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Flattening the Curve: Why Amending the International Health Regulations Is the Common-Sense Solution to Future Pandemics

Brittney Graff

The COVID-19 pandemic presented an unprecedented challenge for the World Health Organization (WHO) and international community. The outbreak and ongoing pandemic prompted States to reassess the efficacy of the International Health Regulations (IHR). In November 2021, the World Health Assembly (WHA) decided to develop a new agreement to increase international pandemic preparedness. This paper analyzes the current gaps in the IHR to present a pragmatic approach wherein the WHA would amend rather than replace the IHR. It starts by examining the purpose and history of the IHR, including past revisions. It then addresses the constitutional framework of the IHR, and legal authority granted to the WHO to enact global health agreements. The paper analyzes specific articles of the IHR and their purported objectives to provide context for the IHR’s shortcomings. The paper argues that amendments are the pragmatic approach to strengthen the existing foundation laid down by the IHR. Specific amendments that prioritize improved detection and surveillance systems, greater multisectoral cooperation, and mitigation of resource scarcity will promote improved preparedness and prevent future outbreaks. The paper includes new language and substance for each proposed amendment that integrates with the existing IHR framework.

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INTRODUCTION

It was December 2019 in Wuhan—the capital and major commercial center of China’s Hubei province and home to over 14 million people. Chinese authorities frantically treated dozens of cases of what was believed to be an unusual strain of pneumonia, but its cause remained unknown. Within days, Chinese researchers identified a novel virus surfacing from a seafood and poultry market as the source of the spreading respiratory infections. By January 11, 2020, China reported its first known

3. See id.
death from the new virus and by January 21, the World Health Organization (WHO) reported confirmed cases outside of China in Japan, South Korea, Thailand, and the United States. Less than a month after the initial infections in Wuhan, the WHO officially declared the Severe Acute Respiratory Syndrome Coronavirus-2 (SARS-CoV-2), later named COVID-19, a “public health emergency of international concern” (PHEIC).

Although a PHEIC declaration suggests a united global response, in reality, the initial international response to COVID-19 was a disparate affair by individual sovereign States, rather than a united global front working under established norms. By late March 2020, several Latin American countries began restrictions, the European Union closed country borders, the U.S. limited gatherings to fifty people, and India announced a twenty-one-day lockdown. However, by the time these differing approaches were taken, COVID-19 had already infected more than one million globally and killed at least 51,000 people. Today, despite claims by President Biden, the pandemic persists, having taken a sobering 7 million lives globally.

Acknowledging the shortcomings of the international COVID-19 response is crucial when looking to prevent future pandemics. The International Health Regulations (IHR) under the WHO is the legally binding international accord created to oversee infectious disease preparedness and response. Under the provisions of the IHR, all 196 signatories of the resolution agree to “detect, assess, notify and report [public health] events.” However, the last four years of the ongoing COVID-19 pandemic have led State leaders to

4. Id.
5. Id.
7. Taylor, supra note 2.
8. Id.
question the efficacy of the IHR, last revised in 2005, in “the control of the international spread of disease.” Consequently, in November 2021, the World Health Assembly (WHA) met and agreed to develop a new Article 19 agreement aimed at strengthening global pandemic preparedness. However, rather than start the treaty process anew with another international agreement, this Note will demonstrate that the WHA should first focus on closing the gaps of the IHR through amendments that prioritize improving detection and surveillance systems, increasing multisectoral cooperation, and mitigating resource scarcity. By doing these things, the WHO can strengthen the foundation laid by the IHR to promote improved preparedness and prevent future outbreaks.

Part II of this paper will look deeper into the background of the IHR, including the history of the regulations from the twentieth century, the IHR’s purpose, and subsequent revisions of the IHR into the twenty-first century. Subsequent sections of Part II will address the constitutional framework of the IHR and the source of the WHO’s legal authority to enact international agreements. Included in this section are relevant articles of the IHR and their purported objectives, which provide context for the IHR’s shortcomings. Part III of this paper will use COVID-19’s context to analyze possible solutions to close the current gaps in the IHR, including why amendments to the IHR are more ideal than a new pandemic treaty. Finally, this paper will propose specific amendments to the IHR, including both the language and the substance for each proposal. Incorporating these amendments would promote improved international response and preparedness mechanisms.

I. BACKGROUND OF THE IHR AND PURPORTED OBJECTIVES

The IHR has been vital in protecting and promoting the health of global citizens since their inception. The IHR persists amidst decades of outbreaks and novel diseases. Rather than create new treaties with each epidemiological advancement, the WHO opted to amend the IHR as society and science advance. Understanding how
the WHO navigated shortcomings and modified the IHR in the past provides context to why the pattern should be followed for COVID-19.

Following the conclusion of World War II, the WHO Constitution was created and shortly thereafter, the WHO issued the first International Sanitary Regulations in 1951. The regulations were renamed the “International Health Regulations” in 1969 and focused on the prevention of six infectious diseases—cholera, plague, relapsing fever, smallpox, typhoid, and yellow fever. The WHO revised the IHR several times in subsequent years as international trade developed and technology advanced.

As the world approached the twenty-first century, globalization and technological improvements facilitated the spread of infectious diseases. It became clear that the IHR could not sufficiently respond to the increasing threat of new emerging infectious diseases. So in 1995, the WHA called for a thorough revision of the IHR with broad cooperation from international organizations and partnerships. This call to revise the IHR coincided with the 2003 emergence of severe acute respiratory syndrome (SARS), largely considered the first global public health emergency of the twenty-first century. The 2003 SARS outbreak illustrated the legal limitations of an outdated twentieth-century IHR: countries around the world failed to rapidly report outbreaks within their borders, and when the WHO attempted to investigate the outbreak’s origins, it met legal roadblocks. For example, at the time of the SARS outbreak, the IHR limited the WHO’s ability to respond because the IHR provided for notification of health emergencies only from State parties and only for yellow fever, plague, and cholera. Because SARS

16. Id. at 8.
17. At the time, the IHR was still limited to addressing just three preselected diseases: cholera, plague, and yellow fever. Relevant emerging and reemerging diseases of the late twentieth century unaddressed by the IHR included HIV/AIDS, malaria, and avian influenza. Id. at 2.
18. Id. at 12.
19. Id. at 13–14.
was outside of the IHR’s scope of reportable diseases, the IHR remained ineffective. A legally binding overhaul was needed.

In response, the IHR’s revision was finally completed in 2005 to prevent disease and provide a public health response proportionate to the relevant risks. Unlike previous revisions, the 2005 IHR was not limited in scope to any specific subset of diseases or modes of transmission. Additionally, the revisions created legally binding obligations for State signatories to develop and maintain minimum public health capacities, notification systems, and procedures to determine international public health emergencies. The specific intention for the 2005 IHR revision is clear and particularly salient, as viewed from 2024, in its foreword: “[I]t is intended that the Regulations will maintain their relevance and applicability for many years to come even in the face of the continued evolution of disease and of the factors determining their emergence and transmission.”

Thus, the WHO intended with the 2005 amendments to enable the IHR to continue as the preeminent agreement for global health, rather than to create new or alternative international agreements.

A. The Legal Power of the WHO

To understand the WHO’s ability to create agreements like the IHR, one must understand from where and how the WHO receives international legal authority. As mentioned in this Part, the WHO

22. Revision of the International Health Regulations, THE FIFTY-EIGHTH WORLD HEALTH ASSEMBLY 5(1) (In adopting the revised IHR, the WHA urged member States “[1] to build, strengthen and maintain the capacities required under the International Health Regulations (2005), and to mobilize the resources necessary for that purpose . . . .”).

23. IHR, supra note 12, at art. 6(1) (“1. Each State Party shall assess events occurring within its territory by using the decision instrument in Annex 2. Each State Party shall notify WHO, by the most efficient means of communication available, by way of the National IHR Focal Point, and within 24 hours of assessment of public health information, of all events which may constitute a public health emergency of international concern within its territory in accordance with the decision instrument, as well as any health measure implemented in response to those events. If the notification received by WHO involves the competency of the International Atomic Energy Agency (IAEA), WHO shall immediately notify the IAEA.”).

24. IHR, supra note 12, at art. 7 (“If a State Party has evidence of an unexpected or unusual public health event within its territory, irrespective of origin or source, which may constitute a public health emergency of international concern, it shall provide to WHO all relevant public health information. In such a case, the provisions of Article 6 shall apply in full.”).

25. Id. at Annex 2.

26. Id. at Foreword.
was created, and its constitution was passed, shortly following the conclusion of World War II. The IHR and creation of the WHO were legally novel because both created an international process whereby States delegated sovereign authority to the WHO. Thus, the WHO creates international health policy under internationally granted and legally binding global authority. When the WHO was established, legal analysts noted how the WHO “had been granted considerably greater operational autonomy and quasi-legislative powers than its predecessors.” These expansive powers can be traced to the WHO Constitution, which strengthened the WHO’s legal authority and created procedures to obtain maximum adherence to the IHR.

Under the WHO Constitution, the organization holds the authority to establish both “soft” global health norms through recommendations and “hard” law through treaty negotiation. The WHO’s “soft” norms are not binding under international law. However, they are nonetheless influential in individual State domestic law. Under Article 23 of the WHO Constitution, the WHA has the authority to make recommendations to WHO Member States regarding global health, ethics, and human rights. Additionally, the WHA is authorized to pass resolutions, though these are generally less formal than regulatory texts like codes or policy frameworks.

The WHO also has significant legal authority to create treaties, including by negotiating agreements, which are considered “hard law,” and by adopting regulations. The WHO’s lawmaking authority is unique in that its Constitution “places affirmative obligations on sovereign states.” Throughout international

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27. Meier, supra note 15.
28. Id.
29. Id. (quoting C.E. Allen, World Health and World Politics, 4 INT’L ORG. 27, 43 (1950)).
30. Id.
32. Id. at 2
33. Id.
34. See id.
35. See id. at 3.
36. Id.
law, constitutions for international organizations rarely create such authority.\textsuperscript{37} Articles 19, 20, and 62 of the WHO Constitution are particularly important. Under Article 19, the WHA has authority to adopt any convention or agreement that passes within its expertise by a two-thirds vote, and such a treaty enters into force for Member States when a State’s government when it accepts the treaty under domestic constitutional law.\textsuperscript{38} Articles 20 and 62 grant the Director General of the WHO with monitoring authority and require States to report annually on progress in treaty implementation.\textsuperscript{39} Thus, the WHO has been granted rare broad legal authority to establish binding international law. It was under this authority that the WHO created the IHR and continues to monitor adherence to the IHR.\textsuperscript{40}

\textbf{B. Relevant Provisions of the IHR}

The IHR already contains several provisions relevant to preventing and responding to disease outbreaks like COVID-19. Although the COVID-19 pandemic demonstrated that these provisions are not infallible, minor modifications are sufficient to prepare the international community for future outbreaks. Specifically, the WHA should focus future IHR amendments on improving detection and surveillance systems, increasing multisectoral cooperation, and mitigating resource scarcity. Through these amendments, the WHA can avoid the need to create a new international health treaty when the IHR already exists.

Moreover, under Articles 19, 21, and 22 of the WHO Constitution, the WHA has “the authority to adopt regulations ‘designed to prevent the international spread of disease,’” and the 2005 IHR revisions are based on such constitutional authority granted by the WHO.\textsuperscript{41} Once such regulations are adopted by the WHA, all WHO Member States that do not opt out of the agreement are then required to abide by the document.\textsuperscript{42}

The 2005 IHR “urges” all Member States:

\textsuperscript{37} See id.
\textsuperscript{38} Id.
\textsuperscript{39} Id.
\textsuperscript{40} Id. at 3–4.
\textsuperscript{41} See IHR, supra note 12, at Foreword, arts. 19, 21, 22.
\textsuperscript{42} Id. at Foreword.
(1) to build, strengthen and maintain the capacities required under the International Health Regulations (2005), and to mobilize the resources necessary for that purpose; (2) to collaborate actively with each other and WHO in accordance with the relevant provisions of the International Health Regulations (2005), so as to ensure their effective implementation; (3) to provide support to developing countries and countries with economies in transition if they so request in the building, strengthening and maintenance of the public health capacities required under the International Health Regulations (2005); (4) to take all appropriate measures for furthering the purpose and eventual implementation of the International Health Regulations (2005) pending their entry into force, including development of the necessary public health capacities and legal and administrative provisions . . . . 43

Thus, if amendments improving disease surveillance, increasing multisectoral collaboration, and mitigating resource scarcity were created and approved, all Member States would be required to implement the necessary changes. The sections that follow include the relevant IHR provisions addressing surveillance, collaboration, and resources.

1. Surveillance and Data Collection: Articles 5, 6, and 12

Article 5 of the IHR deals specifically with the matter of surveillance and the international public health response. Under Article 5, each State must develop “the capacity to detect, assess, notify and report events” according to the regulations within five years of their entry into force in 2007. 44 Additionally, this Article grants legal authority to the WHO to collect information on health-related events via surveillance and “assess their potential to cause international disease spread,” 45 mitigating the previous lack of authority, seen in the 2003 SARS outbreak. 46

Article 6 relates to Article 5 in that it requires States to “assess events occurring within [their] territory” and notify the WHO “by the most efficient means of communication available” within twenty-four hours of any event that “may constitute a public health

43. Id. at pmbl.
44. Id. at art. 5(1).
45. See id. at Foreword, pmbl., art. 5(4)
46. See O’NEILL INST. FOR NAT’L & GLOB. HEALTH L., supra note 20.
emergency” within their borders. Under this Article, a State is obligated to “continue to communicate to WHO timely, accurate and sufficiently detailed public health information available to it on the notified event.” This should include “laboratory results, source and type of the risk, number of cases and deaths, conditions affecting the spread of the disease,” current difficulties, and support needed from the WHO.

Under Article 12, the Director-General of the WHO has the responsibility to determine whether an outbreak “constitutes a public health emergency of international concern.” The criteria and procedure for determining such an emergency are already established within the IHR, rather than being a subjective procedure dependent only upon the judgment of the Director-General. The Director-General works directly with the State in whose territory the event arises to make a preliminary decision and then seeks the Emergency Committee’s views on the ideal temporary recommendations.

2. State and Intergovernmental Collaboration: Articles 14 and 44

Article 14 obligates the WHO to maintain cooperative relations with other intergovernmental and international organizations. Specifically, while the WHO still has the primary responsibility for global health oversight, this Article calls for the WHO to cooperate with and defer to other intergovernmental or international organizations when an outbreak is within their expertise.

Article 44 calls for State collaboration in “detection and assessment” of events, logistical support, “mobilization of financial resources,” and “formulation of proposed laws” to implement the IHR. Under this Article, the WHO also has a duty to collaborate with States upon their request. The WHO is to collaborate in

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47. Id. at art. 6.
48. See id. at art. 6(2).
49. Id.
50. Id. at art. 12(1).
51. See id.
52. Id. at art. 12(2).
53. Id. at art. 14(1).
54. Id. at art. 14.
55. Id. at art. 44(1).
56. See id. at art. 44(2).
evaluating States’ public health capacities, providing technology and logistical support, and mobilizing financial resources, particularly among developing States.57 This collaboration is connected with Article 14, in that State and WHO collaboration can be implemented via intergovernmental and international organizations.58

3. The IHR Roster of Experts, the Emergency Committee, and the Review Committee: Articles 47–51

Under Articles 47–51, the Director-General of the WHO must establish an IHR Expert Roster composed of individuals in “all relevant fields of expertise,” according to the WHO Advisory Panel Regulations.59 Such experts can also, “where appropriate,” be proposed by “relevant intergovernmental and regional economic integration organizations.”60 States can also nominate experts and must note the nominees’ applicable “qualifications and fields of expertise.”61

From the IHR Expert Roster, the Director-General must create an Emergency Committee whose responsibilities include providing counsel on whether an event meets the requirements for “a public health emergency of international concern,” the timeline of such an emergency’s termination, and temporary recommendations for the emergency.62 The Director-General “determine[s] the duration of membership” for the Committee members and has a duty to consider “equitable geographical representation” when selecting members.63 While the views of the individual committee members and the State party in whose territory the event arises are valuable, ultimately, the Director-General makes all final determinations regarding the emergency.64

The Review Committee also includes individuals from the IHR Expert Roster and makes recommendations regarding IHR amendments and “provide[s] technical advice.”65 However, the

57. Id.
58. See id. at arts. 14, 44(3).
59. Id. at art. 47.
60. Id.
61. Id.
62. Id. at art. 48(1)–(2).
63. Id. at art. 48(2).
64. See id. at art. 49.
65. Id. at art. 50(1), (3).
Director-General appoints members to the Review Committee for the duration of only a single session and should consider diversity of geography, gender, expertise, scientific opinion, and approaches in the selection process. Unlike the Emergency Committee, the Review Committee makes decisions based on majority vote, rather than the sole decisions of the Director-General.

4. Amendments to the IHR: Article 55

Article 55 is essential to the IHR because it creates the legal basis whereby individual States or the Director-General may propose an amendment to the regulations. All proposed amendments must be submitted to the WHA and sent to State parties at least four months before the Assembly in which they will be considered. Any amendments to the regulations adopted under this article automatically come into force for all States who are parties to the WHO. The matter of amending the IHR has been a controversial topic within the WHO, even before the COVID-19 pandemic; the IHR Review Committee has repeatedly advised against amending. There has only been one instance in the two decades since the 2005 IHR revision that it has been amended, and that only extended the recognized lifetime of yellow fever vaccines—a relatively benign modification.

5. Additional International Agreements: Article 57

Article 57 of the IHR governs the regulations’ “[r]elationship with other international agreements.” Under this Article, the IHR does not preclude States with certain shared interests from entering into other, related international agreements and cannot impact a

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66. Id. at art. 50(5)-(6).
67. Id. at art. 51(1).
68. See id. at art. 55(1).
69. Id. at art. 55(1)-(2).
70. See id. at art. 55(3).
72. Id.
73. See IHR, supra note 12, at art. 57.
State’s “rights and obligations” under any other agreement. Article 57 grants broad authority to States and parties to create a specialized agreement or international treaty to further the intended goals of the IHR.

C. Shortcomings of the IHR

Considering that the IHR was originally passed in 1969 in an era that was beginning to see widespread advances in technology and international trade but still lacking the ability to foresee the advancements of the twenty-first century, clear gaps persist. Critical revisions in 2005 broadened the application of the IHR to more diseases, modified the process whereby States notify the WHO of public health threats, and created more safeguards for human rights. However, even the 2005 revisions have failed to keep up with the effects of modern trade, transportation, and international human rights on global health, as illustrated by the ongoing COVID-19 pandemic. For example, one significant gap that persists in global health policy, and which international legal scholars repeatedly note, is the failure of the IHR to set specific terms to actively protect individual and international human rights. While the tension between individual rights and global health governance may always persist, many facets of international health regulation inextricably relate to international human rights issues, such as the relationship between surveillance and privacy, vaccination and bodily integrity, and quarantine and liberty.

Additionally, despite the aforementioned IHR provisions, in the initial COVID-19 outbreak, many States generally ignored the WHO and the IHR obligations regarding travel, data collection,

74. See id. at art. 57(1)-(2).
75. Meier, supra note 15. The 2005 revision broadened its application of the IHR to any event that had potential of becoming a PHEIC. Additionally, the revision created “national focal points” of communication to facilitate notifying the WHO of PHEICs within forty-eight hours. Lastly, the revision attempted to address human rights for the first time in the IHR and mandated generally that States implement the IHR with respect for the dignity and fundamental rights of their citizens.
77. Id.
surveillance, and emergency response. Global health scholars noted States’ reluctance toward “sacrific[ing] their sovereignty” as a reason why the WHO was unable to enforce compliance with the IHR. However, the IHR does not have accountability or transparency mechanisms in place to address this phenomenon. Article 44 of the IHR does require States to “collaborate with each other, to the extent possible,” in pandemic response, but the IHR also grants States significant flexibility in areas such as surveillance and notifying the WHO. Consequently, States have repeatedly “pursued nationalist measures that have undermined global governance.”

Currently, the IHR surveillance provisions focus on outbreaks after they occur, rather than widespread prevention of infectious disease spillover events and subsequent outbreaks. Additionally, despite goals of intergovernmental collaboration, under the IHR, the WHO focuses pandemic training and education on ministries of health, rather than across sectors. Lastly, under the current IHR, there is virtually no global infrastructure for pandemic-related emergency funding and resources for developing countries. More powerful, higher-income countries maintain excessive influence over global health priorities. It is clear given the ongoing pandemic that something must be done to address the current gaps in the IHR to improve international pandemic preparedness, with the long-term goal of total pandemic prevention.

D. A Recent Call to Action

Since the initial COVID-19 outbreak, States have recognized the current IHR’s shortcomings. The debate centers around whether the solution is additional IHR amendments or a completely new

80. See IHR, supra note 12, at art. 44.
81. Id. at art. 5-6.
82. Meier, supra note 15, at 32.
83. See IHR, supra note 12, at art. 12.
84. O’NEILL INST. FOR NAT’L & GLOB. HEALTH L., supra note 20, at 3.
85. See id. at 8.
86. Gostin, supra note 76, at 606.
international agreement. In January 2021, the Independent Panel for Pandemic Preparedness and Response, created by the WHO Director-General, reported that the current international disease alert system was “not fit for purpose” and called for “a new global framework” to respond to and prevent future pandemics. In May 2021, a special session of the WHA was called for November 2021 “to consider developing a WHO convention, agreement or other international instrument on pandemic preparedness and response.” A Member States’ working group—the Working Group on Strengthening WHO Preparedness and Response to Health Emergencies (WGPR)—was given the singular responsibility to create a recommendation for the November 2021 WHA special session on whether such an agreement was needed. The WHO Constitution would allow for such an agreement or convention under Article 19, which covers the creation of new agreements for international health.

On December 1, 2021, the WHA adopted a resolution creating an Intergovernmental Negotiating Body (INB), which would be tasked with negotiating a new pandemic agreement. However, from its first public hearings, the INB faced obstacles to consensus on the form of a new international agreement:

There were different views expressed in terms of the overall future governance mechanism of a new international instrument. Some participants advocated for the instrument to be non-binding and advisory in nature. Other speakers stressed that

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88. See Burci, supra note 71.
91. See Burci, supra note 71.
nationalism should be prevented, with steps taken to monitor and enforce national compliance to the international instrument.94

In July 2022, the INB reconvened and determined that the new WHO treaty should be legally binding, and it established a goal to complete the new agreement by May 2024.95 Under Article 19 of the WHO Constitution, an international convention can be adopted even with State dissent so long as there is a two-thirds majority,96 with no obligation for dissenters to join the convention.97 The timeline for a new pandemic treaty remains uncertain; it depends upon the INB’s ability to meet its proposed May 2024 deadline and the time it takes State parties to ratify it once completed.98

The uncertainty in the timeline for a new treaty and disagreement among States regarding its form only reinforce the argument to amend the IHR. State leaders acknowledge the IHR has shortcomings,99 but these shortcomings will be addressed more efficiently through amendments, not a new treaty.

II. EXPLORING THE SOLUTION

A. Amendments vs. A New Treaty

The critical question remaining following the WHA November 2021 Special Session is whether a new pandemic treaty is the most effective route to prevent global outbreaks of the severity and magnitude of COVID-19. State leaders and the legal community must compare the two alternatives—amending the IHR or creating a new pandemic agreement—and some legal scholars argue the two processes would be similar.100 On paper, both may seem relatively straightforward and comparable; however, realistically,


96. See Burci, supra note 71; see also World Health Org. [WHO], supra note 92.


98. See Burci, supra note 71.


100. See Burci, supra note 71.
each process has advantages and disadvantages that must be carefully considered.

The proposed timeline of a new, legally binding pandemic treaty feels highly optimistic, if not altogether dubious. The lack of consensus in the first two WHA meetings debating a new pandemic treaty and creating the INB raises concerns about whether an entirely new treaty, the form of which has few precedents in international law practice,\textsuperscript{101} is the most efficient approach. Supporters of a new treaty may argue that the unprecedented COVID-19 pandemic requires an unprecedented response. However, rather than further draw out the process by debating the form, function, and substance behind a new agreement, the WHA should build upon what it already has through the IHR. The IHR lays a foundation with considerations for national sovereignty, State procedure, and outbreak criteria already established by decades of research and international collaboration.\textsuperscript{102}

Moreover, even if the proposed timeline is accurate, it is uncertain whether the new agreement would be sufficiently specific to fill all the IHR’s current gaps. The desire to appease as many States as possible to achieve easy passage might water down the treaty’s components. Amendments, by contrast, would be narrowed by the WHA to focus on the most critical issues. The IHR has already helped the WHO and international community navigate decades of disease and outbreaks.\textsuperscript{103} When necessary, the WHO has adjusted and amended the language of the agreement as society develops and needs arise.\textsuperscript{104} The WHA need not draw out the process further with a new treaty that may not meet arising needs. The WHA should apply what the international community learned from the initial response and ongoing issues with COVID-19 into specific amendments that fill the gaps in the IHR.

\textit{1. The Framework Convention on Tobacco Control Case Study}

Currently, the only legally binding Article 19 treaty that has been adopted by the WHA is the Framework Convention on Tobacco Control (FCTC), which will be analyzed in the following section. \textit{Id.} at 11. \textit{Id.} at 16-18.
Tobacco Control (FCTC), adopted in 2003. The FCTC provides a case study for what to expect from a new pandemic treaty. While the topic of the treaty differs, its procedures and mechanisms remain comparable to what has been recommended for a pandemic treaty. Therefore, a review of the FCTC may be the most feasible and realistic analysis of the advantages and potential shortcomings of an Article 19 treaty.

“The FCTC aims to reduce harmful tobacco consumption,” through various specific mechanisms, with the long-term goal of decreasing the average of seven million preventable deaths caused by tobacco worldwide each year. By 2019, sixteen years after its initial adoption, 181 countries had ratified the FCTC, so only 13 UN Member States were not legally bound by it. Like the proposed pandemic treaty, the FCTC primarily functions by “establishing broad categories of regulatory action that parties may or must take.” Additionally, the FCTC uses both non-binding advisory language and binding obligatory language throughout the treaty. A study reviewing the impact of the FCTC around fourteen years after it entered into force found no evidence that global cigarette consumption per adult decreased via the FCTC’s legal obligations and State tobacco control policies. The FCTC’s ineffectiveness was due to “countries ignoring [the treaty] after ratifying [it] . . . , insufficient government capacity to act on [it], [and] countries formally adopting treaty provisions into national policy without actual implementation . . . .”

Apart from the aforementioned shortcomings of the treaty, a primary issue surrounding the FCTC for the WHA to consider in formulating a new treaty is that the FCTC “took over a decade to

106. Hoffman et al., supra note 105, at 1.
107. Id. at 2.
110. Hoffman et al., supra note 105, at 1, 7.
111. See id. at 8.
negotiate and” take effect.112 In light of the realities of the FCTC, should the WHA create a new pandemic treaty, the current projected timeline for adoption seems overly optimistic and a timeline closer to the FCTC’s is more likely. As the COVID-19 pandemic enters its fifth year concurrently with Ebola outbreaks in Central Africa, cholera spikes in impoverished regions globally, and the most recent global monkeypox outbreak,113 the realistic timeline for the negotiations and implementation of a new pandemic agreement may be too distant for current global health needs. Nevertheless, proponents of a pandemic agreement may argue the proposed timeline is immaterial, so long as the overall efficiency of the agreement compensates for the required effort.

Amendments to the IHR offer a solution that provides a tailored response to current global health needs, but still applies to public health threats and pandemic prevention broadly. The IHR contains a clear purpose, legal framework, and many mechanisms in place that are familiar territory for Member States. Amending the IHR will likely require less long-term effort by the WHA because modifying an agreement is more straightforward than negotiating an alternative, particularly when many shortcomings needing modification are already identified.114

2. Proposed Benefits of Amendments

The IHR contains the necessary framework to address COVID-19 and other burgeoning threats in a more focused and efficient timeline. Amendments function similarly to an Article 19 treaty, in that IHR amendments could be adopted over dissent from WHO Members States who would have no obligation to be bound by the amendments.115 However, under Articles 21 and 22 of the WHO Constitution, which would apply to any IHR amendments, States are required to opt out rather than opt in to an agreement as they

112. See O’NEILL, INST. FOR NAT’L & GLOB. HEALTH L., supra note 97, at 5. The initial negotiations for the terms of the treaty began in 1995.
114. See Gostin, supra note 76.
would be under Article 19 treaties. In practice this means that WHO Member States would be assumed parties to the IHR amendments, so long as they do not actively opt out of the regulations. This requirement may cause more States to adopt the Article 21 regulations by default because of the necessary steps required to opt out of the regulations. Because of this unique mechanism, the IHR amendments may reach the level of international support necessary not only to pass but also to have enough States on board so that the amendments have a sufficient international impact.

Additionally, as mentioned above, rather than starting from scratch, IHR amendments can build upon the foundation laid by the IHR and focus on addressing targeted features of the regulations that need additional support. Not to mention, the WHA, public health experts, the international legal community, and other stakeholders are already familiar with the IHR, its subject matter, and possible gaps. Ideally, this would facilitate State consensus and result in a more streamlined timeline for a workable pandemic solution.

B. Proposed Amendments*

1. Increase Accountability and Transparency Mechanisms Through Detection and Surveillance Systems

While Articles 5 and 6 of the IHR focus on surveillance and notification, both Articles essentially leave it to each State to develop a surveillance and notification system. Under Article 5, “[e]ach State Party shall develop, strengthen and maintain ... the capacity to detect, assess, notify and report events in accordance with these Regulations ...” The result is that States take individualistic approaches to disease surveillance, rather than using a uniform global system. Moreover, while both of these Articles utilize mandatory “shall” language regarding State responsibility to detect and notify the WHO and global community of a public health emergency, the level to which individual States

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* The proposed amendments that follow are merely ideas upon which the WHA might build.
117. IHR, supra note 12, at art. 5.
spearheaded these mandates varies substantially. China’s response to the initial COVID-19 outbreak illustrates this point.

Much can be said about China’s intense approach to containing the spread of COVID-19 within its borders. China’s strict lockdowns curbed case numbers substantially from the beginning; however, this response may not be practical for other, non-authoritarian States.118 Moreover, there has been some pushback to China’s surveillance and notification systems following the initial outbreaks when COVID-19 was still primarily within its borders. In a report from the Associated Press, journalists lamented the general international lag in governments’ initial responses to the virus.119 Because China was the virus’s country of origin, the country’s initial response was vital; it laid the foundation for the global health response to the outbreak. In the same article, an epidemiologist from the University of California, Los Angeles, noted that China’s delay in notifying the public of the novel coronavirus was so critical that, had State officials notified the public even six days earlier, they could have potentially avoided the collapse of Wuhan’s medical system.120

The point is not to criticize China nor to place blame, as similar delays occurred in other Member States; rather, it is to demonstrate how crucial disease surveillance and notification is in determining a disease’s trajectory internationally. Yet the IHR lacks a strong surveillance and notification system or mechanisms in place for China’s, or other WHO Member States’, responses to be held to a higher standard.

The IHR currently grants States much flexibility regarding what information to share with the WHO and international community, often resulting in a disorganized and unreliable system subject to information gaps and response delays, as demonstrated in this section. While national sovereignty is still a significant consideration in any international agreement, “pathogens do not


120. Id.
respect political boundaries.\textsuperscript{121} Surveillance and State accountability essentially determine the timeline and severity of an outbreak. Therefore, the IHR must be amended to create an internationally uniform system for improved surveillance and State accountability to the WHO to provide outbreak data. WHO Member States would likely need to determine together what an international surveillance and accountability mechanism would entail to create uniform expectations.

The WHO is already using increased modern technology for surveillance and establishing standards for national and global surveillance by gathering and analyzing electronic health records.\textsuperscript{122} It is important to note that there is a risk that a surveillance system will be abused by States, especially when advancing technology facilitates accessing and storing personal data. There is a risk that those who use these mechanisms do so to increase censorship and gather data on citizens. For this reason, strong and effective vertical governance from the WHO and WHA is vital and can mitigate risk. Presently, under the IHR, the WHO already maintains the primary oversight and governance role extending to disease surveillance.\textsuperscript{123} However, a revised IHR could further enhance this role to diminish the risk of abuse. Additionally, subsection 2 of Article 45 of the IHR mandates that States securely process and store any personal health information from citizens, and only for the purpose of “assessing and managing a public health risk.”\textsuperscript{124} Furthermore, while many provisions of the IHR risk being abused, the value of improving global pandemic response and prevention counterweighs the associated risks of the IHR.

In an amendment to Article 5, the WHO would need to first create criteria for the categories and types of data that would be required from each State to create a uniform surveillance and reporting system. The WHO—rather than States—would establish the information, earlier timelines, and dataset requirements for all States to use, further facilitating timely monitoring and uniform reporting. Moreover, States could dedicate the crucial first days of

\textsuperscript{121} O’NEILL INST. FOR NAT’L & GLOB. HEALTH L., supra note 20, at 4.
\textsuperscript{122} Gostin, supra note 76, at 606; see also Adam Cohen & Jillian Murray, Infectious Disease Surveillance, 4 INT’L ENCYCLOPEDIA OF PUB. HEALTH 222, 222–27 (Oct. 24, 2016).
\textsuperscript{123} IHR, supra note 12, at arts. 5, 6.
\textsuperscript{124} Id. at art. 45(2).
a public health emergency to disseminating data to the WHO and National Focal Points, rather than to establishing datasets and key indicators.

Additionally, the IHR currently focuses on responding to disease outbreaks once they have already occurred. However, amending Article 5 to prioritize ongoing surveillance and detection of zoonoses—the primary method of transmission contributing to infectious disease outbreaks—could prevent future outbreaks. Subsection 1 of Article 5 creates a responsibility for States to collect data via surveillance and assess the risk of an outbreak. However, in practice under the IHR, States often begin disease surveillance and monitoring once an outbreak is already detected, as China and other States did in early 2020.

Instead, surveillance and detection could focus on identifying and monitoring locations with high human/animal population interaction, such as trade and meat markets, deforestation sites, and other potential spillover locations. Rather than waiting until the spillover reaches outbreak status, officials could identify any locations or situations with potential to cause a public health emergency and implement interventions to prevent spillover events. Once identified, State and health officials could also monitor identified sites on a regular basis, screen for pathogens, and promptly report any irregular data to the responsible National Focal Point and to the WHO.

125. See Joel Henrique Ellwanger & José Artur Bogo Chies, Zoonotic Spillover: Understanding Basic Aspects for Better Prevention. 44 GENETICS & MOLECULAR BIOLOGY 1, 1 (June 4, 2021), doi: 10.1590/1678-4685-GMB-2020-0355 (“The transmission of pathogens from wild animals to humans is called ‘zoonotic spillover.’ Most human infectious diseases (60–75%) are derived from pathogens that originally circulated in non-human animal species. This demonstrates that spillover has a fundamental role in the emergence of new human infectious diseases.”).

126. IHR, supra note 12, at art. 5(1).

127. See Ellwanger & Chies, supra note 125, at 1. (“Activities and factors that increase the interaction of humans with different animal species and pathogens they host, which include handling, poaching, and consumption of meat from wild animals and derived products, are associated with increased risk of spillover events (Kurpiers et al., 2016; Ellwanger et al., 2020) . . . . In addition to serving as a source of food, in many countries, wild animals and their products are also sold in live animal markets . . . . for medicinal purposes or cultural practices, as souvenirs, pets, among other finalities. These markets contribute significantly to the interaction of humans with different species and new pathogens.”).

When China and fellow Member States managed the initial outbreaks in late 2019 and early 2020, there was no group to oversee compliance with the surveillance, monitoring, and reporting required by the IHR. Therefore, each State could effectively report what and when it wanted, without fear of legitimate backlash from the WHO. To better address States’ accountability to report and monitor public health emergencies, the IHR needs a body to oversee State compliance, particularly with Article 5. The overseeing body could be the WHO, or Member States could elect the individuals that perform oversight. The overseeing body would have the legitimacy to report on IHR compliance and potentially impose sanctions on noncompliant States to promote greater accountability and transparency.

The section that follows includes Articles 5 and 6 of the IHR and includes the author’s proposed amended language for each Article. The purpose of the proposed new language in Articles 5 and 6 is to increase international transparency and State accountability regarding disease detection, surveillance, and notification.

**PROPOSED LANGUAGE OF ARTICLE 5 AMENDMENT**

Each State Party shall implement, as soon as possible under the direction and assistance of the Director-General and the WHO, the uniform surveillance system proposed and overseen by the WHO, for the purpose of promoting consistency in detecting, assessing, notifying, and reporting data and events with the potential to become public health emergencies of international concern (PHEIC).

WHO shall establish the information, key indicators, and timeline required by each State Party to follow when surveying and reporting data sets to the National IHR Focal Point and the WHO, with the assistance and under the recommendation of public health officials.

WHO shall assist States Parties, upon request, to implement, strengthen, and maintain the uniform global surveillance system proposed by paragraph 1 of this Article.

WHO shall collect information regarding events from States Parties and the National IHR Focal Points through its uniform surveillance system and assess their potential to cause international disease spread and possible interference with international traffic and

* Emphasis hereinafter indicates new language proposed by the author amending the IHR (2005).
global markets. Information received by WHO under this paragraph shall be handled in accordance with Articles 11 and 45 where appropriate.  

129. Article 11: Provision of Information by WHO states,

1. Subject to paragraph 2 of this Article, WHO shall send to all States Parties and, as appropriate, to relevant intergovernmental organizations, as soon as possible and by the most efficient means available, in confidence, such public health information which it has received under Articles 5 to 10 inclusive and which is necessary to enable States Parties to respond to a public health risk. WHO should communicate information to other States Parties that might help them in preventing the occurrence of similar incidents.

2. WHO shall use information received under Articles 6 and 8 and paragraph 2 of Article 9 for verification, assessment and assistance purposes under these Regulations and, unless otherwise agreed with the States Parties referred to in those provisions, shall not make this information generally available to other States Parties, until such time as:
   (a) the event is determined to constitute a public health emergency of international concern in accordance with Article 12; or
   (b) information evidencing the international spread of the infection or contamination has been confirmed by WHO in accordance with established epidemiological principles; or
   (c) there is evidence that:
      (i) control measures against the international spread are unlikely to succeed because of the nature of the contamination, disease agent, vector or reservoir; or
      (ii) the State Party lacks sufficient operational capacity to carry out necessary measures to prevent further spread of disease; or
      (d) the nature and scope of the international movement of travellers, baggage, cargo, conveyances, goods or postal parcels that may be affected by the infection or contamination requires the immediate application of international control measures.

3. WHO shall consult with the State Party in whose territory the event is occurring as to its intent to make information available under this Article.

4. When information received by WHO under paragraph 2 of this Article is made available to States Parties in accordance with these Regulations, WHO may also make it available to the public if other information about the same event has already become publicly available and there is a need for the dissemination of authoritative and independent information.

IHR, supra note 12, at art. 11.

130. Article 45: Treatment of Personal Data states,

1. Health information collected or received by a State Party pursuant to these Regulations from another State Party or from WHO which refers to an identified or identifiable person shall be kept confidential and processed anonymously as required by national law.

2. Notwithstanding paragraph 1, States Parties may disclose and process personal data where essential for the purposes of assessing and managing a public health risk, but State Parties, in accordance with national law, and WHO must ensure that the personal data are:
WHO shall assist States Parties to focus surveillance efforts on screening for pathogens and detection of zoonoses that contribute to PHEICs. The WHO shall assist States Parties to identify locations within their borders with high human/animal interaction, with the assistance of public health experts, and regularly screen and monitor the identified locations for novel or reemerging pathogens and report concerning data to the National IHR Focal Point and the WHO. These activities shall be done with the overarching goal of detecting and isolating concerning pathogens as soon as possible before an outbreak can occur.

WHO or States Parties shall elect representatives on a 5-year basis to a commission to oversee compliance with the terms of these Regulations and report non-compliance to the WHO, who maintains the legal authority to obtain maximum adherence to the IHR under its Constitution.

PROPOSED LANGUAGE OF ARTICLE 6 AMENDMENT

Each State Party shall assess events occurring within its territory by using the uniform surveillance system established in Article 5. Each State Party shall notify WHO, by the most efficient means of communication available, by way of the National IHR Focal Point, and within 24 hours of assessment of public health information, of all events or detected pathogens which have the potential to create a public health emergency of international concern within its territory in accordance with the key indicators and data sets established by the WHO in the uniform surveillance system, as well as any health measure implemented in response to those events. If the notification received by WHO involves the competency of the international Atomic Energy Agency (IAEA), WHO shall immediately notify the IAEA.

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(a) processed fairly and lawfully, and not further processed in a way incompatible with that purpose;
(b) adequate, relevant and not excessive in relation to that purpose;
(c) accurate and, where necessary, kept up to date; every reasonable step must be taken to ensure that data which are inaccurate or incomplete are erased or rectified; and
(d) not kept longer than necessary.

3. Upon request, WHO shall as far as practicable provide an individual with his or her personal data referred to in this Article in an intelligible form, without undue delay or expense and, when necessary, allow for correction.

IHR, supra note 12, at art. 45.
Following a notification, a State Party shall continue to communicate to WHO timely, accurate, and sufficiently detailed public health information available to it on the notified event, where possible including case definitions, laboratory results, source and type of the risk, number of cases and deaths, conditions affecting the spread of the disease and the health measures employed; and report, when necessary the difficulties faced and support needed in responding to the potential public health emergency of international concern. The IHR overseeing body established by Article 5 will be responsible for overseeing compliance and notifying the WHO according to the criteria established by this Article to promote State accountability and transparency.

2. Increase Multisectoral Cooperation

A crucial consideration already in place under the IHR is the responsibility of the WHO to assist Member States with needed resources and with the development of disease detection and response systems.\textsuperscript{131} This is essential, particularly for developing countries that may lack the resources and domestic infrastructure to comply with the IHR. While the IHR attempts to create cooperation between individual States and international governing bodies like the WHO through collaboration across sectors, there is still a gap in multisectoral cooperation.

Currently, the WHO focuses on pandemic preparedness training for State ministries of health and other related public health experts.\textsuperscript{132} However, there are additional ministries that are left out of the conversation that not only hold a stake in the issue but may also have resources vital to international pandemic preparedness. These ministries could include ministries of finance and defense, and departments of transportation and the interior, as all are adversely affected by public health emergencies. The O’Neill Institute for National and Global Health Law at Georgetown reported that communication and data collection during the pandemic were “stymied by misunderstanding and less than full cooperation by ministries of finance and trade . . . .”\textsuperscript{133} Under the IHR during the COVID-19 outbreak, the world saw a domino-effect phenomenon when health ministers’ under-resourced attempts to

\textsuperscript{131} IHR, supra note 12, at art. 5(3); see also IHR, supra note 12, at art. 13(1), (3), (6)

\textsuperscript{132} O’NEILL INST. FOR NAT’L & GLOB. HEALTH L., supra note 20, at 3.

\textsuperscript{133} Id. at 2.
contain the outbreak affected transportation, finance, and businesses in the private sector. Moving forward, the WHO and IHR should create mechanisms whereby departments not traditionally involved in public health are integrated into the disease-prevention conversation.

Article 14 currently oversees the cooperation of the WHO with intergovernmental organizations. Its scope is essentially limited to promoting coordination between the WHO and other governmental bodies.\footnote{IHR, supra note 12, at art. 14.} This cooperation focuses primarily on creating intergovernmental agreements.\footnote{Id.} There is no language addressing the role of the private sector in a public health emergency in Article 14 or elsewhere in the IHR. The private sector alone controls so much of the world’s resources and has access to funding, advanced technology, emerging innovations, and marketing. Because its activities would be impacted just as much by a pandemic as are those of ministries of health or other government organizations, the private sector should be involved in pandemic training and collaboration with the WHO.

The international legal community and public health experts have suggested a viable mechanism whereby the private sector could potentially be involved in pandemic prevention and response via access-and-benefit sharing,\footnote{O’NEILL INST. FOR NAT’L & GLOB. HEALTH L., supra note 20, at 18.} which could also be added to an Article 14 amendment. The pandemic influenza preparedness (PIP) framework published by the WHO in 2011 could act as a model for public-private sector engagement for pandemic preparedness.\footnote{The PIP Framework created an arrangement where the WHO could negotiate and create legally binding contracts with the private sector following H5N1 to provide medication, vaccines, and licensing of different technologies to the WHO in the event of circumstances specified by the framework. World Health Org. [WHO], Pandemic Influenza Preparedness Framework for the Sharing of Influenza Viruses and Access to Vaccines and Other Benefits, at 15–21, WC 515 (2011), https://apps.who.int/gb/pip/pdf_files/pandemic-influenza-preparedness-en.pdf.} In an access-and-benefit arrangement similar to the PIP between the public and private sector, just as the name suggests, the private sector could be incentivized to enter into contracts with the WHO and health ministries. This quid-pro-quo arrangement could guarantee business and continued revenue for the private company, even in the event of a pandemic, and the
WHO would also benefit by receiving financing and access to technology and medical innovations for the international community. The section that follows includes Article 14 of the IHR and includes the author’s proposed amended language for the Article. The purpose of the proposed new language in Article 14 is to increase multisectoral cooperation, particularly by expanding funding, information sharing, and pandemic preparedness trainings across sectors.

PROPOSED LANGUAGE OF ARTICLE 14 AMENDMENT

WHO shall cooperate and coordinate its activities, as appropriate, with other competent intergovernmental, nongovernmental, and multisectoral bodies, including but not limited to ministries of defense, finance, transportation, the interior, and private businesses, to collect data, provide funding, share information, access innovations and methods, and collaborate on pandemic training, response, and prevention. This multisectoral collaboration will cooperate in the implementation of these Regulations, including through the conclusion of agreements or similar arrangements, contributing to the overarching goal of international pandemic collaboration and prevention.

WHO shall expand pandemic preparedness training across sectors, involving shareholders identified by the WHO with activities or competencies which affect or are affected by the public health sector.

In cases in which prevention, notification, or verification of, or response to, an event is primarily within the competence of other bodies, such as the private sector, other intergovernmental organizations, or international bodies, WHO shall coordinate its activities with such organizations or bodies in order to ensure adequate training, funding, and measures for the protection of public health.

Notwithstanding the foregoing, nothing in these Regulations shall preclude or limit the provision by WHO of advice, support, or technical or other assistance for public health purposes. Nothing in these Regulations shall preclude or limit the ability of WHO to receive advice, support, or technical or other assistance from organizations or bodies for public health purposes.

3. Aim to Mitigate General Resource Scarcity

As written, the IHR currently has no provisions overseeing global funding in public health emergencies. This substantial gap left the international community in a state of general inequity
during the COVID-19 pandemic. The burden of pandemic funding thus fell in the hands of State governments, NGOs, and private businesses, which were heavily dependent on the resources available in individual States.\textsuperscript{138} While organizations such as the World Bank attempted to mitigate this by committing $200 million in emergency funds for the pandemic in 2020, the required funds—estimated at $11 trillion alone globally by October 2020—could not be met by one organization alone.\textsuperscript{139} The inequity of resources available during pandemics is also evident when considering the resources that an advanced country may have compared to a developing one.

One necessary amendment for the IHR would create a type of reserve fund that is triggered once a public health emergency has been declared by the WHO. Considering the logistics of a reserve fund, the fund would need to be maintained and operated by State governments in conjunction with the WHO, rather than private businesses. However, just like present pandemic funding efforts are met by a conglomeration of governments, donors, banks, charities, and private businesses,\textsuperscript{140} an IHR amendment-generated reserve fund would receive contributions across multisectoral organizations. Providing reserve funding would be too burdensome for the government alone to bear, considering the $24 trillion cost of COVID-19 by early 2021.\textsuperscript{141} Thus, the private sector will also need to collaborate. Multisectoral collaboration may be possible through mechanisms similar to the aforementioned proposed amendments in a quid-pro-quo scenario. Businesses and the private sector may, as a result of contributions, have more say in the pandemic response, but this will also need to be matched by corresponding financial responsibility. However, businesses and the private sector

\textsuperscript{140} See Cornish supra note 138.
benefit significantly from the stable markets that are present when pandemics are avoided, which may be a sufficient incentive.

Infectious disease–related funds involving collaboration between the private and public sectors already exist and could function as a model for a global health reserve fund. For example, the Global Fund was started over twenty years ago and currently invests over $5 billion per year to address HIV/AIDS, tuberculosis, and malaria worldwide.\textsuperscript{142} The Global Fund has succeeded in fostering a coalition between State governments, the private sector, and NGOs, which all pledge funds specifically to address these aforementioned infectious diseases.\textsuperscript{143} The WHO could create a similar fund that it oversees and manages through a proposed IHR amendment, but which organizations in both the private and public sectors could contribute to on an established basis. This would form an emergency reserve that would not go into effect until a public health emergency was declared by the WHO.

Additionally, as mentioned above, a global emergency fund is crucial for an IHR amendment in part because of the inequities faced by developing countries during the COVID-19 pandemic.\textsuperscript{144} In thirty of the fifty-three PEPFAR countries, less than one-third of the population had access to and had received a single dose of the COVID-19 vaccine.\textsuperscript{145} If the populations within these States do not have access to the resources needed to return to pre-pandemic “normalcy,” such as vaccines, it can be presumed that the harsh economic impact of the pandemic will continue beyond the projections for more developed countries. Many developing States also face the daily impact of other infectious diseases endemic to their countries such as HIV/AIDS, Ebola, and malaria. An IHR amendment for global emergency funding would promote greater financial stability worldwide in the face of public health emergencies. Global health funding would also provide


\textsuperscript{145} Id.
resources possibly otherwise unavailable to developing countries affected by outbreaks.¹⁴⁶

As the developed world moves forward, many in the developing world are left behind, attempting to recover as victims of unstable systems. Because many States do not have the resources or systems in place to recover on their own, it is more critical than ever for there to be global solidarity in combatting COVID-19 and future global outbreaks. An IHR amendment for global emergency funding would have to be committed to financial stability worldwide, even if this requires prioritizing funds and distribution of resources primarily to developing countries.

The section that follows includes the author’s proposed language for a new IHR Article. The purpose of the proposed new Article is to mitigate resource scarcity, as the current IHR lacks provisions on this subject. Unfortunately, the COVID-19 pandemic shed light upon the disparities among States in accessing resources during the pandemic. The proposed Article proposes a global health reserve fund that States adversely impacted by a public health emergency may access through the WHO.

PROPOSED LANGUAGE OF A NEW AMENDMENT TO LIMIT RESOURCE SCARCITY FOR GLOBAL HEALTH

WHO shall maintain the ability under the legal authority provided by its Constitution and by these Regulations to establish a global health reserve fund, for the purpose of providing the infrastructure for reliable emergency funding for pandemic prevention and response.

WHO and States Parties shall oversee the management of the global health reserve fund. WHO and States Parties shall provide for multisectoral, intergovernmental, and private business contributions to the global health reserve fund on an established basis or as desired by the organization or body.

The global health reserve fund established by this Article shall be triggered for use solely upon the declaration of a public health emergency of international concern by the WHO.

States and bodies requesting funding from the global health reserve fund shall submit their proposed use of funds to the WHO. WHO shall oversee the distribution of reserve funds to States Parties, upon request, that meet criteria established by WHO and present a need for the resources provided by the emergency fund. Distribution shall be contingent upon individual and global needs and funds presently available.

States and bodies requesting funding from the global health reserve fund shall use allotted funds solely in relation to the public health emergency, whether preventatively or in response to the effects of an emergency.

In addition to pandemic prevention and response, priority for accessing the global health reserve fund shall be granted to States whose unstable systems are left adversely impacted by a public health emergency of international concern, with the goal of promoting equity and financial stability globally, particularly among developing States.

States and bodies receiving funding from the global health reserve fund shall report to WHO accurate and sufficiently detailed information on how allotted funds were used, within 1 year of receiving the funds. The IHR overseeing body established by Article 5 will be responsible for overseeing compliance and notifying the WHO according to the criteria established by this Article to promote State accountability and transparency.

Some of the proposed amendments recommended in this Part add minor details to language already present in the IHR, primarily to make specifications or qualifications. Meanwhile, new amendments with novel language may be required for phenomena such as resource scarcity, given its absence in the current IHR and the inequities among States during COVID-19. The proposed amendments demonstrate key areas in global health governance that were especially impacted by COVID-19 and may mitigate future pandemics if addressed. The proposed amendments and language therein are intended as recommendations upon which the WHA might build.
CONCLUSION

The COVID-19 pandemic has created a unique opportunity for the international community to recognize the devastating impacts of pandemics worldwide and become unified in addressing global health needs. Although the IHR was revised less than two decades ago in 2005, the world has evolved considerably and continues to face novel and reemerging health threats with increasing regularity. With expanding globalization, this phenomenon is only likely to continue in coming years. Amendments to the IHR—with considerations for the gaps identified by legal and global health scholars during the COVID-19 pandemic—should focus on improving surveillance and accountability, fostering multisectoral collaboration, and mitigating resource scarcity, particularly among developing countries. These key amendments will improve the IHR not only making the treaties more effective, but also ensuring it has the legal framework and mechanisms in place to prevent, or at least mitigate, future pandemics.