?_r=0) (subscription required) [https://perma.cc/5WXB-W2A6] (archived Sept. 29, 2016); Lawrence Gostin, *The WHO has not Done Enough*, TIME (Feb. 2, 2016), <http://time.com/4204079/who-zika/> [https://perma.cc/65V4-3ZHX] (archived Sept. 19, 2016).

133. *Ebola*, MSF USA, <http://www.doctorswithoutborders.org/our-work/medical-issues/ebola> (last visited Sept. 16, 2016) [https://perma.cc/VLT5-9TUV] (archived Sept. 19, 2016).

134. Benton & Dionne, *supra* note 52, at 227–28.

135. See generally APPROVED PROGRAMME BUDGET 2014-15 BROKEN DOWN BY PROGRAMME AREA WITH DETAILS ON: STAFFING AND ACTIVITIES, BY MAJOR OFFICE AND ORGANIZATIONAL LEVEL, WHO (June 24, 2013), [http://www.who.int/about/resources\\_planning/PB2014\\_15\\_additional\\_information\\_by\\_Programme\\_Area.pdf](http://www.who.int/about/resources_planning/PB2014_15_additional_information_by_Programme_Area.pdf) [https://perma.cc/U75R-6R59] (archived Sept. 19, 2016) (displaying the WHO budget).

136. *About WHO*, WHO, [http://www.who.int/about/who\\_reform/emergency-capacities/en/](http://www.who.int/about/who_reform/emergency-capacities/en/) (last visited Sept. 16, 2016) [https://perma.cc/SKJ2-7N96] (archived Sept. 19, 2016).

health systems rebuilding, and research and development is \$350 million.<sup>137</sup> Yet, to date, a funding gap of \$171 million (75 percent) remains.<sup>138</sup> Another possible avenue for consolidating substantial international commitment, the G7 Summit, also failed to achieve a concrete commitment, despite the fact that previously the G7 has delivered major public health initiatives—such as the Global Fund to fight AIDS, Tuberculosis, and Malaria in 2002, which forged global health cooperation.<sup>139</sup>

It is worth noting that, during the last two decades, global health security has raised its political prominence in part due to the strategic framings of international infectious disease control as a security as well as a development issue.<sup>140</sup> In 2001, the WHA recognized that “public health is a priority for development and that combating communicable diseases . . . provides important and immediate opportunities for progress.”<sup>141</sup> This development framing gained considerable political recognition with the international community, and has resulted in significant resource mobilization devoted to the eradication of HIV/AIDS.<sup>142</sup>

Similarly, in the realm of international control of infectious diseases, the security framing has also gained considerable political traction internationally.<sup>143</sup> The WHA emphasizes that “any upsurge in cases of infectious disease in a given country is potentially of concern for the international community.”<sup>144</sup> This approach has helped connect

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137. Betsy McKay, *Donors Pledge \$3.4 Billion for Ebola Recovery Plan*, WALL ST. J. (July 11, 2015), <http://www.wsj.com/articles/donors-pledge-3-4-billion-for-ebola-recovery-plan-1436642289> (subscription required) [<https://perma.cc/995B-CTF2>] (archived Sept. 19, 2016).

138. *Funding Gap Looms Amid Efforts to Tackle “Twin Plagues” Ebola*, ISIL, Warns UN Rights Chief, UN NEWS (Oct. 16, 2014), [http://www.un.org/apps/news/story.asp?NewsId=49092#.Vlv\\_eb-2W3g](http://www.un.org/apps/news/story.asp?NewsId=49092#.Vlv_eb-2W3g) [<https://perma.cc/TA7H-D343>] (archived Sept. 19, 2016).

139. *Swedish Assessment of Multilateral Organisations Global Fund to Fight AIDS, Tuberculosis and Malaria*, GOVERNMENT OFFICES SWEDEN, MINISTRY FOR FOREIGN AFFAIRS (2010), <http://www.regeringen.se/contentassets/9fd8d18dfabd45c38d6d12f872a7e2aa/swedish-assessment-of-multilateral-organisations--global-fund-to-fight-aids-tuberculosis-and-malaria-2010> [<https://perma.cc/N775-HBS2>] (archived Sept. 19, 2016).

140. Gavin Yamey, Sabine Campe & Sara Fewer, *Germany, The G7, and Global Health*, 350 B.M.J. 1210 (2015).

141. World Health Assembly, *Global Health Security: Epidemic Alert and Response*, U.N. Doc. WHA54.14 (May 21, 2001).

142. See, e.g., *Who We Are*, USAID, <https://www.usaid.gov/who-we-are> (last visited Sept. 16, 2016) [<https://perma.cc/7TFD-MAN8>] (archived Sept. 19, 2016) (discussing how USAID carries out U.S. foreign policy to help eradicate HIV/AIDS).

143. See *Revision Process of the International Health Regulations (IHR)*, WHO, <http://www.who.int/ihr/revisionprocess/revision/en/> (last visited Sept. 17, 2016) [<https://perma.cc/HZ9U-2FYF>] (archived Sept. 19, 2016) (explaining how World Health Assembly has responded to changes throughout the years).

144. *Global Health Security: Epidemic Alert and Response*, *supra* note 141.

global health with the core political interests of states, transformed the WHO from a technical medical organization into a more politicalized organization, and, importantly, catalyzed the revision of the IHR.<sup>145</sup> However, legal scholar David P. Fidler warns that the 2014 Ebola outbreak has critically damaged the political, institutional, and legal pillars of this approach in elevating global health in the international political agenda.<sup>146</sup> In Fidler's view, both the WHO and its Member States are responsible for undermining this strategy for global health security.<sup>147</sup> Specifically, Fidler argues that the WHO's rejection of the Review Committee's recommendation on the WHO's performance in the SARS outbreak, and its decision to cut funding and reduce staff from its surveillance team, significantly undermined its own authority in global health security.<sup>148</sup> While it is true that the WHO's strategic choice to downplay global health security was, in hindsight, short-sighted, it is also worth emphasizing again that the WHO remains fundamentally a member-driven organization, meaning that the WHO often does not possess the necessary institutional autonomy to make bold political decisions: historically, the WHO has experienced considerable financial cutbacks after making bold decisions that were averse to the interests of strong Member States. This suggests a pressing need to empower the WHO institutionally.

This Article now turns to the IHR—the international legal architecture for infectious disease control—which grounds the discussion on linking the IHR with the PEF, the focus of Part IV.

### C. *The International Health Regulations*

The current infectious disease regime builds from a series of international sanitary conventions and agreements dating from 1851.<sup>149</sup> Beginning in 1948, the WHO initiated a series of revisions and consolidated these agreements into WHO Regulation No. 2—the International Sanitary Regulations (1951 Regulations)—which was later adopted by the Fourth WHA in 1951. The 1951 Regulations underwent a number of revisions as knowledge and control of epidemics evolved.<sup>150</sup> The 1951 Regulations were renamed the “International Health Regulations” in 1969, and focused specifically on

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145. See *Strengthening Health Security by Implementing the International Health Regulations* (2005), WHO, <http://www.who.int/ihr/en/> (last visited Sept. 16, 2016) [<https://perma.cc/L46R-GMRL>] (archived Sept. 19, 2016) (discussing why IHR(2005) was adopted and providing a link to what was enacted).

146. David L. Heymann et al., *Global Health Security: The Wider Lessons from the West African Ebola Virus Disease Epidemic*, 385 THE LANCET 1884, 1888 (2015).

147. *Id.*

148. *Id.*

149. Bruemmer & Taylor, *supra* note 87, at 278.

150. *Id.*

three infectious diseases: cholera, plague, and yellow fever.<sup>151</sup> Over time, it became apparent that the IHR was ill-equipped to handle the growing complexity in global health security, which had been accelerated by the increased flow of international travel and trade. Among the shortcomings of the 1969 IHR were its lack of human rights considerations, the scarcity of mechanisms through which the WHO could collaborate with affected countries in identifying the sources of outbreak, and the lack of legal framework for the WHO to make disease control recommendations.<sup>152</sup>

In 1995, in the wake of plague and EVD in the Democratic Republic of Congo, the WHA passed a resolution to revise and update the IHR. However, it was not until 2003, with the emergence of the SARS epidemic in China, that the revision of IHR began in earnest.<sup>153</sup> Two years later, on May 23, 2005, the WHA adopted the substantively revised IHR (2005 IHR), which entered into force on June 15, 2007.<sup>154</sup>

The key purpose of the 2005 IHR is “to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade.”<sup>155</sup> The 2005 IHR recognizes that a global health emergency necessitates an international coordinated response. Significantly, the WHA adopted the IHR under Article 21 of the WHO Constitution, meaning that all Member States are bound by the IHR unless they expressly announced a reservation to them. The binding nature of Article 21 is unique among international institutions with international lawmaking authority.<sup>156</sup> The 2005 IHR provides a global legal architecture for coordinated and proportionate responses to significant emerging disease threats to global health security. Importantly, the 2005 IHR reaffirms the importance of prevention—a core public health value—and embeds the public health norms into the international health regime. Equally important, the 2005 IHR establishes the WHO as the directing and coordinating authority on

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151. *Id.*

152. *Id.* at 278–79.

153. David P. Fidler, *From International Sanitary Conventions to Global Health Security: The New International Health Regulations*, 4 CHINESE J. INT'L. L. 325, 343 (2005).

154. WHO, *supra* note 145.

155. WHO, INTERNATIONAL HEALTH REGULATIONS (2d ed. 2005), [http://apps.who.int/iris/bitstream/10665/43883/1/9789241580410\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/43883/1/9789241580410_eng.pdf) (last visited Sept. 18, 2016) [<https://perma.cc/DKB4-DNEP>] (archived Sept. 19, 2016) [hereinafter IHR(2005)] (discussing why IHR(2005) was adopted and providing a link to what was enacted); *see also* INTERNATIONAL HEALTH REGULATIONS (1969), WHO, <http://apps.who.int/iris/bitstream/10665/96616/1/9241580070.pdf> [<https://perma.cc/YDL8-S62W>] (archived Sept. 19, 2016) (amended in 1973 and 1981).

156. CONST. OF THE WORLD HEALTH ORGANIZATION, *supra* note 67, at art. 21.

international health within the UN system and recognizes health as a human right.<sup>157</sup>

The WHA adopted the 2005 IHR with three key updates. First, instead of limiting it to specific diseases, the 2005 IHR expands the scope of coverage. Under the new IHR, countries are required to notify the WHO of “events that may constitute a public health emergency of international concern.”<sup>158</sup> Annex 2 of the IHR provides an algorithm for the concerned State Party to assess whether an event may constitute an international public health emergency and procedures for notifying the WHO accordingly.<sup>159</sup> The algorithm includes a risk assessment of public health impact, the risk to human health, the risk of international spread of disease, and the risk of interference with international traffic.<sup>160</sup>

Second, the 2005 IHR encourages non-state actors to submit outbreak reports. Article 9 permits the WHO to consider such reports in accordance with established scientific principles and disclose the information to the relevant State Party, although the WHO may retain the confidentiality of the source if it is duly justified.<sup>161</sup> Third, in determining whether an event constitutes an international public health risk, Article 12 provides that the Director-General of the WHO, in consultation with the State Party concerned, shall make the primary determination of a health emergency of international concern.<sup>162</sup> Article 12 further provides a list of criteria the Director-General shall consider in the initial assessment: information provided by the State Party, the advice of the Emergency Committee, scientific principles, and assessments of the risk to human health, the risk of international spread of disease, and the risk of interference with international traffic. The 2005 IHR requires the Director-General to convene a special IHR Emergency Committee to recommend appropriate temporary measures.<sup>163</sup>

The 2009 H1N1 pandemic Influenza A marked the first major test of the 2005 IHR, which has since seen an improvement in transparency in the WHO’s PHEIC decision-making.<sup>164</sup> Based on the recommendation of the WHO Review Committee on the Functioning of the 2015 International Health Regulations in relation to the 2009

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157. Andraž Zidar, *WHO International Health Regulations and Human Rights: From Allusions to Inclusion*, 19 INT’L J. HUM. RTS. 505, 505–26 (2015).

158. IHR(2005), *supra* note 155, at 1.

159. *Id.* at annex 2.

160. *Id.*

161. *Id.* at art. 9.

162. *Id.* at art. 12.

163. *Id.* at art. 48–49.

164. See, e.g., WHO, *Pandemic Influenza Risk Management WHO Interim Guidance*, U.N.Doc. WHO/HSE/HEA/HSP/2013.3 (2013) (discussing the lessons learned from H1N1 2009 pandemic).



H1N1 pandemic, which was adopted by the WHO's Member States at the sixty-fourth WHA, the WHO has since disclosed the identity and relevant background in its subsequent appointments of an Emergency Committee.<sup>165</sup>

The 2014 Ebola outbreak again tested the IHR, and the widely recognized WHO leadership failure might provide the necessary political momentum to remedy the structural weaknesses of the IHR. There are three notable structural shortcomings related to the WHO, the global health regime, and the IHR, respectively.

First, the WHO has dual, and sometimes competing, missions: the organization acts both as a moral voice for global health as well as an agent for Member States.<sup>166</sup> This potential conflict of interest of the WHO has rendered much of the organization dysfunctional, particularly in instances when the WHO's moral aspirations are at odds with Member States' interests. Member States dissatisfied with the WHO can refuse to cooperate with the organization or express their discontent through budget cuts.<sup>167</sup> As a member-driven organization, the WHO's scientific and technical aspirations for global health remain conditioned by the approvals, needs, and preferences of its Member States, which often do not align with global disease burdens.<sup>168</sup> Since 2011, the WHO's budget has been cut by a half-billion dollars, resulting in a loss of three hundred WHO headquarter jobs, where its emergency unit lost nearly two-thirds of its staff, and the Regional Office for Africa lost nine out of twelve emergency staff members.<sup>169</sup>

Moreover, of the WHO's 2014–2015 budget of \$3.997 billion, only 23 percent (\$930 million) came from mandatory dues, with the remaining 77 percent coming from voluntary contributions, which are typically earmarked for specific projects.<sup>170</sup> As a consequence of the funding allocation, the WHO 2014–2015 budget devoted less than \$4

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165. *List of Members of, and Advisers to, the International Health Regulations (2005) Emergency Committee regarding Ebola*, WHO, [http://www.who.int/ihr/procedures/emerg\\_comm\\_members\\_20140806/en/](http://www.who.int/ihr/procedures/emerg_comm_members_20140806/en/) (last visited Oct. 15, 2016) [<https://perma.cc/4XBW-RH4L>] (archived Oct. 15, 2016).

166. Lawrence O. Gostin & Madison Powers, *What Does Social Justice Require for the Public's Health? Public Health Ethics and Policy Imperatives*, 25 HEALTH AFF. 1053, 1054 (2006).

167. See, e.g., *Special Issue: WHO Past, Present and Future*, 128 PUB. HEALTH 115, 195–99 (2014) (discussing cooperation among states and the threat of budget cuts).

168. See, e.g., Programme Budget 2014–2015, *supra* note 124.

169. Additionally, the WHO has a three-tier structure: each country reports to a regional office where the head of the regional office is elected directly and funded partially by the countries in the region. The WHO Afro regional office therefore is dependent on Africa's ministers of health, instead of possessing full governance autonomy. Sarah Boseley, *Ebola is All But Over, But the Postmortem is Just Getting Started*, GUARDIAN (Sept. 30, 2015), <http://www.theguardian.com/world/2015/sep/30/ebola-inquest-un-united-nations-world-health-organisation> [<https://perma.cc/L2LV-6AST>] (archived Sept. 19, 2016).

170. Programme Budget 2014–2015, *supra* note 124.

billion to epidemic preparedness, evidently incommensurate with its worldwide responsibility.<sup>171</sup> Although in recent years the number of voluntary contributions has increased considerably, the WHO estimates that, in order for the organization to function at its intended capacity, mandatory contribution must exceed more than 30 percent of its total budget.<sup>172</sup> This is because, unlike voluntary contribution, mandatory dues are a reliable funding source and afford the WHO the flexibility to respond rapidly to unforeseen events such as the Ebola outbreak. Accordingly, the WHO proposed a 5 percent increase in its mandatory contribution at the recent WHA, but it was rejected, meaning that the WHO will operate within the same budget it has had for the past eight years.<sup>173</sup> As a side note, it is also worth pointing out that, during the 2014 Ebola outbreak, the WHO was also consulted about the Middle East Respiratory Syndrome Coronavirus.<sup>174</sup> These concurrent demands on the WHO spread the already scarce human resources even thinner. It is therefore unrealistic to expect the WHO to be able to fulfill its constitutional mandate because it does not have sufficient financial resources. In the face of resource and financial constraints, the WHO must have a clear vision of its role in global health: for example, providing technical assistance, supporting ground-level response, or setting global norms.

Second, disparity exists across countries' core capability in containing infectious diseases. Articles 5 and 13 require State Parties to develop minimal "core public health capacities" by 2012, with a possibility of extension until 2016.<sup>175</sup> However, as of 2011, only a third of State Parties to the IHR (74 out of 194 countries) had developed

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171. Lawrence O. Gostin & Eric A. Friedman, *A Retrospective and Prospective Analysis of the West African Ebola Virus Disease Epidemic: Robust National Health Systems at the Foundation and an Empowered WHO at the Apex*, 385 THE LANCET 1902, 1904 (2015).

172. WHO, Proposed Programme Budget 2014–2015, U.N. Doc. A66/7, at 2 (Apr. 19, 2013), [http://www.who.int/about/resources\\_planning/A66\\_7-en.pdf](http://www.who.int/about/resources_planning/A66_7-en.pdf) [<https://perma.cc/Y7PV-8Q9F>] (archived Sept. 19, 2016). In fact, the Ebola Interim Assessment Panel suggests that Member States should reconsider increasing assessed contribution by 5 percent from the policy of zero nominal growth at the 2016 Executive Board and World Health Assembly meetings. REPORT OF THE EBOLA INTERIM ASSESSMENT PANEL, WHO, 7, <http://www.who.int/csr/resources/publications/ebola/ebola-panel-report/en/> (last visited Sept. 18, 2016) [<https://perma.cc/WMM4-B4JV>] (archived Sept. 19, 2016).

173. See WHO, Draft Proposed Programme Budget 2016–2017, U.N. Doc. EB136/34 (Jan. 16, 2015), [http://www.who.int/about/resources\\_planning/EB136\\_34-en.pdf](http://www.who.int/about/resources_planning/EB136_34-en.pdf) [<https://perma.cc/GG8C-R4F6>] (archived Sept. 19, 2016) (displaying the proposed budget).

174. *Middle East Respiratory Syndrome Coronavirus (MERS-CV)*, WHO, <http://www.who.int/emergencies/mers-cov/en/> (last visited Sept. 17, 2016) [<https://perma.cc/C25B-JMJU>] (archived Sept. 29, 2016).

175. IHR(2005), *supra* note 155.

national plans to meet core capacity requirements.<sup>176</sup> An independent Review Committee warned presciently, after reviewing the WHO's performance in the 2009 H1N1 influenza pandemic, that "the world is ill-prepared to respond . . . to a global, sustained and threatening public health emergency."<sup>177</sup> Despite the Review Committee's warning, the WHO did not adopt the Committee's recommendations, even though concerns about global health security features prominently in the WHO's governance reform, which began in 2010. The full implementation of the IHR, the Review Committee urged, is central in securing the shared goal of global health security.<sup>178</sup> While the IHR has limited enforcement mechanisms, the Review Committee pointed out that, within WHO's mandate, the organization could mobilize appropriate agencies and organizations to help provide technical assistance to interested countries and make a business case for investment.<sup>179</sup> However, in part because of the WHO's fiscal difficulties, the WHA rejected the Review Committee's proposals for strengthening the IHR.<sup>180</sup> Instead, the WHO turned its attention to more politically palatable problems such as universal healthcare and non-communicable diseases.<sup>181</sup> The WHO's strategic choice to

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176. See *Accelerating Implementation of the International Health Regulations* (2005), WHO (2013), [http://www.who.int/ihr/publications/WHO\\_HSE\\_GCR\\_2013\\_5en.pdf?ua=1](http://www.who.int/ihr/publications/WHO_HSE_GCR_2013_5en.pdf?ua=1) (last visited Sept. 18, 2016) [<https://perma.cc/J2KF-MXX2>] (archived Sept. 19, 2016) (stating that more than half of State Parties have requested extensions).

177. WHO, Report of the Review Committee on the Functioning of the International Health Regulations (2005) in Relation to Pandemic (H1N1) 2009, U.N. Doc. ¶ 18 A64/10 (May 5, 2011), [http://apps.who.int/gb/ebwha/pdf\\_files/WHA64/A64\\_10-en.pdf](http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_10-en.pdf) [<https://perma.cc/EHU5-6C6Y>] (archived Sept. 19, 2016).

178. *Id.* ("The world is ill-prepared to respond to a severe influenza pandemic or to any similarly global, sustained and threatening public-health emergency. Beyond implementation of core public-health capacities called for in the IHR, global preparedness can be advanced through research, reliance on a multisectoral approach, strengthened health-care delivery systems, economic development in low and middle-income countries and improved health status.")

179. *Id.* at ¶ 26. ("WHO and States Parties should refine and update their strategies for implementing the capacity-building requirements of the IHR, focusing first on those countries that will have difficulty meeting the 2012 deadline for core capacities. One possible way to support and accelerate implementation would be for WHO to mobilize appropriate agencies and organizations that would be willing to provide technical assistance to help interested countries assess their needs and make the business case for investment. Making the case for investment in IHR capacity building and subsequent resource mobilization would increase the likelihood that more States Parties could come into compliance with the IHR. Donor countries and organizations could take advantage of the IHR Annex 1A as a priority list for development support and also seize opportunities to share specialized resources, such as laboratories, across countries. WHO should also update the 2007 guidance on NFP functions, and include examples of good practice to reinforce the value of the IHR.")

180. See *supra* note 109 and accompanying text.

181. See WHO, MONITORING OF THE ACHIEVEMENT OF THE HEALTH-RELATED MILLENNIUM DEVELOPMENT GOALS, REPORT BY THE SECRETARIAT 15 (May, 21, 2010), [http://apps.who.int/gb/ebwha/pdf\\_files/WHA63/A63\\_R15-en.pdf](http://apps.who.int/gb/ebwha/pdf_files/WHA63/A63_R15-en.pdf)

downplay the importance of global health security is partly intertwined with its survival strategy in a crowded global health landscape and partly relates to the WHO's timidity in voicing its concerns with public health issues that are inherently political. A considerable body of literature discusses ways in which a country's core capability can be improved, which is relevant to the discussion, but beyond the scope of this Article.

Third, and perhaps most importantly, the IHR lacks enforcement mechanisms. The absence of IHR enforcement mechanisms fundamentally undermines the overall effectiveness of the IHR. Arguably, routine violations of the IHR occur principally because noncompliance does not result in legal sanctions and states often do not incur high political costs for their noncompliance. This is not, however, to overlook the variety of circumstances and factors—lack of health capacities, poverty, and fear of severe economic, political, and social repercussions from notifying the WHO—underpinning the widespread noncompliance. In the aggregate, noncompliance undermines the overall effectiveness of the IHR and puts global health security at risk.

In the absence of enforceable legal sanctions, states have little incentive to comply with the IHR. One of the most noticeable, and often deliberate violations concerns the implementation of precautionary cross-border control measures that exceed the WHO's recommendation. While the IHR permits a sovereign state to implement additional measures beyond the temporary recommendation issued by the WHO, Article 43 requires the concerned State Party to disclose its public health rationales and relevant scientific information to the WHO within three months after the implementation.<sup>182</sup> In theory, this disclosure provision should function as a disincentive, deterring State Parties from taking measures that would significantly interfere with international travel and traffic. In addition, the provision ensures that health and aid workers can travel to the affected countries without unnecessary travel restrictions and prevents stigmatization of the affected countries.

In practice, the WHO has little power to compel Member States to voluntarily disclose the information that prompted them to implement additional measures in the first place. While it is true that the WHO can publicly shame the violating states, this has proven to be of limited impact. During the 2014 Ebola outbreak, for instance, more than forty countries implemented additional measures without providing scientific justification to the WHO.<sup>183</sup> In addition to the stigmatization

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[<https://perma.cc/BG5U-R6NQ>] (archived Sept. 19, 2016) (evaluating the Millennium Development Goals set forth by the WHO).

182. IHR(2005), *supra* note 155, at art. 43.

183. *Infra* note 186.

faced by affected countries, excessive, and often unjustified measures can also impede international travel and delay international response significantly: a travel ban prevented affected African countries from receiving necessary personnel and supplies during the peak of the Ebola outbreak.<sup>184</sup> Canada and Australia, for instance, imposed a near blanket travel restriction on entry for residents from Ebola's West African epicenter against the WHO's recommendation, which put additional pressure on the worst-affected countries already crippled by the outbreak.<sup>185</sup> The WHO has since called for Canada and Australia to disclose their public health rationales as provided in the IHR, but both countries have yet to comply.<sup>186</sup>

One common way to understand State Parties' deliberate violation of the IHR is through a cost-benefit analysis, which is frequently used as a framework by political scientists to understand state behavior, particularly by those belonging to the rationalist school. Briefly, rationalists argue that states weigh the costs of noncompliance against the benefits of compliance. Such a rationalistic calculation means that states will put their self-interest first, above all else. Eminent jurist Louis Henkin famously observed that "nations will comply with international law only if it is in their interest to do so; they will disregard law or obligation if the advantages of violation outweigh the advantages of observance."<sup>187</sup> Thus, in the context of international infectious diseases control, a state that takes an excessive protective measure may boost its domestic confidence because the government is seen as protecting the public's health and welfare—political capital highly treasured by state governments; however, the WHO's public denouncement of the government's excessive, and often arbitrary, measure tends to have little, if any, political cost for the violating state. The benefits of noncompliance therefore outweigh the benefits of compliance, and explain why many states routinely violate the IHR. Arguably, without enforceable legal sanctions, states will likely

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184. See generally, *supra* note 78 and accompanying text.

185. See *Australia Suspends Visas*, *supra* note 78; *Ebola outbreak: Sierra Leone angry at Australia visa ban*, BBC NEWS (Oct. 28, 2014), <http://www.bbc.com/news/world-africa-29809863> [<https://perma.cc/GD6L-C95J>] (archived Sept. 19, 2016); Euan McKirdy, *Australia Instigates Ebola-Prompted Ban On Travel From West Africa*, CNN (Oct. 28, 2014), <http://edition.cnn.com/2014/10/28/world/asia/australia-immigration-policy-ebola/> [<https://perma.cc/GN4Y-3YYC>] (archived Sept. 19, 2016); *Response to Ebola*, HEALTHY CANADIANS, <http://healthycanadians.gc.ca/diseases-conditions-maladies-affections/disease-maladie/ebola/response-reponse/index-eng.php> (last visited Sept. 18, 2016) [<https://perma.cc/G4FM-GYB4>] (archived Sept. 19, 2016).

186. *Australia Must Explain Ebola Visa Ban: WHO*, SYDNEY MORNING HERALD (Nov. 6, 2014), <http://www.smh.com.au/world/australia-must-explain-ebola-visa-ban-who-20141105-11hk dj.html> [<https://perma.cc/EAA8-KJKM>] (archived Sept. 19, 2016).

187. LOUIS HENKIN, *HOW NATIONS BEHAVE: LAW AND FOREIGN POLICY* 49 (2d ed. 1979).

continue to violate the IHR. It should also be noted that the calculation of national interests is highly complex, and rarely a straightforward process.

Admittedly, not all IHR noncompliance occurs as a product of states' careful political calculus. Under the IHR, State Parties are required to report their IHR implementation progress, but the reporting requirement is widely ignored, notably by Guinea, Liberia, and Sierra Leone.<sup>188</sup> Lack of health capacity largely explains the weak compliance rate among these countries, where their fragile public health infrastructures are the result of decades of civil wars, structural adjustment politics, and postwar foreign aids.<sup>189</sup> In fact, Guinea, Liberia, and Sierra Leone cited the lack of health capacities as the key reason for their IHR noncompliance. Part IV takes up this discussion again, arguing that, in crafting the varying types of incentives and their corresponding legal consequences, a distinction must be made between a state's willingness versus a state's capability to comply with the IHR. The former should result in material legal consequences whereas the latter should not.

The recent devastation in West Africa has also resulted in a surge of financial pledging from countries and multilateral agencies for post-Ebola recovery. The Obama administration, for instance, announced a \$5.4 billion fund to combat Ebola in West Africa.<sup>190</sup> As of May 2015, World Bank Group has mobilized \$1.62 billion for financing post-Ebola recovery efforts in the countries most affected by Ebola.<sup>191</sup> Likewise, the WHO announced at the WHA the creation of a \$228 million contingency fund, aimed at financing its newly established health emergency program.<sup>192</sup> However, serious doubts remain as to the sustainability of these efforts. Indeed, Dr. Bruce Aylward, the WHO Assistant Director-General in charge of the Ebola operational response, warned that the biggest challenge to EVD eradication is not complacency among the countries, but rather the funding gap.<sup>193</sup> Dr.

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188. WHO, IMPLEMENTATION OF THE INTERNATIONAL HEALTH REGULATIONS (2005) Annex (Apr. 5, 2013), [http://apps.who.int/gb/ebwha/pdf\\_files/WHA66/A66\\_16-en.pdf](http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_16-en.pdf) [<https://perma.cc/GFU3-JNB7>] (archived Sept. 18, 2016) (showing that Guinea, Liberia and Sierra Leone have not reported their IHR implementation progress).

189. Benton & Dionne, *supra* note 52.

190. *See supra* note 114 and accompanying text.

191. *See* Press Release, World Bank, Ebola: Most African Countries Avoid Major Economic Loss but Impact on Guinea, Liberia, Sierra Leone Remains Crippling (Jan. 20, 2015) (<http://www.worldbank.org/en/news/press-release/2015/01/20/ebola-most-african-countries-avoid-major-economic-loss-but-impact-on-guinea-liberia-sierra-leone-remains-crippling> [<https://perma.cc/RWE3-PW3S>] (archived Sept. 19, 2016)) (stating as of January 2015 the World Bank Group had mobilized \$1 billion).

192. Grieshaber, *supra* note 2.

193. Stephanie Nebehay, *Ebola set to persist in 2015, but funds for aid are lacking*: WHO, REUTERS (May 26, 2015), <http://www.reuters.com/article/2015/05/26/us-health-who-idUSKBN00B1VG20150526> [<https://perma.cc/W8SA-4G42>] (archived Sept. 19, 2016).

Aylward's concern is not without grounds; the WHO's contingency fund will be financed by flexible, voluntary contributions, most likely to be formalized as public-private partnerships.<sup>194</sup> In other realms of international voluntary financing, such as climate change, sustainable funding also remains a persistent issue.<sup>195</sup> In addition to the unpredictability of funding sources, a real danger exists as the WHO has to compete for funds when the world turns its attention to other, equally important global commitments—for instance, climate change or the Sustainable Development Goals—in a financially parsimonious world.

The remainder of this Article focuses on two fundamental weaknesses of the international infectious disease regime, namely, the weak, or almost non-existent, financing and enforcement mechanisms. This brings an additional insight to the widely discussed WHO governance reform, which is commonly seen as a remedy to the dysfunctional international infectious disease control regime.<sup>196</sup> While it is true that WHO governance reform is much needed, it is also important to look for ways to enhance and foster cooperation in the international infectious disease regime. Accordingly, the Article draws attention to the possible informal institutional linkage between the WHO and the World Bank as a source for building a synergistic relationship between these two organizations. Specifically, it focuses on strengthening the effectiveness of the IHR *vis-à-vis* informal linkage with the PEF, where the financial clout of the World Bank would give the WHO quasi-enforcement power over IHR noncompliance.

As stated above, states will only cooperate if such cooperation furthers their self-interests, according to the rationalist.<sup>197</sup> The rationalist viewpoint may help explain why the 2005 IHR lacks real, actually enforceable mechanisms by design. In an instance of dispute over a treaty application, for example, the IHR favors a conciliatory approach. Article 56 provides that “[i]n the event of a dispute between two or more States Parties concerning the interpretation or application of these Regulations, the States Parties concerned shall seek . . . to settle the dispute through negotiation or any other peaceful

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194. Jim Yong Kim, *We Need A New Global Response to Pandemics*, WORLD ECON. FORUM (Jan. 20, 2015), <https://agenda.weforum.org/2015/01/we-need-a-new-global-response-to-pandemics/> [<https://perma.cc/VU9N-F5P2>] (archived Sept. 19, 2016).

195. See generally Katrina Miriam Wyman, *Responses to Climate Migration*, 37 HARV. ENVTL. L. REV. 167 (2013) (discussing funding gaps in climate change funding).

196. See e.g., Lawrence Gostin, Carmen C. Mundaca-Shah & Patrick W. Kelley, *Neglected Dimensions of Global Security, The Global Health Risk Framework Commission*, 315 JAMA 1451 (2016); Lawrence Gostin, *Reforming The World Health Organization After Ebola*, 313 JAMA 1407 (2015) (discussing reforming WHO's regional structure).

197. JACK L. GOLDSMITH & ERIC A. POSNER, *THE LIMITS OF INTERNATIONAL LAW* 29–32 (2005).

means . . . .”<sup>198</sup> To date, no dispute between State Parties has been documented. While coordination in international infectious disease control is highly desirable, even necessary, sovereign states remain reluctant to agree to enforceable legal obligations. Nonetheless, states need a regime that requires minimal international cooperation and ensures predictability in disease response, particularly when the uncontrolled international spread of infectious diseases can threaten an individual state’s national security. The binding nature of the IHR affords its signatories some general levels of predictability without specific obligations. For instance, the IHR institutionalizes the practice of information sharing, which is critical in international infectious disease surveillance. The participating states, at least in theory, are collectively better off than they would be in the absence of the IHR because they have access to information that otherwise would be difficult to obtain.

Yet the IHR’s lack of enforceable obligations hinders the global progress of international health security in two important and related ways. First, the IHR relies on State Parties to self-report on their implementation progress regarding disease surveillance, diagnosis, and core capability.<sup>199</sup> No external funding is available to assist failed or failing states in implementing their core IHR requirements. Absent this financial assistance, the situations in failed or failing states will remain unchanged, if not worsen. Moreover, since there is no external verification of a country’s implementation progress, self-reporting is the only official source for assessing IHR implementation progress worldwide. This IHR implementation gap puts global health security in significant jeopardy.

Second, and relatedly, while the WHO Constitution provides that, upon request, the WHO should assist governments in strengthening their health services and facilitate the UN’s provision of health services, in practice, failed states often require more than technical assistance; they typically have non-functioning public health systems. The 2014 Ebola outbreak again demonstrated the urgency of remedying the decimated public health systems found in failed or failing states, principally through sustained international financing. Poor public health systems put international health security at risk; the global defense against contagions is only as strong as its weakest link. Although, since the peak of the Ebola outbreak, countries and multilateral agencies have pledged financial commitments to support West Africa, the devil is in the details; namely, these efforts remain voluntary, meaning that they are not enforceable obligations. States have welcomed the WHO’s proposal of the emergency medical reserve at the WHA, and the initiative was promoted by Chancellor Merkel at

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198. IHR(2005), *supra* note 155, at art. 56.

199. *Id.* at art. 43.



the G7 meeting in Germany, but no concrete measures were decided by the end of the summit.<sup>200</sup>

### III. INTERNATIONAL FINANCIAL INSTITUTIONS AND THE GLOBAL GOVERNANCE OF HEALTH

Instead of analyzing the 2014 Ebola outbreak as partly a function of the WHO's institutional and governance failures, the Article now broadens the discussion and situates the debate in the context of the global governance for health. Admittedly, confluences of historical factors—civil wars, colonialism, and slave trade—have lingering effects on the fragile health systems found in West Africa. Since the Article is interested in promoting international cooperation in the realm of the global health security *vis-à-vis* international organizations, this Part focuses the International Financial Institution's (IFI) structural adjustment policies (SAPs) in particular, and foreign aid in general. In so doing, this Part highlights the need to embed public health norms in an international system and the need to re-establish the WHO's leadership in the realm of global health. The discussion here does not, by any means, suggest that past IFI practices are indicative of its future role in global health. Rather, the discussion here highlights that economic development remains the primary goal that guides the IFI's development projects, which, at times, can be in conflict with public health. The discussion also underscores a normative need for the WHO to voice moral concerns on behalf of the world's most vulnerable populations, as mandated in its Constitution.

The involvement of the IFI in failed or failing states' health systems is well documented.<sup>201</sup> The World Bank's poverty alleviation mission often overlaps with the WHO's public health mandate. The World Bank's involvement in the economic and social developments in countries receiving support often has concomitant effects on the

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200. DECLARATION OF THE G7 HEALTH MINISTERS 3 (Oct. 8–9, 2015), [http://www.bmg.bund.de/fileadmin/dateien/Downloads/G/G7-Ges.Minister\\_2015/G7\\_Health\\_Ministers\\_Declaration\\_AMR\\_and\\_EBOLA.pdf](http://www.bmg.bund.de/fileadmin/dateien/Downloads/G/G7-Ges.Minister_2015/G7_Health_Ministers_Declaration_AMR_and_EBOLA.pdf) [<https://perma.cc/ZP44-QK6U>] (archived Sept. 19, 2016).

201. See generally Mohammed Nuruzzaman, *The World Bank, Health Policy Reforms and the Poor*, 37 J. CONTEMP. ASIA 59 (2007) (arguing that health reforms promoting private healthcare have had a severe negative impact on developing countries); Benjamin Mason Meier & Larisa M. Mori, *The Highest Attainable Standard: Advancing a Collective Human Right to Public Health*, 37 COLUM. HUM. RTS. L. REV. 101 (2005) (discussing how globalization has created underlying detriments to health care); Antony Anghie, *Time Present and the Time Past: Globalization, International Financial Institutes, and the Third World*, 32 N.Y.U. J. INT'L L. & POL. 243 (2000) (discussing the role of IFIs in promoting globalization); Daniel D. Bradlow, *Social Justice and Development: Critical Issues Facing the Bretton Woods System: the World Bank, the IMF, and Human Rights*, 6 TRANSNAT'L L. & CONTEMP. PROBS. 47 (1996) (discussing IFIs impact on human rights).

population's health.<sup>202</sup> Beginning in the 1990s, the World Bank's involvement in health projects also increased substantively, as it was increasingly recognized that health is integral to an individual's and a country's economic productivity. Yet the IFI's policy prescriptions for improving health and wellbeing in the recipient country remain grounded in neoliberalism: competitive markets are viewed as a crucial component of a functional healthcare system.<sup>203</sup> Many scholars and practitioners thus credited the World Bank's neoliberal agenda as a key contributor underlying the fragile health systems found in West Africa.<sup>204</sup> Despite the IFI's historical role in failed states' health systems, some scholars remain optimistic about the potential role of the IFI in shaping global health. Political philosopher Jennifer Prah Ruger, for instance, argues that the World Bank, with its enviable financial clout, can help establish good governance in health sectors at the country level.<sup>205</sup>

From a development perspective, good health is essential for economic productivity.<sup>206</sup> Prompted in part by the escalating health care costs globally, the World Bank began to incorporate health into its development paradigm beginning in the 1990s. The 1993 World Development Report, *Investing in Health*, helped inaugurate a market-based view of health systems.<sup>207</sup> The World Development Report identifies four key underlying factors that explain the rising health care cost worldwide: misallocation of funds to less cost-effective intervention, inappropriate deployment of medical staff and resources, inequity in access to basic health care, and the disproportionate cost of healthcare compared to income growth.<sup>208</sup> The World Bank's policy prescription focused chiefly on improving health indicators through a three-pronged approach: educating girls and empowering women,

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202. Robin Stott, *The World Bank: Friend Or Foe To The Poor?*, 318 BRIT. MED. J. 822, 822–23 (1999).

203. WORLD BANK, WORLD DEVELOPMENT REPORT 1993: INVESTING IN HEALTH 14, <http://elibrary.worldbank.org/doi/abs/10.1596/0-1952-0890-0> (last visited Oct. 15, 2016) [<https://perma.cc/4HN7-E29R>] (archived Oct. 15, 2016).

204. *See id.* (describing the neoliberal agenda); *see also* Margaux J. Hall, Aziza Ahmed & Stephanie E. Swanson, *Answering the Millennium Call for the Right to Maternal Health: the Need to Eliminate User Fees*, 12 YALE H.R. & DEV. L.J. 62 (discussing how user fees which are part of the neoliberal agenda have failed); Benjamin Mason Meier, *Employing Health Rights For Global Justice: The Promise Of Public Health In Response To The Insalubrious Ramifications of Globalization*, 39 CORNELL INT'L L.J. 711, 718 (describing SAPs on developing countries' public health infrastructure generally).

205. Jennifer Prah Ruger, *The Changing Role of the World Bank in Global Health*, 95 AM. J. PUB. HEALTH 60, 66–68 (2005).

206. Amartya Sen, *Why Health Equity?*, 11 HEALTH ECON. 659, 659 (2002) (Sen argues that "health equity cannot but be a central feature of the justice of social arrangements in general").

207. WORLD DEVELOPMENT REPORT 1993: INVESTING IN HEALTH, *supra* note 203.

208. *Id.* at 3–5, 52–71.

focusing on cost-effective public health services, and, most controversially, promoting “greater diversity and competition in the financing and delivering of health services.”<sup>209</sup> The 1993 World Development Report soon became the blueprint for the World Bank’s health projects. Unlike the WHO, the World Bank enjoyed considerable financial leverage from its lending practices with recipients, and it extended the World Bank’s reach beyond the economic sphere. Some scholars go further and argue that the World Bank, with its enviable financial clout, has replaced the WHO as the lead agency in health, sidelining the WHO to technical support in health matters.<sup>210</sup>

It is worth noting that while, in general, health outcomes (such as life expectancy and infant mortality rates in developing countries) have improved considerably since the World Bank’s involvement in the health sector, the extent to which the improved health outcomes can be attributed to the World Bank’s projects remains highly disputed: the World Bank in fact conceded that it is difficult to gauge the success of its advice and investment programs in improving health outcomes because of the difficulties in qualifying it.<sup>211</sup> A considerable body of literature suggests that the World Bank’s involvement in health and economic projects in Africa contributed to the diminishing role of the state as the primary provider of healthcare and other basic social welfare. The waning role of the state in the realm of welfare provision in part explained the slow containment of the 2014 Ebola outbreak. Opponents of the IFI’s neoliberal agenda have long warned that the market-oriented policies are often ill-equipped to accommodate social welfare concerns.<sup>212</sup>

Notably, much of the 1993 World Development Report’s policy recommendation echoes the World Bank’s now famous study of Sub-Saharan Africa, published in 1981 (the “Berg Report”). This report cites the inefficient use of government resources as a key cause of the poor economic performance in Africa.<sup>213</sup> In broad strokes, the Berg Report recommends reducing public expenditure on social welfare to remedy

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209. *Id.* at iii.

210. See Thomas E. Novotny, *Global Governance and Public Health Security in the 21st Century*, 38 CAL. W. INT’L L.J. 19, 25 (2007); Charles Clift, *The Role Of The World Health Organization In The International System* 11 (Centre on Global Health Security Working Group Papers No. 1, 2013), [https://www.chathamhouse.org/sites/files/chathamhouse/public/Research/Global%20Health/0213\\_who.pdf](https://www.chathamhouse.org/sites/files/chathamhouse/public/Research/Global%20Health/0213_who.pdf) [<https://perma.cc/2LCV-UCTL>] (archived Sept. 19, 2016) (discussing how the World Bank has challenged the WHO’s authority).

211. Stott, *supra* note 202.

212. Meier & Mori, *supra* note 201; see also, Solomon R. Benatar, Stephen Gill & Isabella Bakker, *Making Progress in Global Health: The Need for New Paradigms*. 85 INT’L AFF. 347, 355 (2009).

213. THE WORLD BANK, ACCELERATED DEVELOPMENT IN SUB-SAHARAN AFRICA: AN AGENDA FOR ACTION (1981), <http://documents.worldbank.org/curated/en/702471468768312009/pdf/multi-page.pdf> [<https://perma.cc/VX7D-VDUG>] (archived Sept. 19, 2016).

poor economic performance in Africa, and the IFI embraced the neoliberal ideology that underlies the Berg Report wholeheartedly: IFI loans were conditioned on commitments of its recipients to market-based reform.<sup>214</sup> This loaning practice was grounded in an unyielding faith in the market, which was perceived as an effective engine for coordinating individual needs and societal interests, in keeping with the IFI's neoliberal development paradigm.<sup>215</sup>

Consequently, the IFI's lending practices have resulted in diminishing healthcare spending in recipient states—as recipient states embraced neoliberal economic policies, hospitals and healthcare job opportunities became fewer, and healthcare quality and the qualified healthcare workforce also decreased considerably.<sup>216</sup> The dramatic reduction in social welfare spending has reversed much of the health progress achieved in recipient countries over the last five decades.<sup>217</sup> A waning healthcare infrastructure also has spillover health and security implications because it creates a gap in global health security.<sup>218</sup>

Incidentally, as the SAPs became increasingly pervasive in countries in Africa during the 1980s and early 1990s, the role of local faith-based organizations, international nongovernmental organizations (NGOs), and humanitarian networks also became more prominent, if not critical, in providing social services.<sup>219</sup> The waning role of the government in providing basic social services in the two decades since the SAPs were implemented created a space for NGOs to overtake the welfare function that was previously the exclusive domain of the government. The shifting roles between the state and the non-

214. ROBERT LENSINK, *STRUCTURAL ADJUSTMENT IN SUB-SAHARAN AFRICA* 57 (1996).

215. *Id.*; see also Tor Krever, *The Legal Turn in Late Development Theory: The Rule of Law and The World Bank's Development Model*, 52 HARV. INT'L L.J. 287 (2011) (describing the World Bank's use of rule of law as an ideological basis for its neoliberal agenda).

216. See generally Anna Breman & Carolyn Shelton, *Structural Adjustment and Health: A Literature Review of the Debate, Its Role-Players and Presented Empirical Evidence* (WHO Commission on Macroeconomics and Health Working Article Series, WG6:6, 2001) (discussing the negative impact of structural adjustments on healthcare).

217. Mahmood Monshipouri, *Promoting Universal Human Rights: Dilemmas of Integrating Developing Countries*, 4 YALE H.R. & DEV. L.J. 25, 41 (2014).

218. See generally Jennifer B. Nuzzo & Gigi Kwik Gronvall, *Global Health Security: Closing the Gaps in Responding to Infectious Disease Emergencies*, 4 GLOBAL HEALTH GOVERNANCE 1 (2011) (discussing the various gaps that are created in global health security).

219. Hansjörg Dilger, *Doing Better? Religion, the Virtue-Ethics of Development, and the Fragmentation of Health Politics in Tanzania*, 56 AFR. TODAY 89, 94. (2009); Diane McIntyre et al., *Beyond Fragmentation and Towards Universal Coverage: Insights from Ghana, South Africa and the United Republic of Tanzania*. 86 BULL. WORLD HEALTH ORG. 817, 871–76 (2015).

state actors proved to be problematic, at least in terms of coordination, as was evident in the 2014 Ebola crisis.

However, beginning in the 1990s, health began to gain considerable political traction in the international development discourse; this discourse resulted in an unprecedented number of global health initiatives, programs, organizations, and actors in the global health landscape. Most commonly, these new initiatives tended to focus on specific interventions or practices—for example, the Global Fund to Fight AIDS, Tuberculosis and Malaria, Global Alliance on Vaccines and Immunization, and The Vaccine Alliance. This diversity of global health actors, issues, and activities reflected the growing political interest in improving health, but the uncoordinated, and often *ad hoc* initiatives also produced an incoherent legal order, resulting in uncertainty about the normative principles that guide global health.

As a legacy of SAPs, nongovernment actors and international aid organizations—MSF being most prominent—became the primary providers of health care. As these aid organizations tend to focus on specific disease prevention, this incidentally overshadowed the need for horizontal integration of health services at national level. Likewise, because local and international NGOs tend to focus on vertical programs, targeting specific diseases and population groups, this further diminished the need for developing comprehensive public health systems and surveillance at national and regional levels. While the involvement of NGOs in the realm of disease prevention is welcome, local and international NGOs have different functions, aspirations, capabilities, and emphases, which create a fragmented healthcare landscape.

The increased influence of the IFI and the multiplicity of new actors in the realm of global health contribute to what scholars commonly term “fragmentation” and “duplication.”<sup>220</sup> The WHO now operates in a competitive environment where international and local actors, at times, compete against each other: recipient states now partner with international agencies based on what best matches their preferences.<sup>221</sup> This phenomenon of fragmentation is not isolated to the realm of global health.<sup>222</sup> Scholars also observe that the international climate change governance exhibits a similarly

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220. GOSTIN, *supra* note 21, at 80.

221. Sarah Wood Pallas et. al, *Responses to Donor Proliferation in Ghana's Health Sector: A Qualitative Case Study*, 92 BULL. WORLD HEALTH ORG. 1, 11 (2015).

222. See, e.g., Philippe Roch & Franz Xaver Perrez, *International Environmental Governance: The Strive Towards a Comprehensive, Coherent, Effective and Efficient International Environmental Regime*, 16 COLO. J. INT'L. ENVTL. L. & POL'Y 1, 16–20 (2005) (discussing fragmentation in the international environmental regime).

fragmented characteristic.<sup>223</sup> Although, some scholars argue that fragmentation is not necessarily a bad thing because fragmentation can catalyze competition and collaboration within the global health sector and foster organizational learning within international institutions.<sup>224</sup> But, beyond the theoretical implications, fragmentation in global health security governance has resulted in real, negative consequences: the proliferation of actors and the web of agencies and programs, for instance, has reduced the efficiency of health services, and poor coordination among partners and ministries has led to a funding misalignment between national strategies and partners' missions.<sup>225</sup> Fragmentation is also costly because it imposes high transaction costs that consume health ministry resources. In this regard, the ensuing discussion focuses on the informal institutional linkage between the WHO and the World Bank as a means of alleviating institutional fragmentation in the governance of global health security.

Again, it should be noted that the historical involvement of the IFI in the realm of global health by no means should be taken as an indicator of its future role in global health. Yet it is also worth reiterating that economic development remains a key aspiration and driver underpinning IFI projects. The World Bank's involvement in developing fields implies that public health interests are often secondary, if not subordinate, to economic development. Nonetheless, the IFI's financial expertise and its enviable position in leveraging states to comply with its standards suggest that the IFI could play a valuable and complementary role to that of the WHO in the realm of global health security. Specifically, the IFI's enviable financial clout could be used as a leverage to enhance the IHR compliance rate, producing a synergy between the two historical rivalries and aligning the IFI's new financial initiatives with the WHO's normative goals in health. Part IV takes up this discussion below.

#### IV. THE PANDEMIC EMERGENCY FACILITY AND THE LINKAGE WITH THE IHR

Turning to the proposal of informally linking the IHR and the PEF, this Part first describes the PEF currently under development and then demonstrates how the IHR—the existing legal architecture

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223. See, e.g., Robert O. Keohane & David G. Victor, *The Regime Complex for Climate Change* (The Harvard Project on International Climate Agreements, Discussion Article 10-33, 2010) (evaluating international law through two optics).

224. Robert Rosenstock & Benjamin K. Grimes, *Current Development: The Fifty-fourth Session of the International Law Commission*, 97 A.J.I.L. 162, 166–67 (2006).

225. See, e.g., Lawrence O. Gostin et al., *Towards a Framework Convention on Global Health*, 91 BULL. WORLD HEALTH ORG. 717, 790 (2013) (stating that ministries are needed for social benefits in society).

for global health security—can provide a ready avenue for the proposed institutional linkage. The discussion herein shows that the linkage would (at least in theory) strengthen the effectiveness of the IHR in reference to compliance and enforcement literatures in international law and international relations. The proposal, in broad strokes, attempts to expand the current legal regime to one that includes innovative financing mechanisms, aiming to foster cooperation in the realm of international infectious disease control. The proposal also aims to align the World Bank's global financing mechanisms, currently under development, with the normative goals of the WHO *vis-à-vis* the IHR-PEF linkage. Specifically, the proposal focuses on the parametric trigger of the PEF, which should be determined by the Director-General of the WHO, in consultation with the World Bank and the relevant stakeholders.

#### A. *The Pandemic Emergency Facility*

Prompted in part by the WHO's leadership failure during the 2014 Ebola outbreak, Dr. Jim Yong Kim, President of the World Bank, announced that the PEF would finance the response to pandemic emergencies, covering a range of response activities such as rapid deployment of global health corps, medical equipment, pharmaceuticals, diagnostic supplies, logistics and food supplies, and coordination and communication.<sup>226</sup> The PEF would not be extended to pandemic preparedness or reconstruction, which would be financed through existing channels, domestic resources, and bilateral development assistance.<sup>227</sup>

The PEF would draw upon the World Bank's financing expertise, and it would build on existing World Bank financing instruments designed for providing immediate financing following a natural disaster. Two market-based mechanisms are under consideration as the funding source for the PEF: private insurance schemes and voluntary public funding.<sup>228</sup> The former would rely on the World Bank purchasing insurance coverage from the private sector to cover risks associated with the outbreak. In contrast, the latter would rely on long-term donor pledges, which are disbursed when necessary to contain the outbreak. The fact that, in the past, donor pledges have not been sustainable strongly suggests that private insurance mechanisms might be the preferable option.

Beyond developing insurance against pandemic threats, the World Bank also points out that private sector participation will be essential in ensuring that pandemic responses are effective and timely.

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226. *Pandemic Emergency Facility: Frequently Asked Questions*, *supra* note 8.

227. *Id.*

228. *Id.*

Potential roles of the private sector include healthcare worker training and coordinating humanitarian response to crises. The World Bank points out that the PEF would also create an incentive for countries to be better prepared for pandemics: states are required to develop a disaster risk management plan as a prerequisite for eligibility.<sup>229</sup> According to the World Bank, such incentive is particularly welcoming in light of the fact that the majority of IHR signatories have not implemented the core capability requirement.

### B. *The Proposal: Informal IHR-PEF Linkage*

Currently, the parametric activation criteria for releasing PEF funds to support rapid and effective response during the early phase of an international public health emergency are under discussion.<sup>230</sup> The parametric trigger is likely to be based on public and observable data, verified by the World Bank.<sup>231</sup> The proposal, outlined below, argues that the verification should be made by the WHO Director-General instead. Specifically, the verification made by the WHO Director-General would be in keeping with Annex 2 of the IHR, and in consultation with the relevant states. The informal linkage of IHR-PEF could embed the potentially synergistic relationship between the WHO and the World Bank, building on the normative functions of the WHO and harnessing the financial expertise of the World Bank.

Crucially, the IHR provides a ready avenue for institutional collaboration between the World Bank and the WHO. Article 11 of the IHR, for instance, provides the legal authority for the WHO to share with relevant intergovernmental organizations the information provided by State Parties for “verification, assessment and assistance purposes” before it formally declares a PHEIC.<sup>232</sup> Article 11 creates an informal channel of communication for the WHO to alert the World Bank about the emerging health crisis without the need for a PHEIC. Such flexibility provides a platform for the WHO Director-General to consult with the World Bank and the relevant stakeholders, including aid organizations such as MSF, on the emerging health crisis. MSF pointed out that, had the WHO given greater weight to MSF’s consistent pleas for a strong international response during the early phase of the 2014 Ebola outbreak in West Africa, the catastrophic loss of human life could have been averted.<sup>233</sup> The lack of a communicative

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229. *Id.*

230. *Id.*

231. *Id.*

232. IHR(2005), *supra* note 155, at art. 11.

233. Hayden, *supra* note 46; MSF, PUSHED TO THE LIMIT AND BEYOND: A YEAR INTO THE LARGEST EVER EBOLA OUTBREAK, [http://www.msf.org/sites/msf.org/files/msf1yearebolareport\\_en\\_230315.pdf](http://www.msf.org/sites/msf.org/files/msf1yearebolareport_en_230315.pdf) (last visited Sept. 18, 2016) [<https://perma.cc/SWD8-6SSC>] (archived Sept. 19, 2016).



platform between the ground organizations and the WHO could be remedied by the informal channel that would be established through the IHR-PEF linkage. The linkage would establish an inclusive participation that extends to non-state actors currently excluded from the WHO governance model. Broadening participation would also shift the decision-making process away from the current technocratic, state-centric process that many scholars and practitioners have criticized as undemocratic.<sup>234</sup> While the WHO Director-General would have the final say in determining whether the parametric trigger to release the PEF funds has been met, requiring the Director-General to consult with the relevant stakeholders before making the call could improve the quality of decision-making and ensure that the decision made at the international level better reflects the situation on the ground. Importantly, allocating the final decision-making to the WHO Director-General reaffirms the normative role of the agency in the international infectious disease control regime. The Ebola Interim Assessment Panel agrees: “[The] WHO should play a central role in the risk assessments that would trigger such payments so that the economic impacts of health crises could be mitigated.”<sup>235</sup> Thus, the linkage would engender better-informed decisions, in addition to enhancing the transparency and accountability of both the WHO and the World Bank.

### C. International Infectious Disease Control and Risk Governance

According to the World Bank, the PEF would function principally as an insurance mechanism because the World Bank would purchase insurance coverage from the private sector on behalf of developing countries to cover costs related to disease outbreak response.<sup>236</sup> Funds would be disbursed to eligible states via the World Bank to finance critical containment measures. In principle, an insurance system functions as a mechanism for pooling and transferring the financial risks of adverse events and builds societal resilience through formal institutions. The idea of pre-financed sovereign risks in large-scale disasters through an established insurance mechanism is not new.<sup>237</sup>

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234. *Special Issue: WHO Past, Present and Future*, *supra* note 167, at 195–201.

235. REPORT OF THE EBOLA INTERIM ASSESSMENT PANEL, *supra* note 172.

236. *Pandemic Emergency Facility: Frequently Asked Questions*, *supra* note 8.

237. See generally Jeffrey McGee et al., *Writing the Fine Print: Developing Regional Insurance for Climate Change Adaptation in the Pacific*, 15 MELBOURNE J. INT'L LAW 444 (2014) (discussing risk pooling facilities for climate change disasters); Alberto Monti, *Climate Change and Weather-Related Disasters: What Role for Insurance, Reinsurance and Financial Sectors?*, 15 HASTINGS W.-N.W. J. ENV. L. & POL'Y 151 (2009) (discussing financial management strategies for the large impacts of climate change); *Disaster Risk Financing*, OCED, <http://www.oecd.org/finance/>

The climate change regime, for instance, pools the financial risks associated with climate change at a regional level through the Caribbean Catastrophe Risk Insurance Facility.<sup>238</sup> Similar programs, such as Mexico's MultiCat, which provides coverage for earthquakes and hurricanes, and African Risk Capacity, which covers the financial risks associated with drought, have all achieved documented success.<sup>239</sup>

Currently, two financial mechanisms are under consideration as a funding source for the PEF: private insurance schemes and voluntary public funding. As mentioned above, public funding is at significant risk of donor fatigue. This strongly suggests that the insurance premium should be funded primarily by a private insurance scheme to ensure long-term sustainability. States that have violated the IHR could also be required to contribute to the insurance premium. For instance, states that have implemented measures additional to the WHO recommendation, and have failed to disclose the public health rationales underlying their actions, could be required to contribute to the insurance premium with a pre-agreed penalty. This mandatory contribution would function as a deterrent for the penalized behavior because material consequences would flow from the IHR violation. This would, at least in theory, function as a signal that would dispel or curb certain unwanted behavior, discouraging potential violation of the IHR.

Likewise, encouraging states to adhere to the IHR through disincentives would mitigate the inherent power asymmetry among state parties that puts weak states at significant disadvantage, as weak states often have lack the necessary financial resources to pursue legal remedy in holding strong states accountable. To that end, weak states may perceive the regime as unfair, which diminishes their willingness to participate in that regime. Thus, from a practical viewpoint, leveling the playing field is also likely to foster a cooperative international infectious disease regime. More importantly, from a

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financial-markets/oecdinternationalnetworkonthefinancialmanagementoflarge-scalecatastrophes.htm (last visited Sept. 16, 2016) [<https://perma.cc/99MZ-7ANQ>] (archived Sept. 29, 2016) (discussing insurance for disaster risks).

238. CARIBBEAN CATASTROPHE RISK INSURANCE, <http://www.ccrif.org/> (last visited Sept. 13, 2016) [<https://perma.cc/22NZ-YEXL>] (archived Sept. 19, 2016).

239. Lucy Nyirend & David Goodman, *From Managing Crises To Managing Risks: The African Risk Capacity (ARC)*, SWISS RE CENTRE FOR GLOBAL DIALOGUE (Jan. 18, 2013), [http://cgd.swissre.com/features/From\\_managing\\_crises\\_to\\_managing\\_risks\\_The\\_African\\_Risk\\_Capacity\\_ARC.html](http://cgd.swissre.com/features/From_managing_crises_to_managing_risks_The_African_Risk_Capacity_ARC.html) [<https://perma.cc/BS7T-QGPC>] (archived Sept. 19, 2016); AFRICAN RISK CAPACITY, <http://www.africanriskcapacity.org/> (last visited Sept. 15, 2016); *Mexico Launches Second Catastrophe Bond to Provide Coverage Against Earthquakes and Hurricanes*, WORLD BANK, [http://treasury.worldbank.org/bdm/html/Financing\\_Noteworthy/Mexico\\_Launches\\_Second\\_Catatrope\\_Bond\\_Oct2012.html](http://treasury.worldbank.org/bdm/html/Financing_Noteworthy/Mexico_Launches_Second_Catatrope_Bond_Oct2012.html) (last visited Sept. 18, 2016) [<https://perma.cc/G6SZ-B2TC>] (archived Sept. 19, 2016).

global justice perspective, leveling the playing field is a morally worthy goal.

In the case of mandatory contribution as a material consequence of an Article 43 violation, the economic disincentive would clearly level the playing field between strong and weak states. Similarly, introducing mandatory contribution would remove the structural disincentives that affected states would otherwise have to report a suspected outbreak within their border. The Ebola Interim Assessment Panel agrees: "incentives are needed to encourage notification of health threats."<sup>240</sup> In sum, requiring violating states to contribute to the PEF insurance premium may move the IHR beyond the moral rhetoric of the international community, narrow the inherent asymmetric power structure between strong and weak states, and avoid unfairly penalizing weak states for disclosing outbreaks within their border.

The above argument is also consistent with political scientist Alexander Thompson's view on enforcement: he argues that the enforcement of legal rules must be managed by international organizations.<sup>241</sup> Thompson's "managing enforcement" model concerns the way in which violations are approached horizontally across different institutions. In the ozone regime, for instance, state parties that failed to develop a "compliance plan" in accordance with the Montreal Protocol were disqualified from receiving funding from the Global Environment Facility. In a similar way, the proposed institutional linkage between the IHR and the PEF is not a far-reaching idea. However, instead of punishing states for failing to implement public health preparedness, as measured against the benchmarks set by the IHR (currently being discussed), this Article proposes that the level of premiums should be linked to deliberate, intentional violations of the IHR, such as Article 43 violations; these enforceable sanctions would empower the WHO and strengthen the international infectious disease control regime.

Thus, in principle, violation of the IHR would result in material legal consequences. However, exceptions should be made when states are unable to comply with the IHR through no fault of their own. For instance, failing or failed states' inability to implement core IHR capability because of poverty or lack of health capacity should be exempt from sanction. Otherwise, weak states would incur a disproportionate and unfair burden. Additionally, punishing weak states for their inherently weak public health infrastructure would

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240. REPORT OF THE EBOLA INTERIM ASSESSMENT PANEL, *supra* note 172, at ¶ 18.

241. Alexander Thompson, *Coercive Enforcement of International Law*, in INTERDISCIPLINARY PERSPECTIVES ON INTERNATIONAL LAW AND INTERNATIONAL RELATIONS: THE STATE OF ART 508 (noting that the enforcement of legal rules "is partly a function of institutions and their design, which can either facilitate or hinder the decentralized sanctioning of violators. Enforcement, in other words, must be managed").

further diminish their willingness to participate in the regime. It is worth emphasizing that the ability to implement the core IHR requirements differs markedly from the willingness to comply with the IHR. The latter concerns deliberate, intentional violation of the IHR, which is often driven by the economics of self-interest and at odds with the cooperative aspirations of the IHR. In contrast, the inability to comply with the IHR is often driven by multiple complex structural factors, namely lack of financial resources, instable political structure, or civil war.

Likewise, linking the IHR with the PEF would engender a thicker form of cooperation and arguably help structuring states' interests differently. Legal scholar Joel Trachtman observes that "international law form[s] a mechanism by which the domestic politics of different states may be linked, modifying the otherwise applicable political equilibrium in different states."<sup>242</sup> The informal linkage could create a thicker form of international cooperation by weaving the domestic politics of different states together. Admittedly, different states often have different reasons for their noncompliance; however, because the informal linkage would also increase the frequency and intensity of repeated interactions among states, it is possible that these repeated interactions would shape states' domestic interests in turn. This thicker form of cooperation is also facilitative of perpetuating the regime, which was created purposely to foster cooperation. Political scientist Robert Keohane argues that states obey regime rules because regimes are difficult to create and replace, and it is therefore in states' long-term interests to avoid noncompliance.<sup>243</sup> In this context, the proposed economic disincentives would function as a signal that the IHR is worth defending, and that the regime is worth maintaining.

Alternatively, the mandatory contribution could be perceived as a small disincentive for defection. Legal scholar Andrew T. Guzman's rationalist model of compliance suggests that states cooperate when the importance of a compliance decision is perceived as minor.<sup>244</sup> Professor Guzman explains that international law encourages cooperation if "its obligations are structured to reduce the importance of each compliance decision. For example, an arms treaty by itself may have little success, but a treaty that provides for periodic inspections by a neutral third party may stand a greater chance of achieving the goal of arms control."<sup>245</sup> Simply put, states comply with a treaty when

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242. JOEL P. TRACHTMAN, *THE FUTURE OF INTERNATIONAL LAW: GLOBAL GOVERNMENT* 42 (2013).

243. See generally Robert Keohane, *International Relations and International Law: Two Optics*, 38 HARV. INT'L L. REV. 487 (1997) (discussing compliance and effectiveness of climate change regimes).

244. Andrew Guzman, *A Compliance-Based Theory of International Law*, 90 CALIF. L. REV. 1823, 1847–51 (2002).

245. *Id.*

the sovereignty cost is perceived as minimal. By extension, mandating that violating states contribute to the insurance premium pool also imposes a minimal sovereignty cost on participating states.

Another way to look at structuring disincentives to increase compliance is by examining the impact of sanctions. In theory, the threat of sanctions compels compliance. Legal scholars Oona Hathaway and Scott Shapiro argue that sanctions need not be a threat or an exercise of violence; rather, a threat of exclusion can encourage states to comply with international law.<sup>246</sup> Likewise, legal scholar Lawrence Gostin maintains that an effective global health regime should include sanctions such as suspension of eligibility for WHO Executive Board membership or other WHO rights.<sup>247</sup> In this context, sanctions signal to other states that noncompliance is politically costly and will result in the suspension of privileges otherwise enjoyed by the violating state.

Additionally, sanctions can act as leverage against the strategic holdouts by strong states from international cooperation. Absent the threat of sanctions, some scholars argue, strong states often lack incentive to cooperate in the international infectious disease regime, despite the fact that infectious diseases penetrate national borders easily. Strong states tend to possess sufficient public health capability to protect their population from the international spread of infectious diseases and can elect to enact strong border control measures such as blanket travel restrictions or compulsory quarantine measures with little fear of retaliation. The latter is not only disruptive to international travel and traffic, but also puts weak states at a considerable disadvantage because they often cannot challenge strong states' unilateral decisions. In this context, an increased insurance premium can discourage that unwanted behavior. By extension, for states, the prospect of contributing to the PEF insurance premium can be akin to the threat of sanctions, which many scholars argue is effective in achieving a desirable outcome at the international level.<sup>248</sup>

Admittedly, this Article's proposal is bold and faces a number of challenges. First and foremost, because the proposal would create a legally enforceable obligation, political resistance from Member States is likely. Nonetheless, in other legal regimes, states have agreed to enforceable sanctions even at the expense of sovereignty, one notable example being the WTO regime.<sup>249</sup> Hence, including some form of

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246. Hathaway & Shapiro, *supra* note 29.

247. Lawrence O. Gostin & Eric A. Friedman, *Towards a Framework Convention on Global Health: A Transformative Agenda for Global Health Justice*, 13 *YALE J. HEALTH POL'Y L. & ETHICS* 1, 69 (2013).

248. See *Pandemic Emergency Facility: Frequently Asked Questions*, *supra* note 8 (discussing how PEF is financed).

249. See Marrakesh Agreement Establishing the World Trade Organization, Apr. 15, 1994, 1867 U.N.T.S. 154 (explaining disciplines for noncompliance).

enforceable obligation in the international infectious disease control regime is not a far-reaching idea. In fact, the Scandinavian states expressed support for sanctions against states that fail to meet the core requirements of the IHR during the sixty-eighth WHA.<sup>250</sup>

Here, it is useful to conceptually separate three closely related, but distinguishable terms: “penalty,” “sanction,” and “financial disincentive.” These terms exist in a spectrum ranging from coercion to persuasion. For the purposes of this Article, “penalty” is defined as a punishment for violating an agreed upon rule. In contrast, “sanction” is an act with the intention to induce compliance through a threat. Finally, “financial disincentive” is understood as a factor that discourages a Member State from taking certain action.

Arguably, mandating that violating states contribute to the insurance premium differs significantly from that of coercing states to comply with the IHR through sanctions. Mandatory contribution is neither punitive nor coercive in nature. Instead, mandatory contribution is a form of financial disincentive that discourages Member States from taking a disproportionate response during an international infectious disease outbreak. Moreover, since the PEF is modeled on the notion of risk management, which means that the legal consequences of noncompliance with the IHR are not, by definition, punitive, the conceptual difference would, arguably, lessen political resistance from states in agreeing to the proposal, as with similar insurance schemes for natural disasters that have already been implemented regionally.<sup>251</sup> Additionally, because the IHR was established chiefly to enhance international cooperation, structuring economic disincentives to discourage certain behaviors is consistent with that goal.

Perhaps most importantly, from a practical viewpoint, this issue is politically ripe. A recent World Bank opinion survey shows that citizens in France, Germany, Japan, the United Kingdom, and the United States are concerned that the world is ill-prepared for another global epidemic like EVD.<sup>252</sup> Similarly, the large number of international initiatives aimed at strengthening global health security suggests that there is a considerable amount of political interest in the issue.<sup>253</sup> Hence, one key challenge likely to confront the proposal will

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250. WHO, Implementation of the International Health Regulations (2005), Report of the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation, U.N. Doc. A68/22 Add.1 (Mar. 27, 2015).

251. See generally, *supra* notes 238–39 and accompanying text.

252. Press Release, World Bank, Poll: Most Not Convinced World is Prepared for Next Epidemic (July 23, 2015) (<http://www.worldbank.org/en/news/press-release/2015/07/23/poll-most-not-convinced-world-is-prepared-for-next-epidemic> [<https://perma.cc/V6LL-7BVF>] (archived Sept. 19, 2016)).

253. See, e.g., GLOBAL HEALTH SECURITY AGENDA, *supra* note 81; UNICEF, *supra* note 111; UNFPA, *supra* note 112; UNDP, *supra* note 113; UNAIDS, *supra* note 115;

not be the lack of political momentum, but rather how to sustain the interest of the international community in order to have a meaningful impact on global health security. Viewed in this light, the informal institutional linkage between the World Bank and the WHO is likely to increase the visibility of the issue and keep global health security as a key item on the international agenda. Admittedly, there are limitations to the proposal: it does not address the implementation gap that exist among states; it requires strong WHO leadership, which many commentators observe is currently absent; and lastly, it will compete with existing international commitments in a financially parsimonious world, including the post-2015 developments,<sup>254</sup> and the replenishment of the Global Fund.<sup>255</sup>

Despite the aforementioned limitations, the proposal should be favored for two key reasons. First, the proposal would compel states to adhere to the WHO's expert recommendation, which, over time, will enhance the WHO's reputation and entrench its normative authority in the international legal order. Relatedly, the linkage would compel states to give more political weight to a PHEIC and likely galvanize cooperation. Second, the proposal would shift the international infectious disease control regime from a principal-agent model to one that encourages Member States to act as stakeholders. Such a change is critical from a global health and justice perspective, where the current regime design tends to embed the inherent power asymmetry of strong and weak states, which is contrary to the WHO's moral mission as a voice for the world's most disadvantaged.

Additionally, the informal PEF-IHR linkage would offer at least three practical advantages. First, because affected states tend to be leery of the social, economic, and political repercussions that stem from notifying the WHO about a potential outbreak in their territory, such flexibility is particularly desirable. Second, the informal linkage would create an intermediate level between the outbreak and a PHEIC, which the Ebola Interim Assessment Panel notes as necessary in alerting and engaging the wider international community at an earlier phase in the crisis.<sup>256</sup> This is primarily because an intermediate level could facilitate preparedness and prevention action, which is critical in

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GAVI, *supra* note 116; THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA, *supra* note 117; PEPFAR, *supra* note 118; DEPARTMENT FOR INTERNATIONAL DEVELOPMENT, *supra* note 119.

254. *Millennium Development Goals and Post-2015 Agenda*, UN ECONOMIC AND SOCIAL COUNCIL, <http://www.un.org/en/ecosoc/about/mdg.shtml> (last visited Sept. 16, 2016) [<https://perma.cc/8PAJ-67PW>] (archived Sept. 19, 2016).

255. See *Japan to Host Key Global Fund Meeting*, GLOBAL FUND, [http://www.theglobalfund.org/en/news/2015-03-16\\_Japan\\_to\\_Host\\_Key\\_Global\\_Fund\\_Meeting/](http://www.theglobalfund.org/en/news/2015-03-16_Japan_to_Host_Key_Global_Fund_Meeting/) (last visited Sept. 13, 2016) [<https://perma.cc/Z7HG-3BMS>] (archived Sept. 19, 2016) (stating that Japan will host the Global Fund's Replenishment Preparatory Meeting).

256. Ebola Interim Assessment Panel Report, *supra* note 53.

averting an escalation of the situation. Third, the intermediate level created by the IHR-PEF linkage would better accommodate the reality of fragile states, where it is a lack of health capability that tends to underlie their delayed responses rather than an unwillingness to respond to a health crisis. Thus, the timely release of the PEF funds would be used to bridge the health capability gap and prevent the fragile states from stigmatization when they notify the WHO of the outbreak in their territories.

In sum, the informal linkage would (1) reaffirm the WHO's normative authority as a global health leader, (2) create incentives for states to comply with the IHR, (3) create a coherent regime of international infectious disease control, (4) give the WHO the financial resources necessary to command international public health emergency response in the early stages of an outbreak, and (5) institutionally, be mutually beneficial for both the WHO and the World Bank because both organizations are struggling to maintain their relevance in an increasingly crowded global health landscape now occupied by new players that are arguably better funded.

#### *D. Potential Challenges to the IHR-PEF Linkage*

This Subsection responds briefly to another key potential criticism of the proposal, which concerns the possible moral hazard that could be created by the informal IHR-PEF linkage. A moral hazard occurs when weak states over-rely on the World Bank for financial assistance and resources once the WHO declares a PHEIC within their territory. In the long run, this availability of funds could diminish the incentive for weak states to develop their own public health infrastructure, encouraging adverse dependency on international financial support instead. However, from the vantage point of morality and practicality, such concern is easily countered. First, as mentioned above, in the instance where failing or failed states do not possess the necessary public health core capability to respond to a PHEIC, as in the 2014 Ebola outbreak, international organizations owe a moral duty to the affected state as an equal, moral subject. In particular, as the spread of infectious disease tends to affect the most vulnerable populations disproportionately, bioethicists argue that failure to invest in global health security can be considered a collective moral failing.<sup>257</sup> Importantly, ensuring that the most vulnerable populations have access to a minimal level of protection in the midst of an infectious disease outbreak is a manifestation of solidarity. The WHO Ebola Interim Assessment Panel recognizes the need to embody solidarity in global health emergency response: “in an increasingly globalized world,

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257. Maxwell J. Smith & Ross E. G. Upshur, *Ebola and Learning Lessons from Moral Failures: Who Cares About Ethics?*, 8 PUB. HEALTH ETHICS 305, 310–11 (2015).



a disease threat in one country is a threat to us all. Shared vulnerability means shared responsibility and therefore requires sharing of resources.”<sup>258</sup>

In addition to the ethical considerations, a sustainable funding source made readily available to the affected population during a PHEIC would also encourage participation and engender trust in the global health security regime. Perceived fairness is important in the creation of an effective international regulatory regime. Legal scholar Ilan Benschalom further argues that, insofar as states participate in the international regime in order to coordinate collective interests, states “should pay for the provision of international public goods . . . according to their relative economic abilities.”<sup>259</sup> Likewise, even from a policy perspective, since the fund would be made readily available to countries in need of financial assistance, irrespective of their economic circumstance, it is important to remember that wealthy countries are not excluded from accessing the fund. Even though the poor countries are more likely to be in need of the fund, the wealthy countries are also protected against a potentially costly human catastrophe. The IHR-PEF linkage would institutionalize processes for consistent funding decisions and serve as a hedge against economic uncertainty and emerging infectious diseases for all countries equally.

#### V. CONCLUSIONS: ADVANCING GLOBAL HEALTH SECURITY

This Article proposed informally linking the PEF with the IHR to ensure consistent and timely global health emergency responses. While some international law scholars have long advocated for enforceable obligations that would compel states to follow international law, global health practitioners have not taken their suggestions seriously, at least not until the recent 2014 Ebola outbreak, after which the WHO established a committee to consider embedding incentives in the existing infectious disease control regime. But such reactive political action to international infectious disease must be avoided, most of all at the expense of human life. While a multitude of reasons explain the slow containment of the 2014 Ebola outbreak, an IHR with enforceable mechanisms would strengthen future international infectious disease control responses. This proposal provides a timely discussion: the world is at a critical juncture, as the shape of the international infectious disease regime is undergoing dramatic transformation. The emergence of infectious diseases, such as the Zika virus, again underscores the urgency of a greater global

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258. WHO Leadership Statement on the Ebola Response and WHO Reforms, *supra* note 4.

259. Ilan Benschalom, *Rethinking International Distributive Justice: Fairness as Insurance*, 31 B.U. INT'L. L. J 267, 268 (2013).

health cooperation. The 2014 Ebola outbreak provided a critical lesson for global health security, and it highlighted the current gap in the international infectious disease regime. Drawing on international law and international relations literature on compliance, this Article demonstrated how global health security can be enhanced through realizing the IHR's potential *vis-à-vis* the financial incentives provided by the PEF. In doing so, the informal linkage would embed global health norms and deepen global health cooperation.

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