**Colombos Public International Law Essay Prize 2020 – Imogen Beltrami**

**‘The WHO’s International Health Regulations are not fit for purpose’. Discuss**

1. **Introduction**

*No man is an island entire of itself; every man*

*is a piece of the continent, a part of the main; [[1]](#footnote-1)*

1. Donne’s 1624 critique of isolationism resonates 400 years later as the world weathers the coronavirus pandemic. It reflects both the factual reality of how indiscriminately coronavirus spread throughout our globalised society and the united response that should have prevailed via the deployment of the WHO’s International Health Regulations (IHR).
2. This essay will discuss the historical development of the IHR and contextual roles played by the Regulations and WHO in responding to the coronavirus pandemic. It will then assess the internal compositional flaws of the IHR and structural failings of the WHO before concluding that it is the positioning of these failings within an external culture of insurmountably protectionist state attitudes that compounds their potency and makes the IHR unfit for purpose. Finally, some suggestions for reform will be posited.
3. **History**
4. In modern society the threat presented by a pandemic is magnified because the interconnected nature of our globalised world enables diseases to spread rapidly and without constraint. COVID-19 was reported by China in December 2019, and on 31st January 2020 was declared a public health emergency of international concern (PHEIC). At the time of writing there have been almost 25 million cases including almost 850,000 deaths.[[2]](#footnote-2)
5. The World Health Assembly (WHA) adopted the original version of the IHR[[3]](#footnote-3) to consolidate an approach to infectious disease control. The 2003 SARS outbreak highlighted the structural failures of the Regulations in the face of the first 21st century pandemic, and triggered reactive amendments.[[4]](#footnote-4) The purpose of the revised IHR is ‘to prevent, protect against, control and provide a public health response to the international spread of disease in ways that…avoid unnecessary interference with international traffic and trade.’[[5]](#footnote-5)
6. Whether the IHR are fit to achieve these purposes is best answered by examining their operation during modern pandemics including the current crisis. Although the prevention purpose was rendered virtually impossible due to the nature of coronavirus (human transmission) and globalisation[[6]](#footnote-6), the other purposes could have been more successfully achieved had states fully complied with their obligations under the Regulations.
7. **Fit for purpose?**
8. ***IHR***
9. The IHR create a framework of obligations. Operational lessons were learnt from preceding pandemics. A review of the 2014 Ebola outbreak identified slow reaction times and poor communication as failures of the IHR[[7]](#footnote-7), and after the 2016 Zika outbreak, the need for ‘efficient surveillance’ was stressed.[[8]](#footnote-8) However, one critical flaw, noted as early as the 2009 H1N1 outbreak,[[9]](#footnote-9) has still not been rectified, namely the lack of an enforcement system. States lack compliance motivation, and since the Regulations are operationally dependent on state cooperation, this key flaw undercuts their success.

**Notification**

1. States are under an obligation to ‘notify…within 24 hours of assessment …events which may constitute a [PHEIC] within its territory’.[[10]](#footnote-10) Rapid reporting is essential to the ability of the WHO to coordinate a global response. However, reporting has consistently been delayed during modern pandemics. The H1N1 outbreak took on average 19 days to be publically communicated, and the emergence of Ebola took over 3 months to report.[[11]](#footnote-11)
2. It seems colloquially accepted[[12]](#footnote-12) that China continued this trend by attempting to hide the emergence of coronavirus. Even if true, it seems unlikely that China can legally be brought to account.
3. China would need to consent to the jurisdiction of the International Court of Justice[[13]](#footnote-13) or the arbitration of disputes under the IHR, which is highly unlikely.[[14]](#footnote-14) Since the IHR were adopted under the WHO Constitution[[15]](#footnote-15) reliance might be placed on its dispute settlement clause.[[16]](#footnote-16) The claim would need to be framed as one ‘concerning the interpretation or application’[[17]](#footnote-17) of the Constitution and there is no concrete way to do so despite the legal gymnastics undertaken by academic commentators to accommodate this argument.[[18]](#footnote-18) Furthermore, the likelihood of any state agreeing to bring a case is also slim, as evidenced by the fact that the Article 56 dispute settlement mechanism in the IHR has never been used.

**Health Measures**

1. After a PHEIC declaration, the WHO releases temporary recommendations of appropriate health measures.[[19]](#footnote-19) States may implement their own measures[[20]](#footnote-20) but they cannot be more restrictive of international traffic than reasonable alternatives, and must be based on scientific evidence and WHO guidance.[[21]](#footnote-21) If implemented measures significantly interfere with international traffic, they must be notified to the WHO within 48 hours.[[22]](#footnote-22) The driving force behind these restrictions is preventing the unchecked introduction of unnecessarily harsh measures that deter ‘countries from reporting new risks’.[[23]](#footnote-23) Unfortunately Article 43 IHR has no practical impact on state behaviour and over 96 states introduced travel restrictions against China by April 2020.[[24]](#footnote-24)
2. Scholars have argued that imposing these restrictions constituted violations of the IHR[[25]](#footnote-25) because there is no scientific evidence that they benefit public health. The WHO has continually maintained this position[[26]](#footnote-26). A study modelling the spread of coronavirus throughout China after the Wuhan lockdown found that 90% of travel restrictions ‘to and from mainland China only modestly affect[ed] epidemic trajectory unless combined with a 50% or higher reduction of transmission in the community’.[[27]](#footnote-27) These statistics reinforce how the rapid reporting obligation assists the WHO in limiting the international spread of the disease more successfully than international travel restrictions. Rapid reporting both ‘increases the likelihood that outbreaks will be contained at the source’ and ‘allows other potentially affected states to prepare internal response measures’.[[28]](#footnote-28) Without this cooperative approach states negate the ability of the IHR to fulfil their purposes of protection, control and coordination. Furthermore, due to the lack of evidence supporting travel restrictions as beneficial to public health, their widespread introduction undermines the purpose of the IHR to avoid unnecessary interferences with international trade and traffic.
3. Moreover, the majority of states imposing travel restrictions further breached the IHR by failing to report them. On 7th February the WHO identified 72 parties that had implemented restrictions but only 32% had reported them.[[29]](#footnote-29) By the 16th March 45 states had reported restrictions, but the number of factual implementations[[30]](#footnote-30) by then was over 80 and climbing.[[31]](#footnote-31)
4. Despite these multi-faceted breaches, the IHR incorporates no enforcement system. This accountability lacuna enables historical non-compliance, which ‘frustrates WHO’s ability to coordinate the world’s response to public health emergencies’[[32]](#footnote-32) because the Regulations are operationally dependent on the rapid provision of initial information from states.
5. ***WHO Structure***
6. The WHO’s structure further undermines the IHR. It is funded by states, together with private and public donations.[[33]](#footnote-33) Accordingly, external influences weigh on the organisation[[34]](#footnote-34) and it is at risk of losing public legitimacy. This is clear from recent criticisms launched by President Trump following claims that the WHO has been unduly influenced by China.[[35]](#footnote-35) Notably there does appear to be conflict between WHO advice against travel restrictions and simultaneous praise of the Chinese response to the pandemic, which included a quarantine of over 60 million people.[[36]](#footnote-36) Regardless of whether the Organization has excessively deferred to China, it remains the case that the WHO is not an independent body. It is very much trapped in the intersection between scientific research and the desires of powerful state players that fund it. For example China is the second largest donor to the WHO and also financially supports wider global health projects.[[37]](#footnote-37) Such financial dependency creates leverage against the WHO and leads to difficulties of international credibility.
7. This problem is exacerbated by the WHO’s refusal to name and shame states that fail to comply with IHR obligations as well as the lack of public access to information analysing implementation of the Regulations by states, which is only available to the states themselves.[[38]](#footnote-38) This lack of transparency about state compliance suggests an inappropriately deferential general attitude to states adopted by the WHO.[[39]](#footnote-39)
8. This lack of legitimacy aggravates the difficulties of enforceability and monitoring under WHO enactments like the IHR because states are not publically made accountable to the Organization.
9. ***Global context***

**IHR**

1. The flaws detailed above are not intrinsically what make the IHR unfit for purpose. They are merely symptomatic of the greatest obstacle to the success of the Regulations, which is the attitude of state isolationism that prevails during pandemics, ‘hinder[ing] international cooperation’.[[40]](#footnote-40)
2. The WHO was designed as a ‘normative’[[41]](#footnote-41) organisation. Benvenisti argues that it is fundamentally flawed as a body ‘designed on an assumption that the improvement of global health was the shared goal of all nations’ and that it could use scientific global strategy to transcend politics.[[42]](#footnote-42) Instead, states have restrained the WHO’s autonomy[[43]](#footnote-43) rather than creating a legal framework that successfully prioritises ‘global health security’[[44]](#footnote-44) as was hoped for.[[45]](#footnote-45)
3. Principally, the IHR linguistically subordinates the action potential of the WHO to that of states. The Regulations emphasise the ability of states to ‘contain outbreaks’ via the development of their core health[[46]](#footnote-46) and surveillance[[47]](#footnote-47) capacities, which is a positive development for public health[[48]](#footnote-48), but still highlights the superior role of states. Furthermore, collaboration with states to develop emergency responses and strengthen their capacities remains specifically at individual state request[[49]](#footnote-49) despite the expertise of the WHO.
4. Additionally, the 2005 amendments to the IHR ‘undercut the WHO’s authority to offer a swift and resolute response to outbreaks’ by limiting the ability of the Organization to provide information facilitating a global health response.[[50]](#footnote-50) The Regulations ensure that the WHO is operationally dependent on information gathered from states,[[51]](#footnote-51) whilst restraining it from acting on that information without consulting source states.[[52]](#footnote-52) Information reported independently similarly cannot be acted upon without consultation with the state ‘in whose territory the event is allegedly occurring’.[[53]](#footnote-53) The WHO relies on states to a degree that negates Benton Heath’s suggestion that the IHR ‘envision a hub-and-spoke model where [the WHO] coordinate the response to international health emergencies’, which implies a highly collaborative scheme not factually or linguistically borne out within the Regulations. Extraordinarily, states even maintain the ability to refuse WHO collaboration to ‘assess the potential for international disease spread’, at which point the WHO may only share the information detailing the emergency ‘when justified by the magnitude of the public health risk’.[[54]](#footnote-54) Presumably once the public health risk had reached a sufficient magnitude, it would be too late for an effective preventative response to be launched.
5. These requirements entrench the degree to which the WHO is reliant on states to operate, and cause functional delays when the key to successful management of a pandemic is efficient action.

**State Responses**

1. States are also economically discouraged from complying with reporting obligations.[[55]](#footnote-55) Historically, states rapidly implement travel restrictions despite consistent WHO advice to the contrary.[[56]](#footnote-56) Roughly 25% of states implemented restrictions in response to H1N1 and Ebola. [[57]](#footnote-57) The three West African countries at the epicentre of Ebola suffered cumulative GDP loss of over 10% as a result of these restrictions, which were unjustified to the WHO[[58]](#footnote-58).
2. Writing in the context of the Ebola outbreak, Pattani argued that border restrictions compromised the ‘global social contract and our ability to respond collectively to future epidemics’.[[59]](#footnote-59) The truth of that prediction is evident in 2020. The Article 43 measure justification mechanism contained in the revised IHR was intended as a quid pro quo arrangement that encouraged information sharing in return for proportionate responses from states.[[60]](#footnote-60) However that system has failed to operate in practice and during the coronavirus pandemic a collective response was foregone in favour of border restrictions. The New Zealand Prime Minister proudly stated that:

*“New Zealanders did something remarkable in our fight to beat COVID-19. We united in unprecedented ways to crush the virus”[[61]](#footnote-61)*

1. New Zealand united as a state but not as a party to the global contract. It banned foreign travellers from China at the beginning of February, and all non-citizens in mid-March. Such behaviour perpetuates the history of economic deterrents that encourage non-compliance with the IHR, a trend exacerbated by the lack of consequences for doing so. It ensures that the WHO does not receive information critical to the successful achievement of its purposes whilst perpetuating unnecessary interference with international traffic and trade.
2. **Reform?**
3. The above analysis shows that political and economic factors primarily drive the flaws that render the IHR unfit for purpose, suggesting that multi-tiered reforms would be needed to ameliorate them.

**Economics**

1. Franck argued that states are motivated to ‘obey powerless rules’ by ideas of legitimacy.[[62]](#footnote-62) This tallies with the concept of global health as a shared goal to be achieved by international cooperation. However, this motivation has historically been insufficient to overcome the competing economic deterrents. Nor would sanctions be sufficient to improve compliance. Chayes observes that ‘effective mobilization of sanctions to influence state behavior has been rare’[[63]](#footnote-63) and in order to counteract the economic disadvantages of travel bans, the sanctions would have to be larger than losses sustained, which is impractical.
2. However, a positive method of counterbalancing the economic impacts of early reporting could be to introduce a compensatory fund for states placed in this position.[[64]](#footnote-64) This could encourage early reporting and ensure that the WHO receives the information needed to coordinate pandemic responses rapidly.

**Politics**

1. It is unlikely that states will fully progress beyond a protectionist mentality and drive a comprehensive reorientation of the IHR. The goal should instead be to evolve the impacts of protectionism in the long term.
2. Firstly, domestic legal protection for non-state actors who choose to report disease outbreaks could be provided.[[65]](#footnote-65) Currently the WHO has a legal duty to disclose any independent sources of information to the state from which they originate unless confidentiality is ‘duly justified’.[[66]](#footnote-66) This requirement discourages whistle-blowers, which is understandable considering the highly publicised legal action taken against Chinese doctor Li Wenliang after his attempt to raise the alarm about coronavirus.[[67]](#footnote-67) Legal protection of such sources could increase information flow to the WHO.
3. Secondly, an independent Committee of experts could be introduced to monitor IHR implementation based around the model operating in human rights law. The Committee on Economic, Social and Cultural Rights requires regular reports on the implementation of rights under the International Convention on Economic, Social and Cultural Rights[[68]](#footnote-68), and publicly holds states to account through a system of inquiries and complaints. Creating a similar Committee removed from the political legitimacy obstacles faced by the WHO would improve the IHR monitoring and accountability gaps.
4. Furthermore, the public accountability aspect of a Committee like this could be further buttressed by a strengthened emphasis on the importance of human rights compliance during pandemics, a requirement of the IHR which has been notably neglected. The IHR require additional health measures to be implemented ‘with full respect for the dignity, human rights and fundamental freedoms of persons’.[[69]](#footnote-69) Despite this, Anti-Chinese sentiment has been a well-publicised theme of the pandemic with racism and discrimination permeating the political responses to coronavirus.[[70]](#footnote-70) Policy responses globally have ‘disproportionally affected people of colour’, with political leaders spreading misinformation about the links between the spread of the virus and immigration,[[71]](#footnote-71) and the UN documenting the emerging discrimination concerns in detail.[[72]](#footnote-72) Davies and Youde argue that ‘shame undermines the ability [of states] to implement policies and act in the international arena’ and that states ‘depend on a sense of ontological security…to perform [effectively]’.[[73]](#footnote-73) Human rights is undoubtedly a field of intense public scrutiny, and publicly shaming non-compliant states could assist in the long-term evolution of state behaviour.
5. Finally the IHR could be amended to encourage legal action and accountability for non-compliant states. For example, the dispute settlement clause could be made mandatory upon opting into the Regulations rather than consent based.
6. **Conclusion**
7. Donne’s claim that ‘no man is an island’ echoes as a profound warning about the dangers of isolationism. It has proven prescient as coronavirus swept indiscriminately across the globe. The idea that each man is instead ‘part of the main’ is not, however, one that states currently encompass.
8. The weakness of the WHO feeds into the unstable legal nature of its Regulations. This weakness is compounded by the structure of the IHR, which lacks an effective compliance mechanism and leaves the WHO operationally dependent on information and collaboration from states during pandemics. These flaws alone would not necessarily act as a barrier to the Regulations fulfilling their purposes. However, when combined with the protectionist state attitudes that historically prevail during pandemics, the result is the functionality of the IHR being undermined. A paradox emerges whereby the IHR require information from states to operate, but states refuse to provide it rapidly in an attempt to evade the economic fallout from the measures imposed in reaction to the news of a potential pandemic.

1. John Donne, ‘No Man is an Island’, *Devotions upon Emergent Occasions*, (1624) [↑](#footnote-ref-1)
2. WHO Coronavirus Disease (COVID-19) Dashboard *at* <https://covid19.who.int/?gclid=CjwKCAjwps75BRAcEiwAEiACMZLwgON66FwW2Hm5FZRAlxCpeMjRgA3I8GYmmnnwFC4Dd-8ugQrpUxoCpsUQAvD_BwE> (accessed 30th August 2020) [↑](#footnote-ref-2)
3. International Sanitary Regulations (1951) [↑](#footnote-ref-3)
4. Hans Kluge et al, ‘Strengthening global health security by embedding the International Health Regulations requirements into national health systems, *BMJ Global Health Journals*, Volume 3, (2018) [↑](#footnote-ref-4)
5. International Health Regulations (IHR) (2005), Article 2 [↑](#footnote-ref-5)
6. Ian Goldin, ‘Coronavirus shows how globalization spreads contagion of all kinds’, *Financial Times*, 2020 [↑](#footnote-ref-6)
7. WHO, Report of the Ebola Interim Assessment Panel, (2015) [↑](#footnote-ref-7)
8. Henry Kluge et al (*supra* note 6) [↑](#footnote-ref-8)
9. (1) Implementation of the International Health Regulations (2005): report of the Review Committee on the Functioning of the International Health Regulations (2005) in relation to pandemic (H1N1) 2009. Geneva: WHO, May 5, 2011, (2) Harvey V Fineberg, ‘Pandemic Preparedness and Response – Lessons from the H1N1 Influenza of 2009’, *New England Medical Journal*, (2014) [↑](#footnote-ref-9)
10. IHR, Article 6(1) [↑](#footnote-ref-10)
11. Catherine Z Worsnop, ‘Concealing Disease: Trade and Travel Barriers and the Timeliness of Outbreak Reporting’, *International Studies Perspectives*, (2019) [↑](#footnote-ref-11)
12. Gian Luca Burci: *EJIL: The Podcast!*: Episode 1, ‘Contagion’, (2020) [↑](#footnote-ref-12)
13. ICJ Statute (1946), Article 36(1) [↑](#footnote-ref-13)
14. IHR, Article 56(3) [↑](#footnote-ref-14)
15. WHO Constitution (1948), Articles 21 and 22 [↑](#footnote-ref-15)
16. Ibid, Article 75 [↑](#footnote-ref-16)
17. Ibid [↑](#footnote-ref-17)
18. Eg. Peter Tzeng, ‘Taking China to the International Court of Justice over COVID-19’, *EJIL:Talk!*, (2020), *EJIL: The Podcast!*: Episode 1, ‘Contagion’, (2020) [↑](#footnote-ref-18)
19. IHR, Article 1, Article 15, Article 18 [↑](#footnote-ref-19)
20. Ibid, Article 43(1) [↑](#footnote-ref-20)
21. Ibid, Article 43(2) [↑](#footnote-ref-21)
22. Ibid, Article 43(5) [↑](#footnote-ref-22)
23. Roojin Habibi et al, ‘Do not violate the International Health Regulations during the COVID-19 outbreak’, *The Lancet*, Volume 395, (2020) [↑](#footnote-ref-23)
24. Samantha Kiernan and Madeleine DeVita, ‘Travel Restrictions on China due to COVID-19’, *Think Global Health*, (2020) at <https://www.thinkglobalhealth.org/article/travel-restrictions-china-due-covid-19> (accessed 17th August 2020) [↑](#footnote-ref-24)
25. Habibi et al (*supra* note 23) [↑](#footnote-ref-25)
26. Updated WHO recommendations for international traffic in relation to COVID-19 outbreak *at* <https://www.who.int/news-room/articles-detail/updated-who-recommendations-for-international-traffic-in-relation-to-covid-19-outbreak> (accessed 13th August 2020) [↑](#footnote-ref-26)
27. Matteo Chiazzi et al, ‘The effect of travel restrictions on the spread of the 2019 novel coronavirus (COVID-19) outbreak’, *Science*, 2020 [↑](#footnote-ref-27)
28. Worsnop, (*supra* note 11) [↑](#footnote-ref-28)
29. WHO. Novel coronavirus (2019-nCoV) situation report – 18. 7th February 2020 [↑](#footnote-ref-29)
30. WHO. Novel coronavirus (2019-nCoV) situation report – 50. 10th March 2020 [↑](#footnote-ref-30)
31. Mayer Brown’s COVID-19 Global Travel Restrictions by Country, 13th March 2020 [↑](#footnote-ref-31)
32. Habibi et al (*supra* note 23) [↑](#footnote-ref-32)
33. WHO, How the WHO is funded at <https://www.who.int/about/planning-finance-and-accountability/how-who-is-funded> (accessed 15th August 2020) [↑](#footnote-ref-33)
34. Samantha Besson, ‘COVID-19 and the WHO’s Political Moment’, *EJIL:Talk!*, (2020) [↑](#footnote-ref-34)
35. ‘Coronavirus: What are President Trump’s charges against the WHO?’ *BBC News*, (2020) *at* <https://www.bbc.co.uk/news/world-us-canada-52294623> (Accessed 14th August 2020) [↑](#footnote-ref-35)
36. Jeremy Page and Betsy McKay, ‘The World Health Organization Draws Flak for Coronavirus Response’, *The Wall Street Journal*, (2020) at <https://www.wsj.com/articles/the-world-health-organization-draws-flak-for-coronavirus-response-11581525207> (accessed 30th August 2020) [↑](#footnote-ref-36)
37. Adam Minter, ‘WHO Need to Quit Being Polite With China’, *Bloomberg Opinion* (2020) at <https://www.bloomberg.com/opinion/articles/2020-02-18/coronavirus-threat-means-who-should-demand-more-help-from-china> (accessed 30th August 2020) [↑](#footnote-ref-37)
38. Gian Luca. Burci, ‘The Outbreak of Covid-19 Coronavirus: are the International Health Regulations fit for purpose?’, *EJIL: Talk!,* (2020) [↑](#footnote-ref-38)
39. (1) Adam Kamradt-Scott, ‘WHO’s to blame? The World Health Organization and the 2014 Ebola outbreak in West Africa’, *Third World Quarterly*, 37:3 2016, (2) Burci (*supra* note 36) [↑](#footnote-ref-39)
40. Enemark, ‘Is Pandemic Flu a Security Threat?’, *Survival*, 51:1, (2009) [↑](#footnote-ref-40)
41. Gian Luca Bardi, *EJIL: The Podcast!*: Episode 2: ‘WHO Let The Bats Out’, (2020) [↑](#footnote-ref-41)
42. Eyal Benvenisti, ‘The WHO – Destined to Fail?: Political Cooperation and the COVID-19 Pandemic, *University of Cambridge Legal Studies Research Paper* No.24, (2020) [↑](#footnote-ref-42)
43. Adam Kamradt-Scott, ‘The Evolving WHO: Implications for Global Health Security’, *Global Public Health*, (2011) [↑](#footnote-ref-43)
44. J. Benton Heath, ‘Pandemics and Other Health Emergencies, *Oxford Handbook of International Law and Global Security*, (2020) [↑](#footnote-ref-44)
45. David P Fidler, ‘From International Sanitary Conventions to Global Health Security’, *4 Chinese Journal of International Law 325*, (2005) [↑](#footnote-ref-45)
46. IHR, Article 4 [↑](#footnote-ref-46)
47. Ibid Article 5 [↑](#footnote-ref-47)
48. Kamradt-Scott (*supra* note 43) [↑](#footnote-ref-48)
49. IHR, Article 5(3), Article 13(3) and Article 44 [↑](#footnote-ref-49)
50. Benvenisti (*supra* note 42) [↑](#footnote-ref-50)
51. IHR, Part II [↑](#footnote-ref-51)
52. Ibid, Article 12(2) [↑](#footnote-ref-52)
53. Ibid, Article 9(1) [↑](#footnote-ref-53)
54. Ibid, Article 10 [↑](#footnote-ref-54)
55. Lawrence O Gostin and Rebecca Katz, The International Health Regulations: The Governing Framework for Global Health Security, *The Milbank Quarterly*, Volume 94(2), (2016) [↑](#footnote-ref-55)
56. Updated WHO recommendations for international traffic in relation to COVID-19 outbreak at <https://www.who.int/news-room/articles-detail/updated-who-recommendations-for-international-traffic-in-relation-to-covid-19-outbreak> (accessed 14th August 2020) [↑](#footnote-ref-56)
57. Worsnop (*supra* note 11) [↑](#footnote-ref-57)
58. United Nations Development Group – Western and Central Africa, ‘Socio-Economic Impact of Ebola Virus Disease in West African Countries’, (2015) [↑](#footnote-ref-58)
59. Reena Pattani, ‘Unsanctioned travel restrictions related to Ebola unravel the global social contract’, *Canadian Medical Association Journal*, Volume 187(3), (2015) [↑](#footnote-ref-59)
60. Adam Ferhani and Simon Rushton, ‘The International Health Regulations: COVID-19, and bordering practices: Who gets in, what gets out, and who gets rescued?’, *Contemporary Security Policy*, 41:3, (2020) [↑](#footnote-ref-60)
61. Jacinda Ardern, ‘New Zealand moves to Alert Level 1’, `(June 2020) at <https://www.beehive.govt.nz/speech/new-zealand-moves-alert-level-1> (accessed 14th August 2020) [↑](#footnote-ref-61)
62. Thomas M Franck, *Fairness in International Law and Institutions* (1995) [↑](#footnote-ref-62)
63. Abram Chayes and Antonia H Chayes, *The New Sovereignty Compliance with International Regulatory Agreements* 3 (1995) [↑](#footnote-ref-63)
64. Worsnop (*supra* note 11) [↑](#footnote-ref-64)
65. Ibid [↑](#footnote-ref-65)
66. IHR, Article 9(1) [↑](#footnote-ref-66)
67. ‘Hero who told the truth’: Chinese rage over coronavirus death of whistleblower doctor’ at <https://www.theguardian.com/global-development/2020/feb/07/coronavirus-chinese-rage-death-whistleblower-doctor-li-wenliang> (accessed 14th August 2020) [↑](#footnote-ref-67)
68. UNHR Office of the High Commissioner, ‘Monitoring the economic, social and cultural rights’ at <https://www.ohchr.org/EN/HRBodies/CESCR/Pages/CESCRIntro.aspx> (accessed 20th August 2020) [↑](#footnote-ref-68)
69. IHR, Article 3 [↑](#footnote-ref-69)
70. Delan Devakumar et al, ‘Racism and discrimination in COVID-19 responses’, *The Lancet*, Volume 395, (2020) [↑](#footnote-ref-70)
71. (1) Devakumar et al (*supra* note 70), (2), White, ‘Historical Linkages: epidemic threat, economic risk, and xenophobia’, *The Lancet*, Volume 395, (2020) [↑](#footnote-ref-71)
72. ‘Covid-19 and Human Rights, We are all in this together’, 2020 at <https://www.un.org/sites/un2.un.org/files/un_policy_brief_on_human_rights_and_covid_23_april_2020.pdf> (accessed 14th August 2020) [↑](#footnote-ref-72)
73. Sara E Davies & Jeremy Youde, ‘The IHR (2005), Disease Surveillance, and the Individual in Global Health Politics’, *The International Journal of Human Rights*, 17:1, (2013) [↑](#footnote-ref-73)