The World Health Organization's Governance Framework in Disease Outbreaks: A Legal Perspective

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Abstract

The 2014-2016 West African Ebola outbreak displayed a plethora of shortcomings within the governance for disease outbreak alert and response, with the World Health Organization (WHO) at the epicenter. Although part of the possible explanation for these failures may be grounded on the technical complexities inherent when assessing the magnitude of this public health event, governance-related problems due either to the institutional background or to the exercise of authority through administrative discretion cannot be overlooked. This article employs an understanding of a governance framework that includes not only norms such as the International Health Regulations, but also the ways in which organs such as WHO's Director-General and its Emergency Committee exercise the discretion granted by such norms. For this goal, a presumption of the idea of International Organizations as bureaucracies largely based on rational authorities will be used. Lastly, the article argues that this prima facie descriptive endeavor can serve as a basis for future normative proposals aimed at addressing governance deficiencies, whether through legal reforms, or even by focusing on the way in which officials themselves exercise authority on a case-by-case basis.

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I Introduction

On March 29, 2016, the WHO issued a statement declaring that the West African Ebola outbreak was no longer a Public Health Emergency of International Concern (PHEIC),[1] thus marking a conclusion to the initial declaration of August 8, 2014.[2] A mere three days later, there was yet another WHO statement reporting a new fatality in Liberia due to the Ebola virus.[3] However, this fact did not lead to another declaration of a PHEIC by the WHO's Director-General. Concurrently, on February 1, 2016, another PHEIC had already been declared, this time due to the explosive spread of Zika virus throughout the Americas, and mainly in light of a suspected link between the virus and microcephaly in newborns.[4] Moreover, another statement by the WHO on November 18, 2016, declared that the Zika epidemic no longer constituted a PHEIC, thus limiting its formal duration to less than ten months.[5] By contrast, a new coronavirus later named as Middle East respiratory syndrome emerged in 2012 in Saudi Arabia, also causing an outbreak in South Korea in 2015.[6] Even though by December 2016 the virus had infected more than 1840 persons, killing more than 650 in the process,[7]

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1 WHO, *Statement on the 9th meeting of the IHR Emergency Committee regarding the Ebola outbreak in West Africa*, available at http://www.who.int/mediacentre/news/statements/2016/end-of-ebola-pheic/en/.

2 WHO, *Statement on the 1st meeting of the IHR Emergency Committee on the 2014 Ebola outbreak in West Africa*, available at http://www.who.int/mediacentre/news/statements/2014/ebola-20140808/en/.

3 Resurgences of the Ebola virus across zones which had been previously deemed Ebola-free are referred to as "flare-ups". See the WHO's Statement, *New positive case of Ebola virus disease confirmed in Liberia*, available at http://www.who.int/mediacentre/news/statements/2016/liberia-ebola/en/.

4 Heymann, D L, Hodgson, A & Sall, A A et al., "Zika virus and microcephaly: why is this situation a PHEIC?" (2016), 387 *The Lancet*, 719 (719-720).

5 See WHO, *Fifth meeting of the Emergency Committee under the International Health Regulations (2005) regarding microcephaly, other neurological disorders and Zika virus*, available at http://www.who.int/mediacentre/news/statements/2016/zika-fifth-ec/en/.

6 Butler, D, "South Korean MERS outbreak is not a global threat" (June 5, 2015), *Nature News*, available at http://go.nature.com/1FSEdvy.

7 See the WHO's situation report on Middle East respiratory syndrome, December 5, 2016, available at http://www.who.int/emergencies/mers-cov/en/.

after several discussions the WHO's Director-General has explicitly decided not to declare outbreaks of Middle East respiratory syndrome as a PHEIC.[8]

These parallel outbreaks of diverging diseases showcase how variable the application of the legal definition of a PHEIC can be. Enshrined in the International Health Regulations (IHR), the main authorities in charge of interpreting its scope are the WHO's Director-General and the corresponding Emergency Committee.[9] As the use of PHEIC Declarations referred to in the previous paragraph illustrates, the criteria used for the application of the IHR to specific facts are not manifestly straightforward. To the contrary, it can be argued that WHO officials exercise a visible amount of discretion in their use of the legal mandate provided by the IHR.

In this sense, the delay of the PHEIC Declaration at the beginning of the 2014-2016 West African Ebola outbreak is a dramatic case in point. The catastrophic consequences of the belated response to the crisis displays how the international community, as a whole, is simply unable to meet the minimum requirements for effective disease outbreak preparedness and response. Arguably, this goal has been the driving motif of international cooperation in health ever since the first International Sanitary Conference took place in 1851.[10] Yet, even with the long-standing tradition of international coordination in communicable disease control, and despite the advances in medical science and technology ever since, the claim that the world is insufficiently prepared for public health emergencies still stands.

Given that the WHO is the International Organization with the specific mandate to act as the "directing and co-ordinating authority on international health work",[11] its legal powers merit particular scrutiny when revisiting recent events such as the West African Ebola crisis and the Zika outbreak in the Americas. For this goal, governance is understood in this contribution as encompassing both formal and informal instruments aimed at decision-

8 By January, 2017, an Emergency Committee had met ten times, the last of which occurred in September 2015. See WHO, *Statement on the tenth meeting of the IHR Emergency Committee regarding MERS*, September 3, 2015, available at http://bit.ly/2mXVshE.

9 Articles 12, 48 and 49, IHR.

10 Goodman, N, *International Health Organizations and their Work*, 1971, 247; Fidler, D, *International Law and Infectious Diseases*, 1999, 7; Burci, G, "Health and Infectious Disease" in Weiss, T & Daws, S (eds.), *The Oxford Handbook on the United Nations*, 2007, 583.

11 Article 2(a), Constitution of the WHO.

making.[12] The fact that the current analysis is limited to an International Organization does not imply disregarding the relevance of other institutions and actors as part of the broader governance framework of disease outbreaks. Such an understanding of governance includes norms, regulations and internal resolutions, regardless of whether they are legally binding for States or not.

This article deals with the governance framework designed within the WHO *qua* specialized agency of the United Nations (UN), aimed at infectious disease outbreak preparedness and response.[13] As for legal sources, the central focus will be the International Health Regulations (IHR) of 2005, considered as the core instrument designed at the international level for dealing with public health emergencies such as epidemics and pandemics. These Regulations will be addressed jointly with resolutions, and also by the institutional practice of WHO, deriving mainly from the World Health Assembly and the Secretariat.[14] Such institutional practice becomes all the more relevant, particularly since dispute settlement case law within the WHO is scarce.[15]

Furthermore, although this article focuses on a legal analysis of the governance structure of the WHO, a broader vision on how administrative-based discretion is exercised by International Organizations will be adopted, which includes issues located beyond the limits of positive law. The idea of authority is useful for this goal, given how it can operate as a

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12 See the seminal work of Rosenau, J & Czempiel, E (eds.), *Governance without government: Order and change in world politics*, 1992, 4; likewise, Levi-Faur, D, "From 'Big Government' to 'Big Governance'?" in Levi-Faur, D (ed.), *Oxford Handbook of Governance*, 2013, 3 et seq. From a legal standpoint, see also Bogdandy, A von, Goldmann, M & Dann, P, "Developing the Publicness of Public International Law: Towards a Legal Framework for Global Governance Activities" in Bogdandy, A von, Wolfrum, R & Bernstorff, J von et al. (eds.), *The Exercise of Public Authority by International Institutions: Advancing International Institutional Law*, 2010, 10-12; Kingsbury, B, Krisch, N & Stewart, R, "The Emergence of Global Administrative Law" (2005), 68 *Law and Contemporary Problems,* 15 (17 et seq.).

13 Other UN agencies also have a direct role in combatting infectious diseases. For instance, UNICEF has actively participated in disease-eradication campaigns alongside the WHO. See Burci, "Health and Infectious Disease", above Fn. 10.

14 For a legal framing of the institutional practice of International Organizations when interpreting norms, see Alvarez, J, *International Organizations as Law-makers*, 2005, 87-92.

15 See the contribution of *Leonie Vierck*, "The Case Law of International Public Health and Why its Scarcity is a Problem" in this volume.

conceptual bridge between legal and political theory.[16] Authority by International Organizations in general, and by the WHO in particular, is addressed here in its "legal-rational" model rooted in the Weberian tradition.[17] In general terms, the WHO can be viewed as a technocratic[18] institution in which the expertise of its members is seen as enhancing its legitimacy *vis-à-vis* Member States, and perhaps even the public at large.[19] Consequently, the theoretical background of this article rests upon the concept of authority as understood within the project of International Public Authority (IPA), which visualizes authority as the possibility to shape a legal or factual situation.[20]

Although States have a primary role in confronting disease outbreaks, particularly in terms of the IHR, this article will be limited to the governance structure within the WHO. However, as mentioned below, it should be noted that a major part of WHO governance is based upon the direct link to Member States' authorities, and in the case of events like outbreaks, it occurs mainly through IHR National Focal Points. Besides, ultimately the IHR are the product of State consent, albeit a peculiar form of it with regard to standard treaty-making in the sense of the 1969 Vienna Convention on the Law of Treaties. In the facts, the framework designed for disease outbreak alert and response displays an inseparable link between the WHO's organs and Member States.

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16 For a general understanding of the authority exercised by International Organizations see Barnett, M & Finnemore, M, *Rules for the World. International Organizations in Global Politics*, 2004, 29-31.

17 See this influential distinction in Weber, M, Mommsen, W (ed.) & Schluchter, W (ed.), *Wissenschaft als Beruf 1917/1919 - Politik als Beruf, 1919*, 1992, 160-161.

18 Here, "technocracy" is understood as decision-making by a body of experts which do not necessarily rely on democratic credentials in their authority. It is not used in a pejorative sense whatsoever. See Barnett & Finnemore, *Rules for the World*, above Fn. 16, 24-25; Delbrück, J, "Exercising Public Authority Beyond the State: Transnational Democracy and/or Alternative Legitimation Strategies" (2003), 10 *Indiana Journal of Global Legal Studies*, 29 (34); Venzke, I, "International Bureaucracies from a Political Science Perspective. Agency, Authority and International Institutional Law" in Bogdandy, Wolfrum & Bernstorff et al. (eds.), *The Exercise of Public Authority*, above Fn. 12, 83-85.

19 However, the idea of how this international community is to be framed *vis-à-vis* states and peoples, is a matter of further debate. For a proposal on this matter with regard to international courts, see Bogdandy, A von & Venzke, I, *In Whose Name? A Public Law Theory of International Adjudication*, 2014, 207-216.

20 Bogdandy, Dann & Goldmann, "Developing the Publicness", above Fn. 12, 11.

With this introductory input in mind, the article is structured as follows: The following section (II) will briefly relate the most visible transborder disease outbreaks since the turn of the 21st Century. It shows how the legal interpretation of the IHR was, and continues to be shaped as a response to diverging facts which are difficult to pinpoint under concise, pre-established rules. Next (III), two of the international legal instruments related to the containment of the spread of disease throughout countries are addressed, namely the Constitution of the WHO and the IHR. Certain salient features are underscored for understanding some of the current debates about their potential as well as their possible pitfalls. Later (IV) and in a similar vein, an overview of the legal role of bodies within the WHO intervening in disease outbreaks, namely the World Health Assembly, the Secretariat and the Regional Organizations,[21] is developed. Afterwards (V), a descriptive outline of the existing "bad" governance arrangements within the WHO is followed by some normative considerations. The closing section (VI) presents conclusions deriving from the arguments formulated throughout the article.

II Transborder Disease Outbreaks on the 21st Century

A brief account of recent transborder disease outbreaks can set the stage for the following sections and arguments. The aim is to provide a factual background with which the legal reasoning will be contrasted. The current shape of the governance framework for epidemics and pandemics within the WHO can be understood as an adaptive process, insofar as it resulted from reactions to various public health events transcending geographical borders. In turn, this reaffirms the notion that leeway granted to officials is based mostly on technical grounds, in order to accommodate the heterogeneous nature of events which may fall under general legal hypotheses.

In order to further grasp this leeway, a brief overview of recent disease outbreaks of international reach can be useful for understanding some elements that might be shared, and others that are contrasted between them. The following paragraphs address the different responses in the cases of

21 While the Executive Board also has a role to play in light of the extraordinary powers it can expressly confer to Director-General according to Article 28(i) of the Constitution of the WHO, it is thus far merely a theoretical possibility, as it has never been exercised in practice. Therefore, this legal power will not be developed in further detail in this contribution. For more on this issue, see Kamradt-Scott, A, *Managing Global Health Security. The World Health Organization and Disease Outbreak Control*, 2015, 33-38.

SARS, A(H1N1) Influenza, Poliomyelitis, Ebola and Zika. These events are divergent in many ways, including the epidemiological features of each virus and the geographical context in which they took place. Therefore, they may not be comparable for extrapolating general statements or conclusions. Although distinct from one another, an overview can also help to retrospectively identify common threads, such as a consistency, or lack thereof, in decision-making.

1 The 2002-2003 SARS Outbreak

During November 2002, an outbreak of a previously unknown virus, later named Severe Acute Respiratory Syndrome (SARS), began in China. But officials from the Chinese government failed to formally notify the WHO at the initial stage of its emergence.[22] As the international community at large was not aware of its presence, other countries did not implement screening processes accordingly.[23] The virus eventually spread to other regions,[24] whereby authorities only identified the pathogen after it was already inside their borders.

After the 2002-2003 SARS crisis and the subsequent response by the WHO, there was political momentum within the international community for an overarching reform of the then-existing legal framework of disease outbreak alert and response.[25] Some of the salient legal problems around the SARS crisis were focused, on the responsibility of States in the absence of explicit legal obligations to notify the WHO of the emergence of new

22 The Chinese government notified the presence of SARS to the WHO on February 2003, several months after the outbreak had been detected. Heymann, D & Rodier, G, "SARS: A global response to an international threat" (2004), 10 *Brown Journal of World Affairs*, 185 (189-190).

23 Awareness of the presence of a virus directly affects surveillance, insofar as individual medics resort to known pathogens for reaching a diagnosis. This is more acute in the case of emergencies, as contact-tracing is essential for curtailing the spread of a pathogen. See Cookson, S & Buehler, J, "Emergency and Disaster Health Surveillance" in Ahrens, W & Pigeot, I (eds.), *Handbook of Epidemiology,* 2nd edition, 2014, 732-738.

24 Heymann & Rodier, "SARS: A global response", above Fn. 22, 190.

25 Fidler, D, "From International Sanitary Conventions to Global Health Security: The New International Health Regulations" (2005), 4 *Chinese Journal of International Law,* 325 (354-355).

diseases within their territory.[26] The failure to do so in the case of SARS raised questions about the applicability of the legal instrument originally designed for such situations, the 1969 version of the IHR.[27] Then in force, the 1969 IHR played at most a marginal role, if any at all. Its obsolescence was mostly due to its scope: It was only applicable on a casuistic model towards diseases that, by 2002-2003, only established cholera, plague and yellow fever as falling under its purview.[28]

The WHO took center stage in the international response to the outbreak during the SARS crisis. Concerns about the possible outreach of the WHO's powers were raised, given that it had no explicit mandate for dealing with SARS – or other novel pathogens – according to the 1969 IHR.[29] By following the doctrine of implied powers,[30] the WHO would not be acting *ultra vires*, as all matters of international health, and communicable diseases in particular, would fall under its legal mandate.[31] But the fact that the WHO issued a declaration in this uncertain context was still troubling for some Member States, and the precise obligations of the Chinese government according to international law were disputed.[32]

2 The 2009-2010 A(H1N1) Influenza Pandemic

On April 25, 2009,[33] the WHO's Director-General declared, for the first time, that the unusual cases of A(H1N1) influenza reported by Mexico and

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26 Ibid., 369.
27 Heymann & Rodier, "SARS: A global response", above Fn. 22, 190.
28 Articles 50 to 75 of the 1969 IHR.
29 Hanrieder, T & Kreuder-Sonnen, C, "WHO decides on the exception? Securitization and emergency governance in global health" (2014), 45 *Security Dialogue*, 331 (336-338).
30 Schermers, H & Blokker, N, *International Institutional Law. Unity Within Diversity*, 5th edition, 2011, 180-182.
31 For the relationship between the doctrine of implied powers and the Constitution of the WHO, see Burci, G & Quirin, J, "Legality of the Use by a State of Nuclear Weapons in Armed Conflict, International Court of Justice, Advisory Opinion of 8 July 1996" in Ryngaert, C, Dekker, I F & Wessel, R A et al. (eds.), *Judicial Decisions on the Law of International Organizations*, 2016, 108-111.
32 A discussion of the reaction of China to this epidemic from an international law perspective can be seen in Reader, J, "The case against China. Establishing International Liability for China's Response to the 2002-2003 SARS Epidemic" (2006), 19 *Columbia Journal of Asian Law*, 519 (568-570).
33 WHO, *Swine influenza*, 2009, available at http://bit.ly/2nekbtY.

the United States of America constituted a PHEIC. Later, on June 11, 2009, there was also a declaration of the highest pandemic alert level (then level 6),[34] which led to criticisms from other countries that were not as affected by the virus as Mexico and the United States of America were.[35] Broadly speaking, after the "formal" end of the 2009-2010 influenza pandemic was declared in August 2010, the outcome was far less drastic than the previously feared scenario of a deadly avian-flu pandemic.

The main source of criticism against the WHO's reaction to the pandemic was the fact that pharmaceutical companies made huge profits as a result of the declaration of the maximum pandemic phase (level 6).[36] The backlash resulted in, among other things, an investigation within the Council of Europe[37] due to what was perceived as pernicious influence by the pharmaceutical industry. Although the eventual report presented at the Parliamentary Assembly of the Council did not yield evidence of malfeasance, it did include criticisms related to lackluster transparency in decision-making. Not disclosing the names of members of the Emergency Committee, which falls under the discretion of the WHO Director-General in the absence of any explicit legal provision in the IHR mandating it, was a notable point of controversy. An extensive report by an IHR Review Committee was issued.[38] Several recommendations for enhancing decision-making within the WHO were presented to the World Health Assembly in 2011. However, there were no calls for a reform of any of the provisions within the IHR.

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34 WHO, *World now at the start of 2009 influenza pandemic. Statement to the press by the WHO Director-General Dr Margaret Chan*, available at http://bit.ly/1gIUU2R.

35 There is a formal distinction between a PHEIC and a Pandemic Declaration, as stipulated by the WHO itself in its latest edition of pandemic guidelines. See WHO, *Pandemic Influenza Risk Management. WHO Interim Guidance*, 2013, 7, available at http://bit.ly/2nengug; also, Villarreal, P, "Pandemic Declarations of the World Health Organization as an Exercise of International Public Authority: The Possible Legal Answers to Frictions Between Legitimacies" (2016), 7 *Göttingen Journal of International Law*, 95.

36 See the investigative report by Cohen, D & Carter, P, "WHO and the pandemic flu 'conspiracies'" (2010), 340 *The BMJ*, 1274 (1279).

37 Parliamentary Assembly of the Council of Europe, *Resolution 1749*, 2010, available at http://bit.ly/2mj1x5a.

38 WHO, *Strengthening Response to Pandemics and other Public Health Emergencies: Report of the Review Committee on the Functioning of the International Health Regulations (2005) and on Pandemic Influenza (H1N1) 2009*, 2011, 29, available at http://www.who.int/ihr/publications/RC_report/en/.

3 PHEICs as an Accelerator: The Push Against Poliomyelitis

On May 5, 2014,[39] a PHEIC was declared for the second time in relation to the spread of wild poliovirus throughout regions of Africa and the Middle East. This was considered a consequence of both an anti-vaccination sentiment,[40] as well as longstanding military conflict[41] that dramatically undermined the provision of health services throughout these regions. Here, the PHEIC declaration was a companion to the decades-old global polio eradication campaign. It has served as an accelerator for a previously existent threat, and not just as a reaction to a new, unprecedented event.

The legal justification for declaring a PHEIC in the fight for eradicating Poliomyelitis can contribute to understanding how the figure is more or less flexible in order to face different arrays of challenges. While the Poliomyelitis PHEIC did not generate the same level of criticism as the A(H1N1) influenza pandemic, caution and balance still have a role to play. Using the legal understanding of emergency too often could gradually erode its weight, as it is usually understood as an extraordinary event requiring equally extraordinary measures. Similarly, if its sole purpose is to enhance the effectiveness of previously deployed public health campaigns, it can lead, on one hand, to the dilution of the notion of emergency, like the "cry wolf" scenario. On the other hand, it can also lead to questioning the discretion of the authority in charge of the declaration.

4 Deadly Delay: The Ebola Outbreak in West Africa

Despite initial reports on March 2014 by Médecins Sans Frontières[42] and the government of Guinea about the out-of-control spread of Ebola virus

39 WHO, *Statement on the meeting of the International Health Regulations Emergency Committee concerning the international spread of wild poliovirus*, 2014, available at http://bit.ly/Q5J4qw.

40 See the Interactive Map of the Global Health Program at the Council of Foreign Relations, available at http://www.cfr.org/interactives/GH_Vaccine_Map/.

41 Gayer, M, Legros, D & Formenty, P et al., "Conflict and Emerging Infectious Diseases" (2007), 13 *Emerging Infectious Diseases*, 1625 (1628), available at http://wwwnc.cdc.gov/eid/article/13/11/06-1093_article.

42 Médecins Sans Frontières, *Pushed to the limit and beyond. A critical analysis of the global Ebola response one year into the deadliest outbreak in history*, 2015, available at http://www.msf.org/article/ebola-pushed-limit-and-beyond.

throughout the country, a PHEIC was only declared on August 8[43] of the same year. The WHO was then criticized for opposite reasons compared to the 2009 A(H1N1) influenza pandemic: It was now chastised for not raising the alarm fast enough.[44] While it is difficult to argue in terms of causality, it is asserted elsewhere that had this alarm been raised before, more resources could have been directed earlier for containing the spread of Ebola.[45]

As mentioned at the beginning of this article, on March 29, 2016, the WHO Director-General declared that the Ebola PHEIC had formally ended,[46] although the disease was still present in the West African region.[47] Failure to quickly respond to the spread of this disease can be considered as a consequence of both a flawed decision-making process within the WHO, as well as a prevalence of uncertainty within the community of experts. Deliberate choices by officials within the WHO cannot be overlooked. The conscious wait-and-see approach proved to be fatal in this case, leading to questions of why it took months for officials to sound the alarm.[48] Even if it is not measurable, the impact of the ill-fated reaction to the Ebola crisis on the institutional reputation of the WHO may affect future confidence by Member States towards its standards, guidelines and declarations. Considering how it is seen as an institution relying upon its technical expertise for enhancing observance with non-binding standards,[49] lack of trust can turn into a particularly dire hindrance.

As further argued in another section, the response – or lack thereof – of Regional Organizations of the WHO also needs to be taken into account. The contrast between the A(H1N1) Influenza pandemic and Zika, on one hand, and Ebola, on the other, could also be understood as a visible asymmetry between one Regional Organization and the other. The predominant

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43 See WHO, *Statement on the 1st meeting*, above Fn. 2.

44 For an overview, see Moon, S, Sridhar, D & Pate, M A 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" (2015), 386 *The Lancet*, 2204 (2206-2207).

45 The point is vehemently stated in the Report by Médecins Sans Frontières, *Pushed to the limit and beyond*, above Fn. 42, 11.

46 See WHO, *Statement on the 9th meeting of the IHR Emergency Committee*, above Fn. 1.

47 See WHO's Statement, *New positive case of Ebola*, above Fn. 3.

48 Moon, Sridhar & Pate et al., "Will Ebola change the game?", above Fn. 44, 2210-2211.

49 Burci, G & Vignes, C, *World Health Organization*, 2004, 155.

historical position of the Pan American Health Organization (PAHO), which precedes the WHO itself and is today the regional body for the Americas, is reflected in Article 54 of the Constitution of the WHO and is analyzed by other authors elsewhere.[50]

Unlike the other PHEICs mentioned herein, the magnitude of the Ebola crisis in West Africa also led to atypical resolutions within the general aegis of the United Nations. These consisted of Security Council Resolution 2177 (2014),[51] as well as General Assembly Resolution 69/1 (2014).[52] As discussed elsewhere in this book,[53] these resolutions were unprecedented in terms of its subject matter, contributing to the conceptualization of health as a security issue. Moreover, at the governance level, Resolution 69/1 sparked the creation of an ad hoc body, the United Nations Mission for Ebola Emergency Response (UNMEER), with a temporal mandate that lasted from September 19, 2014 until July 31, 2015. Nevertheless, its ad hoc nature has also been subject to criticisms, insofar as it was "superimposed"[54] on already existing structures without duly taking into account the ongoing operations.

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50 Lee, K, *The World Health Organization (WHO)*, 2009, 30-34; Hanrieder, T, *International Organization in Time. Fragmentation and Reform*, 2015, 58-61.

51 United Nations Security Council, *Resolution 2177 (2014)*, available at http://bit.ly/1qidtMV.

52 United Nations General Assembly Resolution 69/1, *Measures to contain and combat the recent Ebola outbreak in West Africa*, available at http://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/69/1. For a more detailed analysis of both resolutions, see Burci, G & Kirin, J, "Ebola, WHO, and the United Nations: Convergence of Global Public Health and International Peace and Security" (2014), 18 *ASIL Insights,* available at http://bit.ly/2m5AFIF.

53 See particularly the contributions of *Robert Frau*, "Combining the WHO's International Health Regulations (2005) with the UN Security Council's Powers: Does it Make Sense for Health Governance?" and *Ilja Robert Pavone*, "Ebola and Securitization of Health: UN Security Council Resolution 2177/2014 and its Limits" in this volume.

54 See the Report of the United Nations High Level Panel on the Global Response to Health Crises, *Protecting Humanity from Future Health Crises*, 2016, para. 160.

5 The Race for Knowledge: The Zika Emergency of 2016

On February 1, 2016, the WHO's Director-General declared the Zika virus epidemic in the Americas a PHEIC.[55] The reasons for declaring this event as a PHEIC were not grounded on the severity of the disease in terms of fatalities.[56] Rather, the major source of concern was the then-suspected link between Zika virus and a surge in cases of microcephaly and a risk of developing Guillain-Barré syndrome.[57] To-date, Brazil has been the most affected country by the spread of the virus.

The criteria for assessing the justification for declaring a PHEIC can also be distinguished between Zika and the other instances mentioned above. Uncertainty can also be used as a legal argument: The Zika PHEIC Declaration was not made based upon what was known at the time, but rather because of what was unknown.[58] As stated at the beginning of this article, the Zika PHEIC was declared to be over in November 2016, despite how the virus itself is likely to linger throughout the coming years.[59] However, uncertainty surrounding the disease has been reduced perhaps as a result of the attention brought about by the PHEIC Declaration. The reorientation of resources towards research has yielded results that confirmed initial suspicions.[60] While there is still more to learn about the virus, the overall progress supports the usefulness of a PHEIC Declaration for the purpose of knowing more about a disease.

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55 See WHO, *Fifth meeting of the Emergency Committee under the International Health Regulations (2005)*, above Fn. 5.

56 Illness caused by this virus is very rarely fatal, and it causes mild symptoms: rash, headaches, conjunctivitis, sometimes fever and joint pains. See the United States Centers for Disease Control and Prevention's factsheet on Zika, available at http://www.cdc.gov/zika/symptoms/index.html.

57 Heymann, Hodgson & Sall et al., "Zika virus and microcephaly", above Fn. 4, 719 (719-720).

58 Ibid.

59 See WHO, *Fifth meeting of the Emergency Committee under the International Health Regulations (2005)*, above Fn. 5.

60 There is a growing body of evidence confirming its link to microcephaly in newborns. For example see Brasil, P, José, P & Moreira, E et al., "Zika Virus Infection in Pregnant Women in Rio de Janeiro" (2016), 375 *New England Journal of Medicine*, 2321 (2332-2333).

6 Non-Emergencies as a Piece of the Puzzle

On par with the PHEIC declarations that have taken place, those occasions in which they have not been declared after an initial consideration merit further analysis. Information of why a situation did not constitute a PHEIC is just as relevant for clarifying its reach and applicability.[61] That being said, the appearance of Middle East respiratory syndrome in Saudi Arabia and South Korea since 2012, and the Yellow Fever crisis in Angola and the Democratic Republic of Congo in 2016[62] provide another piece of the puzzle. They were not determined to require a PHEIC declaration for their handling, despite being national emergencies on their own. And, unlike the West African Ebola crisis, such a cautious decision has thus far not yielded a devastating outcome, though this should by no means underestimate its danger.

To the question of which facts justify resorting to extraordinary measures, the narrative would be incomplete without addressing instances where the possibility of raising the alarm was discussed, but eventually discarded. It may be due to the epidemiological features of the corresponding viruses, or rather the social or economic context in which they took place. Whatever the reason, they also entail an exercise of authority through (technical) discretion on behalf of WHO officials. Decisions to not sound the alarm are just as consequential, and at times even moreso, than those to do so.

III Main International Legal Instruments Related to Disease Outbreaks

1 The Constitution of the WHO: The Core Mandate

According to its Constitution, and in light of its institutional history, responding to public health emergencies caused by communicable diseases is

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61 In other instances, such as the spread of extensively drug-resistant tuberculosis, application of the IHR has been discussed outside of the WHO, but has not taken place. See the comment by Calain, P & Fidler, D, "XDR Tuberculosis, the New International Health Regulations, and Human Rights" (2007), 1 *Global Health Governance*, 1, available at http://bit.ly/2mYzBX8.

62 WHO, *Meeting of the Emergency Committee under the International Health Regulations (2005) concerning Yellow Fever*, available at http://www.who.int/mediacentre/news/statements/2016/ec-yellow-fever/en/.

one of the core functions of the WHO.[63] But the constant threat of epidemics and pandemics keeps raising questions as to which role the WHO already *has*, and which one it *should* have. For the purposes of this article, the descriptive and the normative elements are strictly distinguished. Any normative proposal should first be based on an accurate description, if it is to have any chance of succeeding *qua* proposal. As long as a steer in the leadership of the WHO can be accommodated within the basic legal framework, there can be diverging views on whether the WHO as an institution should have either an operative role or be limited to creating norms and standards.[64]

As a descriptive matter, the Constitution of the WHO has historically been understood as providing leeway in light of its broad wording.[65] Be that as it may, provisions within the Constitution constrain all of the WHO's bodies and officials. Therefore, concretely worded provisions cannot be circumvented, although the wording of several of the Constitution's Articles is vague, leaving ample room for their interpretation.[66] As seen during the SARS crisis, the established role of the WHO in its Constitution, as well as the broad definition of health in its Preamble, have led to it taking over emergency response even in the absence of an explicit mandate. It should be noted that this extended interpretation has not always been well received by Member States.[67]

2 The 2005 IHR

After the 2002-2003 SARS outbreak described above, a new consensus within the World Health Assembly emerged in order to revive the debate

63 Kamradt-Scott, *Managing Global Health Security*, above Fn. 21, 21.

64 For example see an opinion in favor of a normative role in Velasquez, G & Alas, M, "The slow shipwreck of the World Health Organization?" (2016), *Third World Network*, available at http://www.twn.my/title2/health.info/2016/hi160503.htm.

65 Lee, *The World Health Organization*, above Fn. 50, 16-21.

66 Making this point with regards to Article 18, see in this sense Burci & Vignes, *World Health Organization*, above Fn. 49, 56.

67 The idea of an overreach by the WHO was also raised in 1970 with regard to a cholera outbreak in Guinea. See Kamradt-Scott, A, "WHO's to blame? The World Health Organization and the 2014 Ebola outbreak in West Africa" (2016), 37 *Third World Quarterly*, 401 (402-403).

about reforming the 1969 IHR.[68] The result was a rarely seen[69] willingness to resort to the atypical[70] powers provided by Article 21 of the Constitution of the WHO. The outcome of this process was the approval in 2005 of the new version of the IHR, which is currently in force and represents the main international legal instrument for disease outbreak alert and response. The IHR are legally binding for WHO Member States,[71] as provided for in Articles 21-22 of its Constitution. State consent for being bound could then be traced back to an original delegation made through the approval of the Constitution itself, from 1946 onwards.

The underlying objective of the IHR, according to its Article 2, is the containment of the international spread of diseases through a public health response, whilst avoiding unnecessary interference with traffic and trade. This can be seen as the normative (in the sense of what *ought* to be) dimension of the IHR, and it is possible to interpret the descriptive part of its provisions with this lens. More specific arguments of whether particular public health measures, such as those foreseen in Part V of the IHR, are justified or not, can only be effectuated by contrasting available factual data with existing technical knowledge. It is not possible to ascertain whether a particular decision, such as denial of entry of persons or goods, are "more restrictive of international traffic […] [or] more invasive or intrusive to persons than reasonably available alternatives" (Article 43 IHR), unless there is an assessment of the epidemiological features of a pathogen, which inevitably requires technical input from medical experts.

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68 The debate had stagnated even after a World Health Assembly Resolution in 1995 called for such reforms in light of outbreaks of plague in India, and Ebola in Congo. See Resolution WHA48.7, World Health Assembly, 1998; also, Fidler, "From International Sanitary Conventions", above Fn. 25, 343; likewise, see the Editorial Comment, "Ebola: what lessons for the International Health Regulations?" (2014), 384 *The Lancet*, 1321 (1321).

69 See Aginam, O, "Mission (Im)possible? The WHO as a 'Norm Entrepreneur' in Global Health Governance" in Freeman, M, Hawkes, S & Bennett, B (eds.), *Law and Global Health. Current Legal Issues*, 2014, 559; labeling it a "cosmopolitan moment", see Kickbusch, I & Reddy, K, "Global health governance – The next political revolution" (2015), 129 *Public Health*, 838 (840).

70 Fidler, "From International Sanitary Conventions", above Fn. 25, 332-333.

71 However, this formal legal status can, of course, be detached from on-the-ground circumstances, as witnessed during the 2014-2016 Ebola crisis. See the contribution of *Susan L. Erikson*, "The Limits of the International Health Regulations: Ebola Governance, Regulatory Breach, and the Non-Negotiable Necessity of National Healthcare" in this volume.

The WHO's discretion in disease outbreaks is related to the way in which abstract legal norms of the IHR have been interpreted, so as to apply them to particular cases.[72] Interpretations are undertaken on a case-by-case basis, though it should be clarified that it is put into force through the application of rules of the IHR by what is generally referred to as "practice",[73] and not through dispute-settlement case law.[74] The broad wording of IHR provisions can give way to an expansion or reduction of its applicability in future instances, depending on who is interpreting them. A descriptive endeavor requires a broader approach in order to complete this picture. In this sense, the inclusion of expertise clauses within the IHR[75] leads to a specific type of leeway when applying a provision to a particular case. Consequently, in line with arguments put forward above, a descriptive statement of whether an IHR provision is legally applicable in a particular context can only be reached by resorting to the technical knowledge on the subject matter (such as Medicine, Public Health, Epidemiology).[76] The 2016 Zika emergency also shows how uncertainty can be invoked as sufficient grounds for declaring a PHEIC.[77]

a PHEIC Declarations

The legal definition of a PHEIC is a guiding axis in the legal role of the WHO *vis-à-vis* disease outbreaks. Once heralded as an innovative tool of

72 In Weberian terms, this would amount to a distinction between "lawmaking" and "lawfinding", wherein he also includes members of public administrations in charge of the application of a general rule to a particular case. Kennedy, D, "The Disenchantment of Logically Formal Legal Rationality, or Max Weber's Sociology in the Genealogy of the Contemporary Mode of Western Legal Thought" (2004), 55 *Hastings Law Journal*, 1031 (1040).

73 "Interpretation" is understood here in its wide sense, encompassing all applications of a rule to concrete cases. See on this matter Schermer, H & Blokker, N, *International Institutional Law*, above Fn. 30, 841 et seq.

74 See the contribution of *Leonie Vierck*, "The Case Law of International Public Health and Why its Scarcity is a Problem" in this volume.

75 Articles 47-49 of the 2005 IHR.

76 Articles 9 and 11(2) of the 2005 IHR.

77 Annex 2 of the IHR provides examples of diseases which will be notified to the WHO on the basis of their likelihood of being a PHEIC. It is an "open list" of diseases, as drawn upon the following clause: "including those of unknown causes or sources".

the 2005 version of the IHR,[78] its heterogeneous application between one case and another illustrates how its flexibility has been adopted by WHO public officials, namely its Director-General and the IHR Emergency Committee. This legal definition has thus far been used in events related to the international spread of an infectious disease (H1N1 influenza, Poliomyelitis, Ebola and Zika). Amidst the vague wording of its definition in Article 1 IHR,[79] every one of these PHEIC Declarations has had its own particular features, both from a legal and a medical perspective.

The question of how far this figure can be extended is a matter of interpretation by WHO officials. Public statements informing that a PHEIC has been declared may contain a more or less detailed description of the facts motivating this step. Yet explanations provided for doing so tend to be brief, with statements being nowhere near as thorough as, for example, a ruling by a Court would be. As case law related to PHEICs is mostly absent[80] despite there being a dispute-settlement mechanism established by Article 56 IHR, there is still no possibility to extract elaborate legal interpretations like those deriving from the reconstruction of facts by adjudicative bodies.

Additionally, the binary feature of either having a PHEIC or not has recently been revisited and subjected to criticism.[81] Attempts at reforming the current configuration of PHEIC declarations have not been fruitful,[82] even though, as explained in a subsequent section, there are ongoing changes to the internal WHO structure in the corresponding area. While the current formulation of PHEICs is riddled with questions concerning their relevance

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78 Labeling it as one of the "major substantive" novelties of the 2005 IHR, see Fidler, "From International Sanitary Conventions", above Fn. 25, 358.

79 The definition of a PHEIC in Article 1 IHR reads as follows:
"[…] an extraordinary event which is determined, as provided in these Regulations:
(i) to constitute a public health risk to other States through the international spread of disease and
(ii) to potentially require a coordinated international response."

80 See the contributions of *Leonie Vierck*, "The Case Law of International Public Health and Why its Scarcity is a Problem" and *Susan L. Erikson*, "The Limits of the International Health Regulations: Ebola Governance, Regulatory Breach, and the Non-Negotiable Necessity of National Healthcare" in this volume.

81 WHO, *Report of the Ebola Interim Assessment Panel*, para. 23, available at http://bit.ly/1CYf2Yv.

82 WHO, *Report of the Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response*, World Health Assembly document A69/21, 2016, para. 104-109.

for disease outbreak preparedness and response, the perils of being over- or underused can already be factually attested.

b Temporary Technical Recommendations

On par with a declaration of a PHEIC, the WHO Director-General can issue temporary recommendations after consulting the corresponding Emergency Committee. These tag-along recommendations issued during a PHEIC in light of Article 12(2) could not be considered as "new" legal obligations for Member States.[83] According to Article 18 IHR, temporary recommendations range from providing safety measures for medical personnel to placing persons under quarantine and isolation, as well as suggesting States to implement travel bans or, conversely, refraining from doing so.[84] As seen during the 2014-2016 Ebola epidemic in West Africa, Security Council Resolution 2177 (2014), declaring this outbreak a "threat to international peace and security" amounted to invoking chapter VII of the UN Charter.[85] This included a mention of the temporary recommendations issued by the WHO, for example abstaining from imposing general travel bans to the most affected countries.[86] Nevertheless, in this contribution they are not seen as having elevated technical recommendations to a binding level.[87]

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83 See the contribution of *Robert Frau*, "Combining the WHO's International Health Regulations (2005) with the UN Security Council's Powers: Does it Make Sense for Health Governance?" in this volume. Also, see WHO, *Report of the Review Committee*, above Fn. 82, para. 68. However, in no way does this suggest that they are irrelevant. See Kamradt-Scott, "WHO's to blame?", above Fn. 67, 411; likewise, Benton, J, "Global Emergency Power in the Age of Ebola" (2016), 57 *Harvard International Law Journal*, 1 (23-26).

84 Technical recommendations issued when the West African Ebola crisis was declared a PHEIC on August 8, 2014, favored not implementing general travel bans to the affected countries, but rather to install individual screening processes for possible cases instead. See the WHO, *Statement on the 1st meeting*, above Fn. 2.

85 To this effect, see the contributions of *Robert Frau*, "Combining the WHO's International Health Regulations (2005) with the UN Security Council's Powers: Does it Make Sense for Health Governance?" and *Ilja Robert Pavone*, "Ebola and Securitization of Health: UN Security Council Resolution 2177/2014 and its Limits" in this volume.

86 United Nations Security Council Resolution 2177 (2014), para. 9.

87 See the contribution of *Robert Frau*, "Combining the WHO's International Health Regulations (2005) with the UN Security Council's Powers: Does it Make Sense for Health Governance?" in this volume.

Likewise, proposals to imbue them with a binding nature have not prospered, as this approach has been deemed by some as "recycled" and unlikely to be accepted by States.[88] Still other arguments deal with whether recommendations *are* (descriptively), in fact, more than that, or whether they *should* (normatively) be something more. After all, if disregarding technical recommendations issued on par with a PHEIC constitute a violation of the IHR per se, they might actually have a different legal status. To consider the status of temporary recommendations as legally binding[89] would thus render the WHO, and its Director-General in particular, into perhaps the most powerful of the specialized agencies of the UN. It would also entail that the more legally-intrusive recommendations, such as those promoting the declaration of national emergencies, might touch upon sensitive sovereignty issues. This debate, however, will not be further developed in this article. Suffice it to say, that the view considering the WHO's temporary recommendations as legally binding will not be adopted along these lines.

IV Functions of WHO's Bodies in the Context of Disease Outbreaks

The internal governance structure of the WHO does not differ dramatically in comparison to those of other International Organizations.[90] As mentioned before, most of its functions are directly drawn out from the Constitution of the WHO, whereas others derive from the IHR. A brief outline of each of the main bodies can be illustrative as an overview of the governance for disease outbreak alert and response within the WHO.

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88 Namely, see Fidler, D, "Ebola Report Misses Mark on International Health Regulations" (2015), *Chatham House Expert Comment*, available at http://bit.ly/2lSS2Yk.

89 See for example Acconci, P, "The Reaction to the Ebola Epidemic within the United Nations Framework: What Next for the World Health Organization?" in Lachenmann, F, Röder, T & Wolfrum, R (eds.), *Max Planck Yearbook of United Nations Law*, 2014, 423.

90 For a general sketch of the structure of International Organizations, see Davies, M & Woodward, R, *International Organizations. A Companion*, 2014, 87-88.

1 The World Health Assembly

As the supreme decision-making authority of the WHO,[91] the World Health Assembly can assign new competences to the other organs, as well as limit their scope.[92] It is also the organ in charge of ultimately reforming the IHR. Insofar as it has a one member, one vote system, there is a *prima facie* democratic element to decisions within the WHO. In this sense, the World Health Assembly acts as a norm-creator, providing a general framework of action for other bodies to follow. For the purposes of this contribution, the most salient powers of the World Health Assembly are those inserted in Articles 21 and 22 of its Constitution, which grant the authority to adopt legally binding regulations for all Member States, unless they explicitly reject this within a determined period (opt out). Given how voting-based processes may make the World Health Assembly unsuitable for dealing with emergencies caused by disease outbreaks, executive decision-making can be justified on grounds of celerity. It is at this point where the role performed by the WHO's administrative branch enters the scene.

2 The Secretariat

a WHO Director-General

The degree of autonomy possessed by the WHO's Secretariat as established in Article 37 of its Constitution has led to it being considered, along with other International Organisations (IO) from the United Nations with legal mandates, as reaching beyond initial consent by Member States.[93] As a display of expedient decision-making in the context of emergencies, the

91 The list of its broad powers is enshrined in Article 18 of the Constitution of the WHO.

92 Perhaps the most telling example of this is how the World Health Assembly's reforms to its Rules of Procedure have led to limiting Director-General's reelection to only one additional term, despite the fact that the Constitution of the WHO contains no such limitation. See Rule 106 of the Rules of Procedure of the World Health Assembly.

93 Explained with more detail in Kamradt-Scott, *Managing Global Health Security*, above Fn. 21, 37; also Cortell, A & Peterson, S, "Dutiful agents, rogue actors, or both? Staffing, voting rules, and slack in the WHO and WTO" in Hawkins, D, Lake D A & Nielson, D L et al. (eds.), *Delegation and Agency in International Organizations*, 2006, 265.

Secretariat of the WHO, headed by the Director-General, is the organ with the exclusive authority in terms of the IHR for issuing PHEIC Declarations and temporary technical recommendations.

Similar to national administrative law, the head of the Executive body in the WHO performs an exclusive decision-making role in emergency settings. But, unlike several national constituencies,[94] there is no corresponding legal procedure for overturning Director-General's exercise of discretion when using the powers granted by Article 12 of the IHR. Aside from obligations to report to the World Health Assembly under Article 54 of the IHR, the Director-General's discretion does not foresee the possibility of legally challenging its decisions regarding PHEIC declarations. The only accountability mechanism is the option of creating ex-post Review Committees under Articles 50-53 of the IHR; that is, only *after* the emergency alert has been issued.

b Emergency Committee

Although the adoption of the IHR did not lead to a structural overhaul inside the WHO, it did lead to the creation of intermittent bodies such as the Emergency Committee. According to Articles 12 and 48 of the IHR, the WHO Director-General is obliged to "consult" an Emergency Committee before declaring a PHEIC. The Committee will be convened with specialists of the relevant fields chosen by the WHO Director-General, a feature that displays its technocratic nature.[95] Yet the Middle East respiratory syndrome outbreaks in Saudi Arabia and South Korea and the ongoing Yellow Fever crisis in African countries display how the process of declaring PHEICs is not necessarily streamlined after the WHO Director-General's preliminary assessment under Article 12 of the IHR. Hence, the Emergency Committee's autonomy is not just a theoretical possibility, since its mere summoning has not always led to a PHEIC Declaration. As seen in the cases described in previous paragraphs, the constant convergence between the Emergency Committee's advice and the Director-General's final decisions reaffirms the former's sway in determining whether a PHEIC should be declared or not.

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94 This contrast between national and international administrative acts is also discussed in Benvenisti, E, *The Law of Global Governance*, 2014, 96-98.

95 Here, "technocracy" is understood as decision-making by a body of experts, which do not necessarily rely on their democratic credentials. See Barnett & Finnemore, *Rules for the World*, above Fn. 16, 83-85.

It is very difficult – though legally still possible – to imagine a scenario in which the Director-General disregards the input by the Emergency Committee altogether.

3 WHO Regional Organizations

In the cases of the 2009 A(H1N1) Influenza pandemic and the 2016 Zika outbreak, the governments of primarily affected countries,[96] particularly through their Ministries of Health, notified the WHO through their National IHR Focal Points. Conversely, at the outset of the Ebola crisis in April 2014, even though national authorities were in continuous communication with the WHO, it was a Non-Governmental Organization (Médecins Sans Frontières) insisting on the need to take more urgent measures.[97] As discussed above, the declaration only took place several months later, leading to widespread criticism of the WHO's response.

As mentioned elsewhere in this edited volume,[98] decision-making at WHO headquarters has been based on factual assessments of the severity of the outbreak. While the technical aspects of epidemiological surveillance are beyond the reach of this contribution, it is perhaps illustrative how complexities inherent to this task can mislead even renowned experts, casting light upon how complicated such an assessment may become.

Secondly, differences in expediency could also be attributed to diverging capacities of the national and regional health institutions in each of the affected regions.[99] The WHO receives regular notifications through the IHR National Focal Points, with the assumption that under Article 6 of the IHR, national authorities have the legal responsibility to notify the International Organization. The WHO itself does not have sufficient capacity to deploy

96 Specifically, in the case of A(H1N1) Influenza, the National IHR Focal Points of Mexico and the United States of America; in the case of Zika, Brazil's National IHR Focal Point.

97 Moon, Sridhar & Pate et al., "Will Ebola change the game?", above Fn. 44, 2206.

98 See particularly the contribution of *Wolfgang Hein*, "The Response to the West African Ebola Outbreak (2014-2016): A Failure of Global Health Governance?" in this volume.

99 For a study on the role of regional institutions in West Africa during the Ebola crisis, see the contribution of *Edefe Ojomo*, "Fostering Regional Health Governance in West Africa: The Role of the WAHO" in this volume.

on-the-ground surveillance in every country, as this would require considerably more resources than it currently has. It could also possibly lead to even more controversies related to interferences with State sovereignty.

Thirdly, and similar to the national levels, the WHO Regional Organizations' role is supposed to be that of a more direct operator in the countries of different regions. Article 44 of the IHR (2005) vaguely contemplates the possibility of "collaboration" of the WHO with its Member States on several fronts, which may also take place through the WHO Regional Organizations, each of them composed of Committees and Offices. Yet, aside from ample and unspecific collaborative possibilities enumerated in Article 44, there is no clear role for the Regional Organizations in the case of PHEICs.

The "federalist"[100] arrangement between WHO Headquarters and its Regional Organizations has also been criticized by virtue of the fragmentation of functions it caused, mainly during emergency settings.[101] After failed attempts at the beginning of the 2000s to unify decision-making processes within the WHO,[102] lack of oversight over decision-making within its Regional Organizations allowed for the appointment of several officials almost exclusively as political rewards, instead of the legally-based criteria of professional merits or technical expertise.[103] Thus, the lack of coordination witnessed during the West African Ebola crisis showcased how underlying shortcomings at the WHO's Regional Organizations can spill over to the central, broader institution.

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100 Hanrieder, T, "The path-dependent design of international organizations: Federalism in the World Health Organization" (2015), 21 *European Journal of International Relations*, 215 (223-226).

101 Benton, "Global Emergency Power", above Fn. 83, 29-30.

102 The objectives and results of the "One WHO" campaign contribute to this understanding. See Lee, *The World Health Organization*, above Fn. 50; Hanrieder, T, *International Organization in Time. Fragmentation and Reform*, 2015, 93-116.

103 For a glimpse at these criticisms, see WHO, *Report of the Review Committee on the Role of the International Health Regulations (2005)*, above Fn. 82, para. 176 et seq.

V The Promises and Pitfalls in the Governance of Disease Outbreaks

1 Fleshing Out "Bad" Governance in Disease Outbreaks

A combination of factors have been interpreted as the source of the dysfunctional response to the surge of Ebola in 2014. The Ebola crisis displayed how on-the-ground assessments of the severity of outbreaks are not always streamlined, least of all when dealing with disagreements between experts on the subject matter.[104] Additionally, during the previous year when the Ebola crisis was declared as a PHEIC, there were severe budget cuts to the WHO's Emergency branch.[105]

The process that led to the current budgetary stagnation, starting from the 1980s, has been documented elsewhere.[106] Partly as a result of the chronic budgetary problems, there is a dominance of voluntary contributions, which are "earmarked" for favored donor projects.[107] Hence, the WHO bodies often have little to no say on where and how to allocate resources. This has been the source of many ailments within the WHO governance throughout the last three decades, and the governance of disease outbreaks is not exempt from this disruptive inertia.

Likewise, debates between Member States within the WHO, and specifically within the World Health Assembly, are likely to lead to occasional disagreements. It would not be a deliberative forum if this possibility did not exist. Still, there are concerns related to the constant paralysis and the varying level of discussions within this organ.[108] And, in effect, the afore-

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104 Particularly, see the heated disagreement between Médecins Sans Frontières, on one hand, and WHO and Centers for Disease Control and Prevention (CDC) officials, on the other. For a more detailed description of the initial assessments of the magnitude of the Ebola crisis by several experts, see the contribution of *Wolfgang Hein*, "The Response to the West African Ebola Outbreak (2014-2016): A Failure of Global Health Governance?" in this volume.

105 Moon, Sridhar & Pate et al., "Will Ebola change the game?", above Fn. 44, 2210.

106 Mostly, it is the result of the decision of Member States to impose a policy of zero growth on its contributions to the United Nations system. See Beigbeder, Y, *The World Health Organization*, 1998, 154; see also the contribution of *Mateja Steinbrück Platise*, "The Changing Structure of Global Health Governance" in this volume.

107 Gostin, L, *Global Health Law*, 2014, 123-125.

108 Lee, K & Pang, T, "WHO: Retirement or reinvention?" (2014), 128 *Public Health*, 119 (122).

mentioned budgetary problems can themselves be seen as a result of political dysfunction within the WHO. In the context of the Cold War, ideological disagreements between the two competing powers led to stalemates at the UN level.[109] Belief in the possibility of having politically isolated decision-making in the WHO has been heavily contested.[110]

Furthermore, in tune with the understanding of International Organizations as bureaucracies,[111] legal analysis usually focuses on impersonal rules and norms, hence the personal dimension of discretion tends to be overlooked.[112] But the fact that there is a high degree of leeway in several provisions of the IHR makes paying attention to the personal dimension all the more necessary. Even if this falls beyond the limits of the current analysis, multiple calls for leadership renewal and a change of mindset have gained more relevance in several instances.[113] Persons in charge of interpreting norms matter as well. Until today, PHEIC Declarations have only been issued under one Director-General's mandate. The possibility for each Director-General to provide her/his own imprint under both the Constitution of the WHO and the IHR is reason enough for paying attention to the person occupying that post.

For instance, when comparing the 2009-2010 A(H1N1) influenza pandemic with the 2014-2016 Ebola crisis, both a premature and a delayed response can reflect upon the WHO Director-General's role at the helm of the institution. By questioning the appropriateness of the model of executive authority for declaring a PHEIC, the possibility of delegating this function on another organ was put forward on some fronts.[114] Even if these proposals

109 Notably, the backlash against the Alma-Ata Declaration of 1978. Lee, *The World Health Organization*, above Fn. 50, 14 (79-86).

110 Benton, "Global Emergency Power", above Fn. 83, at footnote 160.

111 Barnett & Finnemore, *Rules for the World*, above Fn. 16, 17-19.

112 The longstanding impersonal element in legal analysis is also linked to *Max Weber*'s conception of legally-legitimized authority. It should be noted, though, that Weber himself posited that the "pure" versions of authority are seldom to be found, allowing for a mixture of personal and impersonal modes. See Weber, M, *Max Weber on Law in Economy and Society (edited by Max Rheinstein)*, 1969, 334-337.

113 This includes literature within the medical community. See Moon, Sridhar & Pate et al., "Will Ebola change the game?", above Fn. 44, 2204.

114 See WHO, *Report of the Ebola Interim Assessment Panel*, above Fn. 81; see also WHO, *Report of the Review Committee on the Role of the International Health Regulations (2005)*, above Fn. 82, para. 160.

did not prosper, it might reflect a loss of confidence towards the unipersonal model.

2 In Search of Normative Answers to Technical Discretion

The legal framing of PHEICs, as envisioned by the 2005 version of the IHR, can be construed as granting leeway to the WHO, and particularly to its Director-General. One of the main reasons for the obsolescence of the 1969 version of the IHR was its rigid approach towards diseases, which left new and reemerging pathogens out of its purview.[115] Given how uncertainty is an ever-present factor in disease outbreak preparedness and response, a broad approach can be justified. The complexities of every outbreak entail that a definite, "one-size-fits-all" legal category is a long shot. Existing knowledge in the field of Epidemiology has not reached the level of complete foresight. To the contrary, uncertainty and risk regarding communicable diseases are a constant, as witnessed with the spread of Zika virus.

The powers of the WHO's Director-General deriving from the IHR do not constitute a "blank check". The conundrum has been, and will continue to be, how to draw a clear line between over- and underreacting. An overarching challenge is how to better ensure the justified use of powers when authorities such as the Director-General and the Emergency Committee engage in interpretation. In light of the heterogeneous set of events that can fall under the purview of PHEIC declarations, a more fine-tuned predetermined framework is currently not available.[116] Devising one would also require a technical-medical assessment which, in fact, acquires a legal dimension at the same time. The broad wording of the IHR can be seen as factually justified amidst prevailing uncertainties. As exemplified by the contrast between the controversy surrounding the cases of H1N1 influenza and Ebola, flexibility also entails granting more room for wrongful assessments with fatal consequences.

If a higher level of discretion is directly proportionate to the need for its normative assessment, the fact that flexibility is justified on technical grounds is not enough on its own to settle the normative discussion. Exercises of authority by International Organizations need to be subjected to

115 For more on this matter, see Villarreal, "Pandemic Declarations as an Exercise", above Fn. 35.

116 Benton, "Global Emergency Power", above Fn. 83, 35-36.

normative standards, with corresponding responses deriving from legal approaches.[117] Even if authority exercised by WHO officials is not deliberation-based in the same democratic vein as that of other institutions,[118] it does not mean normative assessments are pointless.[119] The current accountability model contemplates an ex-post evaluation by an External Review Committee. Moreover, reviews do not have a legally binding nature by themselves. At most, they can lead to an adverse resolution by the World Health Assembly and the legal nature of these acts *vis-à-vis* Member States can be contested.

The political momentum created by the catastrophic magnitude of the West African Ebola epidemic has thus far led to noticeable, albeit not dramatic, internal reforms. For instance, further adding to the existing governance framework, the creation of a Health Emergency Programme was proposed at the 69th World Health Assembly in May 2016, including delegation of logistical but not decision-making functions to other administrative posts.[120] This, of course, is a minor step towards addressing the roots of the "bad" governance issues underlying disease outbreak preparedness and response in the WHO.

One proposal for enhancing the governance related to emergency decision-making in the WHO would be to introduce a series of additional *ex ante* assessments that aim at guaranteeing that these declarations have justified grounds.[121] The problem is its practical feasibility: The WHO reportedly receives more than three hundred yearly notifications of events that might constitute a PHEIC.[122] Additional hurdles could effectively overload an already overburdened structure, which might prove to be untenable resource-wise.[123]

Likewise, there have been discussions related to the legal responsibility of the WHO when declaring a PHEIC. Despite their current embryonic

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117 Bogdandy, Dann & Goldmann, "Developing the Publicness", above Fn. 12, 13-16.

118 Already posited by Stein, E, "International Integration and Democracy: No Love at First Sight" (2001), 95 *American Journal of International Law*, 489 (497-499 and 532).

119 Delbrück, "Exercising Public Authority", above Fn. 18, 42.

120 See the Report by Direct-General to the 69th World Health Assembly, *Reform of WHO's work in health emergency management,* May 5, 2016, particularly para. 5.

121 Benton, "Global Emergency Power", above Fn. 83, 40.

122 See WHO, *Report of the Review Committee on the Role of the International Health Regulations (2005)*, above Fn. 82, para. 91.

123 Ibid., para. 88 and 107.

stage, the (Draft) Articles on the Responsibility of International Organizations provide a parameter for this matter. According to *Burci* and *Feinäugle*, declaring a PHEIC without following the steps stipulated within the IHR for doing so could possibly lead to responsibility on behalf of the WHO.[124] There is still a long way ahead for reaching this goal, as determining the existence of responsibility would give way to lengthy procedures filled with countless bureaucratic obstacles and fact-finding tasks consuming essential economic resources. Therefore, a formal proposal of this kind, logically and legally sound as it may be, would have to first circumvent the factual limitations present in the complicated scenario of the responsibility of Inter-national Organizations in general,[125] a problem ranging far beyond the WHO.

VI Conclusion

The failure to effectively respond to the 2014-2016 West African Ebola crisis put several structural shortcomings of the WHO into the fore. Among them, the governance framework for dealing with epidemics and pandemics stands out. Insofar as disease outbreak preparedness and response is one of the pillars of international cooperation in the field of health, it is all the more reason to be concerned with the status of affairs as it stands.

It is only after reaching an understanding of the governance framework from a descriptive perspective that normative work can aim at successfully tackling a problem. Given how public health emergencies do not wait for the "appropriate" moment, discussions of legal reforms take place as the subject matter is in motion. For the time being, the exercise of international public authority in the case of disease outbreaks relies mostly upon technical expertise, under the assumption that it is more likely to lead to an accurate result. Consequently, assessments on the justification of the use of

124 Although issuing a PHEIC Declaration falls under the authority of WHO Director-General, according to Article 6 of the Draft Articles on the Responsibility of International Organizations, legal responsibility for actions of an organization's organs or agents falls upon the organization itself. See Burci, G & Feinäugle, C, "The ILC's articles seen from a WHO perspective" in Ragazzi, M (ed.), *Responsibility of International Organizations. Essays in memory of Sir Ian Brownlie*, 2013, 186.

125 The challenge of determining when exactly an International Organization has acted wrongfully in legal terms is also presented in Blokker, N, "Member State Responsibility for Wrongdoings of International Organizations" (2015), 12 *International Organizations Law Review*, 319 (324).

legal powers cannot be untangled from the technical dimension of decisions. Even if not all facts can be interpreted under the aegis of causality, there will be no lessons learned unless there is explicit recognition of what went wrong, including, among other things, the scientific input of experts.

Claims against the WHO's lack of celerity in the 2014 West African Ebola crisis shed light on the fact that legal acts such as a PHEIC declaration can fulfill vital functions for addressing an initially local outbreak. As discussed throughout the article, the process leading to this declaration is not necessarily straightforward. Obstacles may result from either a wrongful assessment of the situation by decision-makers, or a long-standing pathological governance permeating across the whole of the institution.

In sum, the flexibility of norms within the IHR require balancing between the weight of the governance framework, and the particular acts by officials. Although this article focuses more on the first aspect, the latter dimension should not be underestimated when engaging in further analysis. An overview of the governance issues can help to incorporate additional elements for obtaining a more complete picture of what goes wrong during public health emergencies, and to what extent the shortcomings can be attributed to the framework of disease outbreak preparedness and response. Normative appraisals for improvements need to be solidly grounded on accurate factual and legal diagnostics. Otherwise, future attempts at improvements may amount to trying to construct a skyscraper without noticing its fragile foundations: By the time the problem is identified, it may already be too late to change course.