Enhancing Global Legal Preparedness to Reflect a Post-COVID World

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Abstract

The COVID-19 pandemic has exposed the inability of the global political community to effectively respond to a public health emergency, especially one that crosses national borders. As a result, global health experts, government officials, and international organizations have mobilized to assess what went wrong in the international response to COVID-19. A primary gap that has been identified is the inadequacy and ineffectiveness of global legal frameworks, underscoring the poor legal preparedness of international intergovernmental organizations and nations when faced with public health crises. This essay aims to describe and review the current primary global coordination frameworks for public health emergency preparedness and provide feasible recommendations for enhancing legal preparedness. It defines and explains the concept of legal preparedness, and other concepts important to legal preparedness, including public health law, global health law, and global health security. This essay will explain the International Health Regulations (IHR), Global Health Security Agenda (GHSA), and Joint External Evaluation (JEE), highlighting how these legal structures, and the World Health Organization (WHO), frame global legal preparedness. Following a discussion of these legal instruments in the context of the COVID-19 pandemic (the Pandemic) and key legal barriers that emerged during the Pandemic, I will apply what was learned during this international public health crisis to present three recommendations to enhance global legal preparedness: (1) strengthen the legal and political legitimacy of the WHO;
(2) encourage countries to partner with the GHSA, and; (3) expand the WHO’s role in aiding in legal preparedness development in low-income countries.
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Preface

As I reflect on the process of writing my essay, I am reminded of all the people who made this achievement possible. First, I would like to thank my essay readers, Professor Hershey and Dr. Salter, for their guidance, support, and patience throughout this process. A special thank you to Professor Hershey for her mentorship and feedback throughout the long undertaking that was my essay, in my classes, and in my role as her TA. To Dr. Bryce and the HPM faculty and staff, thank you for fostering such an encouraging and motivating environment for me to learn and grow as a student. A thank you Dr. Denny Pencheva at UCL, who has had such a profound impact on my confidence as a student, and to all the teachers I have had since the start of my education who have, in one way or another, shaped me into the student I am today.

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x
1.0 Introduction

In the wake of the COVID-19 pandemic, it has become starkly evident how vastly unprepared the world is to sufficiently respond to global health-related threats. Outdated public health legal frameworks, weak global governance, and the lack of coordinated international cooperation have underscored the inability of the world to effectively navigate and mitigate an unprecedented infectious disease outbreak. As such, the COVID-19 pandemic has served as a catalyst for the reevaluation of existing global legal preparedness frameworks in order to be prepared for future global public health threats.

There has been a growing recognition of the importance of law in public health emergency detection, prevention, and response. The 2030 Sustainable Development Goals (SDGs) exemplify this shift through the interplay among SDG 16.3, established as the “[promotion of] the rule of law at national and international levels to ensure equal access to justice for all,” SDG 16.8, which is “to broaden and strengthen the participation of developing countries in the institutions of global governance,” and SDG 3.d, of which aims to “strengthen the capacity of all countries… for early warning, risk reduction, and management of national and global health risks.” Based on this shift in the global landscape, this essay aims to review and describe the current global legal frameworks that guide the legal responses to pandemics and other public health emergencies. Additionally, this essay will look at global legal preparedness in the context of the COVID-19 pandemic, applying lessons learned by experts in the global community to provide feasible recommendations to improve global legal preparedness.

This essay will begin with an overview of four key concepts relevant to legal preparedness and emergency response – public health law, global health and global health law, global health
security, and legal preparedness. Thereafter, I will discuss the history, jurisdiction, and governance of the International Health Regulations, the Global Health Security Agenda, and the Joint External Evaluation, all of which currently frame the legal aspect of public health emergency preparedness. Next, I will briefly discuss these legal instruments in the context of the COVID-19 pandemic, highlighting the challenges that emerged at the global level in the detection, prevention, and response to the Pandemic when applying these frameworks, as identified by global experts. Finally, applying lessons learned from the COVID-19 pandemic, I will provide an overview of three recommendations that aim to fundamentally strengthen global legal preparedness and response during global public health emergencies.
2.0 Public Health Significance

The COVID-19 pandemic (the “Pandemic”) was unprecedented in its devastation to communities around the world, with significant political, economic, social implications. Within mere months of the official detection of the first case of COVID, in December 2019, conversations began about what went wrong in the public health response – by April 2020, there were already one million confirmed cases, widespread economic devastation, and rampant misinformation. Through weak governance and poor international collaboration, nation-states failed to uphold global health law and the world was unable to effectively mitigate the Pandemic.

In post-COVID conversations, we see increased discussions about the need for law to be at the center of global health. There are many arguments for the better integration of law and legal preparedness into the global preparedness framework, including the following three distinct reasons: (1) the capacity of law as a health intervention, (2) the current gaps in the legal preparedness system, and (3) preparation for the future.

First, the Pandemic showed the world that law is indispensable in modern public health practice. The implementation of specific public health-related laws is an effective intervention for achieving public health goals and improving health; it is also important in structuring health systems and providing the authority to the government to protect public health. However, it became clear during the Pandemic that governments have yet to fully realize the ability of law to affect health; thus, they have not harnessed the full power of existing, as well as additional, health laws. It is imperative that law becomes integral to public health systems and responses, especially during public health emergencies. Legal frameworks at the international level have the potential to empower governments to strengthen their public health and preparedness systems to better
detect and respond to infectious disease outbreaks and public health emergencies.\textsuperscript{10} Thus, having sustainable laws and policies that maintain preparedness for public health emergencies is essential for ensuring the protection of individuals all around the world.

Second, the Pandemic exposed the current gaps and weaknesses in the existing legal preparedness frameworks. For example, delays in disease detection and notification affected the WHO’s ability to understand the scope of COVID-19 and slowed down information releases from the WHO.\textsuperscript{5} As international and national legal frameworks are critical in assisting governments in improving their health infrastructures and operations, the lack of compliance with the IHR and poor governance from the WHO reduced global solidarity and coordination, leaving states to revert to isolationist policies and geopolitical competition.\textsuperscript{5, 11} These issues led to an unstable public health response and exacerbated the health, economic, social, and community impacts caused by COVID-19.

Third, the world needs to be prepared for future threats. COVID-19 is not the last pandemic we will see, nor is it the only current global public health threat. As the world continues to become more globalized and interconnected, the potential for rapid spread of global health threats – whether they be infectious disease outbreaks, terrorist incidents, or natural disasters – is a common reality. As a global community, we need to be prepared for whatever may come next as to prevent a repeat of what we saw during COVID, therefore, it is imperative that law becomes structurally ingrained in global public health emergency preparedness.
3.0 Relevant Concepts

3.1 Public Health Law

Public health law is defined as “the study of the legal powers and duties of the state to assure the conditions for people to be health (e.g., to identify, prevent, and ameliorate risks to health in a population) and the limitation on the power of the state to constrain the autonomy, privacy, liberty or other legally-protected interests of individuals for the protection and promotion of community health.”12, 13 Before this more modern interpretation of public health law became the standard, public health law concentrated solely on the application of legal expertise and counsel when defining the authority of health agencies and analyzing issues that arise on the account of this authority.13, 14 Public health law has since evolved to have the main aim of supporting the design, implementation, monitoring, evaluation, and application of laws that improve public health and health system performance.13 This renewed purpose of public health law implies that human rights and the assurance of the values of equity, justice, self-governance, and fairness remain centered in all lawmaking activities and public health responses.11, 14

The discipline of public health law is vast, inherently multidisciplinary, and diverse in its role in assuring good health. Public health lawyer Lawrence Gostin has identified five key characteristics of public health law, presented in Table 1 below.:15
Table 1

<table>
<thead>
<tr>
<th></th>
<th>Lawrence Gostin’s Characteristics of Public Health Law$^{16}$</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The government’s responsibility to defend against health risks and promote the public’s health.</td>
</tr>
<tr>
<td>2</td>
<td>Population-based prevention.</td>
</tr>
<tr>
<td>3</td>
<td>The relationship between the government and the populace.</td>
</tr>
<tr>
<td>4</td>
<td>The mission and core functions of the public health system.</td>
</tr>
<tr>
<td>5</td>
<td>The power to coerce the behavior of entities and actors to protect the community.</td>
</tr>
</tbody>
</table>

In addition, this specialty of law can be categorized into three classifications which are critical to shaping the legal landscape as it applies to health$^{7,17,18}$:

- **Interventional Public Health Law**: laws or legal practices that are intended to influence health outcomes directly through preventative interventions;

- **Infrastructural Public Health Law**: laws and policies that establish the powers, duties, and institutions of public health and defines the governance and authority of public health agencies; and,

- **Incidental Public Health Law**: law that, on its face, is not oriented towards health, but affects or deploys a population health framework.

Within these categorizations, public health law establishes and defines the responsibilities of government authorities in addressing public health and public health threats, creates and promotes healthier environments and better access to care, and generates the information base needed for the timely evaluation and implementation of policies.$^{11}$
Public health law can also be divided into three different components that define its different uses. First is counsel, which builds the capacity of public health practitioners to use law to solve population health problems through lawyers drafting model ordinances, regulations, laws, or policies and providing legal information, analysis, and advice. Next is representation, which includes litigation processes that enforce or defend public health laws and regulations. Lastly, lawmaking in public health includes a research component. Public health law research is the collection, assessment, and analysis of laws on the books and legal language to understand how they may be prescribed to answer legal questions.

Law is important in developing the frameworks that guide public health interventions, empowering governments to strengthen public health and preparedness systems, researching the impact of laws on public health, assessing laws and policies across jurisdictions, building the capacities of agencies to response to public health threats, and ensuring that governments are doing their duty in safeguarding the health of the population. In addition, law is powerful to ensuring global security and advancing health equity, setting norms and standards of good health, holding actors and institutions accountable, and structuring, perpetuating, and mediating the conditions that shape the social determinants of health.

### 3.2 Global Health and Global Health Law

To best conceptualize global health law, it is important to clarify what is meant by global health. There is no universal, comprehensive definition of global health; however, the most widely accepted definition is that global health “is an area for study, research, and practice that places a priority on improving health and achieving health equity. Global health emphasizes transnational
health issues, determinants, and solutions; involves many disciplines within and beyond the health sciences and promotes interdisciplinary collaboration; and is a synthesis of population-based prevention within individual level clinical care.\textsuperscript{22, 23} Global health aims to address health disparities with the underlying focus of the universal right to health grounded in international human rights.\textsuperscript{21} Global health includes the study of health that transcends borders, as well as health issues that emerge within defined borders, but are affected by global factors.\textsuperscript{23}

There has been a growing recognition of global health as a separate field in the past two decades, which has been accelerated by the COVID-19 pandemic.\textsuperscript{23} Due to its interdisciplinary nature, global health has increasingly become integrated into conversations regarding politics and law. Global health law is defined as “the study and practice of international law – both hard (e.g., treaties that bind states) and soft instruments (e.g., codes of practices negotiated by states) – that shapes norms, processes, and institutions to attain the highest attainable standard of physical and mental health for the world’s population.”\textsuperscript{10} This facet of public health law aims to set norms, standards, and rules – typically through treaties, non-binding general principles and regulations, and customary law.\textsuperscript{21, 24}

The cross-border and inter-jurisdictional nature of global health law leaves its management and governance without a sovereign authority. As a result, international intergovernmental organizations with some lawmaking abilities, such as the United Nations, the WHO, and the World Trade Organization (WTO), typically act as forums to facilitate the negotiation of treaties between autonomous states.\textsuperscript{21}

The field of global health law has some challenges, particularly related to enforcement, implementation, and compliance. Without a sovereign authority or defined governance structure, global health law is difficult establish, govern, and maintain. Coordinated action and leadership
are often undermined by this weak governance structure, leaving the world scrambling to address threats that extend beyond national borders.\textsuperscript{21} Additionally, global health law is complex and entangled with domestic law, as sovereign governments maintain the authority and duty to protect the health of all inhabitants in their region as they see fit, despite any international policies and stances.\textsuperscript{10,21} The two legal jurisdictions are interrelated and bidirectional when impacting health, either leading to clashes between the two or a positive diffusion of influence of widely accepted norms from the international to the domestic level.\textsuperscript{21} Figure 1 depicts the complex, entwined interplay between international law, subnational policy, and various other pressures that impact individuals and environments.

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure1.png}
\caption{Simplified model depicting the interplay between international laws, policies, and norms, and national and subnational policy and how together they affect people, places and products.}
\end{figure}

\textsuperscript{POIRIER, ET. AL., 2022\textsuperscript{25}}
3.2.1 The World Health Organization (WHO)

The WHO is the main intergovernmental organization that frames and guides global health law. Established in 1948 as a United Nations specialized agency for health, the role of the WHO is to direct and coordinate the authority of international health work. Currently, the WHO has 194 member countries (Member States), which govern, own, and lead the institution. The WHO plays a coordinating role to support these 194 Member States in strengthening their health systems and public health capacities. The WHO has a long history and complicated governance structure, influenced by changing global politics, ideological tensions, social movements and progress, and evolutions in the way health is approached. A discussion of various roles, responsibilities, and achievements of the WHO goes beyond the scope of this essay; however, relevant to this essay is the provision in the WHO Constitution that gives the WHO the power to adopt legally binding treaties.

In certain circumstances, the WHO – supported by its primary decision-making body, the World Health Assembly (WHA) – has the authority to develop, adopt, and impose legally binding treaties and conventions. Article 19 states:

*The Health Assembly shall have the authority to adopt conventions or agreements with respect to any matter within the competence of the Organization. A two-thirds vote of the Health Assembly shall be required for the adoption of such conventions or agreements, which shall come into force for each Member when accepted by it in accordance with its constitutional processes.*

Article 21 outlines the specific circumstances the WHO may act on this authority:

*The Health Assembly shall have authority to adopt regulations concerning: (a) sanitary and quarantine requirements and other procedures designed to*
prevent the international spread of disease; (b) nomenclatures with respect to
diseases, causes of death, and public health practices; (c) standards with
respect to diagnostic procedures for international use; (d) standards with
respect to the safety, purity, and potency of biological, pharmaceutical, and
similar products moving in international commerce; (e) advertising and
labelling of biological, pharmaceutical, and similar products moving in
international commerce.28

The WHO has acted only twice using this authority to adopt health-related treaties, including the
IHR in 1969, which will be discussed in depth later in this essay.

3.3 Global Health Security

Like global health law, within the broad spectrum of global health is the concept of global
health security, which is the existence of strong and resilient public health systems that can prevent,
detect, and respond to infectious disease threats, wherever they occur in the world.29 The concept
of global health security supports and guides international preparedness for global public health
threats, particularly that of infectious disease outbreaks.30 Global health security includes access
to medicines, vaccines, and healthcare, particularly honing in on reducing vulnerabilities to global
public health events, like infectious disease outbreaks, that have the potential to cross borders.30
The top threats to global health security are the emergence and spread of new infectious diseases,
increased potential for disease spread due to the globalization of travel and trade, the rise of drug-
resistant pathogens, and the potential for the accidental release and illicit use of dangerous
pathogens.31

Global health security is increasingly becoming a concern in global health due to the rising
interconnectedness of our world. The world population is expanding, travel and trade across
borders is increasing, and urbanization is rapidly occurring, all of which have accelerated the transmission of communicable diseases. No single country can address all threats to global health security; thus, coordination, collaboration, and a recognition of shared responsibility are all necessary for ensuring the safety, security, and health of the world population. The IHR, the Global Health Security Agenda (GHSA), and Joint External Evaluation (JEE) – which will be discussed in depth below– are all examples of coordinated global efforts to build capacity for global health security.

3.4 Legal Preparedness

Public health law, global health law, and global health security all contribute to the concept of legal preparedness. Legal preparedness is the capability to map, define, refine, and use legal instruments that enable the implementation of capacities to prevent, detect, and respond to infectious disease threats and public health emergencies (PHEs). Despite its importance in assuring global health security, until recently, there have been limited attempts to define legal preparedness, and like global health, the definition is not comprehensive and interpreted differently by different entities and scholars. COVID, however, has reignited the interest in finding a common understanding of legal preparedness and emphasized the importance of legal preparedness in pandemic response.

Legal preparedness includes both the existing laws and regulations of a country, as well as the capacity to activate and implement them effectively and make necessary changes based on policy evidence. It implies that law plays a critical role in supporting public health capacities that are essential in preventing, detecting, and responding to a PHE, and involves the identification of
legal approaches that have the potential to impact a public health response through the interpretation and provision of guidance on the implementation of such legal instruments. Legal preparedness is built upon a strong foundation of effective legal frameworks, functioning people-centered justice systems, effective legal protection for vulnerable groups, multisectoral approaches, and sound national legal capacity.

For addressing health emergencies, legal preparedness is a key indicator for the assessment of a country, state, or region’s ability to appropriately respond to a PHE. Through fostering clear and transparent legal processes, legal preparedness identifies the roles and responsibilities, promotes accountability, and establishes a framework for governments to take action to prevent, detect, and respond to a PHE.
Legal treaties and coordinated global efforts have the potential to advance health, particularly in pandemic preparedness and response. In the mid-20th century, international legal regimes that addressed public health issues began to emerge, as global health security increasingly became a concern of nation states.\textsuperscript{24} Now, in the 21st century, the promotion, protection, and control of public health threats \textit{requires} cooperation and collaboration between states, as a result of increased globalization. Law provides the foundation that guides these global interactions and can shape norms for behavior of individuals and governments during public health emergencies.\textsuperscript{11, 21, 24, 35} Currently, the IHR, the GHSA, and the JEE are the three main frameworks that direct coordinated global efforts during public health crises.

4.1 The International Health Regulations (IHR)

Formally adopted by the WHA in 1969, the IHR fulfills a core tenant and responsibility of the WHO: the management of the global regime of the control of the international spread of disease.\textsuperscript{36} The adoption and subsequent ratification of the IHR represent a significant shift in the scope of the power of the WHO as it is the first legally binding international treaty negotiated under its auspices.\textsuperscript{36} The IHR’s main purpose is to set obligations for governments to strengthen national public health capabilities and provide a path for international collaboration and the maintained of the core public health emergency capacities.\textsuperscript{5}
Prior to the adoption of the IHR, the international political community relied on non-binding international agreements to guide global responses to communicable disease threats. The IHR were built from the foundation of the International Sanitary Regulations (1951), which can trace its roots back to a series of Sanitary Conferences that were held around Europe in the 1800s. During this time, countries in Europe began to recognize the need for an international response framework to maintain health security following a series of epidemics that occurred in the region. However, while it was a priority to provide health security, countries wanted to ensure that there was minimal interference in international traffic and commerce resulting from the International Sanitary Regulations framework. The International Sanitary Regulations named six notifiable diseases that required reporting, detection, and response under its provisions: yellow fever, plague, cholera, relapsing fever, typhoid, and smallpox. By 1969, the International Sanitary Regulations had been revised and renamed the International Health Regulations (or ‘Regulations’), establishing a unified code of conduct for infectious disease. The Regulations were revised multiple times – in 1973, 1981, and 1995 – ultimately resulting in the most recent revisions in 2005, which frame international pandemic response today. Currently, 196 countries are legally bound to the provisions set forth in the IHR, with 194 of those countries being WHO Member States.

4.1.1 Public Health Emergency of International Concern

Before discussing the main provisions of the IHR, it is important to clarify what is meant by public health emergency of international concern (PHEIC). Defined in Article 1 of the IHR, a PHEIC is “an extraordinary event which is determined, as provided in these Regulations, to constitute a public health risk to other States through the international spread of disease and to
potentially require a coordinated international response. Features of PHEICs include communicable diseases that are not bound by borders, risks with common underlying causes (e.g., dangerous pathogens, unhealthy behaviors, and unsafe environments), risks that may be further exacerbated by inequities related to the social determinants of health, and emergencies that requires a coordinated, multisectoral global response. As part of the identification of a PHEIC, the WHO uses a decision instrument (Figure 2) to assess whether a public health risk is considered an emergency of international concern.
Figure 2

Decision instrument for the assessment and notification of events that may constitute a public health emergency of international concern as provided in the IHR (2005).
4.1.2 Scope, Responsibilities, and Function

The purpose and scope of the current, revised IHR is:

*To prevent, protect against, control, and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade.*

The IHR serves as a vehicle to protect global health security through the development of a global surveillance and reporting system, the establishment of national minimum obligations for pandemic control and response, and through outlining permissible limitations on individual rights during a public health emergency. The treaty jurisdiction no longer covers specific diseases, but rather any threat that may constitute a PHEIC, including communicable diseases, noncommunicable diseases caused by chemicals or radiological agents, or releases of dangerous biology, chemical, and/or radiological substances.

The WHO acts as the main advisory board for the IHR, with the primary role of developing tools, guidance and advice, and technical mechanisms to strengthen and maintain country capacity for responding to PHEICs. While legally binding, the IHR does not establish enforcement mechanisms to ensure compliance – enforcement and accountability relies on naming and shaming, peer pressure tactics, and the expectation that countries uphold the provisions in the IHR. The IHR states that Member States and signees (States Parties) uphold and maintain their sovereignty and their right to develop legislation as they see fit, without the interference of the WHO. Thus, implementation of the IHR falls on States Parties – countries are expected to legislate and implement policies that align with the minimum core obligations and capacities outlined by the WHO in the IHR for PHEIC response. A component of these obligations includes
a provision for States Parties to designate a National IHR Focal point responsible for periodically communicating with the WHO. This complex governance structure requires multisectoral collaboration and cooperation, and relies on communication from States to ensure that provisions are able to be met. *Figure 3* below depicts the governance and channel of collaboration structure.

As part of the minimum core obligations, the IHR specifically requires that all States Parties fulfill three core responsibilities: detection, assessment and report, and response. The detection responsibilities asks that countries develop and maintain a surveillance system to detect acute public health events in a timely manner. Assessment and report obligates States Parties to assess public health events and risks using the decision instrument (*see Figure 2*). If a country
finds that the public health risk detected qualifies as a PHEIC, the state is obligated to report the
detection to the WHO within 24 hours through their National IHR Focal Point.\textsuperscript{37} Finally, States
Parties are required to have the appropriate structures in place to respond to a PHEIC.\textsuperscript{37} States
Parties must implement the structures and policies required to fulfill these obligations at the local,
regional, and national levels to effectively limit the spread of health risks.\textsuperscript{20, 39}

4.2 Global Health Security Agenda (GHSA)

The GHSA was established in February 2014 as an international structural body with the
goal of responding to infectious disease threats due to the growing interconnectedness of the world.
\textsuperscript{31} The GHSA was established following the H1N1, SARS, and Ebola outbreaks, which had
significant health, economic, and social impacts, and highlighted the need for programs and
frameworks that addressed public health concerns that were exacerbated by globalization.\textsuperscript{33} The
GHSA was initiated by the United States government, the WHO, the Food and Agricultural
Organization, the World Bank, and the World Organization for Animal Health, and was supported
by 29 other countries. It is a multilateral, multisectoral partnership that is now made up of more
than 70 countries, intergovernmental organizations, nongovernmental organizations, and private
sector entities that positions and mobilizes member countries to develop the leadership, technical
knowledge, and collaborative foundation to sustain health security long term.\textsuperscript{33}

As implied previously, the primary aim of the GHSA is to strengthen the world’s ability to
prevent, detect, and respond to infectious disease threats.\textsuperscript{2, 33} The GHSA is an important tool in
galvanizing stakeholders around the world to strengthen their capacities to manage and respond to
global public health threats, particularly through facilitating the ability for countries to comply
with the IHR. The GHSA emphasizes the need for multisectoral engagement to address cross-border issues, including stakeholders and entities in human and animal health, agriculture, security, defense, law enforcement, development, foreign affairs, and research. The entity is framed around the core principles of country-ownership, inclusiveness, cost-effectiveness, mutual accountability, multi-sectorality, measurable progress and impact, sustainability, partnership, and proactivity and has the following five key objectives:

1. The promotion of international initiatives, instruments, and frameworks relevant to health security.

2. Increase domestic and international partner financial support for strengthening and maintaining capacities to prevent, detect, and respond to PHEs.

3. The strengthening and support of multi-sectoral engagement and commitment to health security.

4. Improvement of the sharing of best practices and lessons learned and support of the use and development of tools and mechanisms.

5. Strengthen the accountability of all members under the GHSA.

Figure 4 outlines the governance structure of the GHSA. The GHSA is governed by 15 rotating GHSA members, which make up the GHSA Steering Group. Currently chaired by Pakistan, the Steering Group provides strategic guidance, identifies GHSA priorities, and coordinates among GHSA members.
The objectives of Action Packages align with the IHR GHSA Action Packages are the main instruments through which the GHSA provides guidance and assistance to facilitate global collaboration.\textsuperscript{1} The objectives of Action Packages align with the IHR to support the mission of the GHSA to increase global health security capacity in countries around the world. Current action packages include Antimicrobial Resistance, Biosecurity & Biosafety, Immunization, Laboratory Systems, Legal Preparedness, Surveillance, Sustainable Financing for Surveillance, Workforce Development, and Zoonotic Diseases.\textsuperscript{1}
4.2.1 Legal Preparedness Action Package

Of primary importance to the scope of this essay is the Legal Preparedness Action Plan (LPAP). The LPAP was developed and proposed as a GHSA Action Package by Argentina, the United States, and Georgetown Law’s O’Neill Institute for National and Global Health Law in June 2021 and accepted by the GHSA in August 2021 – in the midst of the COVID-19 pandemic. The LPAP was created as a direct response to the poor legal preparedness that was observed during the Pandemic and in recognition of the priority of capacity-building in legal preparedness in order to address global health threats. Work on the LPAP brings together global legal experts, international organizations, and government officials from around the world to build a solid foundation and common understanding of the competencies necessary for strengthening global legal preparedness. Since its establishment, the LPAP has been leveraging lessons learned during the COVID-19 pandemic to enhance legal preparedness frameworks.

The primary aim of the LPAP is to promote legal preparedness as a critical capacity for an effective public health emergency response and strengthening global health security. Through the development of technical and capacity building tools and advocacy efforts, LPAP intends to fulfill its three strategic objectives: outreach and advocacy, guidance tools, and capacity development (see Figure 5 for detailed information on each strategic objective).
Figure 5

GLOBAL HEALTH SECURITY AGENDA, 2023.3

Detailed tasks and checkpoints for LPAP strategic goals.

4.3 Joint External Evaluation (JEE)

The final coordinated effort of interest to PHEIC preparedness and response is the JEE. Part of the IHR Monitoring and Evaluation Framework, the JEE is a voluntary, collaborative, multisectoral process that is used to assess country capacities to prevent, direct, and rapidly respond to public health risks.11, 42 The JEE was born from a collaboration between the WHO and the GHSA, and aims to assist countries in identifying gaps in their health systems using a common platform.11

The purpose of the external evaluation is to measure country-specific status and progress in developing capacity to prevent, detect, and rapidly respond to public health threats whether they
are naturally occurring, deliberate, or accidental. Features of the JEE include voluntary country participation, a multisectoral approach, information sharing and transparent data, and the public release of reports. Through the information sharing platform, the JEE allows countries to identify urgent needs within their health security system to enhance preparedness and operational readiness.

The JEE process begins with a voluntary country self-evaluation that uses both the JEE tool and country implementation guide. Nineteen capacities are covered in the self-evaluation tool, which is given, following completion, to an external JEE team that is comprised of international subject matter experts. As part of the process, the JEE team then visits the country of interest to conduct meetings and evaluate health system capacities. After a complete assessment, a report – that includes identified gaps, indication of the level of each preparedness indicator, and capacity development challenges and opportunities – is compiled. The report is shared with the country that was assessed, finalized, then posted on the WHO website; it is accessible to the public. Overall, the JEE aims to share best practices, promote international accountability, engage stakeholders, and inform and guide IHR implementation.
5.0 Legal Preparedness During COVID-19

As previously discussed, the COVID-19 pandemic exposed the weaknesses in the existing legal preparedness frameworks. At the beginning of the Pandemic, it became clear that the world was unequipped to handle an emergency of this caliber. The virus that causes COVID-19 had been circulating in China for weeks before the WHO was first notified, which delayed the WHO from the beginning in developing any guidelines. Additionally, China was not communicating through its National IHR Focal Point, thus limiting the information the WHO could disseminate to other countries. The IHR Emergency Committee met on multiple occasions prior to concluding that the coronavirus outbreak was a PHEIC, which was not official until January 30, 2020. It was not until February and March 2020 that the WHO began publishing strategic guidelines to assist countries in responding to the outbreak; however, by April there were already one million reported cases.

From this series of events, it is clear that the WHO was hesitant and tentative to declare a PHEIC, which ended up having devastating effects. This diplomatic hesitancy of the WHO in acting on its authority hampered global coordination and affected the legitimacy of the WHO’s power due to a lack of transparency in PHEIC deliberations. Moreover, the WHO’s limited enforcement mechanisms made it essentially powerless in mobilizing States Parties to comply with the IHR or additional WHO guidelines.

Within months of the onset of the Pandemic, committees of global experts began meeting to assess the global legal preparedness and countries specifically. Findings from these meetings provide the best overarching perspective of the legal preparedness landscape and where it failed during the Pandemic. The IHR were primarily assessed for effectiveness, as the Regulations are
the principal standards involved in pandemic response. The GHSA and JEE support IHR implementation, so there are few analyses of the effectiveness of both frameworks on their own; however, the adoption of the LPAP by GHSA during the Pandemic is very telling regarding the state of legal preparedness during this public health emergency.

In September 2020, the IHR Review Committee was convened and began meeting regularly to assess the functioning of the IHR during COVID.\textsuperscript{44},\textsuperscript{45} Comprised of the Chair of the Review Committee and 19 other experts, the Review Committee examined each article of the Regulations in relation to country and global capacities to respond to the Pandemic.\textsuperscript{45} Overall, the Review Committee concluded that many of the provisions in the IHR are “well considered, appropriate, and meaningful” in any PHEIC; however, many countries did not have the public health capacities in place to protect individuals in their country, or inform the WHO and other countries of disease outbreaks.\textsuperscript{45} Additionally, it was found that WHO did not have sufficient resources to assist countries in capacity-building or protecting the health of individuals during the Pandemic.\textsuperscript{45}

The Review Committee assessed all areas of IHR implementation; however, for this essay, of key interest is their findings on legal preparedness. The Review Committee reported five key findings regarding legal preparedness:

1. Nearly all States Parties made use of legislation in responses for surveillance, contact tracing, data collection, quarantine, vaccination, issuing information, and limiting freedom of movement. Legislation was used to establish emergency response task forces and guide appropriate public health response measures.

2. States Parties that amended PHE legislation following the SARS, H1N1, and MERS outbreaks reported better legal preparedness to respond to COVID. However, most
States Parties were unprepared to respond to the Pandemic because of outdated public health emergency legislation.

3. Most States Parties passed new legislation – mostly related to quarantine and isolation measures, commercial activity slowdowns, control of information and misinformation, and allowing for flexibility in government activities – during the Pandemic. Much of this legislation was passed as emergency laws and will therefore need to be analyzed with regard to human rights.

4. Law reform ahead of a public health crisis is a key part of preparedness. While law development is a long process, it is important that basic legislative architecture is established, understood, administered, funded, and implemented before a public health emergency.

5. The WHO does not currently have a central repository for health-related legislation and the provision of technical assistance from the WHO to States Parties is currently on an ad hoc basis. These facts hinder the capacity of countries to appropriately respond to a crisis.45

Similar to the IHR Review Committee Report, the WHO Regional Office for the Western Pacific held a forum in November 2021 that assessed the crucial weaknesses that were observed in legal preparedness during the Pandemic up to this point. The Forum on Law and COVID-19 (the Forum) emphasized the importance of legal frameworks in enabling in good health and discussed the importance of investing in their strengthening to be best prepared for the next global health crisis.34 Expert meetings and discussions at the Forum led to the identification of three areas of broad consensus that were brought to light during the Pandemic:
1. COVID-19 highlighted weaknesses in key areas of several countries’ legal frameworks – outdated public health powers, unclear roles and responsibilities, and a lack of alignment across legal frameworks and health in other sectors.

2. Countries have an opportunity to identify lessons from the response to COVID-19 and consider opportunities to strengthen legal preparedness for future health emergencies.

3. Strengthening legal preparedness will contribute to building stronger, more resilient health systems through more effective legal frameworks for health service surge capacity, health governance, private sector engagement, workforce utilization, and health equity.\(^3^4\)

**5.1 Key Legal Barriers**

Considering the assessments and reviews provided above, three main complications can be identified as legal barriers during the COVID-19 response:

- Outdated public health laws;
- Poor implementation of international norms, standards, and obligations (i.e., the IHR); and
- Insufficient coordination and surveillance mechanisms.

To best conceptualize these barriers in the context of the legal response to the COVID-19 pandemic, I have provided examples of these challenges as observed in countries and regions around the world. Exhaustive country-specific analyses related to these legal barriers goes beyond the scope of this essay; however, for illustrative purposes, these examples demonstrate how
framework weaknesses and poor preparedness capacity around the world hindered the COVID-19 response.

An example of outdated public health laws acting as significant contributors to the spread of the coronavirus occurred in India. India enacted the Epidemic Diseases Act in 1897 as a response to a plague outbreak in Bombay, which was then also applied to the COVID-19 pandemic beginning in 2020. This act empowered the State and Central governments of India to enact and enforce protective measures in the entire country during an infectious disease outbreak. This act also allows the government to enact temporary regulations that must be obeyed, with the consequence being a punishable offense for individuals who did not comply with the provisions set forth. The application of the Epidemic Diseases Act was supported by the Disaster Management Act (2005), which gave the government the authority to take any actions necessary to mitigate the spread of disease during an outbreak.

As the Epidemic Diseases Act is over a century old, it is not surprising that there were clear gaps in emergency response legislation in India. The Epidemic Diseases Act was adopted during the precolonial era, and in the time since, disease dynamics have changed, scientific breakthroughs regarding infectious disease response have emerged, and human rights are now expected to be at the center of all legislative and policy actions. Therefore, this law was obsolete and did not provide appropriate guidance for addressing an infectious disease outbreak in the 21st century.46

Poor implementation of international norms, standards, and obligations during the Pandemic was mainly born from geopolitical tensions in the backdrop of the coronavirus outbreak. While not a country-specific example, scholars Jones and Hameiri have claimed that the degradation of the authority of the WHO was mainly to do with acrimony between the United States and China. As they put it, global health governance was one of COVID-19’s earliest victims,
and without strong governance, the implementation of international standards was obsolete. The attacks on the WHO from the American and Chinese governments devastated the WHO’s credibility, which had a domino effect that resulted in a lack of compliance with the advisory body’s recommendations around the world. As such, the WHO was unable to manage the Pandemic as two major international players were discrediting the provisions and guidelines that the institution was promulgating. Thus, countries fell back on isolationist and individualistic policies that impacted coordination throughout the Pandemic response.47

Regarding insufficient coordination and surveillance, a study done in 2021 identified 13 African countries that had experienced surveillance system challenges during the COVID-19 response. The 13 countries evaluated – Mauritius, Algeria, Nigeria, Angola, Cote d’Ivoire, the Democratic Republic of the Congo, Ghana, Ethiopia, South Africa, Kenya, Zambia, Tanzania, and Uganda – were found to have ramped up surveillance during the Pandemic; however, existing variations in the level of implementation of these surveillance systems across countries hindered coordination during the response. While the WHO Regional Office for Africa published the Integrated Disease Surveillance and Response (IDSR) strategy to assist with capacity building for core obligation achievement under the IHR and strengthen surveillance systems years before the COVID-19 pandemic, many African countries have been unable to implement the framework. Challenges that were ascertained in the study included a shortage of human resources, stigma and misinformation, diagnostic insufficiency, the burden of co-epidemic surveillance, complexities of ethical consideration, geographical barriers, and weak healthcare systems. Without support and technical assistance from the WHO under the IHR, coordination is almost impossible to achieve, especially if countries are unprepared for a PHEIC.48
6.0 Recommendations and Discussion

As discussed in the previous sections, there is a lot that can be learned from the COVID-19 pandemic. The Pandemic exposed significant gaps in how pandemics and public health emergencies are addressed at the global level. The current legal frameworks, which in theory have good foundations, are insufficient in practice. Governments were not legally prepared to handle the Pandemic. There was not a comprehensive understanding of what it means to be legally prepared for a public health emergency, nor were any of the legislative measures that were already in place sustainable, adaptable, or well-established enough to have a meaningful impact. Weak legal measures also led to poor governance and a lack of collaboration and shared responsibility at the global level, which is paramount to addressing a cross-border crisis.

Based on the conclusions made by experts during reviews of the IHR and legal preparedness and the specific examples of legal barriers encountered during the Pandemic, I have identified three main recommendations to improve global legal preparedness in order to address the gaps that were observed during COVID-19 and prepare for the next public health crisis. These recommendations are not perfect or all encompassing, nor do they even address all aspects of improvement in legal preparedness. Nonetheless, they offer a starting point for incremental changes to be made at the global level to enhance the detection and responsiveness of the international community during a PHEIC.
6.1 Recommendation I: Increase the Legal and Political Legitimacy of the WHO

It is clear from the aforementioned legal barriers and examples that weak governance was a key problem during the Pandemic. Weak governance led to a lack of compliance with the IHR and therefore, led to poor legal preparedness during the Pandemic. Thus, it is necessary that the political and legal legitimacy of the WHO, and consequently the IHR, is strengthened to ensure compliance with the Regulations and guidance from the WHO.

Strengthening political and legal legitimacy is not a straightforward endeavor, as it requires navigating geopolitical tensions and asymmetric trust, cooperation, and compliance between Member States and the WHO. For the WHO, to strengthen legitimacy, the institution should aim to increase transparency in decision-making.\textsuperscript{49} Studies have been conducted that indicate that increasing transparency reduces uncertainty of an international organization’s intentions and procedures, thus enhancing the confidence in States Parties to delegate authorities to another governmental body.\textsuperscript{49} Additionally, while during COVID the WHO did not inappropriately exercise authority, increasing transparency regarding the authority of the WHO and IHR during PHEICs can promote States Parties compliance with WHO guidelines while ensuring they will maintain their sovereignty.

At the international level, legitimacy shapes the capacity for international organizations to develop rules and norms, remain relevant as arenas for coordination among nation-states to safeguard global public interest, promote compliance with international rules and norms, and establish effective global governance.\textsuperscript{50} Thus, increased legitimacy will encourage States Parties to maintain their legal preparedness capacities. Increasing legitimacy may also lead to increased funding to the WHO because the value of the IHR would be better realized, and increased legitimacy has been shown to produce practical political and financial benefits. This would allow
for the WHO to assist in strengthening the legal capacity of lower income countries that need technical and financial aid. Additionally, a benefit of increasing political and legal legitimacy is the basic IHR framework is already developed, well thought out, and agreed upon by multiple countries. It is more feasible to adapt an existing framework rather than creating a new one – there just needs to be a push for greater country compliance with the provisions.

Some challenges that come with increasing the political and legal legitimacy of the WHO and the IHR is it requires States Parties to change their perception of the WHO and the IHR. The authority of the WHO degraded significantly during COVID-19, and Member States fell into individualist mindsets, ignoring the legally binding nature of the IHR. Isolationist country movements is an obstacle to compliance, and they will be difficult to reverse without respect for the authority of the WHO.

6.2 Recommendation II: Encourage Countries to Sign onto the GHSA

My second recommendation is to encourage countries to sign onto the GHSA. Again, part of what went wrong during the COVID-19 pandemic response was that country capacities for IHR compliance were not well-established in many countries. The GHSA has the ability, foundations, and expertise to assist countries in building capacity, and as an entity, recognizes the importance of law and legal preparedness in responding to PHEICs. Right now, less than 70 countries are signed onto the GHSA, but if we have learned one thing from the Pandemic, it is that tackling international public health threats requires global cooperation and collaboration. The GHSA can also encourage JEE completion by countries, which will lead to overarching improvements to legal preparedness and pandemic response.
The GHSA has been working to demonstrate the political will and commitment towards their goal of strengthening global health security, however, part of the reason that countries have been hesitant to sign onto the GHSA is that it is voluntary. There is no obligation for countries to partner with the organization, nor has there been strong evidence of current GHSA Member States seeing improvements in health security capacity, as there has been limited progress towards meeting target goals. Currently, the GHSA does not have any tangible benefit – it does not have the finances to support countries, and it is very likely that higher income countries would end up having to put funds towards the GHSA. Therefore, countries are not likely to be inclined to add another partnership to their repertoire.

One way to get countries, primarily States Parties already signed onto the IHR, to join the GHSA is to add an addendum to the IHR that requires States Parties to sign on to the GHSA and asks that their National IHR Focal Points work with the GHSA to achieve greater global health security. Making it a requirement to become a Member State of the GHSA will help to expand and advance the mission. Strengthening global health security requires coordination and shared responsibility from countries, and expanding the partnership will facilitate the realization of GHSA goals. This addendum will also ensure that that countries that adopt the IHR in the future will automatically be part of the GHSA partnership.

Asking States Parties to also align their National IHR Focal Points with GHSA efforts will assist with defining how a GHSA partnership will fit into the current global health security structures established in States Parties. As the National IHR Focal Points are responsible for IHR implementation within countries, connecting these entities with the GHSA will be most effective in IHR capacity-building overall, and will assure States Parties that the development of a new entity is not a necessary part of partnering with the GHSA.
A possible challenge that could emerge with this additional requirement would be that it could lead to States Parties to opt out of the IHR. Currently, Member States to the WHO are automatically signatories of the IHR and must specifically opt out of the IHR if there is the intention to not comply with them. Thus, it is possible for countries to not partner with the GHSA and opt out of the IHR. However, because a GHSA provision is not necessarily controversial nor costly – financially and politically – most States Parties are likely to remain as signatories.

6.3 Recommendation III: Expand the Role of the WHO in Aiding in Developing Legal Preparedness Policies at the National Level

Finally, the role of the WHO in assisting countries, particularly low and middle resource countries, in their development of preparedness policies should be expanded so that a basic structure for legal preparedness is in place for these countries prior to a PHEIC. Many States Parties have requested stronger and more systemic support from the WHO for developing their pandemic legal policies. This would help achieve a more coordinated approach to addressing public health issues because strengthened country capacities will make it more feasible for states to respond to public health threats. Additionally, this enhanced WHO role will provide sustained support for legal preparedness capacity growth.

To do this, the WHO should establish a working group that specifically works with States Parties, the GHSA, and JEE on legal preparedness. Currently, the JEE process includes the deployment of international experts to States Parties after they complete the voluntary self-assessment, however, they only compile a report of identified gaps, challenges and opportunities, and levels of preparedness indicators. The JEE team does not provide assistance or advice about
how to address these gaps, therefore, States Parties are left with no guidance regarding next steps. A working group comprised of international experts that are familiar with the GHSA LPAP can designate specific time to work with a State Party that needs assistance in legal preparedness, helping with developing sustainable laws that coincide with the government structure of that country. Ensuring that countries that need assistance receive such assistance and that the laws developed are sustainable can have long-term benefits for both PHEIC response in the future and the overall view of the WHO.

Some challenges for this recommendation, however, include the lack of WHO funding to undertake a project of this caliber, as this would require staffing, resources, and time that the WHO does not currently possess. Also, because the international legal sector lacks strong governing authority, intergovernmental institutions trying to establish any type of authority or influence over an autonomous state can lead to clashes and an unwillingness from states to comply with the recommendations of intergovernmental organizations, even if that advice was wanted in the first place. Nonetheless, the hope would be that States Parties in need of assistance will work and collaborate with the WHO jointly to achieve their shared goals for building the structures needed to properly respond to global health threats and protect their citizens.
7.0 Conclusion

To conclude, it is imperative that legal preparedness at the global level is addressed to assure readiness for whatever public health threat may come next. The COVID-19 pandemic exposed the interconnectedness of our world and the need for multijurisdictional collaboration among states when tackling public health threats; however, weaknesses in the current frameworks were an impediment. Gaps in the existing legal structures have led to poor governance and poor national capacity building, which ultimately had negative effects on population health during the Pandemic. Legal frameworks are effective interventions for improving health governance, infrastructure, and operations. By building upon the IHR and better utilizing the GHSA and JEE, the global community can better ensure that the health of individuals around the world is protected. Changes to existing legal frameworks have the potential to positively impact population health, and it is important that global political institutions act now to ensure that health is protected for the future.


38. International Health Regulations. World Health Organization; 2024; Available from: https://www.who.int/health-topics/international-health-regulations#tab=tab_3.


