Ebola Postmortem: Treating the World Health Organization’s Regulatory Maladies

INTRODUCTION

The 2014 Ebola virus disease (EVD)\(^1\) outbreak captured the public imagination in a way that even Severe Acute Respiratory Syndrome (SARS),\(^2\) its predecessor as shorthand for fear of a massive

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1. Ebola virus disease was first discovered in 1976 in the Sudan and the Democratic Republic of Congo. It spreads through human-to-human transmission via direct contact with bodily fluids of infected materials as well as surfaces and materials contaminated by these fluids. The average fatality rate is 50%, but has reached as high as 90% in past outbreaks. For more information, see Ebola virus disease: Fact sheet. WORLD HEALTH ORGANIZATION [WHO] (April 2015), http://www.who.int/mediacentre/factsheets/fs103/en/.

2. This is not to downplay the public and human impact of the 2003 SARS outbreak. SARS is a viral respiratory illness that begins in a high fever and then evolves into pneumonia and acute respiratory distress (severe breathing difficulty). However, SARS proved less contagious or deadly than EVD; the outbreak killed 774 of the 8,093 infected. See SARS Basics Fact Sheet, CENTERS FOR DISEASE CONTROL AND PREVENTION (July 2, 2012), http://www.cdc.gov/sars/about/fs-sars.html. Moreover, that the SARS epicenter was in Asian states with strong central governments and the ability to mobilize resources to prevent its spread, compared to the West African nations in which EVD first struck, mitigated both the perception and reality of the disease spreading in the absence of a strong international response, a factor the author contends contributed to the relative prominence of the recent EVD outbreak in public discourse.
global pandemic, failed to do. The EVD epidemic raged across West Africa: while the first confirmed case was in Liberia, EVD soon appeared in Sierra Leone, Guinea, Nigeria, Mali, Senegal, and the Democratic Republic of the Congo. Then, for the first time, EVD managed to escape its historical locus, spreading beyond West Africa to other continents.\(^3\) Citizens everywhere were confronted by the possibility of a global epidemic as people fell ill in New York City, Dallas, and Madrid.\(^4\) Other states risked exposure as patients were airlifted to hospitals in Atlanta, Hamburg, London, Paris, and Omaha for specialized treatment.

From a global regulatory perspective, however, the international community’s attention to the EVD outbreak came relatively late. As early as March 18, 2014, Guinean health officials had announced the outbreak of a hemorrhagic fever, confirming it was EVD on March 22.\(^5\) By the end of March, the World Health Organization (WHO) announced there had been 112 cases and 70 deaths due to EVD between the neighboring countries of Guinea, Liberia, and Sierra Leone.\(^6\) In the meantime, the situation within those countries began to deteriorate. Nearby states began to close off their borders to prevent infected individuals from crossing over.\(^7\) The Government of Liberia tried to reverse its declaration that EVD had been detected in its territory.\(^8\) By the end of July, WHO statistics calculated 1,603 cases and 887 deaths overall. Yet it wasn’t until August 7 that the WHO—coordinating and ensuring disease surveillance worldwide through its International Health Regulations—declared the EVD epidemic a Public Health

\(^3\) While the disease has been reported in various areas of Africa, see *Ebola virus disease*, supra note 1, until 2014 it had never been detected outside of the continent.


Emergency of International Concern to reflect the geographic scope of the threat and the need for a coordinated response. This five-month gap between multi-State detection and subsequent, coordinated international response is only one troubling aspect of the WHO’s treatment of the outbreak.

How might the WHO better perform the role it was constituted to play as a regulatory agency post-2014? This Bulletin Note assesses the WHO’s response to the EVD pandemic in light of its regulatory capabilities. Part I discusses the WHO’s constitutive documents and the rules it has promulgated in the attempt to regulate health internationally—the International Health Regulations (“IHR”); it also addresses the weaknesses of the IHR exposed by the EVD crisis. Part II offers some insights and suggestions as to how the WHO could better regulate to mitigate the impact of infectious disease in the future.

I. THE WHO AND EBOLA: THE OUTBREAK IN DEPTH

A. The World Health Organization as Regulator

The World Health Organization is a technical institution that endeavors to regulate health worldwide. The WHO consists of three bodies: the World Health Assembly (“WHA”), or the legislative body of representatives from each Member State; the Executive Board, a program-developing subset of the WHA comprised of 34 elected technical experts; and the Secretariat, which carries out the decisions of the other two organs through a Director-General, another health expert elected by the WHA, and staff. In 1948, its original Member States

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11. As the Member States of the United Nations began to conceptualize the full reach of the organization, they recognized that security is more than concern for armaments; rather, they intended for the United Nations to stabilize the international system by social and economic means as well. This included the establishment of an organization dedicated to solely to attaining optimal health and minimizing health risks. The preamble of the WHO Constitution “linked the enjoyment of the highest attainable standard of health with international security, economic development, and human rights”—relevant concerns in the wake of World War II. David P. Fidler, The UN and the Responsibility to Practice Public Health, 2 J. INT’L L. & INT’L REL. 41, 47 (2005). The earliest Member States envisioned a three-part organization consisting of the following branches: the World Health Assembly (“WHA”), or the legislative body; the Executive Board, the executive, program-developing subset of the WHA; and the Secretariat, which carries out the decisions of the other two organs through a Director-General and staff.
envisioned a robust international regulatory body that would have the power to legislate and bind its State Members.\textsuperscript{13} They defined the mission of the WHO broadly: to help attain a “state of complete physical, mental and social well-being” worldwide.\textsuperscript{14} Moreover, the WHO may take “all necessary action to attain the objective of the organization.”\textsuperscript{15} Even if the WHO has not exercised the full extent of its regulatory capacity, its Member States did provide for virtually limitless courses of action to deal with the complexity of disease and its consequences.

By and large, the WHO maintained a more technocratic reputation,\textsuperscript{16} forgoing a primarily regulatory role. Instead, its focus has been promulgating nonbinding recommendations via Article 23\textsuperscript{17} to its Member States and developing its programming capacity.\textsuperscript{18} Though there is an internationally recognized right to health, the WHO has not promoted the development of international law to protect that right.\textsuperscript{19} It, for the most part, has placed no obligations on States to raise health standards. For this reason, the International Health Regulations...
(“IHR”) are in fact an anomaly in the WHO’s history and this anomalous character highlights how important of an instrument they are.

B. The International Health Regulations

The World Health Assembly functions as the legislative or policy-making branch of the WHO.20 It consists of a representative from each WHO Member State, each with a single vote.21 The WHA may adopt two types of binding regulations under Articles 1922 and 21. The regulations examined in this Bulletin Note, the International Health Regulations, were passed by the WHA pursuant to Article 21, which lists five specific areas in which the WHO may regulate.23 Regulations passed under Article 21 authority become legally binding without consent by all the Member States—

Regulations adopted pursuant to Article 21 shall come into force for all Members after due notice has been given of their adoption by the Health Assembly except for such Members as may notify the Director-General of rejection or reservations within the period stated in the notice.24

Such regulations are self-executing, and come into force as soon as due notice has been given.25 Adopted in 1951, the IHR, a legal instrument to prevent and respond to acute public health risks, became immediately binding upon all Member States. Practically speaking, the instrument yielded power to the WHO to regulate and direct Member State response to infectious disease. Over time, the WHO attempted to revise and strengthen “the moribund and largely mothballed IHR,” carv-

20. In terms of the procedural process, each Member State has one vote in the WHA. WHO CONST., art. 59, supra note 12. Decisions are made by a two-thirds majority of the Members present and voting. Id. art. 60.
21. Id. art. 59.
22. Article 19 has been described as one that provides the WHO with virtually limitless treaty-making power, granting the authority to adopt conventions or agreements with respect to any matter within the competence of the Organization. A two-thirds vote of the Health Assembly shall be required for the adoption of such conventions or agreements, which shall come into force for each Member when accepted by it in accordance with its constitutional processes.
23. Id. art. 21.
24. See id. art. 21.
25. Id. art. 22.
ing out a greater role and competency for itself as an international organization.  

The most recent revision of 2005 occurred in a moment of convergence of several trends: international trade and travel as channels of microbial traffic; deteriorating or non-existent public health capabilities in developing countries; decreasing effectiveness of antimicrobial drugs; unprecedented levels of social, economic, and environmental problems as catalysts for disease; and the globalization of markets, which has minimized state capacity to address public health concerns.  

First proposed by the WHA in 1995, the revision did not begin in earnest until 2004, after the SARS outbreak. The new IHR expand the conception of communicable disease, allowing the WHO to monitor “public health risks” and “public health emergencies of international concern,” no longer limited to the three enumerated diseases of previous revisions.

The 2005 revision places affirmative obligations upon States, such as the obligation to develop core capacity to meet reporting and public health response obligations. States also must, as far as practicable, notify the WHO of risks to the spread of disease beyond their own territory. Note, though, that this supposes a suitable chain of communications and infrastructure. Moreover, the 2005 IHR involve non-State actors; the WHO sought to improve its surveillance by extending its reach to non-governmental organizations for reporting purposes.

On its face, the revision embodies a broader vision of illness...


30. IHR, art. 13, supra note 29.

31. Id. art. 9.

32. Id.
as a security risk and improves reporting mechanisms.\textsuperscript{33} This broad conception is a far cry from the stunted coverage offered by the earlier IHR and a testament to the evolving understanding of communicable disease and potential bioterrorism. But did the promise of amendment become a reality in the course of the Ebola epidemic, or remain an empty gesture?

**C. EVD and The International Health Regulations in Action**

By and large, the WHO response to the EVD outbreak has been characterized as “too little, too late.” The organization is meant to symbolize the belief that minimizing public health risks and ensuring an optimal level of healthcare for all is an essential component of international peace and security.\textsuperscript{34} Health experts and practitioners alike, however, have expressed discontent with how the pandemic was managed, particularly with respect to the role of the WHO.\textsuperscript{35} Médicins Sans Frontières (MSF), a medical humanitarian organization that serves as a first responder in such crises, openly criticized the WHO and the international community for its inaction.\textsuperscript{36} MSF highlighted these faults bluntly in August 2014, from the closure after the global financial crisis of the WHO unit that oversaw hemorrhagic fevers like EVD, to a simple lack of operational capacity.\textsuperscript{37} By that point, President Ellen Johnson Sirleaf of Liberia had declared a state of emergency

\textsuperscript{33} But see Dhubajyoti Bhattacharya, Symposium, An Exploration of Conceptual and Temporal Fallacies in International Health Law and Promotion of Global Health Preparedness, 35 J.L. MED. ETHICS 588, 590 (2007) (arguing the IHR are meaningless absent guidance on State capacity building). Parts I.C.2 and II, infra, address the capacity-building problem.


\textsuperscript{35} See generally HOUSE OF COMMONS INT’L DEVELOPMENT COMM., RESPONSES TO THE EBOLA CRISIS, 2013-2014, available at http://www.publications.parliament.uk/pa/cm201415/cmselect/cmintdev/876/876.pdf; see also Somini Sengupta, Effort on Ebola Hurt W.H.O. Chief, N. Y. TIMES, Jan. 6, 2015, http://nyti.ms/1zSw9s7 (noting that the WHO head Dr. Margaret Chan’s critics believe “she let governments around the world steer the agency to fit their own needs, instead of firmly taking the helm as the world’s doctor in chief”). Even Dr. Chan herself acknowledged “she wished she had acted a little earlier to mount a much stronger, more aggressive response.” Id.


\textsuperscript{37} Id. The account blamed not only the WHO but also the international community as a whole:
including “the suspensions of certain rights and privileges”—complete with Liberian troops firing tear gas and live rounds at citizens trying to escape quarantine.

Looking beneath the surface-level criticism of inaction, it is the IHR, in particular, whose shortcomings have been exposed by the 2014 EVD outbreak; that is, there is an issue with the deeper, institutional framework under which the WHO operates. Primarily, these failures include the designation of a Public Health Emergency of International Concern, the capacity-building requirements, and the existing enforcement mechanisms. First, while the conception of a “public health emergency of international concern” contained in Article 48 of the revised IHR could be a potent designation in the global notification and response system, the flexibility of its definition undermined its purpose; as it was, the designation did not come until five months after the emergence of a pandemic. Second, obligating capacity building is meaningless absent institutional support. Third, regulatory schemes offer nothing without the threat of real penalty and enforcement. These weaknesses in the course of the EVD crisis have underscored the continuing failure of the IHR and, consequently, the WHO.

1. Public Health Emergencies of International Concern

Under the IHR, the WHO defined a Public Health Emergency of International Concern (“PHEIC”) as “an extraordinary event which is determined, as provided in these Regulations: to constitute a public health risk to other States through the international spread of disease; and to potentially require a coordinated international response.” In essence, a PHEIC is a health event that is not merely internal to a State. A PHEIC triggers the meeting of an emergency committee of experts

[O]perational capacities in the United Nations system have been gradually reduced through reforms. For example, the restructuring of the World Health Organization in Geneva has led to the closure of its viral hemorrhagic fever unit. Member states should be held accountable for an unceasing reduction of response capacity. A destructive spiral has materialized, leading to what we see today: lack of leadership, deficient coordination and, last but not least, a striking absence of operational capacity. This is compounded by the fact that the international community simply doesn’t feel responsible for responding to what is happening in regions that are not perceived as politically or economically interesting.

Id.


40. IHR, supra note 29, art. 1.
to make coordinated recommendations. Moreover, the PHEIC designation signals to external domestic health agencies to take preventative measures.

Despite the fact that EVD had spread to two States in West Africa by the end of March, WHO Director-General Dr. Margaret Chan, exercising discretion to accept the IHR Emergency Committee’s recommendation, did not declare EVD a “public health emergency of international concern” until the end of August, a full five months after EVD had been confirmed in West Africa. Liberia began sending cables pleading for advice, including from the local United Nations peacekeepers and the mission chief, beginning March 24, 2014; officials copied Dr. Chan in Geneva, particularly when the disease had been detected at the border of Liberia and seemed ready to cross it. The WHO itself confirmed cases in March on its website. Some participating doctors called the WHO’s efforts to subsequently track and contain the outbreak “poorly led and limited . . . contributing to a sense that the problem was not as bad as it actually was.”

To be sure, some WHO leaders thought the 2014 outbreak would be “typical,” not the “unprecedented, unusual outbreak” requiring a quicker response than occurred. Fundamentally concerning, however, was the Director-General’s understanding of the WHO’s role in an outbreak; Dr. Chan, after meeting with the president of Doctors Without Borders to discuss the outbreak, recounted “[i]t was a fantasy . . . to think of the W.H.O. as a first responder ready to lead the fight against deadly outbreaks around the world.” This logic renders the PHEIC designation moot. Dr. Chan did not call for an emergency committee to determine the risk of an international spread of EVD until August, when an infected Liberian man flew to Nigeria. In effect, this created less opportunity for a coordinated response from the States already affected, as well as unilateral action by other States to prevent infection. By August, Secretary-General of the United Nations Ban Ki-moon signaled discontent with the WHO’s response, telling Dr. Chan he intended to appoint a new mission to coordinate the Ebola response.

41. Sengupta, supra note 35.
42. See supra note 5.
43. Sheri Fink, Cuts at W.H.O. Hurt Response to Ebola Crisis, N.Y. TIMES, (Sept. 3, 2014), http://nyti.ms/1tuN8IY.
44. Id.
45. Id.
46. Sengupta, supra note 35.
47. Id.
2. Mandatory Capacity Building

The IHR obligate Member States to develop infrastructure and capacity to comply with its surveillance and public health requirements. Within five years of the IHR entering into force, States were required under Article 5 to build the necessary capacity in both areas; when the deadline passed, in 2010, only 20% of nations had enacted the requirements. An example of the required capabilities Member States must develop are competent procedures at points of entry into States to monitor for disease. A recent qualitative study set out to test challenges nations have faced in implementing the 2005 IHR. Amongst the many challenges perceived, the study unearthed difficulties related to uncoordinated government response, infrastructure and resources to deal with emergencies and public health events, insufficient budget allocations to implement requirements, as well as a lack of direction to implement the IHR. All of these were apparent in the EVD crisis. For example, the response to EVD entailed “lax enforcement” of quarantines even though the disease has a 21-day incubation period, and some States recommended—for lack of an alternative for treatment and care—”reflection” and “prayers” for their citizens. Making matters worse, the outbreak was so virulent that it killed off a significant portion of an already inadequate health workforce.

The 2005 IHR bind the WHO as much as States, requiring the organization to aid those nations that cannot meet the deadline on their own. The success of a surveillance and notification system is abso-

48. IHR, art. 5, para. 1, supra note 29 (“Each State Party shall develop, strengthen and maintain, as soon as possible but no later than five years from the entry into force of these Regulations for that State Party, the capacity to detect, assess, notify and report events in accordance with these Regulations, as specified in Annex 1”); id. art. 13, para. 1 (“Each State Party shall develop, strengthen and maintain, as soon as possible but no later than five years from the entry into force of these Regulations for that State Party, the capacity to respond promptly and effectively to public health risks and public health emergencies of international concern as set out in Annex 1.”).

49. Fink, supra note 43.

50. See Edith Bakari & Gasto Frumence, Challenges to the implementation of International Health Regulations (2005) on Preventing Infectious Diseases: experience from Julius Nyerere International Airport, Tanzania, 6 GLOB. HEALTH ACTION (2013).


53. IHR, art. 5, para. 3, supra note 29 (committing the WHO to “assist[ing] States Parties, upon request, to develop, strengthen and maintain the capacities referred to in paragraph 1 of this Article”); id. art. 13, para. 3 (“WHO shall collaborate in the response to
lutely dependent upon a nation’s ability to identify disease and communicate information. The WHO Director-General has publicly emphasized the need to build capacity to effectively combat illness. Unfortunately, “[t]he majority of the world’s governments not only lack sufficient funds to respond to a superflu; they also have no health infrastructure to handle the burdens of disease, social disruption, and panic.” This is particularly striking given that “developing states are the crucible for emerging infectious diseases.” And, given their status as developing nations, they are those struck hardest by being the source of a pandemic both in political stature and in financial costs. It is no coincidence that EVD has managed to ravage developing West African States.

But the WHO has been able to offer little in capacity-building efforts. Its finances are member-dependent; Article 7 of the WHO Constitution allows the WHA to “suspend voting privileges and services to which a Member is entitled” when a Member State “fails to meet its financial obligations to the Organization.” Those same States that lack the necessary funds to engage in capacity building—whether through the creation of infrastructure, staffing, or funding—are supposed to contribute to the community pot. In fact, despite its size, the WHO’s annual budget equals that of a “medium-sized teaching hospital in an industrial country,” which is to say the WHO subsists on pocket change. This is particularly true after the global financial crisis, which forced the WHO to cut nearly $1 billion from its

54. Taylor, supra note 19 at 1355 (“Ultimately, however, the effectiveness of the global surveillance system envisaged by the IHR relies on frank and prompt reporting by all state parties: any gap in the surveillance system threatens the efficacy of the entire operation.”).

55. Dr. Margaret Chan, Director-General of the World Health Organization, Opening statement at the International Forum on Universal Health Coverage: Sustaining universal health coverage: sharing experiences and supporting progress (Apr. 2, 2012), available at http://www.who.int/dg/speeches/2012/universal_health_coverage_20120402/en/ (“We see full recognition of the need to build capacities, notably information capacity, which is so vital to the monitoring of progress and the introduction of corrective strategies, and regulatory capacity, which is the bedrock of quality assurance and cost control.”).


57. Id. at 241.

58. WHO CONST., art. 7, supra note 12.

budget, and ultimately meant cutting the outbreak and emergency response team. 60

Additionally, the WHO controls approximately 30% of its own budget, the rest directed by the individual donors themselves. 61 What it does control is also subject to the whims of individual Member States and donors. Indeed, after the SARS scare, wealthy donors offered the WHO “literally hundreds of millions because their businesses were affected . . . [b]ut as SARS burned out, those guys disappeared, and [the WHO] forgot very quickly.” 62 Dr. Chan has faced accusations of deferring to Member States instead of “leading from above,” with the full power accorded to the WHO in the area of disease regulation. 63 The WHO lacks the control it needs to direct what funds and resources it does have to the projects it would designate necessary to meet the requirements of the IHR; infrastructure-based needs are the first to lose out to popular health-based movements, which do not necessarily reflect the most pressing needs of the global health system. 64 As a result, there is little in the way of options for Member States to meet capacity requirements on their own nor for the WHO to meet its commitment to aid in that endeavor.

3. Lack of Enforcement Proceedings

The 2005 IHR promulgated no changes in the enforcement options available to the WHO and Member States. Irrespective of the positive changes included in the revision, they will be meaningless absent strengthened enforcement mechanisms; this is not to say that ca-

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60. Fink, supra note 43. Worse, the WHO’s staff of regional emergency outbreak experts in Africa was reduced from a dozen to three.
62. Fink, supra note 43.
63. Despite having publicly promised to make Africa a top priority, Dr. Chan barely spoke of the EVD outbreak in May of 2014—instead addressing issues largely associated with already developed nations, such as cancer and sugar consumption. See Sengupta, supra note 35.
64. There often is a great disparity between which illnesses are prioritized and which illnesses actually create the greatest global burden as measured in disability-adjusted life years (or years of potential life lost due to premature mortality and the years of productive life lost due to disability). One might be surprised to know unipolar depressive disorders alone account for a higher burden of disease than, say, HIV/AIDS, and far outstrip tuberculosis. The Global Burden of Disease: 2004 Update, World Health Organization (2004), http://www.who.int/healthinfo/global_burden_disease/2004_report_update/en/.
capacity building is any less important, but a legal obligation is no obligation at all absent enforcement.65

The IHR establish a dispute resolution settlement process as the only means by which to address issues. This raises the question of whether the enforcement problem, coupled with the capacity-building problem, can be resolved at this time.66 Noncompliance, often an issue in international law, frequently stems from issues of sovereignty and lack of resources and infrastructure.67 This is particularly true in the realm of global health surveillance, which relies upon national structures of Member States with large political and economic disparities. Specifically, alongside the question of what means of enforcement exist for the IHR’s legal obligations remains underlying concern that such obligations thrust onto developing countries cannot practically be met.

Here we have a regulatory space in which no one, whether the organization itself or a Member State, has historically put forth effort to ensure compliance. The WHO has not taken action when a Member State violated the IHR—at most, Member States were subjected to dispute resolution under what is now Article 56.68 The 2005 IHR do provide an option for the organization itself to address noncompliance: Article 56 provides that in the event a dispute arises between the WHO and a Member State concerning interpretation or application of the IHR, the matter may be submitted to the WHA for consideration and resolution.69 It does not, however, provide for responding to those States that act unilaterally to impose measures beyond those recommended by WHO.

In truth, the first line of defense relies upon Member States themselves to settle matters. For State-State disputes, Article 56 provides that:

[i]n the event of a dispute between two or more States
Parties concerning the interpretation or application of

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66. Belinda Bennett & Terry Carney, Trade, Travel and Disease: The Role of Law in Pandemic Preparedness, 5 ASIAN J. WTO & INT’L HEALTH L. & POL’Y 301, 313 (2010) (“Although countries have reporting obligations under the IHR, WHO has no basis for challenging them in the event of a failure to report.”).


68. Although, as mentioned before, it seems the dispute resolution mechanism has only been used once since the adoption of the IHR.

69. IHR, art. 56, para. 5, supra note 29.
these Regulations, the States Parties concerned shall seek in the first instance to settle the dispute through negotiation or any other peaceful means of their own choice, including good offices, mediation or conciliation.\textsuperscript{70}

The 2005 revision also provides that Members may submit disputes to arbitration in accordance with the Permanent Court of Arbitration Optional Rules for Arbitrating Disputes between Two States, complete with a binding, compulsory arbitral award.\textsuperscript{71} Member States rarely use dispute settlement procedures established by the WHO.\textsuperscript{72} The inadequacy of such mechanisms exemplifies the collective action problem inherent in such a complex regulatory issue. A State may unilaterally take actions outside those recommended by the WHO, but to date the Member States as a whole have not sought to collectively address violations of the IHR within the WHO.

As it is, the only means by which Member States may adjudicate claims, however infrequently, is by an external dispute resolution process. For example, States could turn to mediation, conciliation, or even arbitration to resolve conflicts. However, such procedures have substantial weaknesses in comparison to a strengthened regulatory scheme. They prevent a substantial, reliable body of law from developing, because international dispute resolution procedures are confidential, non-binding, and non-prospective. Moreover, the present options develop no sense of accountability, as the WHO, while responsible for the content of the regulations themselves, takes no part in their enforcement and development. The EVD crisis has illustrated as much—perhaps the only recourse has been pressure in the media by third parties for reform, but all involved have “been slow to acknowledge their mistakes publicly and reckon with them.”\textsuperscript{73} But beyond simple mistakes, there are preexisting deficiencies that have made effective response by the WHO essentially impossible. Institutional reform is necessary moving forward.

\section*{II. PROSPECTS FOR THE FUTURE}

The WHO is constitutionally committed to pursuing health by any means necessary. At the crux of the failure of the earlier IHR was

\begin{itemize}
\item \textsuperscript{70} IHR, art. 56, para. 1, \textit{supra} note 29
\item \textsuperscript{71} IHR, art. 56, para. 3, \textit{supra} note 29.
\item \textsuperscript{72} See Fidler, \textit{supra} note 18, n. 401 (reporting no use of the dispute settlement procedure since 1974, and citing E. Roelsgaard, \textit{Health Regulations and International Travel}, 28 WHO \textit{CHRON}. 265, 266 (1974), for one use between 1954 and 1974).
\item \textsuperscript{73} Fink & Belluck, \textit{supra} note 52.
\end{itemize}
the deeply ingrained reverence to sovereignty, after which the WHO has failed to develop its capacity to pursue compliance on behalf of all its Member States.74 “As with the responsibility to protect, the responsibility to practice public health is a norm that overrides the principles of sovereignty and non-intervention when the state fails to live up to its responsibilities.”75 The WHO was granted the competence by its Member States to flex its regulatory muscles in circumstances falling within the scope of the IHR—and must build the institutional strength to do so accordingly. The EVD epidemic has at the very least been constructive in illuminating those areas of the IHR which require further reform after 2005.

First, the WHO needs to clearly delineate what constitutes a Public Health Emergency of International Concern. If such a designation is to serve a pragmatic purpose, the WHO cannot wait, willy-nilly, as it did in the case of EVD. The Director-General may, at present, convene an Emergency Committee to consider whether there is a PHEIC. Given the reluctance with which Dr. Chan did so, there must be another avenue by which the Emergency Committee can be convened by the request of a Regional Office of the WHO. As a supplemental matter, the WHO should reconsider the meaning of “Public Health Emergency of International Concern” to make it more functional. Within the first month, EVD had spread across one State’s borders, which on its face should have amounted to an incident that was “international.” At the very least, the uncoordinated, unilateral actions taken by surrounding Member States as they closed off their borders and cut travel to infected regions should have amounted to a scenario requiring a coordinated international response. This problem of unilateral action existed long before the 2005 Amendment, and should be resolved by taking matters from the hands of Member States and putting them into the hands of the expert Emergency Committee—but the designation must come sooner rather than later.

Second, the capacity requirements should be revisited for greater sensitivity to Member State conditions and a stronger, meaningful role for WHO involvement. The deadline has passed, and—even with more actors involved in surveillance and notification—the notification systems have failed.76 In large part, they have failed because of infrastructure and supply deficits. Basic infrastructure is required, such as passable roads for the delivery of services, electricity

75. Fidler, supra note 26, at 52.
for quick reporting, and doctors for the administration of aid. The capacity requirements presupposed a functioning public health system. The WHO is required to help its Member States attain their objectives, and was incapable of doing so, which speaks somewhat to the ambitiousness of the objectives. But in any event, the WHO ultimately is too constrained by the operating budget, very little of which is disposable or even flexible. Donors should not be the ones to earmark funds for projects—rarely is it within their realm of expertise to decide what constitutes a health priority. Rather, the WHO must have more control over its budget in order to put the expertise it prizes so greatly to use. Offers of donations from other Member States came too late in EVD crisis, and more must be done ex ante to improve not just reporting capacity but also general public health capacity.

Finally, the WHO must begin to enforce the IHR through its dispute resolution procedures. While the justiciability of compliance with capacity-related requirements is questionable, the WHO must be willing to keep other Member States from unilateral action that can only exacerbate further deteriorating conditions. With earlier designation of PHEICs, the WHO will be able to set a course of action and have grounds to enforce its mandates. For example, the WHO could determine that borders cannot be closed in order to transport patients to facilities in a neighboring country. Should a Member State not comply, the WHO must be able to have recourse in order to implement its response fully. The extent of such recourse will prove difficult, especially in the initial stages. The WHO will be able to resort to soft enforcement mechanisms such as naming and blaming, or removing voting privileges. In more egregious situations, the WHO could involve the U.N. Security Council. As it is, the Security Council became involved in the EVD outbreak, determining the outbreak was a threat to international peace and security. If the WHO cannot itself utilize hard enforcement mechanisms, it may be able to work in tandem with the Security Council to do so under Chapter VII of the U.N. Charter.

77. The current recommendation to the WHO has been a $100 million contingency fund expressly for emergency public health response, fully financed by member states. See Jason Beaubien, WHO CALLS FOR $100 MILLION EMERGENCY FUND, DOCTOR “SWAT TEAM,” NPR (May 21, 2015), http://www.npr.org/sections/goatsandsoda/2015/05/21/408289115/who-calls-for-100-million-emergency-fund-doctor-swat-team

78. See Mark Colvin, CALLS FOR CIVIL AND MILITARY AID TO COMBAT EBOLA, NOT JUST CASH, ABC NEWS, (Sept. 17, 2014), http://www.abc.net.au/pm/content/2014/s4089668.htm.

CONCLUSION

CDC Director Thomas A. Frieden stated recently, “We are all connected by the food we eat, the water we drink, and the air we breathe.” 80  There is no escaping the interconnectedness that characterizes modernity.  Furthermore, “[b]inding international obligations of justice in health must be built over time.” 81  Yet the issue of regulating health risks is one that remains important in the present.  Actors in health law cannot sit by and wait for the next EVD crisis.  We also cannot underscore enough—the crisis is not yet over.  As of July 16, 2015, six cases of Ebola have resurfaced in Liberia, two months since the nation was declared EVD-free.  EVD persists in neighboring Sierra Leone and Guinea.  And the weaknesses of the WHO remain.  Now is not the time for sluggishness, or hope that infectious disease can be managed by “good diplomacy.” 82  Instead, we must toil to enact the changes necessary to regulate the spread of disease to the fullest extent.  This means building over time, but it also means accepting that real change must begin now.  The WHO must remember that health is a right that should be achieved by any means possible.

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