

Summary

REJECTING MONOPOLY POWER OVER GLOBAL PUBLIC HEALTH

On the proposed IHR (2005) amendments and WHO pandemic accord

An expert group in political science and law has prepared **an in-depth, 45-page policy brief** on the proposed amendments to the International Health Regulations (2005) and the WHO pandemic treaty/accord (WHO CA+). The policy brief offers professional insight into the proposed legal instruments. It also features an historical account of what went wrong during the COVID pandemic, describes the attempts being made to establish these wrongs as accepted standards, and provides valuable insights into how to correct course before it is too late. **Central points of the policy brief are outlined below for your convenience.**

Introduction

Negotiations are taking place to significantly expand the control of the World Health Organisation (WHO) over global public health responses and thinking via a) amendments to the International Health Regulations (2005), and b) a pandemic treaty/accord (WHO CA+). Both instruments can be seen as complementary. While the submitted IHR amendments, if approved, would greatly enhance the powers of the WHO as well as its Director-General vis-à-vis states and non-state actors, the pandemic treaty in its current form would create a new, cost-intensive supranational bureaucracy and impose an ideological framework under which to operate in matters of global health.

The World Health Assembly (WHA) has set a deadline of May 2024 for putting the proposed amendments to the IHR and the pandemic treaty to a vote. Some amendments to the IHR could already be voted upon and accepted in May 2023. Amendments to the IHR are adopted via simple majority vote by delegates in the World Health Assembly with no further national ratification procedures. States retain the right to individually opt out within a specified time (10 months). If they don't do so, the revised version automatically applies to them. The treaty, meanwhile, necessitates a two-third majority in the WHA with subsequent national ratification. However, per Article 35 of the zero draft of the treaty, the agreement can come into effect on a provisional basis before the conclusion of ratification processes. The WHO pandemic treaty is being considered for adoption under Article 19 (which relates to the adoption of conventions or agreements) of the WHO Constitution with an additional consideration of the suitability of Article 21 (which is concerned with the adoption of regulations).

Officially, the IHR amendments and the pandemic treaty are presented as instruments to increase international collaboration, efficient sharing of information and equity in the case of another global health crisis. De facto, they can turn into instruments to replace

international collaboration with centralised dictates, to encourage the stifling of dissent and to legitimise a cartel that imposes on populations interest-driven health products that generate profits over those that work better but are less profitable.

A number of the submitted IHR (2005) amendments provide a legal framework for WHO monopoly power over aspects of global public health in times of actual and potential crisis. If these amendments were to be approved, this power would be exercised by a few potent WHO primary donors that exert meaningful control over the organisation. It is noteworthy in this context that the WHO only has full control over roughly a quarter of its own budget. The rest consists of earmarked voluntary contributions by its funders. If agreed upon, some of the IHR (2005) amendments would enable the special interests that have compromised the organisation (see e.g. Cohen & Carter 2010) to standardise and impose how states and even non-state actors worldwide shall respond to public health emergencies and approach a variety of global health matters in general.

Mandatory measures and state sovereignty

Some of the proposed amendments to the IHR (2005) would change the nature of temporary and standing recommendations mentioned under Articles 15 and 16 that can be issued by the WHO and its Director-General from non-binding advice to mandatory to implement by State Parties. Article 15 of the International Health Regulations (2005) states: If "it has been determined [...] that a public health emergency of international concern is occurring, the Director-General shall issue temporary recommendations". Article 16 adds that the "WHO may [also] make standing recommendations of appropriate health measures [...] for routine or periodic application." In the IHR (2005), the temporary recommendations issued by the Director-General and the standing recommendations are defined as non-binding advice to consider.¹

A number of the newly proposed amendments, if adopted, would change the nature of the recommendations that can be issued making them mandatory and legally binding. The amendments would achieve this by removing the descriptor *non-binding* from the definition of the terms *temporary recommendations* and *standing recommendations* in Article 1 while simultaneously inserting a mandate to follow these in a variety of subsequent articles. The WHO's own International Health Regulations Review Committee or IHRRC in its report notes with regards to a proposed New Article 13A: "This proposal [...] renders mandatory the temporary and standing recommendations addressed under Articles 15 and 16." (WHO 2023: 55) With regards to Paragraph 7 of the submitted article, the WHO Committee continues that "these proposals effectively give WHO the authority to instruct States" (ibid.: 57). Concerning a suggested amendment to Article 42, the IHRRC explains likewise: "The proposed amendment to include a

¹ While the International Health Regulations (2005) are a legally binding document under which State Parties agree to fulfill delineated obligations outlined in the document, they do not give power to the WHO nor its Director-General to issue obligations at will to emerging situations. Instead, the WHO and its Director-General in such situations may, per the IHR (2005), only issue non-binding recommendations.

reference to temporary and standing recommendations seems to make application of these recommendations obligatory”. (ibid.: 67)

Different amendments would also significantly expand the powers of the Director-General who is chosen in an undemocratic, opaque process. An amendment to Article 15, for example, would enable the Director-General to issue recommendations not only during a PHEIC declared by him or her but in all situations that are assessed by him or her to have the potential to become one (WHO 2023a: 15). An addition to Article 42, meanwhile, states that WHO measures such as recommendations made by the Director-General not only “shall be initiated and completed without delay by all State Parties” but that “State Parties shall also take measures to ensure Non-State Actors operating in their respective territories comply with such measures” (ibid: 22).

Article 18 of the IHR features a non-exhaustive list of measures the WHO may tell State Parties to implement via recommendations when it comes to persons. This list includes among other things to require medical examinations, to review proof of medical examinations and laboratory analysis, to require vaccination or other prophylaxis, to review proof of vaccination or other prophylaxis, to place individuals under public health observation, to implement quarantine or other health measures and to implement isolation or treatment (cf. WHO 2023a: 17).

The proposed amendments that would make recommendations issued by the WHO or its Director-General mandatory raise serious questions regarding their ramifications for state sovereignty and democratic governance that need to be urgently addressed. Answers might differ from nation to nation. While the WHO has no effective enforcement mechanism vis-à-vis high-income countries, the proposed IHR amendments could lead to powerful governments in alignment with or even behind WHO directives arguing that these must be complied with and enforced internally due to their legally binding nature under an instrument of international law. Powerful nation states and private stakeholders in alignment with the directives as well as the WHO itself could further use the revised IHR as a legal framework in trying to legitimise health colonialism and financially pressuring low-income countries into compliance – severely undermining their sovereignty in the process.

Countering dissent globally

Both the introduced IHR (2005) amendments and the draft pandemic treaty/accord encourage systematic global collaboration to counter dissent from positions held by governments and the WHO – which is a UN agency – thereby promoting concentrated power over information. Melissa Fleming, Deputy Secretary-General of the UN, stated the following belief at a 2022 World Economic Forum (2022: 1) meeting in Davos: “We own the science and we think that the world should know it.”

The draft pandemic treaty/accord encourages all State Parties – which includes democratic, authoritarian and dictatorial ones – to identify *profiles* of what is perceived as

misinformation by the WHO or State Parties and to tackle information and opinions that deviate from the official line. The WHO's IHRRC even suggests that the WHO might have an obligation "to verify information coming from other sources than States Parties" (WHO 2023: 21). It further states that core human rights such as freedom of speech and freedom of the press need to be balanced with what the WHO and governments proclaim to be accurate information at any given moment (cf. *ibid.*: 21). This narrative is dangerous, anti-democratic and the precise inverse of what should happen based on the lessons learned from COVID.

The SARS-CoV-2 outbreak could have been contained early on and the vast majority of what followed could have been prevented. This did not happen explicitly because of false and fatal governmental as well as WHO guidance in the early months of the coronavirus outbreak. This also explicitly did not happen because Chinese government authorities stifled free speech, censoring any attempts of frontline hospital physicians in Wuhan to warn the world about what they saw as severe SARS-like symptoms in their patients in late 2019. Whistleblowers like Dr. Li Wenliang and his colleagues were arrested. As one op-ed in *The Guardian* (2020: 1) put it: "If China valued free speech, there would be no coronavirus crisis."

Khosla & McCoy (2022: 1–2) explain in the *British Medical Journal*: "A tolerance of dissent not only marks the ability to challenge and hold governments (and other powerful actors) accountable and the willingness to respect minority views, it encourages debate and deliberation in society in ways that drive positive social change and development. Dissent can help inform public opinion, change policy, accelerate reform and promote and protect other human rights. Dissent has been central to the advancement of gender equity and women's rights and the reversal of ethnic and racial oppression as exemplified by the civil rights movement in the USA and the anti-apartheid struggle in South Africa. It has been a critical ingredient in many successful campaigns aimed at protecting the natural environment from harm and destruction. And in the field of health, dissent played an important role in advancing access to treatment for the HIV pandemic. [...] The right to dissent must be respected and viewed as a healthy expression of democracy and freedom, and we must consciously strive to continuously monitor and protect this right. [...] Importantly, the voices of health professionals are [...] crucial in ensuring that pandemic control measures are not abused as a pretext for further repressing human rights, arresting journalists and activists or introducing draconian laws to combat 'fake news'. [...] Those working in the global health space have a critical role to play in protecting, preserving and advancing critical thought. As we confront unprecedented challenges, it is more important than ever to stand firm and defend these basic principles of human rights."

Surveillance: (digital) health certificates and locator forms

Additional amendments to the IHR (2005) foresee an expanded surveillance system with (preferably digital) health certificates and locator forms to ensure mass com-

pliance with centralised directives. Amendments concerning the use of (digital) health certificates or locator forms for control and surveillance have not only been proposed with regards to articles relating to international health emergencies but also in relation to Article 23 which is about general health measures on arrival as well as departure. According to the WHO's IHRRC, this article applies to all situations, not just public health emergencies of international concern (PHEICs).

Submitted amendments to Article 23, for instance, include a “new proposed paragraph 6 [that] introduces a specific reference to passenger locator forms as part of the documents that may be required, and a preference for these to be in digital format” (WHO 2023: 61). Another amendment suggests to include information concerning laboratory tests in travellers’ health documents. The IHRRC manages to note: “[G]iven that Article 23 applies to all situations, not only PHEICs, the Committee is concerned that such a requirement may overburden travellers, and may even raise ethical and discrimination-related concerns.” (ibid.: 62) In general, the IHRRC also acknowledges a concern regarding “the appropriate level of protection of personal data” (ibid.: 66).

As explained by the Indonesian health minister Sadikin during the G20 Summit in Bali in November 2022, the introduction of global digital health certificates constitutes a main aim in the revision of the IHR (2005). Indonesia itself has already started implementing mandatory digital health certificates by using an app that can be downloaded via Android and Apple. The country provides an example of how global digital health certificates, if adopted via the IHR amendments, can be abused by those in power to coerce people, including children, into receiving medical treatments, to restrict their movement, to compel the personal use of certain digital apps and to thereby mine private (health) data.

Cartel rights and regulation

A number of IHR (2005) amendments, if approved, would hand power over the identification, production and allocation of health products to the WHO under specific circumstances (cf. WHO 2023a: 13–14), effectively turning it into a cartel. Under the revised IHR, the WHO could, for example, tell State Parties to effect an increase in the production of a certain pharmaceutical – boosting the profits of the manufacturer and/or shareholders who might have relations with the WHO – for the WHO to then distribute as it sees fit, building up a patronage system over recipients. One suggested amendment also sees a role for the WHO in creating standardised “regulatory guidelines for the rapid approval of health products of quality” (WHO 2023: 14).

The infrastructure required to implement the amendments related to the WHO allocation mechanism would be established via the complementary pandemic treaty or accord. The latter would set up the WHO Global Supply Chain and Logistics Network (aka The Network), if adopted.

Support for gain-of-function research

The draft pandemic treaty/accord, in particular, further has negative implications for global (health) security as it supports gain-of-function research despite its exceptional biosafety hazards (on these hazards see e.g. Kahn 2023). The draft treaty declares that when it comes to “laboratories and research facilities that carry out work to genetically alter organisms to increase their pathogenicity and transmissibility” standards should be adhered to in order “to prevent accidental release of these pathogens” but that it needs to be ensured that “these measures do not create any unnecessary administrative hurdles for research” (WHO 2023b: 16). Given that a lab leak of a human engineered virus is most likely responsible for the COVID pandemic that has led to the death of about 6.8 million people, the proposed pandemic treaty reveals a worrisome disregard for the exceptional devastation that can be caused due to biosafety hazards associated with gain-of-function research with pandemic potential pathogens. The world could witness the escape or release of a significantly more deadly engineered virus than SARS-CoV-2.

Conclusion

A number of the proposed IHR amendments and the pandemic treaty (WHO CA+) – if agreed upon – will inevitably be used to advance the interests of a few powerful actors at the expense of others. They represent an unprecedented attempt at legalising the concentration of undemocratic power under false pretence that necessitates a swift, effective and robust response. Some of the proposed IHR (2005) amendments, in particular, represent a framework for the illegitimate exercise of global governmental power without popular accord, constitutional control mechanisms or accountability. As such, they create a dangerous precedent if passed.

The envisioned legal framework for monopoly power over aspects of global public health will not lead to better pandemic preparedness but to a repetition of some of the worst decisions taken during the COVID pandemic in the event of a future emergency. The envisioned legal framework for monopoly power over aspects of global public health is not a sign of progress but represents a backsliding in human development to the times of centralised empires, feudal systems and colonialism.

It is well established that monopoly power eliminates free choice and competition, thereby violating individual rights while dramatically reducing the quality of solutions and innovation. There are few fields where this has consequences as dire as in the area of human health. Undue concentration of power also presents a threat to democratic systems and the right of people to self-governance. Democracies are preserved by preventing a build-up of concentrated power and by breaking up monopolies while at the same time safeguarding essential democratic core values.

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