CLOSING THE COMPLIANCE GAP: FROM SOFT TO HARD MONITORING MECHANISMS UNDER THE INTERNATIONAL HEALTH REGULATIONS

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I. INTRODUCTION

The world has been caught unprepared for COVID-19. Many countries, including highly developed countries such as the U.S. and the U.K., scrambled to craft a response to the pandemic. The consequences of their unpreparedness have been and continue to be catastrophic, with millions dying and economies being crushed. This would not have been the case, or would not have been as extreme, had countries invested in the core public health capacities needed to prevent pandemics – in other words, had countries rigorously complied with their obligations under the International Health Regulations (IHR).

Under the IHR, Member States are under an obligation to develop and maintain core health capacities for effective responses to disease outbreaks. Core capacities are the capacities needed to prevent, detect, assess, notify, report, and respond to public health risks and emergencies. This includes having in place, for example, surveillance systems, reporting systems, and laboratory services.[1]

The COVID-19 pandemic is not the first time that governments' unpreparedness for disease outbreaks has been exposed. Following the 2014 Ebola virus outbreak in West Africa, it became clear that many of the failures leading to the spread of the fatal disease had been caused not by gaps in the IHR themselves but by a lack of IHR implementation.[2] One of the main recommendations coming out of the Ebola experience was,

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1 World Health Org., 2005 International Health Regulations arts. 5, 13, annex 1 (3d ed. 2016), https://www.who.int/publications/i/item/9789241580496 [hereinafter IHR].

2 *C.f.* Alison Agnew, *A Combative Disease: The Ebola Epidemic in International Law*, 39 B.C. INT'L & COMPAR. L. REV. 97 (2016); Andra Le Roux-Kemp, *International and Operational Responses to Disease Control: Beyond Ebola and Epistemological Confines*, 15 IND. HEALTH L. REV. 247 (2018); David P. Fidler, *To Declare Or Not to Declare: The Controversy over Declaring a Public Health Emergency of International Concern for the Ebola Outbreak in the Democratic Republic of the Congo*, 14 ASIAN J. WTO & INT'L HEALTH L. & POL'Y 287 (2019); Laurie Garrett, *Ebola's Lessons: How the WHO Mishandled the Crisis*, 94 FOREIGN AFFS. 80 (2015) (narrative exploration of Ebola crisis).

therefore, that full IHR implementation in all Member States was an urgent task that should be given the highest priority.[3]

To this end, there have been sustained calls by health and policy experts to improve compliance through the installation of monitoring mechanisms with compulsory external oversight that are more stringent than the weak mechanisms that the World Health Organization (WHO) currently has in place.[4] Current monitoring mechanisms rely on self-assessment by Member States (rather than external oversight) and are voluntary in nature.[5]

Yet despite these calls for better monitoring, the immense gap between the critical nature of core capacity obligations and the institutional mechanisms in place to monitor their implementation persists. This gap persists because although stringent monitoring mechanisms would potentially bring benefits to global health security, WHO Member States tend to be concerned about interference in their domestic affairs and have, as of yet, resisted more intrusive monitoring mechanisms.[6] As a result, despite the preventable tragedies caused by disease outbreaks, many WHO Member States continue to fall short on core capacity implementation. COVID-19, it is hoped, has created the momentum needed for states to agree on stronger accountability measures which would contribute to closing the gap between core capacity obligations and their implementation.

Against this background, the purpose of this short Essay is to examine the role of monitoring mechanisms in improving IHR core capacity implementation. While acknowledging that improving compliance is a complex task requiring a holistic and multifaceted response – such as significant financial and technical support and systemic capacity building in developing countries– the focus in this Essay is on the singular topic of monitoring mechanisms. The Essay seeks to draw lessons from other, more stringent monitoring mechanisms found in other international

3 Sixty-Ninth World Health Assembly, WHO Director-General, Implementation of the International Health Regulations (2005) Rep. of the Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response, A69/21, at 9 (May 13, 2016) [hereinafter Implementation of the IHR].

4 Gian Luca Burci, *The Outbreak of COVID-19 Coronavirus: are the International Health Regulations fit for purpose?*, EJIL:TALK! (Feb. 27, 2020) https://www.ejiltalk.org/the-outbreak-of-covid-19-coronavirus-are-the-international-health-regulations-fit-for-purpose/.

5 Allyn L. Taylor, Roojin Habibi, Gian Luca Burci, Stephanie Dagron, Mark Eccleston-Turner, Lawrence O. Gostin, Benjamin Mason Meier, Alexandra Phelan, Pedro A. Villareal, Alicia Ely Yamin, Danwood Chirwa, Lisa Forman, Gorik Ooms, Sharifah Sekalala, Steven J. Hoffman, *Solidarity in the wake of COVID-19: reimagining the International Health Regulations*, 396 LANCET 82 (2020).

6 *C.f.* Tsung-Ling Lee, *Making International Health Regulations Work: Lessons from the 2014 Ebola Outbreak*, 49 VAND. J. TRANSNAT'L L. 931 (2016) (describing unpopularity of enforcement mechanisms and arguing that pros outweigh the cons).

organizations. It should be noted that dispute settlement mechanisms for settling disputes between Member States are also accountability mechanisms that may incentivize compliance but are beyond the scope of this Essay.

Below, this Essay lays out the core capacity obligations (section 2) and the current WHO monitoring mechanisms (section 3). It then assesses the current mechanisms against a typology of monitoring mechanisms found in international governance (section 4) and suggests possible avenues for strengthening IHR monitoring mechanisms in the future (section 5). Section 6 concludes.

II. WHO MEMBER STATES' OBLIGATION TO DEVELOP AND MAINTAIN CORE HEALTH CAPACITIES

Under Articles 5 and 13, the IHR mandates that WHO Member States develop, strengthen, and maintain minimum core public health capacities. States must develop, strengthen, and maintain the capacity to detect, assess, notify, and report public health risks[7] and to respond promptly and effectively when such risks occur.[8] The minimum core capacity requirements are spelled out in the IHR Annex and include surveillance, rapid response, risk communication, human resources, laboratory services, logistical and communication capacities, the maintenance of a national public health emergency response plan, and more.[9] Member States had five years to meet these requirements (2007–2012), and the WHO then provided two extension periods.[10] These extension periods expired in 2016 – nine years after the entry into force of the IHR in 2007.

Despite the legally binding nature of the IHR 2005 and despite having many years to implement core capacities, compliance with these requirements remains low, especially in developing countries,[11] but – as showcased with COVID-19 – in developed countries as well. COVID-19 has now clearly revealed the tragic consequences of this deficit, but the unfortunate truth is that public health experts have long been warning about

7 IHR, *supra* note 1, art. 5(1).

8 *Id.* art. 13(1).

9 *Id.* annex 1.

10 *Id.* art. 5(2).

11 *See* Seventy-second World Health Assembly, WHO Director-General, Public health emergencies: preparedness and response: Annual report on the implementation of the International Health Regulations (2005), A72/8 (April 4, 2019); *see also* Lawrence O. Gostin & Ana Ayala, *Global Health Security in an Era of Explosive Pandemic Potential*, 9 J. NAT'L SEC. L. & POL'Y 53 (2018).

the high level of unpreparedness across the globe.[12] IHR implementation reviews undertaken in recent years have concluded that only thirty percent of states had reasonably implemented core capacities.[13] Recently, a group of leading global health scholars warned that "following more than a decade under the revised IHR, only a third of countries meet the core capacities of public health systems required therein, impacting countries' abilities to prevent, detect, and respond to disease outbreaks and putting the whole world at risk."[14]

III. CURRENT MONITORING MECHANISMS UNDER THE IHR

In general, monitoring mechanisms are mechanisms or procedures created under a respective treaty for an international organization or other international body to monitor the compliance of the treaty's parties with their obligations under the treaty.

Monitoring mechanisms are commonly perceived as carrot-and-stick mechanisms: On the one hand, through transparency, accountability and oversight, noncomplying states suffer reputational or other sanctions; on the

12 *See* Harvey V. Fineberg, *Report of the Review Committee on the Functioning of the International Health Regulations (2005) in Relations to the Pandemic (H1N1) 2009*, BULL. WORLD HEALTH ORG. (May 2011), http://www.who.int/ihr/WHA64_10_HVF_2011.pdf (finding that health capacities were nowhere near "a path to timely implementation worldwide"); *see also* NUCLEAR THREAT INITIATIVE & JOHNS HOPKINS CTR. FOR HEALTH SEC., GLOBAL HEALTH SECURITY INDEX: BUILDING COLLECTIVE ACTION AND ACCOUNTABILITY 9 (2019), https://www.ghsindex.org (finding that the average country preparedness score was 40.2/100); *accord* Lawrence Gostin & Rebecca Katz, *The International Health Regulations: The Governing Framework for Global Health Security*, 94 MILBANK Q. 264 (2016); Matiangai Sirleaf, *Capacity-Building, International Cooperation, and COVID-19*, 24 ASIL UNBOUND (2020), https://www.asil.org/insights/volume/24/issue/17/capacity-building-international-cooperation-and-covid-19. "Even states that the [GHSI] predicted to have comparatively robust health capacity [found] their health systems [– at least initially –] overwhelmed during the COVID-19 pandemic. For example, in the United States and the United Kingdom, healthcare workers lack adequate access to personal protective equipment and the health system in the United States especially has insufficient hospital beds to accommodate the growing number that need them." *Id.*; STEPHEN J. HOFFMAN, MAKING THE INTERNATIONAL HEALTH REGULATIONS MATTER: PROMOTING COMPLIANCE THROUGH EFFECTIVE DISPUTE RESOLUTION, *in* HANDBOOK OF GLOBAL HEALTH SECURITY 239 (2015) (stating that many countries did not meet the June 2012 requirements).

13 *See* WHO Director-General, Implementation of the International Health Regulations (2005): Rep. of the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation, A68/22 Add. 1 (Mar. 27, 2015) (reporting that only 64 of 196 States Parties had reported meeting their minimum core capacities); WHO Director-General, Implementation of the International Health Regulations (2005): Rep. of the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation, EB136/22 Add.1 (Jan. 16, 2015), http://www.who.int/ihr/B136_22Add1-en_IHR_RC_Second_extensions.pdf?ua=1. *See also* Lawrence O. Gostin, Mary C. DeBartolo & Eric A. Friedman, *The International Health Regulations 10 Years On: The Governing Framework for Global Health Security*, 386 LANCET 2222 (2015); Gostin & Ayala, *supra* note 11, at 66.

14 Taylor et al., *supra* note 5, at 82.

other hand, by identifying the obstacles that undermine compliance, such mechanisms provide expertise or technical support to Member States to address identified problems.

Not all monitoring mechanisms in international governance are made equal. As I elaborate below (Section 4), monitoring mechanisms range between stringent mechanisms with external inspection powers to weaker mechanisms, which rely on State self-assessment. As I describe next, the monitoring mechanisms under the IHR have undergone some strengthening since the adoption of the IHR in 2005.[15] The mechanisms have, nevertheless, largely retained their soft and weak nature by relying on self-assessment and voluntary review.

A. Self-Assessment Reporting

In accordance with Article 54 of the IHR 2005 on "Reporting and Review" and WHA Resolution A61.2, *Implementation of the International Health Regulations*, States Parties and the WHO are required to report to the World Health Assembly (WHA) on the progress they have made in implementing the IHR.[16] In the first few years after the 2005 IHR revision, the WHO Secretariat sent an annual questionnaire to Member States. Then, in 2010, the WHO adopted the *IHR Core Capacity Monitoring Framework*, which identified twenty indicators[17] to be included in the annual questionnaire.[18] States were required to self-assess and score their capacities

15 For an overview of the history of IHR monitoring mechanisms, see Seventy-first World Health Assembly, WHO Director-General, Public health preparedness and response: Implementation of the International Health Regulations (2005), DWHA A71/8 at appx. 2 (Apr. 11, 2018).

16 The Sixty-First World Health Assembly (WHA) in 2008 adopted a resolution in accordance with Article 54 to this end. The IHR Secretariat provides an annual report to the World Health Assembly detailing progress on IHR core capacity implementation. To this end, the Secretariat gathers standardized data from the Member States. *See* Sixty-first World Health Assembly, Resolution WHA61.2 (Implementation of the International Health Regulations (2005)), WHA61/2008/REC/1 (2008).

17 Two IHR core capacity monitoring framework: checklist and indicators for monitoring progress in the development of IHR core capacities in States Parties. *See* WORLD HEALTH ORG., IHR CORE CAPACITY MONITORING FRAMEWORK: CHECKLIST AND INDICATORS FOR MONITORING PROGRESS IN THE DEVELOPMENT OF IHR CORE CAPACITIES IN STATE PARTIES, at 6 (2013), http://apps.who.int/iris/bitstream/10665/84933/1/WHO_HSE_GCR_2013.2_eng.pdf?ua=1 (WHO/HSE/GCR/2013.2); IHR Monitoring, WORLD HEALTH ORG., https://www.who.int/ihr/procedures/monitoring/en/ (last visited Dec. 20, 2020); WORLD HEALTH ORG., MONITORING AND EVALUATION FRAMEWORK, at 6 (2018), https://apps.who.int/iris/bitstream/handle/10665/276651/WHO-WHE-CPI-2018.51-eng.pdf?sequence=1 (WHO/WHE/CPI/2018.51) [hereinafter MONITORING AND EVALUATION FRAMEWORK].

18 Eight core capacities, capacities of points of entry and four hazards (biological, chemical, radiological and nuclear). World Health Org., *IHR Core Capacity Monitoring Framework:*

in thirteen topics, including laboratories, human resources, surveillance, and risk communication.[19]

In recent years, most notably after the end of the implementation of grace periods granted to Member States and following the Ebola outbreak, the necessity of implementing core capacities has, as mentioned in the introduction, received more attention. A series of reviews carried out within the UN system[20] and by independent experts[21] have all highlighted the need to improve core capacity implementation and, in turn, monitoring. Notably, many have criticized the monitoring system based on self-evaluation as being inherently self-interested and unreliable, which undermines the integrity and utility of the self-assessment.[22]

The 2015 *IHR Review Committee on Second Extensions for Establishing National Public Health Capacities on IHR Implementation* thus recommended that the WHO move away from self-evaluation to a variety of other approaches for improving implementation, combining self-evaluation, peer review, and voluntary external evaluations involving domestic and independent experts.[23] This approach was also supported by the 2016 *Review Committee on the Role of International Health Regulations (2005) in the Ebola Outbreak and Response*, which determined that inadequate core capacities had contributed to the outbreak and that IHR implementation was a matter of priority. The 2016 committee recommended promoting the external assessment of core capacities. It found that "self-assessment has significant weaknesses" and that external evaluations will

Questionnaire for Monitoring Progress in the Implementation of IHR Core Capacities in States Parties (2015), https://apps.who.int/iris/bitstream/handle/10665/163737/WHO_HSE_GCR_2015.8_eng.pdf;jsessionid=4C23D71E4B7C83F2F4407CF1BD18BDFD?sequence=1 (WHO/HSE/GCR/2015.8).

19 *Id.* Initially, these scores were included in the WHO Secretariat's annual implementation report to the Health Assembly. Since 2015, they are available online at: Global Health Observatory, Global Health Observatory data: International Health Regulations (2005) monitoring framework, http://www.who.int/gho/ihr (last visited Dec. 30, 2020).

20 Rep. of the High-level Panel on the Global Response to Health Crises, Protecting humanity from future health crises, U.N. Doc. A/70/723 (2016); Global Health Crises Task Force, UNITED NATIONS, https://www.un.org/en/global-health-crises-task-force/ (last visited Dec. 30, 2020).

21 *See generally* GLOBAL PREPAREDNESS MONITORING BOARD, A WORLD AT RISK: ANNUAL REPORT ON GLOBAL PREPAREDNESS FOR HEALTH EMERGENCIES (2019), https://apps.who.int/gpmb/assets/annual_report/GPMB_annualreport_2019.pdf; NATIONAL ACADEMY OF MEDICINE, THE NEGLECTED DIMENSION OF GLOBAL SECURITY: A FRAMEWORK TO COUNTER INFECTIOUS DISEASE CRISES (NATIONAL ACADEMIES PRESS 2016).

22 Gostin & Katz, *supra* note 12, at 276, 278; Gostin & Ayala, *supra* note 11, at 66.

23 WHO Director-General, Implementation of the International Health Regulations (2005): Rep. of the Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response, A69/21 (May 13, 2016).

reveal "shortfalls in core capacities not identified or recognized [in] … self-assessment."[24]

The WHO, consequently, adopted the *IHR Monitoring and Evaluation Framework*, which introduced some new monitoring components.[25] First, it continues the mandatory annual self-reporting to the World Health Assembly (above). Reporting is now based on the 2018 State Parties Self-Assessment Annual Reporting (SPAR) tool, a quantitative questionnaire through which Member States self-assess and score their progress towards implementing core capacities.[26] Second, it adds three voluntary components: after-action review (that is, reviews of significant public health events to assess the functionality of capacities in real events), simulation exercises, and voluntary external evaluation. Such voluntary external evaluation is being carried out by the Joint External Evaluation (JEE).[27]

B. Joint External Evaluation

Composed of independent international subject matter experts tasked with evaluating the national implementation of IHR 2005 core capacities,[28] the JEE is a move away from the monitoring mechanisms that exclusively employed self-assessments and reflects a recognition that accountability is better achieved through external oversight. At the same time, being voluntary, and as a joint initiative of external and local experts, the JEE is far from the more stringent, purely external inspection bodies found in other treaties (see below), leaving room for improvement if and when the WHO seeks to reform and strengthen its monitoring mechanisms after COVID-19. I address some of the JEE's shortcomings in Section 5 below.

C. How can IHR Monitoring be Reformed?

COVID-19 has made it evident that the implementation of core health capacities remains of highest priority. However, the WHO's monitoring mechanisms are soft.[29] They rely on self-reporting and on information

24 *Id.* at 61.

25 MONITORING AND EVALUATION FRAMEWORK, *supra* note 17.

26 *Id.* at 12. SPAR consist of twenty-four indicators for thirteen IHR capacities. *Id.*

27 WHO, *Technical Framework in Support to IHR (2015) Monitoring and Evaluation: Joint External Evaluation Tool (Second Edition) International Health Regulations (2005)*, 7-8 (2018), https://apps.who.int/iris/bitstream/handle/10665/259961/9789241550222-eng.pdf.

28 *Id*. at 9.

29 *See, e.g.*, Pedro Villarreal, *COVID-19 Symposium: "Can They Really Do That?" States' Obligations Under the International Health Regulations in Light of COVID-19 (Part II)*, OPINIOJURIS

provided by Member States, but there are no mandatory external inspections and no sanctions for noncompliance. Against this background, there is a growing consensus that the existing monitoring mechanisms should be made more rigorous and that new, more stringent mechanisms should be added. For example, leading global health thinkers, in a recent *Lancet* essay, urge that "to ensure accountability for national capacity building, states should integrate an effective reporting mechanism to monitor implementation of IHR obligations … The absence of any provision for such monitoring in the IHR hampers its effectiveness and relevance."[30] The Council of EU Draft Conclusion on the Role of the EU in Strengthening the WHO stresses the necessity of "increased transparency on national compliance with the IHR, together with a more effective and consistently applied reporting system by States Parties to the WHO Secretariat, as well as strengthening joint external evaluations and their follow up."[31]

In thinking about how to reform monitoring under the IHR, what kind of monitoring system can or should the WHO adopt? In the sections below, this Essay examines other monitoring mechanisms in international organizations from which design ideas and lessons could be drawn.

IV. TYPOLOGY OF MONITORING MECHANISMS

Looking beyond the WHO, many international agreements and international organizations in diverse policy fields – from human rights to environment, finance, drugs and arms control – have monitoring mechanisms.[32] These monitoring mechanisms range from softer to more rigorous mechanisms.

Rigor is understood as the extent to which the monitoring body has the authority to oversee, intervene in, or inspect domestic State behavior.

(2020), http://opiniojuris.org/2020/03/31/covid-19-symposium-can-they-really-do-that-states-obligations-under-the-international-health-regulations-in-light-of-covid-19-part-ii/ (noting IHR enforcement strategies); Svêt Lustig Vijay, *WHO's Legal Mandate Is Weak In Responding to COVID-19 Emergency: But Changes Are Up to Member States*, HEALTH POL'Y WATCH (2020), https://healthpolicy-watch.news/whos-legal-mandate-is-weak-in-responding-to-covid-19-emergency-but-changes-are-up-to-member-states/ (critiquing weakness of current enforcement mechanisms).

30 Taylor et al., *supra* note 5.

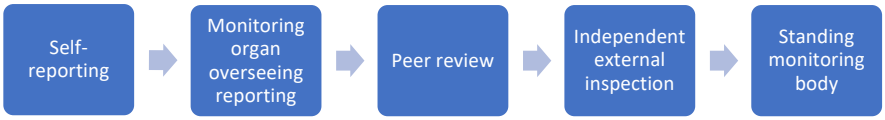
31 Council of the European Union, *Draft Conclusions of the Council and the Representatives of the Governments of the Member States on the role of the EU in strengthening the World Health Organization*, Oct. 27, 2020, https://data.consilium.europa.eu/doc/document/ST-12276-2020-INIT/en/pdf.

32 *See, e.g.*, Craig Murray, *Implementing the New International Health Regulations: The Role of the WTO's Sanitary and Phytosanitary Agreement*, 40 GEO. J. INT'L L. 625 (2009) (comparing IHR enforcement mechanisms with those under the WTO's Sanitary and Phytosanitary Agreement).

In an attempt to introduce some clarity into our thinking about the possible monitoring improvements the WHO could adopt, drawing from existing practices, I lay out a typology of the main kinds of monitoring mechanisms in international governance and flag other factors that influence their level of authority and rigor. Hopefully, this will provide some clarity – within the scope of a short essay – to our thinking about the options available to the WHO.

This Essay lists five main institutional monitoring mechanisms, ranging from more restrained to more intrusive upon domestic affairs or sovereignty. Rather than being alternative mechanisms, it is common for stringent treaties to apply all or some of these mechanisms.

(1) Self-reporting,
(2) A monitoring organ (within international organizations) overseeing reporting,
(3) Peer review,
(4) Independent external inspection,
(5) Standing monitoring body.



The level of intrusiveness into domestic affairs depends not only on the institutional form (internal or external to the organization), but also on other factors. In this Essay, I flag two factors: first, the obligatory nature of the measures (voluntary measures are less intrusive than mandatory measures), and second, the source of information (when the source of information is from the State alone, it is less intrusive than when other sources may be taken into account).

STRENGTHENING MONITORING MECHANISMS UNDER THE IHR 2005

A. Self-Reporting

Self-reporting as a monitoring tool is common practice in international agreements. Most treaties, across diverse fields, require states to make periodic reports of their compliance. The popularity of reporting emanates from the resistance of Member States against measures that intrude into their domestic affairs while arguably raising governmental awareness of the

state's international obligations and helping identify domestic hurdles to compliance. Thus, many international treaties require Member States to issue periodic reports regarding the implementation of their treaty obligations, typically addressing the measures that they have adopted, the progress made, the challenges incurred, and plans of action to address implementation gaps.

Despite their softness, self-reporting requirements may still contribute to compliance by requiring states to self-reflect on their implementation status, thereby increasing their awareness of their legal obligations.[33] They also help in identifying gaps in implementation and where more support or efforts are needed.

Annual self-reporting is, as noted, mandatory under the IHR. Such self-reporting is, however, widely viewed as unreliable in obtaining an accurate picture of the state of pandemic preparedness because it relies on information provided by the state.[34] To achieve more accurate and encompassing information, Gostin and others have, for example, proposed that reporting under a revised IHR would allow for "unofficial data sources, including civil society and academic experts, and the independent collection of public health data where necessary by WHO staff."[35]

B. Monitoring Body Overseeing Reporting

A further problem with the reporting system under the IHR 2005 is that although reports are submitted to the Secretariat, the WHO lacks a centralized body that rigorously and actively manages and oversees implementation on a day-to-day basis and provides feedback on the reports. For example, in 2019, only eighty-eight percent of members submitted reports,[36] but there were no negative consequences for those countries that did not submit reports or that submitted reports late. The absence of any accountability for failing to fulfil reporting obligations has arguably

33 Periodic self-reports under human rights treaties have been quite effective. *See* David Kretzmer, *Human Rights, State Reports*, MAX PLANCK ENCYCLOPEDIA OF INTERNATIONAL LAW (2008).

34 *See, e.g.*, Taylor et al., *supra* note 5; Lawrence O. Gostin, Roojin Habibi, & Benjamin Mason Meier, *Has Global Health Law Risen to Meet the COVID-19 Challenge? Revisiting the International Health Regulations to Prepare for Future Threats*, 48 J.L. MED. & ETHICS 376 (2020).

35 Gostin, Habibi, & Meier, *supra* note 33, at 980.

36 MONITORING AND EVALUATION FRAMEWORK, *supra* note 17, at 14–15.

contributed to the fact that states have not given implementation a high priority.[37]

Moreover, implementation is a progressive process, and an oversight body cannot only provide a stick but also act as a carrot by engaging in ongoing dialogue with Member States. Such a dialogue would support the implementation process by identifying missing information, helping states identify domestic obstacles that need to be addressed, and identifying matters that require international financial or technical support. Further, such a mechanism could also gather information from other sources, such as other IOs, civil society, or academia, or could gather information independently.

We can find examples of such centralized oversight of reporting in other treaties. For example, under CITES, a treaty that deals with endangered species, a standing committee oversees that reports have been submitted on time and issues a report that makes recommendations regarding ways to improve implementation.[38] Under the Single Convention on Narcotic Drugs, after states submit their reports,[39] the International Narcotics Control Board (INCB) may require additional studies and information.[40] The INCB then publishes its findings regarding the implementation status and recommendations for improvements.[41] The Board also has the right to publish a report on any matter concerning compliance with the treaty – without the consent of the state.[42] In contrast, such powers are currently not expressly granted to the WHO Secretariat under the IHR.

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37 *See* Giulio Bartolini, *Are You Ready for a Pandemic? The International Health Regulations Put to the Test of Their 'Core Capacity Requirements'*, EJIL:TALK! (June 1, 2020), https://www.ejiltalk.org/are-you-ready-for-a-pandemic-the-international-health-regulations-put-to-the-test-of-their-core-capacity-requirements/; *see also* Jaouad Mahjour, Stella Chungong, Michael Dumiak, Olaa Mohamed-Ahmed, Margot Nauleau, Abbas Omaar & Beatrice Progida, *Thematic Paper on the Status of Country Preparedness Capacities,* WORLD HEALTH ORG. (Sept. 15, 2019), https://apps.who.int/gpmb/assets/thematic_papers/tr-2.pdf.

38 *Implementation Report*, CITES, https://cites.org/eng/resources/reports/Implementation_report#:~:text=Implementation%20reports%20provide%20an%20opportunity,incentives%20and%20wildlife%20trade%20policies (last visited Dec. 30, 2020).

39 Single Convention on Narcotic Drugs art. 18, Dec. 13, 1964, 520 U.N.T.S. 7515.

40 *Id.* art. 14. Article 14 provides the board with a list of legal powers. Among others, Article 14(1)(a) and (c) determine that if the board has reason to believe that the "aims of the Convention are being seriously endangered by reason of the failure if any Party, country or territory to carry out the provisions" of the convention, it may "propose to the Government concerned that a study of the matter be carried out in its territory by such means as the Government deems appropriate."

41 *Id.* art. 15.

42 *Id.* art. 14(3) determines that the Board may publish information on the actions of States even without their consent, saying that it "has the right to publish a report on any matter dealt with under the provisions of this article, and communicate it to the Council., which shall forward it to all Parties."

The World Organization for Animal Health (OIE) Observatory is a standing mechanism that monitors the implementation of OIE standards by Member States.[43] The Observatory identifies compliance gaps and tailors capacity-building activities to address identified needs.[44] Finally, the World Anti-Doping Agency (WADA), which oversees the 2015 World Anti-Doping Code, has an internal compliance taskforce that reviews self-reports and recommends corrective action when it identifies implementation gaps. WADA also has a continuous monitoring program that seeks to continuously oversee the corrective actions undertaken following these reviews.[45]

C. Peer Review

An additional kind of monitoring mechanism that the WHO could consider integrating into its practices involves peer review by Member States.[46] Some organizations not only require reporting but also subject members to peer reviews.

Peer review introduces more transparency towards the other members and creates a reputational incentive to comply with the obligations. Such peer review by Member States thus increases the likelihood that states who care about their reputation as law-abiding members of the international community will comply with their obligations. Through the peer review process, states also exchange best practices and experiences that support them in tackling their implementation challenges. Examples of a peer review process include the OECD peer review process in relation to the OECD Anti-Bribery Convention, which is carried out within the Working Group on Bribery. The International Energy Agency (IEA) also conducts periodic peer reviews called "Emergency Response Reviews," which assess the readiness of each Member State to respond to an emergency. The review team includes the IEA Secretariat and all the other IEA Member States.[47]

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43 *OIE Observatory: For a better understanding of the implementation of OIE International Standards*, WORLD ORG. FOR ANIMAL HEALTH, https://www.oie.int/standard-setting/overview/oie-observatory/ (last visited Jan. 4, 2021).

44 *Id.*

45 *Compliance Monitoring Program*, WORLD ANTI-DOPING AGENCY, https://www.wada-ama.org/en/compliance-monitoring-program (last visited Jan. 4, 2021).

46 For example, it could be integrated into and included in the World Health Assembly meetings.

47 INT'L ENERGY AGENCY, https://www.iea.org/ (last visited Jan. 4, 2021).

D. External Independent Review

In a recent *Lancet* article on COVID-19, public health experts stressed the need for external, independent oversight, saying, "To ensure accountability for national capacity building, states should integrate an effective reporting mechanism to monitor implementation of IHR obligations … and, crucially, to incorporate some type of independent review."[48]

These calls are not new and had, in fact, previously gained traction following the Ebola crisis, with many reviews and public health experts recommending that monitoring should be bolstered through rigorous inspection carried out by external, independent inspectors.[49] The *Review Committee on the Role of the IHR in the Ebola Outbreak* found that "independent external evaluation … will add considerable constructive value to the [assessment] process" and that "external evaluation appears to be a necessary complement to self-assessment."[50] The committee recommended that "[s]elf-assessment, complemented by external assessment of IHR core capacities, becomes recognized best-practice to monitor and strengthen the implementation of the IHR."[51] Further, the *Harvard-London School of Hygiene & Tropical Medicine* report recommended that all governments agree to the regular, independent, external assessment of their IHR core capacities.[52] Similarly, the *National Academy of Medicines Commission on a Global Health Risk Framework for the Future* recommended that there be independent, external assessments.[53] The UN Secretary General High Level Panel on the Global Response to Health Crises recommended that the WHO carry out independent assessments of compliance every four years in addition to self-assessment.[54]

The JEE, described above, captures the idea of external evaluation. However, compared with rigorous external evaluation, the JEE has

48 Taylor et al., *supra* note 5; *cf.* Alison Duxbury, *The World Health Organization as Pandemic Police?*, PURSUIT (May 29, 2020), https://pursuit.unimelb.edu.au/articles/the-world-health-organization-as-pandemic-police.

49 *See, e.g.*, Taylor et al., *supra* note 5; Gostin & Katz, *supra* note 12, at 291.

50 Implementation of the IHR, *supra* note 3, at 10–11, 61.

51 *Id.* at 61.

52 Suerie Moon, Devi Sridhar, Muhammad A. Pate, Ashish K. Jha, Chelsea Clinton, Sophie Delaunay et al., *Will Ebola change the game? Ten essential reforms before the next pandemic. The report of the Harvard-LSHTM Independent Panel on the Global Response to Ebola*, 386 LANCET 2204 (2015).

53 The academy also recommended that the World Bank and others declare that funding is conditional on independent assessments.

54 The panel also recommended that independent assessment be tied to guarantees of financial and technical assistance.

shortcomings. The JEE is voluntary, and as of this writing, only 112 Member States have chosen to undergo an evaluation. Further, the evaluation is infrequent, rather than periodical, such as every five years. The evaluation also relies on self-reported data, which the inspected State compiles for the examiners. To be more effective, inspectors should be able to rely on other sources of information (*e.g.*, civil society or other states) without requiring State approval. The gathering of independent sources of information would allow for a more accurate picture of a State's compliance status.[55] The JEE also depends on cooperation with the State concerned, as the State's approval is required in selecting experts for the JEE to work with. The States must also agree to the publication of the WHO findings (so far, only ninety-seven reports have been made public).[56]

Despite these shortcomings, WHO Member States concerned about sovereignty and domestic affairs have been reluctant to agree to mandatory independent inspections, let alone to independent information seeking.[57] As Burci and Quirin point out, even the *2018–2023 Global Strategic Plan to Improve Public Health Preparedness and Response* continues to prefer self-assessment over external review.[58] Gostin, Katz, and Ayala have recommended incentivizing States to undertake independent evaluations by granting a carrot – that is, by tying such evaluations to financial and technical assistance. They suggest conditioning financial assistance received by the IMF or World Bank on meeting core capacities and participating in independent inspections.[59]

Although such external inspections are relatively uncommon in international agreements, in areas that governments perceive to be critical for security, such as drugs, nuclear weapons, and arms control, states have agreed on more stringent external inspection mechanisms from which the WHO could draw inspiration. For example, under the United Nations Single Convention on Narcotic Drugs (UNSCND), the International Narcotics Control Board (INCB)[60] carries out periodic missions to inspect compliance

55 *See, e.g.*, Taylor et al., *supra* note 5.

56 *Joint External Evaluation Mission Reports*, WORLD HEALTH ORG., https://www.who.int/ihr/procedures/mission-reports/en/ (last visited Dec. 30, 2020).

57 Gostin & Ayala, *supra* note 11, at 66.

58 Gian Luca Burci & Jakob Quirin, *Implementation of the International Health Regulations (2005): Recent Developments at the World Health Organization*, 22 ASIL INSIGHTS (Sept. 25, 2018), https://www.asil.org/insights/volume/22/issue/13/implementation-international-health-regulations-2005-recent-developments.

59 Gostin & Katz, *supra* note 12, at 291–92; Gostin & Ayala *supra* note 56, at 67.

60 The INCB is composed of thirteen expert members with medical or pharmacological backgrounds. Allyn Taylor, *Addressing the global tragedy of needless pain: rethinking the United Nations Single Convention on Narcotic Drugs*, 35 J.L. MED. & ETHICS 556 (2007).

in Member States. The mission publishes its findings and recommendations in a report. Moreover, the board also has the authority to demand an inspection if it suspects noncompliance. The board may also alert other parties to the state's noncompliance. It also has the power to impose soft sanctions, as it may "recommend to Parties that they stop the import of drugs, the export of drugs, or both, from or to the country."[61]

Another example is the inspections carried out by the International Atomic Energy Agency, which is entrusted with ensuring compliance with the Nuclear Non-Proliferation Treaty (NPT) and other treaties preventing the spread of nuclear weapons. The IAEA safeguard measures, as set out under the Comprehensive Safeguards Agreement, include diverse monitoring tools, including on-site inspections, visits, and ongoing monitoring and evaluation. The IAEA verifies the reports made by Member States and has independent inspection capacities. The IAEA undertakes four kinds of inspections: ad hoc, routine, special, and safeguard visits.[62] The IAEA relies on Member State information but may also independently collect information and data or accept information from other sources.[63]

A further example is WADA, which carries out audits undertaken by external experts. WADA also uses diverse sources of information to conduct its monitoring activity, including investigations. In fact, in 2020, WADA created the Compliance Investigation Section dedicated to investigating noncompliance by Signatories.[64]

E. Standing Monitoring or Review Bodies

An independent, standing monitoring body for overseeing compliance would introduce an additional layer of accountability. This was suggested after the Ebola crisis and is receiving renewed attention after COVID-19. After the Ebola crisis, the *Harvard-London School of Hygiene & Tropical Medicine Independent Panel on the Global Response to Ebola Commission* recommended the establishment of an *Accountability Commission for Disease Outbreak Prevention and Response*.[65] This would be a central,

61 Single Convention on Narcotic Drugs, *supra* note 38, art. 14(2).

62 *IAEA Safeguards Overview*, International Atomic Energy Agency, https://www.iaea.org/publications/factsheets/iaea-safeguards-overview (last visited Dec. 30, 2020).

63 *Id.*

64 *Compliance Monitoring Program*, *supra* note 44.

65 The panel said that "this proposal builds on analogous efforts to strengthen system-wide accountability for other global efforts, such as the UN Commission on Information and Accountability for Women's and Children's Health and the Independent Monitoring Board of the Global Polio

permanent, and independent monitoring body set up by the United Nations Secretary General and comprised of members of civil society, academia, and independent experts. It would report to the World Health Assembly and a proposed Security Council Global Health Committee[66] and would publish its findings regularly. Among its responsibilities[67] would be monitoring efforts to build and sustain national core capacities.[68] The proposed Security Council Committee would not be tasked with overseeing IHR implementation but would rather be "an arena for high level attention to health threats and a forum for problems not adequately resolved by the WHO governing bodies."[69] Such a committee would publish an annual report on progress in building a strong and effective global health security system, taking into account analyses from the Accountability Commission and WHO.[70]

Moreover, some commentators have called for the adoption of review mechanisms that would induce states to take corrective action and comply with their obligations. The idea is that the threat of sanctions or the publication of a state's failure to comply would trigger reputational concerns, in turn incentivizing action. For example, in early discussions regarding the desired WHO reforms in response to COVID-19, the U.S. Department of Health and Human Services set out a roadmap for areas in need of IHR reform, proposing a "universal review mechanism for IHR compliance" that would "encourage countries to view preparedness as fundamental to national and health security as well as incentivize fulfillment of IHR obligations."[71] Similarly, France and Germany have bemoaned that while other international agreements have accountability mechanisms in place that incentivize implementation and other international frameworks grant the relevant international organization the right to intervene, the IHR 2005 lack such mechanisms, and implementation largely depends on Member States' willingness to cooperate. France and Germany have

Eradication Initiative, credited with helping to reinvigorate the performance of this effort. The Accountability Commission would be a more permanent institution, however, with a broader mandate than these two previous initiatives." Moon et al., *supra* note 51, at 2212–13.

66 *Id.* at 2215–16 (providing details in Recommendation 8).

67 For further details concerning the proposed accountability commission, see *id.*, which provides details in Recommendations 5 and 8.

68 *Id.* at 2212–13 (providing details in Recommendation 5).

69 *Id.* at 2216.

70 *Id.* at 2215–16.

71 *Reviewing COVID-19 Response and Strengthening the WHO's Global Emergency Preparedness and Response WHO ROADMAP*, HHS.GOV (Sept. 9, 2020) https://www.hhs.gov/about/agencies/oga/about-oga/what-we-do/international-relations-division/multilateral-relations/who-roadmap-2020.html.

therefore called for the establishment of a "review mechanism for IHR compliance."[72]

Here, too, the WHO could draw inspiration from similar examples in other international frameworks. Examples include the 1961 United Nations Single Convention on Narcotic Drugs, which established the International Narcotics Control Board (INCB), an independent, quasi-judicial body whose role is to monitor and support governments' compliance with the treaty.[73] Among its different roles (as mentioned above), the Board oversees the noncompliance procedure.[74] Under this procedure, if the Board has reason to believe that a member is failing to comply with the treaty, it has the authority to "propose consultations, request explanations, and recommend that a government modify its policies." If the Board finds that governments have failed to comply with its recommendations for remedial action, it can publicize this information widely, including among the other States Parties, the UN Economic and Social Council, and more. Similarly, the WADA Compliance Review Committee is an independent standing committee that provides guidance and recommendations to WADA's governing bodies on matters pertaining to compliance.[75]

VI. CONCLUSION

As has become quite clear, the current mechanisms for monitoring Member States' compliance with IHR core capacities are of a soft nature. There are two main mechanisms: mandatory annual self-reporting and voluntary external inspection. Both mechanisms have shortcomings that result in a monitoring system that provides little stick and little carrot: it puts hardly any external pressure for compliance on Member States, let alone provides ongoing and rigorous support in overcoming compliance obstacles.

Given the immense devastation caused to society and the economy by disease outbreaks such as COVID-19, the gap between the critical importance of the core capacity obligations and the soft mechanisms used

72 *Non-Paper on Strengthening WHO's leading and coordinating role in global health with a specific view on WHO's work in health emergencies and improving IHR Implementation*, GENEVA GLOB. HEALTH HUB (Aug. 2020), http://g2h2.org/wp-content/uploads/2020/08/Non-paper-1.pdf.

73 The INCB is composed of thirteen expert members with medical or pharmacological backgrounds, and they are elected by the UN Economic and Social Council. Single Convention on Narcotic Drugs, *supra* note 38, art. 9.

74 *Id.* art. 14.

75 *Compliance Review Committee*, WORLD ANTI-DOPING AGENCY, https://www.wada-ama.org/en/who-we-are/governance/compliance-review-committee (last visited Jan. 4, 2021).

to oversee and support compliance can no longer be justified. The purpose of this short essay has been to draw from the experiences of other international agreements and to describe some of the ways through which the existing IHR mechanisms could be strengthened and additional monitoring mechanisms added. The collective mandatory application of stronger reporting, including a body overseeing and supporting reporting, external inspections and a standing review body, would provide important mechanisms for putting pressure on governments to fulfil their obligations while also providing ongoing support in overcoming their compliance obstacles.

The legal method for effectuating such reforms would ideally be by way of a treaty. That is, through the amendment of the IHR 2005 or the conclusion of another global health security treaty. Although such multilateral legal amendment processes promise to be extremely complicated from a political standpoint and a legally nonbinding resolution would be easier and faster to obtain (as was the case, for example, with the *IHR Monitoring and Evaluation Framework*), a binding legal treaty would be the only way to grant the WHO (or any other international body, for that matter) more legal authority to intervene in domestic affairs. Given the need for lasting and meaningful change, a soft law approach will hardly be effective.

Be that as it may, it is important to stress that any and all IHR reform proposals will remain obsolete without the necessary political support and financial commitment – factors that have, as of yet, been lacking in the WHO. In fact, similar reform calls were made after the Ebola crisis, yet states remained reluctant to permit stronger monitoring. The social and economic hardship caused by COVID-19 will hopefully trigger more political willingness to agree to more far-reaching monitoring reforms, yet it is hard to predict what can be achieved in the current geopolitical circumstances.

Finally, although this Essay has focused on monitoring mechanisms, it is important to keep in mind that while stronger monitoring mechanisms may increase the pressure on states and support them with their implementation challenges, in developing and vulnerable countries, such mechanisms need to go hand in hand with capacity building. Any reform also needs to factor in a grace period and support for implementation in low-income countries.