Developing the WHO's Pandemic Treaty To Facilitate Global Solidarity and International Accountability*

The COVID-19 pandemic continues to cause suffering for millions of people around the world. The virus, initially discovered in 2019, has spread rapidly due to increased globalization and has affected every country. Many of the approaches to containing the pandemic have led to human rights violations and have furthered human suffering. Global health governance has attempted to control the spread of COVID-19 through existing international law. However, the pandemic has exposed gaps in that governance framework, highlighting the need for international law reform to close those gaps and prevent, detect, and respond to the next pandemic. In response to the COVID-19 pandemic, the World Health Organization ("WHO") has prioritized drafting and enacting a convention, agreement, or other international instrument on pandemic preparedness and response. The WHO proposes using its constitutional powers to pass one of these legal instruments, making this so-called "pandemic treaty" only the second time the WHO has used its Article 19 powers to create a legally binding instrument. With negotiations and discussions currently happening on the global stage as to what should go into this treaty, the WHO should take this opportunity to include meaningful accountability measures and provisions to ensure global solidarity in pandemic responses, complementing existing global health law sources to prevent, detect, and respond to the next pandemic, and respect human rights in responses to future pandemic threats.

INTRODUCTION

The Coronavirus disease ("COVID-19") pandemic has caused immense suffering through millions of unnecessary deaths and repeated violations of inalienable human rights, such as travel restrictions and inhumane detentions.[1] The pandemic has tested the readiness of global public health laws to respond to a public health emergency of international concern and highlighted gaps in existing international law as it pertains to addressing outbreaks of diseases. Many countries have taken nationalistic approaches in addressing the pandemic by closing borders and refusing to cooperate with other countries that are still struggling to contain the disease.[2] As the COVID-19 pandemic has made painfully clear, existing international law has been ineffective at preventing, detecting, and responding to disease outbreaks that have the potential to become pandemics. Due to the lack of adequate accountability measures, countries have been slow to implement global health law in their national legislation to respond to international health threats. The pandemic has highlighted the need for systemic reform of global health governance to promote coordination and equity in responses to outbreaks of disease. The World Health Organization ("WHO")[3] is working to bridge the gap between nations and create a more comprehensive system that will be better equipped to address future pandemics.

1. *See About*, COVID-19 HEALTH & HUM. RTS. MONITOR, https://tarheels.live/unccovid19healthandhumanrightsmonitor/about/ [https://perma.cc/8D9G-BER9].

2. *See id.*

3. The World Health Organization is a United Nations agency that connects nations and other actors to promote health and achieve the highest attainable standards. The WHO leads global efforts to coordinate global responses to public health emergencies. *See About WHO*, WORLD HEALTH ORG., https://www.who.int/about [https://perma.cc/3TX9-4P83].

At an unprecedented special session of the World Health Assembly ("WHA")[4] in November 2021, the WHO's member states[5] agreed to kick-start a global process of drafting and negotiating a convention, agreement, or other international instrument on pandemic preparedness and response under the WHO Constitution to strengthen pandemic prevention, preparedness, and response.[6] Many member states and global health actors are advocating for this so-called "pandemic treaty" to work alongside other international legal standards under the existing International Health Regulations.[7] The WHO began negotiating this treaty on July 15, 2022, and will continue deliberations into 2023.[8] During these deliberations, the WHO seeks to facilitate the participation of the United Nations ("UN"), nonstate actors, and other stakeholders in global health governance.[9]

This new pandemic treaty is an opportunity for countries to create a legally binding document that has the potential to be influential in creating a comprehensive global health system that fosters accountability for implementation of global health law. The WHO defines accountability as an "obligation of every member of the Organization to be answerable for his/her actions and decisions, and to accept responsibility for them."[10] Accountability facilitated by monitoring and review supports legal and policy reforms to implement global health obligations on WHO member states.[11] In creating this

4. The World Health Assembly is

> the decision-making body of WHO. It is attended by delegations from all WHO Member States and focuses on a specific health agenda prepared by the Executive Board. The main functions of the World Health Assembly are to determine the policies of the Organization, appoint the Director-General, supervise financial policies, and review and approve the proposed programme budget. The Health Assembly is held annually in Geneva, Switzerland.

World Health Assembly, WORLD HEALTH ORG., https://www.who.int/about/governance/world-health-assembly [https://perma.cc/A29H-3P3J].

5. *See Countries*, WORLD HEALTH ORG., https://www.who.int/countries [https://perma.cc/VW4Z-T3QC] (explaining how a country can become a WHO member state and listing all the countries that are WHO member states).

6. *See World Health Assembly Agrees To Launch Process To Develop Historic Global Accord on Pandemic Prevention, Preparedness and Response*, WORLD HEALTH ORG. (Dec. 1, 2021), https://www.who.int/news/item/01-12-2021-world-health-assembly-agrees-to-launch-process-to-develop-historic-global-accord-on-pandemic-prevention-preparedness-and-response [https://perma.cc/UQU8-43JW] [hereinafter *World Health Assembly Process*].

7. *See Learn from COVID Before Diving into a Pandemic Treaty*, 592 NATURE 165, 165 (2021).

8. *See World Health Assembly Process*, *supra* note 6.

9. *See id.*

10. WORLD HEALTH ORG., CODE OF ETHICS AND PROFESSIONAL CONDUCT 10 (2017), https://cdn.who.int/media/docs/default-source/ethics/code_of_ethics_full_version.pdf?sfvrsn=2393d888_12&download=true [https://perma.cc/5WUH-A54K].

11. *See* Benjamin Mason Meier, Hanna Huffstetler & Judith Bueno de Mesquita, *Monitoring and Review To Assess Human Rights Implementation*, *in* FOUNDATIONS OF GLOBAL HEALTH & HUMAN RIGHTS 155 (Lawrence O. Gostin & Benjamin Mason Meier eds., 2020) [hereinafter Meier et al., *Monitoring and Review*].

new pandemic treaty, the WHO will need to develop a legal framework that emphasizes the need for accountability for implementation of global health law, which will help realize global health solidarity and human rights obligations.

This Comment will highlight the evolution of global health law leading up to the COVID-19 pandemic, examine the limitations of these legal standards in the pandemic, and explain why a pandemic treaty with meaningful accountability mechanisms can promote global solidarity and human rights in future pandemic responses. This Comment proceeds in four parts. Part I discusses the evolving development of international law that has been used to address infectious disease outbreaks in the past, as well as the background of existing global health documents. Part II examines how countries have failed to implement global health law into their national legal systems and identifies the lack of effective accountability in existing legal documents that limited their efficacy during the COVID-19 pandemic. Part III demonstrates why creating a pandemic treaty should be prioritized over other forms of global health law reform. Part IV analyzes legal frameworks that could be implemented in the pandemic treaty to resolve gaps in normative concepts under international law and facilitate accountability mechanisms to help prevent future pandemics and react to those that transpire. This Comment argues that the pandemic treaty will be a necessary part of the larger legal landscape to prevent and respond to new pandemic threats, requiring alignment and harmonization across legal regimes to facilitate solidarity and accountability.

I. EVOLUTION OF GLOBAL HEALTH LAW TO ADDRESS INFECTIOUS DISEASE

A number of global health law doctrines have addressed previous disease outbreaks.[12] These doctrines have been revised and implemented numerous times in response to changes in the global health landscape, the emergence of new actors and new technologies, and increases in international traffic and trade.[13] International law concerning infectious disease originated in the nineteenth century with the adoption of the International Sanitary Convention.[14] This convention brought together physicians and diplomats from across countries in the Mediterranean Basin to reach a consensus on how to address the transmission of disease along trade routes.[15] Countries met over the course of more than fifty years, working to harmonize national efforts to prevent the spread of disease without harming international trade.[16] In 1903,

12. *See* Lawrence O. Gostin & Benjamin Mason Meier, *Introducing Global Health Law*, 47 J.L. MED. & ETHICS 788, 788 (2019) [hereinafter Gostin & Meier, *Introducing Global Health Law*].

13. *See id.* at 790.

14. *See id.* at 789.

15. *See id.*

16. *See id.*

delegates to the International Sanitary Conference in Paris drafted the first International Sanitary Regulations of widespread applicability.[17] This document set the stage for the establishment of future global health doctrines.

During the International Sanitary Convention meetings, countries discussed the possibility of creating a permanent specialized agency for international health.[18] In the wake of heightened cholera transmission in Europe in the twentieth century, European health officials urged the creation of a permanent health agency, culminating in the establishment of the Office International d'Hygiene Publique ("OIHP") in 1907.[19] However, this organization was not comprehensive in its mission or membership, serving only a select number of European nations and aiming simply to collect knowledge and information on public health.[20] After World War I, another new international health organization emerged: the League of Nations Health Organization ("LNHO").[21] The LNHO, a specialized department within the League of Nations that was galvanized by the 1918 flu pandemic, was meant to address fears of epidemic diseases that sprung from disruptions, troop movements, and social turmoil associated with World War I.[22] However, as a result of disruptions and geopolitical tensions emerging during World War II, the LNHO and the OIHP proved to be ineffective in preventing the spread of disease.[23] In 1944, the LNHO conducted a comprehensive study to investigate the need for a new international health organization for the postwar period.[24]

Following World War II, many nations came together to form the WHO in 1945 to "create a centralized authority to coordinate" national and international responses to global health threats.[25] As the leading legal authority on global health governance under the new UN system,[26] the WHO subsumed the responsibilities of previous global health actors, such as the LNHO, the OIHP, and the Health Division of the UN Relief and Rehabilitation Administration.[27] In drafting its constitution, member states intended the WHO to differ from its predecessors by requiring states to accept its

17. *See id.*

18. *See* MARCUS CUETO, THEODORE M. BROWN & ELIZABETH FEE, THE WORLD HEALTH ORGANIZATION: A HISTORY 15 (2019) (noting that this discussion occurred at the eleventh International Sanitary Conference, which took place in 1903 in Paris).

19. *See id.*

20. *See id.* at 15–16.

21. *See id.* at 18.

22. *See id.*

23. *See id.* at 31–33.

24. *See id.* at 33.

25. Benjamin Mason Meier, Allyn Taylor, Mark Eccleston-Turner, Roojin Habibi, Sharifah Sekalala & Lawrence O. Gostin, *The World Health Organization in Global Health Law*, 48 J.L. MED. & ETHICS 796, 797 (2020) [hereinafter Meier et al., *The World Health Organization*].

26. *See id.*

27. *See id.*

constitution for full membership in the organization.[28] The 1946 WHO Constitution declared "the highest attainable standard of health" to be a fundamental human right[29] and granted the WHO the "legal authority [necessary] to codify international treaties, regulations, and recommendations" to address global health matters.[30]

A. *WHO Constitutional Provisions That Support Global Health Law*

The WHO's constitution provides the organization with the "authority to develop international law on any public health matter."[31] This lawmaking authority is far more expansive than that of the WHO's institutional predecessors.[32] The articles of the WHO's constitution provide the bounds within which the WHO can create conventions, regulations, and recommendations to guide member states.[33] These articles also outline the goals of the WHO and provide a framework for how the WHO can create international law to achieve these goals.[34]

Certain provisions of the WHO's constitution, such as Articles 2(a) and 2(b), provide guidelines on the goals that WHO legal instruments need to achieve.[35] Article 2(a) states that in order for the WHO to achieve its objective, the function of the organization should be to "act as the directing and coordinating authority on international health work."[36] Article 2(b) illustrates how the WHO should "establish and maintain effective collaboration with the UN, specialized agencies, governmental health administrations, professional groups and such other organizations that may be deemed appropriate."[37] This language establishes the WHO as the premier global health leader by allowing the organization to work closely with other agencies and actors under the UN, national health ministries, and professional organizations to further the organization's global health goals.[38] These articles grant the WHO extensive normative powers to achieve the goals outlined in its constitution.

28. *See* CUETO ET AL., *supra* note 18, at 45.

29. WORLD HEALTH ORG., CONSTITUTION OF THE WORLD HEALTH ORGANIZATION 1 (1946), https://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf?ua=1 [https://perma.cc/DL73-6SNR] [hereinafter WORLD HEALTH ORG., CONSTITUTION].

30. Meier et al., *The World Health Organization*, *supra* note 25, at 797.

31. Lawrence O. Gostin, Benjamin Mason Meier & Barbara Stocking, *Developing an Innovative Pandemic Treaty To Advance Global Health Security*, 49 J.L. MED. & ETHICS 503, 504 (2021) [hereinafter Gostin et al., *Developing an Innovative Pandemic Treaty*].

32. *See* Meier et al., *The World Health Organization*, *supra* note 25, at 797.

33. *See id.*

34. *See id.*

35. WORLD HEALTH ORG., CONSTITUTION, *supra* note 29, at 2.

36. *Id.*

37. *Id.*

38. L.O. Gostin, D. Sridhar & D. Hougendobler, *The Normative Authority of the World Health Organization*, 129 PUB. HEALTH 854, 855 (2015) [hereinafter Gostin et al., *The Normative Authority*].

Three articles are particularly illustrative of the types of legal instruments the WHO can adopt and what those legal instruments try to achieve. Article 19 gives the WHO the power to create treaties and agreements that set standards to promote public health.[39] Article 21 allows the WHO to make regulations, which are legally binding standards that designate specific actions that must be taken by member states.[40] Finally, Article 23 allows the WHO to recommend nonbinding guidelines to member states with standards to promote public health.[41]

Considering the WHO's wish to facilitate accountability, these articles are best analyzed in order of their legally binding authority. The WHO has spelled out its least binding legal option in Article 23, which says the WHO "shall have authority to make recommendations to Members with respect to any matter within the competence of the Organization."[42] While this legal option is nonbinding on member states, Article 62 does require states to report annually on actions taken to implement these recommendations, offering some form of accountability to ensure state compliance with the recommendations.[43] There are some benefits to passing pandemic-related legal instruments through Article 23. First, this form of "soft" law, while lacking in legal enforceability, can better facilitate cooperation across state and nonstate actors, while also codifying global consensus to set priorities.[44] "Soft" law tends to better facilitate cooperation because states are more willing to comply with such recommendations due to their nonbinding nature.[45] With more cooperation, these recommendations can be passed more quickly, which is vital to addressing public health emergencies as they occur. The organization usually exercises its normative authority through the utilization of "soft" law, which comes in the form of recommendations or other informal and nonbinding actions.[46]

Another article that provides the WHO with legal authority is Article 21, which gives the WHO the power to adopt regulations on a broad range of health-related topics.[47] Article 22 says that regulations enter into force for all

39. *See* Gostin et al., *Developing an Innovative Pandemic Treaty*, *supra* note 31, at 504.

40. *See id.*

41. *See id.*

42. WORLD HEALTH ORG., CONSTITUTION, *supra* note 29, at 8.

43. *Id.* at 15 ("Each Member shall report annually on the action taken with respect to recommendations made to it by the Organization and with respect to conventions, agreements, and regulations.").

44. Gostin & Meier, *Introducing Global Health Law*, *supra* note 12, at 791.

45. *See* Sharifah Sekalala & Haleema Masud, *Soft Law Possibilities in Global Health Law*, 49 J.L. MED. & ETHICS 152, 153 (2021).

46. *See id.* at 152–53.

47. WORLD HEALTH ORG., CONSTITUTION, *supra* note 29, at 7 (describing the five areas in which the WHO is allowed to implement regulations: (1) sanitary and quarantine requirements; (2) nomenclature with respect to disease; (3) standards of diagnostic procedures; (4) standards with respect

member states "after due notice has been given of their adoption by the Health Assembly except for such Members as may notify the Director-General of rejection or reservations within the period stated in the notice."[48] Regulations are rules maintained by a legal authority.[49] The WHO's constitutional language for regulations automatically binds member states, unless they specifically opt out of any regulations that are passed.[50] However, even if a state notifies the Director-General of reservations to the regulation, international law has evolved since the adoption of the WHO Constitution to allow regulations to still enter into force over these states.[51] The organization has rarely used its constitutional mandate to adopt binding international law through regulations on member states.[52]

The WHO may also use Article 19 of its constitution to create binding international law.[53] Article 19 states, "The Health Assembly shall have authority to adopt conventions or agreements with respect to any matter within the competence of the Organization."[54] Any convention passed under Article 19 would be an example of "hard" law because it is binding on states that adopt these treaties.[55] Conventions or agreements passed under Article 19 may deal with any matter within the competence of the WHO and require a formal state ratification process after passage.[56] Although Article 19 provides the WHO with the power to create binding legal doctrines, the WHO has been reluctant to exercise this authority, instead opting to utilize regulations under Article 21.[57]

Emerging from the WHO's legal authority in addressing disease outbreaks, the International Health Regulations ("IHR") have had various levels of success in addressing previous disease outbreaks.

to safety, purity, and potency or biological, pharmaceutical, and similar products moving in international commerce; and (5) advertising and labelling of biological, pharmaceutical, and similar products moving in international commerce).

48. *Id.*

49. *Regulation*, MERRIAM-WEBSTERS DICTIONARY, https://www.merriam-webster.com/dictionary/regulation [https://perma.cc/3PWN-BE7V].

50. WORLD HEALTH ORG., CONSTITUTION, *supra* note 29, at 7.

51. *See* Gostin et al., *The Normative Authority*, *supra* note 38, at 856.

52. *Id.* at 855.

53. WORLD HEALTH ORG., CONSTITUTION, *supra* note 29, at 7.

54. *Id.*

55. Sekalala & Masud, *supra* note 45, at 152.

56. WORLD HEALTH ORG., BACKGROUND INFORMATION RELATED TO THE IDENTIFICATION BY THE INTERGOVERNMENTAL NEGOTIATING BODY OF THE PROVISION OF THE WHO CONSTITUTION UNDER WHICH THE INSTRUMENT SHOULD BE ADOPTED 4 (2022), https://apps.who.int/gb/inb/pdf_files/inb2/A_INB2_INF1-en.pdf [https://perma.cc/6K7D-JGNZ].

57. *See* Gostin et al., *Developing an Innovative Pandemic Treaty*, *supra* note 31, at 504.

B. *The International Health Regulations*

The IHR, arising out of the pre-WHO International Sanitary Regulations, were initially developed to address the spread of diseases across borders, culminating in the establishment of the WHO to adequately address global health.[58] Reestablished under WHO governance, these International Sanitary Regulations were renamed the "International Health Regulations" in 1969 and revised to ensure maximum security against the international spread of diseases with minimal disruptions to daily life.[59] The IHR were initially developed to address only three diseases: cholera, yellow fever, and plague.[60] The WHO used its constitutional lawmaking authority to create the regulations under Article 21 of the WHO Constitution.[61] The IHR have been revised several times since they were adopted in 1969 to address perceived weaknesses in their implementation.[62]

During the Severe Acute Respiratory Syndrome ("SARS") outbreak between 2002 and 2003, the IHR remained limited in terms of notifications on public health emergencies to the WHO, only requiring states to report on a handful of diseases, even if other diseases posed international concern.[63] Since SARS was not a disease that the IHR required states to report, the IHR were rendered ineffective during the outbreak.[64] As a result, no legal justification existed to pressure the Chinese government to report cases of SARS, leading to a failure to control the spread of the disease in Asia.[65] In response to the SARS outbreak, the WHO attempted to change its notification requirements in the IHR by broadening the definition of reportable events to public health emergencies of international concern and by requiring notification of these events to the WHO within twenty-four hours of detection.[66] However, this requirement has not led to member states adequately reporting disease

58. *See* David P. Fidler, *Return of the Fourth Horseman: Emerging Infectious Diseases and International Law*, 81 MINN. L. REV. 771, 835–36 (1997) [hereinafter Fidler, *Return of the Fourth Horseman*].

59. *See* WORLD HEALTH ORG., INTERNATIONAL HEALTH REGULATIONS (1969) 5 (1983), https://apps.who.int/iris/bitstream/handle/10665/96616/9241580070.pdf?sequence=1&isAllowed=y [https://perma.cc/P4HQ-UQKU] [hereinafter WORLD HEALTH ORG., INTERNATIONAL].

60. *See* David P. Fidler, *From International Sanitary Conventions to Global Health Security: The New International Health Regulations*, 4 CHINESE J. INT'L L. 325, 338 (2005) [hereinafter Fidler, *From International Sanitary*].

61. *See* Fidler, *Return of the Fourth Horseman*, *supra* note 58, at 835.

62. *See* Gostin & Meier, *Introducing Global Health Law*, *supra* note 12, at 790.

63. *See* Lawrence O. Gostin, *International Infectious Disease Law: Revision of the World Health Organization's International Health Regulations*, 291 J. AM. MED. ASS'N 2623, 2625 (2004).

64. *See* David P. Fidler, *Germs, Governance, and Global Public Health in the Wake of SARS*, 113 J. CLINICAL INVESTIGATION 799, 801 (2004).

65. *See id.*

66. Lawrence O. Gostin, Roojin Habibi & Benjamin Mason Meier, *Has Global Health Law Risen To Meet the COVID-19 Challenge? Revisiting the International Health Regulations To Prepare for Future Threats*, 48 J.L. MED. & ETHICS 376, 377 (2020) [hereinafter Gostin et al., *Global Health Law*].

outbreaks in a timely manner.[67] By not having independent investigative powers to review national implementation, the WHO has relied completely on member states to self-report disease threats within their borders.[68] Many of these member states have failed to implement adequate reporting for fear of potential economic repercussions, such as drops in tourism and international trade.[69]

Reflecting on these limitations, WHO member states revised the IHR in 2005 to account for new actors in global health, such as nongovernmental surveillance sources, and to provide a more comprehensive response to disease outbreaks.[70] Through the establishment and revision of the IHR, the requirements are binding on all WHO member states unless member states specifically and affirmatively opt out of the IHR within a stated period of time.[71] This "opt out" process of ratification is extremely powerful because member states automatically become parties to WHO regulations unless they take specific action to reject the legal instrument.[72] The 2005 IHR were widely accepted, with 196 state parties formally adopting the measures.[73] This reception is important because the most recent revision of the IHR incorporated human rights obligations, stating that implementation of the IHR "shall be with the full respect for the dignity, human rights, and fundamental freedoms of persons."[74] Human rights obligations are essential to health policy because they help ensure that nations are implementing policies that help to maintain the health of their populations without stripping away their rights secured under international human rights law.

The WHO oversees the governance and implementation of the IHR by member states.[75] However, the success of the IHR depends on member states meeting the obligations required by the IHR, rather than just adopting the instrument. State parties are required to implement legal obligations under the IHR into their national health systems, strengthening their national capacities

67. *See id.* at 378 (explaining that notification delays still existed in the COVID-19 response and these delays significantly hindered the WHO's ability to respond to the spread of COVID-19).

68. *See id.*

69. Morten Broberg, *A Critical Appraisal of the World Health Organization's International Health Regulations (2005) in Times of Pandemic: It Is Time for Revision*, 11 EUR. J. RISK REGUL. 202, 207 (2020).

70. *See* Fidler, *From International Sanitary*, *supra* note 60, at 373–74.

71. *See* WORLD HEALTH ORG., INTERNATIONAL HEALTH REGULATIONS (2005) 36–37 (2d. ed. 2008), https://www.who.int/publications/i/item/9789241580410 [https://perma.cc/H5S5-TD9G (staff-uploaded archive)] [hereinafter WORLD HEALTH ORG., IHR (2005)] (click "Download (386.8 kB)").

72. *See id.* In IHR (2005), the period for state rejection is eighteen months from the Director-General's notification of IHR adoption. *Id.*

73. *See International Health Regulations: Overview*, WORLD HEALTH ORG., https://www.who.int/health-topics/international-health-regulations#tab=tab_1 [https://perma.cc/G3V3-RK2C].

74. WORLD HEALTH ORG., IHR (2005), *supra* note 71, at 10.

75. *See id.* at 3–5.

to address disease outbreaks.[76] Within the document are requirements for timely and adequate reporting of disease cases and core national capacity requirements for national legislation, policy, financing, risk communication, response, preparedness, and surveillance.[77] These requirements are designed to provide countries with robust detection and response systems to public health emergencies.[78]

However, not all states have reformed their national laws to meet IHR obligations, pushing the WHO to work with states to develop monitoring mechanisms to facilitate accountability for public health reforms.[79] This push resulted in the establishment of the Joint External Evaluation ("JEE"), which provides monitoring and evaluation tools to assess IHR implementation at the country level and creates an independent expert review process to assess national progress, find gaps in implementation, and identify best practices for each country.[80]

Along with failing to ensure adequate reporting, the IHR requirements have not aided countries—particularly low-income countries—in developing core capacities necessary to effectively respond to disease outbreaks.[81] The IHR required signatories to establish eight national surveillance and response capacities; however, very few signatories developed these capacities after the 2005 IHR revision.[82] One particularly important capacity is a comprehensive surveillance system.[83] Consider the H1N1 virus,[84] first reported by Mexico in

76. *See id.* at 4.

77. *See* WORLD HEALTH ORG., CHECKLIST AND INDICATORS FOR MONITORING PROGRESS IN THE DEVELOPMENT OF IHR CORE CAPACITIES IN STATES PARTIES 15–16 (2013), https://www.who.int/publications/i/item/who-hse-gcr-2013-2 [https://perma.cc/FU5A-W4TC (staff-uploaded archive) [hereinafter WORLD HEALTH ORG., CHECKLIST] (click "Download (823.9 kB)"); Amitabh B. Suthar, Lisa G. Allen, Sara Cifuentes, Christopher Dye & Jason M. Nagata, *Lessons Learnt from Implementation of the International Health Regulations: A Systematic Review*, 96 BULL. WORLD HEALTH ORG. 110 (2018).

78. *See* Rebecca Katz, *Use of Revised International Health Regulations During Influenza A (H1N1) Epidemic, 2009*, 15 EMERGING INFECTIOUS DISEASES 1165, 1165 (2009).

79. *See* Gostin et al., *Global Health Law*, *supra* note 66, at 378.

80. *Id.*

81. *See* Olushayo Oluseun Olu, *The Ebola Virus Disease Outbreak in West Africa: A Wake-Up Call To Revitalize Implementation of the International Health Regulations*, FRONTIERS PUB. HEALTH, 1, 1–2 (2020). These eight core capacities are as follows: (1) national legislation, policy, and financing; (2) coordination and national focal point; (3) surveillance; (4) response; (5) preparedness; (6) risk communication; (7) human resources; and (8) laboratory. *Id.*

82. *Id.*

83. *Id.* at 2 (explaining how a weak disease surveillance system made it impossible for officials to declare the Ebola Virus Disease a public health emergency until well after the initial outbreak).

84. The H1N1 virus is a novel influenza virus that was first detected in the United States in 2009 and quickly spread across the world. Between April 2009 and April 2010, the CDC estimates that there were 60.8 million cases of H1N1 in the United States. *See 2009 H1N1 Pandemic*, CTRS. FOR DISEASE CONTROL & PREVENTION (June 11, 2009), https://www.cdc.gov/flu/pandemic-resources/2009-h1n1-pandemic.html [https://perma.cc/L9CP-H382].

March 2009.[85] Mexico did not have a high-quality, readily available surveillance system, which led to a delay in reporting any detected H1N1 cases and the inflation mortality numbers.[86] Similarly, during the Ebola crisis, many countries in West Africa had not developed the core capacities required by the WHO.[87] The lack of core capacities caused countries like Guinea, Liberia, and Sierra Leone to fail to report cases of Ebola, preventing the WHO from declaring Ebola a Public Health Emergency of International Concern.[88] Seeing weaknesses in the IHR's ability to help build national capacities, forty-four countries came together in 2014 to develop the Global Health Security Agenda ("GHSA"), which operates outside the structures of the WHO to support countries' efforts to prevent, detect, and respond to public health emergencies.[89]

C. *The Global Health Security Agenda*

The GHSA seeks to accelerate progress to implement health security at the country level through eleven "Action Packages" that are designed to help countries prevent, detect, and respond to public health emergencies.[90] Realizing these Action Packages would require public health law reforms to support states in implementing IHR responsibilities.[91] National public health law reforms are necessary to realize national capacities, meet legal obligations from these Action Packages, and promote global health security.[92]

85. Rebecca Katz & Julie Fischer, *The Revised International Health Regulations: A Framework for Global Pandemic Response*, GLOB. HEALTH GOVERNANCE, Spring 2010, at 1, 4.

86. Kumanan Wilson, John S. Brownstein & David P. Fidler, *Strengthening the International Health Regulations: Lessons from the H1N1 Pandemic*, 25 HEALTH POL'Y & PLAN. 505, 506 (2010).

87. Lawrence O. Gostin, *The Future of the World Health Organization: Lessons Learned from Ebola*, 93 MILBANK Q. 475, 477 (2015).

88. *See* Tsung-Ling Lee, *Making International Health Regulations Work: Lessons from the 2014 Ebola Outbreak*, 49 VAND. J. TRANSNAT'L L. 931, 942–43 (2016).

89. *See* Rebecca Katz, Erin M Sorrell, Sarah A. Kornblet & Julie E. Fisher, *Global Health Security Agenda and the International Health Regulations: Moving Forward*, 12 BIOSECURITY & BIOTERRORISM 231, 231–32 (2014) [hereinafter Katz et al., *Global Health Security*]; Hae-Wol Cho & Chaeshin Chu, *Out of Africa, into Global Health Security Agenda*, 5 OSONG PUB. HEALTH & RSCH. PERSPS. 313, 313 (2014).

90. The eleven Action Packages are: (1) Antimicrobial Resistance, (2) Zoonotic Diseases, (3) Biosafety/Biosecurity, (4) Immunizations, (5) Laboratory Systems, (6) Surveillance, (7) Reporting, (8) Workforce Development, (9) Emergency Operations Centers, (10) Law Enforcement, and (11) Medical Countermeasures. *See generally* CTRS. FOR DISEASE CONTROL & PREVENTION, GLOBAL HEALTH SECURITY ACTION PACKAGES (2014), https://www.cdc.gov/globalhealth/healthprotection/ghs/pdf/ghsa-action-packages_24-september-2014.pdf [https://perma.cc/3L7K-SWVK] (describing the contents of each Action Package).

91. *See* Benjamin Mason Meier, Kara Tureski, Emily Bockh, Derek Carr, Ana Ayala, Anna Roberts, Lindsay Cloud, Nicolas Wilhelm & Scott Burris, *Examining National Public Health Law To Realize the Global Health Security Agenda*, 25 MED. L. REV. 240, 242 (2017) [hereinafter Meier et al., *Examining National*].

92. *Id.*

The GHSA focuses on low- and middle-income countries because of their limited ability to establish minimum core capacities under the IHR.[93] This focus highlights the need for cooperation on a global scale to adequately address public health emergencies. While the GHSA emphasizes the need for stronger legal frameworks to address infectious disease outbreaks, gaps in public health laws have hindered responses to public health emergencies.[94]

With many countries slow to initially adopt the GHSA in 2014, the Ebola crisis increased the number of countries that eventually signed on to this agenda.[95] The GHSA provides a collaborative path outside the WHO to support those states' efforts to implement the IHR by working directly with national governments to develop the core public health capacities required by the IHR.[96] The Ebola crisis highlighted the inefficiency of national laws to respond to infectious diseases, demonstrating that national laws that reflect international norms and the core capacities contained in the IHR are imperative for proper GHSA implementation.[97]

However, with rising inequity in national laws aimed at addressing public health emergencies, the GHSA has faced continuing obstacles in addressing infectious disease outbreaks, such as COVID-19, leading to the birth of a twelfth GHSA Action Package on Legal Preparedness in 2021.[98] This legal Action Package has two main purposes: (1) to bring together state and nonstate actors to define legal preparedness and (2) to advocate for the use of existing legal preparedness tools to advance the GHSA's mission and goals of better supporting countries around the world in building capacity for preparedness.[99]

II. GAPS IN EXISTING GLOBAL HEALTH LAW

Despite past reforms, including states' revisions to the IHR in 2005 and the establishment of the GHSA in 2014, these legal instruments have remained limited in addressing infectious disease outbreaks. The COVID-19 pandemic has exposed the global impact of these gaps in global health law. Some of these

93. *See* Aida Hassan, *There Is No Global in Global Health Security*, PLOS (May 5, 2022), https://speakingofmedicine.plos.org/2022/05/05/there-is-no-global-in-global-health-security/ [https://perma.cc/4KYV-3GQA].

94. Tsion Berhane Ghedamu & Benjamin Mason Meier, *Assessing National Public Health Law To Prevent Infectious Disease Outbreaks: Immunization Law as a Basis for Global Health Security*, 47 J.L. MED. & ETHICS 412, 414 (2019).

95. Cho & Chu, *supra* note 89, at 313.

96. *See* Katz et al., *Global Health Security*, *supra* note 89, at 232.

97. *See* Meier et al., *Examining National*, *supra* note 91, at 244–45.

98. *See Legal Preparedness*, GLOB. HEALTH SEC. AGENDA, https://ghsagenda.org/legal-preparedness/ [https://perma.cc/XXS3-5BK3].

99. Ana Ayala, Adam Brush, Sheun Chai, Jose Fernandez, Katherine Ginsbach, Katie Gottschalk, Sam Halabi, Divya Hosangadi, Dawn Mapatano, John Monahan, Carla Moretti, Mara Pillinger, Gabriela Silvana Ramirez & Emily Rosenfeld, *Advancing Legal Preparedness Through the Global Health Security Agenda*, 50 J.L. MED. & ETHICS 200, 201 (2022).

gaps became apparent during previous disease outbreaks, while others have emerged with this novel COVID-19 pandemic.[100] These gaps have led to countries not implementing IHR and GHSA guidelines in their national health systems, allowing for an avoidable increase in COVID-19 cases around the world.[101] These global health instruments were designed to prevent, detect, and respond to the next disease outbreak, but have fallen well short of these goals for several reasons, including a lack of effective accountability mechanisms that ensure compliance with public health capacities, global health solidarity, and human rights obligations.

A. *Noncompliance with Global Health Law Endangers Global Health*

Many of the problems exposed by the COVID-19 pandemic can be solved with an adequate accountability framework that requires parties to the IHR and the GHSA to adequately implement their requirements. Without these measures to ensure compliance with international human rights standards and global solidarity, both the IHR and the GHSA have allowed countries to pursue responses to the pandemic that are clear violations of human rights, such as travel bans and school closures.[102] To realize global health law, "national governments must establish appropriate legal authorities."[103] However, the fact that many countries struggled to implement these IHR legal norms proves that "[n]ational reforms are necessary to realize national capacities, meet international legal obligations, and promote global health security."[104] After years of spending cuts and structural adjustments, many governments have been left ill-equipped to treat the growing number of COVID-19 patients, violating the right to health under international law.[105]

The lack of meaningful accountability mechanisms has resulted in states ignoring their obligations towards global solidarity.[106] Under the IHR, states have vertical and horizontal coordination obligations.[107] The IHR require

100. *See* Joshua Busby, Karen A. Grépin & Jeremy Youde, *Ebola: Implications for Global Health Governance*, GLOB. HEALTH GOVERNANCE (Apr. 25, 2016), http://blogs.shu.edu/ghg/2016/04/25/ebola-implications-for-global-health-governance/ [https://perma.cc/965T-LDEM] (explaining that the Ebola epidemic highlighted the shortcomings in national implementation of the IHR); Gostin et al., *Developing an Innovative Pandemic Treaty*, *supra* note 31, at 505.

101. Gostin et al., *Developing an Innovative Pandemic Treaty*, *supra* note 31, at 505.

102. *Id.* at 504; *see also About*, *supra* note 1.

103. Meier et al., *Examining National*, *supra* note 91, at 241.

104. *Id.* at 242.

105. Dainius Pūras, Judith Bueno de Mesquita, Juisa Cabal, Allan Maleche & Benjamin Mason Meier, *The Right to Health Must Guide Responses to COVID-19*, 395 LANCET 1888, 1888 (2020).

106. *See* Gostin et al., *Global Health Law*, *supra* note 66, at 379.

107. Horizontal coordination obligations involve different sectors within a country working together to create a national public health response. Vertical coordination involves different member

international collaboration and assistance, yet this coordination requires sharing health research, medical equipment, and best practices, which was not done in the early days of the COVID-19 pandemic by many countries.[108] Coordination also involves collaboration across sectors, whose activities have an impact on the health of the nation's population.[109] The IHR pull in relevant population health stakeholders, whose responsibilities include surveillance, reporting, points of entry, public health services, clinics and hospitals, and other government departments.[110] Previously, the 2012 Middle East Respiratory Syndrome ("MERS") outbreak highlighted the need to strengthen collaboration between health and other key sectors, such as the aviation industry, to enhance the communication process between them.[111] MERS also highlighted the need for international coordination under global governance, resulting in the WHO contacting states to share public updates about the number of cases, the spread, and potential treatment options of MERS.[112] With regard to vertical coordination during the COVID-19 pandemic, there was insufficient international assistance to support vulnerable health systems, leading to outbreaks that continued to overwhelm health systems, particularly in low-income countries.[113]

Additionally, without effective accountability mechanisms, countries violated a wide range of human rights in their COVID-19 responses, such as the freedom of movement through border closures, and the right to essential vaccines through restrictive intellectual property laws.[114] Quarantine and social distancing policies also have their own human rights implications, affecting a range of social and economic rights such as rights to housing, food, water, and sanitation, which disproportionally affect marginalized and disadvantaged

states working together in global solidarity to address a Public Health Event of International Concern. *See* Lawrence O. Gostin & Rebecca Katz, *The International Health Regulations: The Governing Framework for Global Health Security*, 94 MILBANK Q. 264, 291 (2016) [hereinafter Gostin & Katz, *The International Health Regulations*].

108. Pūras et al., *supra* note 105, at 1889.

109. See Meier et al., *The World Health Organization*, *supra* note 25, at 798.

110. *See* WORLD HEALTH ORG., IHR (2005), *supra* note 71, at 11.

111. *World Health Organization Statement on the Ninth Meeting of the IHR Emergency Committee Regarding MERS-CoV*, WORLD HEALTH ORG. (June 17, 2015), https://www.who.int/news/item/17-06-2015-who-statement-on-the-ninth-meeting-of-the-ihr-emergency-committee-regarding-mers-cov [https://perma.cc/9WGU-6EPY].

112. Jeremy Youde, *MERS and Global Health Governance*, 70 INT'L J. 119, 129 (2014).

113. *See* Caitlin R. Williams, Jocelyn Getgen Kestenbaum & Benjamin Mason Meier, *Populist Nationalism Threatens Health and Human Rights in the COVID-19 Response*, 110 AM. J. PUB. HEALTH 1766, 1767 (2020).

114. *See* Hanna E. Huffstetler, Caitlin R. Williams, Benjamin M. Meier & UNC Health and Human Rights Working Group, *Human Rights in Domestic Responses to the COVID-19 Pandemic: Preliminary Findings from a Media-Coverage Database To Track Human Rights Violations*, 9 LANCET GLOB. HEALTH, S16, S16 (2021).

communities.[115] These inadequacies challenge human rights under international law. Nations continue to violate human rights in their pandemic policies, leading to even more global suffering throughout the COVID-19 pandemic.[116]

With the IHR and the GHSA failing to properly respond to and mitigate the effects of the COVID-19 pandemic, global health leaders have raised an imperative for international legal reforms to better define state obligations in the face of disease outbreaks, facilitate accountability for meeting these obligations, and effectively respond to future disease threats to prevent the next pandemic.[117] There have also been calls to mainstream human rights in these reforms to prevent further violations in responses to global health emergencies.[118] These goals can best be achieved by creating a new comprehensive document solely dedicated to responding to a pandemic, with strong accountability mechanisms to buttress its obligations and support the implementation of ancillary standards.

B. *Existing Global Health Law Lacks Accountability for Implementation*

With the IHR and the GHSA acting as leading sources of global health law, it is important that these sources include meaningful accountability mechanisms to ensure the proper translation of global health law into national law by member states. However, both the IHR and the GHSA lack these accountability mechanisms, resulting in weak national health systems.[119] Early versions of the IHR remained weak on accountability mechanisms, causing the WHO to rely completely on member states to voluntarily report cases of diseases (with many countries failing to report these cases for fear of economic consequences).[120] The current IHR also have no meaningful accountability mechanisms.[121] While the JEE seeks to provide an accountability mechanism to ensure that countries implement the IHR, not all states participate in this

115. Benjamin Mason Meier & Judith Bueno de Mesquita, *Realizing the Right to Health Must Be the Foundation of the COVID-19 Response*, UNIVERSAL RTS. GRP. (May 6, 2020), https://www.universal-rights.org/nyc/blog-nyc/realizing-the-right-to-health-must-be-the-foundation-of-the-covid-19-response/ [https://perma.cc/V5AA-YME2].

116. *The Coronavirus World Map: Tracking the Global Outbreak*, N.Y. TIMES (Aug. 13, 2022), https://www.nytimes.com/interactive/2021/world/covid-cases.html [https://perma.cc/RQ2J-2TJ8 (dark archive)].

117. *See Learn from COVID Before Diving into a Pandemic Treaty*, *supra* note 7, at 165.

118. Global health scholars and human rights advocates have criticized WHO member states for their lack of cooperation in mainstreaming human rights in approaches to prevent and curtail public health emergencies. *See* Roojin Habibi, Tim Fish Hodgson, Benjamin Mason Meier, Ian Seiderman & Steven Hoffman, *Reshaping Global Health Law in the Wake of COVID-19 To Uphold Human Rights*, HEALTH & HUM. RTS. J. (June 1, 2021), https://www.hhrjournal.org/2021/06/reshaping-global-health-law-in-the-wake-of-covid-19-to-uphold-human-rights/ [https://perma.cc/GP7X-6WD8].

119. *See* Gostin et al., *Global Health Law*, *supra* note 66, at 378.

120. *See* Gostin & Katz, *The International Health Regulations*, *supra* note 107, at 279.

121. *See* Gostin et al., *Global Health Law*, *supra* note 66, at 378 ("[S]tates were slow to reform their public health capacities following IHR (2005).").

process, as it is completely voluntary, thereby limiting its effectiveness.[122] The JEE acts within the WHO and provides an independent expert review that audits national progress in attaining IHR core capacities, finds gaps in implementation, and identifies best practices.[123] However, this measure has not been as effective as global leaders initially hoped, and many states continue to have weak health systems with inadequate legal capacities.[124] Additionally, there are no meaningful sanctions imposed by the JEE on member states, meaning that countries do not have any real punishment for noncompliance.[125] The lack of meaningful accountability mechanisms in the IHR was highlighted during the Ebola crisis and has made it necessary for the WHO to create outside monitoring mechanisms to facilitate accountability for public health reform.[126]

Emphasizing the need to harmonize national laws to better achieve IHR requirements, the GHSA was developed as a solution to the IHR, which lacked the legal capacities necessary for proper implementation. Yet, as of August 2022, only seventy countries have signed on to the GHSA, showing that while it has immense political backing, it still does not have the consensus exhibited by the IHR.[127] This lack of universal acceptance creates gaps in global health governance and disjointed efforts to address global health emergencies. Additionally, many of the GHSA Action Packages reference human rights issues, including the protection of privacy rights in surveillance and reporting initiatives, medical countermeasures and bodily integrity, freedom of movement rights, and interventions that may raise procedural rights issues.[128] However, the GHSA does not have adequate safeguards to ensure that activities

122. THE INDEP. PANEL FOR PANDEMIC PREPAREDNESS & RESPONSE, COVID-19: MAKE IT THE LAST PANDEMIC 16 (2021), https://theindependentpanel.org/wp-content/uploads/2021/05/COVID-19-Make-it-the-Last-Pandemic_final.pdf [https://perma.cc/MKY7-4ZHR].

123. *See* WORLD HEALTH ORG., JOINT EXTERNAL EVALUATION: INTERNATIONAL HEALTH REGULATIONS (2005) 2 (2005), https://apps.who.int/iris/bitstream/handle/10665/204368/9789241510172_eng.pdf [https://perma.cc/W3GW-VF56] [hereinafter WORLD HEALTH ORG., JOINT EXTERNAL EVALUATION].

124. *See* Meier et al., *Examining National*, *supra* note 91, at 245.

125. *See* Matthew J. Boyd, Nick Wilson & Cassidy Nelson, *Validation Analysis of Global Health Security Index (GHSI) Scores 2019*, 5 BMJ GLOB. HEALTH 1, 2 (2020) (explaining the process of the JEE and how the process only produces a score on how countries are doing in terms of addressing public health emergencies of international concern).

126. *See* Lee, *supra* note 88, at 977–78.

127. *Compare Key Achievements of GHSA*, CTRS. FOR DISEASE CONTROL & PREVENTION (May 19, 2022), https://www.cdc.gov/globalhealth/resources/factsheets/5-years-of-ghsa.html [https://perma.cc/VV6N-QSM9] (explaining that over seventy countries have joined the GHSA), *with International Health Regulations*, WORLD HEALTH ORG., https://www.who.int/health-topics/international-health-regulations#tab=tab_1 [https://perma.cc/WB2P-E2EW] (explaining that 196 countries have joined the IHR).

128. Sharifah Sekalala & John Harrington, *Communicable Diseases, Health Security, and Human Rights: From AIDS to Ebola*, *in* FOUNDATIONS OF GLOBAL HEALTH & HUMAN RIGHTS 221, 236 (Lawrence O. Gostin & Benjamin Mason Meier eds., 2020).

conducted in furtherance of the Action Packages are conducted in ways that respect, protect, and fulfill human rights.[129] Like the IHR, the GHSA contains no requirements that countries comply with international human rights standards, representing a lost opportunity for accountability and enforceability on human rights obligations.[130]

III. A PANDEMIC TREATY IS NECESSARY TO ADVANCE GLOBAL HEALTH LAW

With its December 1, 2021, agreement to develop a treaty on pandemic prevention, preparedness, and response, the WHO decided to create a new legal instrument in addition to revising existing global health law.[131] In analyzing why the creation of a pandemic treaty is necessary, this part will examine how this treaty can complement existing global health law and facilitate accountability for national reforms in addition to revising legal instruments like the GHSA and the IHR.

A. *Creating a New Legal Instrument in Addition to Revising Existing Doctrines*

With the COVID-19 pandemic exposing gaps in existing global health law, world leaders came together to call for united action to predict, prevent, detect, assess, and effectively respond to pandemics in the future.[132] These leaders said that collective action could "foster an all-of-government and all-of-society approach, strengthening national, regional and global capacities and resilience to future pandemics."[133] With the question not being if, but when another pandemic will occur, it is important for the world to be better prepared to address future pandemics in a coordinated manner. This can be achieved with a pandemic treaty.[134]

In discussions related to developing a new legal instrument, many scholars have questioned why the WHO should create a new legal instrument as opposed to revising an existing source of global health law that has already been

129. *Id.*

130. *Id.*

131. *World Health Assembly Process*, *supra* note 6.

132. *Global Leaders United in Urgent Call for International Pandemic Treaty*, WORLD HEALTH ORG. (Mar. 30, 2021), https://www.who.int/news/item/30-03-2021-global-leaders-unite-in-urgent-call-for-international-pandemic-treaty [https://perma.cc/UY9X-9SQ8].

133. *COVID-19 Shows Why United Action Is Needed for More Robust International Health Architecture*, WORLD HEALTH ORG. (Mar. 30, 2021), https://www.who.int/news-room/commentaries/detail/op-ed---covid-19-shows-why-united-action-is-needed-for-more-robust-international-health-architecture [https://perma.cc/K5D3-TUBK].

134. WORLD HEALTH ORG., JOINT EXTERNAL EVALUATION, *supra* note 123.

adopted, such as the IHR.[135] This is a valid concern since many countries are hesitant to start from scratch in creating a robust international doctrine.[136] Other countries still prefer to take an isolationist approach and are unwilling to even join the negotiation table.[137] However, there are many reasons why a new pandemic treaty would prove to be more effective in responding to another pandemic.

Many national leaders and scholars have suggested that instead of creating a new pandemic treaty, the WHO should only try to revise the IHR.[138] There are valid reasons for this argument. For one, the IHR has already been approved unanimously by all 194 WHO member states, showing that there is immense consensus on IHR being a leading global health regulation.[139] Developing this kind of consensus for another document, especially in an age where populist nationalism is rampant, would be difficult.[140] Because the IHR has existed since the start of the WHO, there is a reliance interest in maintaining this document as the leading source of international law on global health.[141] Additionally, the IHR has a well-funded secretariat under the WHO, which oversees health security and has convened an eighteen-member state panel called the COVID-19 Emergency Committee.[142] Certain members of this committee, such as China, Brazil, and Russia, have indicated that they would not support a pandemic treaty.[143] Other member states, particularly in the Global South,[144] have also indicated that they would be reluctant to join the negotiation table to

135. *See generally* Clare Wenham, Mark Eccleston-Turner & Maike Voss, *The Futility of the Pandemic Treaty: Caught Between Globalism and Statism*, 98 INT'L AFFS. 837 (2022) (explaining that a pandemic treaty will not solve all the problems exposed by COVID-19 and that the IHR can be revised to be more relevant and current).

136. Ronald Labonté, Mary Wiktorowicz, Corrine Packer, Arne Ruckert, Kumanan Wilson & Sam Halabi, *A Pandemic Treaty, Revised International Health Regulations, or Both?*, 17 GLOBALIZATION & HEALTH, Nov. 2021, at 3, 3.

137. *See id.* at 2 (mentioning that China, the United States, Russia, and Brazil have expressed that they would not support a pandemic treaty).

138. *See generally* Labonté et al., *supra* note 136 (explaining the reasoning scholars believe that global health actors should prioritize revising the IHR instead of drafting a new legal instrument).

139. Labonté et al., *supra* note 136, at 2.

140. Populist nationalism refers to the tendency for countries to turn inward and prioritize national interests over the globalized world. *See* Williams et al., *supra* note 113, at 1766.

141. Meier et al., *The World Health Organization*, *supra* note 25, at 797 (explaining that the WHO inherited and then adopted the IHR in 1951 and that the current IHR is one of the most widely subscribed agreements under the UN system).

142. Labonté et al., *supra* note 136, at 2.

143. *Id.*

144. The "Global South" is often used to refer to lower-income countries, mainly countries outside of North America and Europe. *See* Marlea Clark, *Global South: What Does It Mean and Why Use the Term?*, U. VICTORIA POL. SCI. (Aug. 8, 2018), https://onlineacademiccommunity.uvic.ca/globalsouthpolitics/2018/08/08/global-south-what-does-it-mean-and-why-use-the-term/ [https://perma.cc/JQX3-MNVJ].

draft such a legal instrument.[145] With many of these countries pursuing nationalistic policies,[146] it is unclear how these countries will respond to a legally binding instrument.

While getting national governments to sign on to a pandemic treaty would require immense political will, there are legal advantages to drafting an entirely new legal document. The revision process for the IHR is extremely time-consuming. In 1995, the World Health Assembly called on the WHO to begin exploring options to revise the IHR.[147] Those revisions were finally implemented in 2005.[148] Developing a pandemic treaty, which is also a somewhat lengthy process,[149] will allow for critical change to happen faster and more efficiently through member states addressing competing priorities.[150] It is unclear how many countries will eventually support creating a pandemic treaty. However, as of October 2021, sixty-one countries, including Germany and the United Kingdom, support this initiative, evidencing a significant amount of political will to continue to develop this instrument.[151] This growing political will is also visible with a consensus WHA decision made in December 2021 to begin negotiations on creating a legal instrument under the WHO Constitution to strengthen pandemic prevention, preparedness, and response.[152]

With this decision, the WHA laid out the process that will take place to negotiate, develop, and agree to a legal instrument. The decision created an Intergovernmental Negotiating Body ("INB"), which the WHA determined will begin the development of a working draft with substantive elements that were presented at the INB's second meeting, which took place between July 18 and 21, 2022.[153] During this meeting, the INB affirmed several guiding principles that should be included in the pandemic treaty, such as transparency, accountability, and solidarity in pandemic responses.[154] In 2023, the INB will

145. *See WHO: Should Members Pursue a Pandemic Treaty, in the Midst of a Global Pandemic*, THIRD WORLD NETWORK (May 12, 2021), https://www.twn.my/title2/health.info/2021/hi210507.htm [https://perma.cc/7E9C-5A94].

146. *See supra* note 2 and accompanying text.

147. U.N. WHA, 48th Sess., 12th plen. mtg. at 2, U.N. Doc. A48/VR/12 (May 12, 1995).

148. WORLD HEALTH ORG., INTERNATIONAL, *supra* note 59.

149. Labonté et al., *supra* note 136, at 3 (explaining that the twelve years it took to adopt the Framework Convention on Tobacco Control was a lengthy negotiating process to draft the treaty).

150. *Id.* at 2.

151. *Global Leaders Unite in Urgent Call for International Pandemic Treaty*, WORLD HEALTH ORG. (Mar. 30, 2021), https://www.who.int/news/item/30-03-2021-global-leaders-unite-in-urgent-call-for-international-pandemic-treaty [https://perma.cc/H8N8-MT4X].

152. *World Health Assembly Process*, *supra* note 6.

153. *Pandemic Instrument Should Be Legally Binding, INB Meeting Concludes*, WORLD HEALTH ORG. (July 21, 2022), https://www.who.int/news/item/21-07-2022-pandemic-instrument-should-be-legally-binding--inb-meeting-concludes [https://perma.cc/8BFY-MXWU].

154. WORLD HEALTH ORG., WORKING DRAFT, PRESENTED ON THE BASIS OF PROGRESS ACHIEVED, FOR THE CONSIDERATION OF THE INTERGOVERNMENTAL NEGOTIATING BODY AT

hold public hearings to inform its deliberations and deliver a progress report to the WHA.[155] It will then submit its outcome for consideration by the WHA in 2024.[156] Throughout this negotiation process, the INB will call on UN system bodies, nonstate actors, and other relevant stakeholders to support the creation of this instrument, reflecting the importance of coordination in addressing public health emergencies.[157]

B. *Process of Creating a Pandemic Treaty*

Part of the decision made at the December 2021 WHA Special Assembly was that the WHO would be the actor responsible for the creation of a pandemic treaty, as opposed to the UN or other international organizations.[158] Acting under the WHO's constitution, the article that best supports the creation of a pandemic treaty is Article 19. Although Article 19 provides the WHO with the power to create binding agreements under international law, the WHO has been reluctant to exercise this authority since it is easier to gather consensus on nonbinding soft law initiatives under Article 21.[159] Despite the WHO's hesitancy to use Article 19 to create a binding legal document, several global health actors are calling for the WHO to use this power to create more effective accountability measures to help respond to the next pandemic.[160] For example, the Independent Panel for Pandemic Preparedness & Response ("IPPPR"), a panel of global health experts empaneled by the WHO, urged the WHO to create a convention complementary to the IHR that would involve the highest levels of government, scientific experts, and civil society to address future pandemics.[161]

Creating a binding convention with the support of WHO member states will be challenging. In considering how the WHO will pursue drafting and enacting a pandemic treaty, it is important to analyze past instances in which the WHO has utilized Article 19. The WHO was only able to accomplish this once before, with the formation of the Framework Convention on Tobacco Control ("FCTC"),[162] a covenant developed in response to the globalization of the tobacco epidemic.[163] The FCTC came about through the participation of

ITS SECOND MEETING 4 (2022), https://apps.who.int/gb/inb/pdf_files/inb2/A_INB2_3-en.pdf [https://perma.cc/F4SX-7KAW].

155. *World Health Assembly Process*, *supra* note 6.

156. *Id.*

157. *Id.*

158. *Id.*

159. *See* Gostin et al., *Developing an Innovative Pandemic Treaty*, *supra* note 31, at 505.

160. *See* Wenham et al., *supra* note 135, at 8.

161. THE INDEP. PANEL FOR PANDEMIC PREPAREDNESS & RESPONSE, *supra* note 122, at 47.

162. WORLD HEALTH ORG., WHO FRAMEWORK CONVENTION ON TOBACCO CONTROL 5 (2003), https://fctc.who.int/publications/i/item/9241591013 [https://perma.cc/LE6W-W4U4].

163. *Id.*

nongovernmental organizations and public policy networks in the negotiation process.[164] The negotiation process for the FCTC was also notable because of the over 170 member states that participated and gave input on the provisions of the convention.[165]

The WHO will utilize a formation process similar to that of the FCTC when it starts negotiating a new pandemic treaty. In creating a new convention on pandemic preparedness and response, the INB must engage in wide-ranging diplomatic efforts with the UN, nonstate actors, and other relevant stakeholders in creating an intergovernmental negotiating body.[166] This negotiating body will then hold public hearings to inform its deliberations and deliver progress reports to determine the essential details of the convention until the WHA session in May 2024.[167] In order for the treaty to be enacted by the WHA, two-thirds of the 194 WHO member states must adopt the treaty.[168] This process will be arduous and will last for years before this legally binding document can be implemented.

A key challenge in negotiating a pandemic treaty will be to overcome geopolitical rivalries and health inequities that exist between countries.[169] During the COVID-19 pandemic, conflicts between countries, particularly between the United States and China, became more pronounced, highlighting the weakness of the WHO in promoting global solidarity.[170] Throughout the negotiation of the pandemic treaty, the WHO will have to be cognizant of these conflicts and ensure that certain essential elements, described in Part IV, are implemented in the treaty to prevent the next pandemic.[171]

C. *How a Pandemic Treaty Will Impact the United States*

Article 19 of the WHO Constitution says that once the WHO Health Assembly passes a treaty, it will come into force for a member state "when accepted by it in accordance with its constitutional processes."[172] Because the WHO Constitution requires that any treaty passed by the organization be adopted by member states in accordance with their constitutional processes, any treaty passed under Article 19 would not be self-executing apart from those

164. Michael Sparks, *Governance Beyond Governments: The Role of NGOs in the Implementation of the FCTC*, 17 GLOB. HEALTH PROMOTION, Issue 1 supplement, 2010, at 67, 68–69.

165. Jeff Collin, *Tobacco Politics*, 47 DEV. 91, 92 (2004).

166. *See World Health Assembly Process*, *supra* note 6.

167. Amy Maxmen, *World Commits to a Pandemic Response Pact: What's Next*, NATURE (Dec. 1, 2021), https://www.nature.com/articles/d41586-021-03596-y [https://perma.cc/TK62-HFJY].

168. *Id.*

169. Ilona Kickbusch & Anna Holzscheiter, *Can Geopolitics Derail the Pandemic Treaty?*, BMJ, Nov. 2021, at 1, 2.

170. *See id.* at 1.

171. *See infra* Part V.

172. WORLD HEALTH ORG., CONSTITUTION, *supra* note 29, at 7.

processes.[173] In the United States, in order for a self-executing treaty to be binding, it must be ratified by the President and a two-thirds supermajority of the Senate.[174] Treaties that are non-self-executing will become the law of the land in the United States and supersede state law only when implemented by Congress.[175] The Framers of the U.S. Constitution purposefully made room for international treaties through the treaty supremacy rule, which is codified in the Supremacy Clause, that would ensure the nation's ability to comply with its international obligations.[176] For a human rights treaty, the United States will either ratify it, like it has done for the International Covenant on Civil and Political Rights,[177] or declare the treaty non-self-executing, requiring Congress to pass a statute for the treaty to come into effect in the United States.

Ratifying a treaty or passing a statute to enforce international obligations will be extremely difficult in the United States. With partisan gridlock creating roadblocks to a consensus necessary to ratify treaties or pass statutes, it will be difficult for global health advocates to bring claims under this treaty. Even today, the United States still refuses to ratify most human rights treaties and, even if it does ratify a treaty, it usually does so with reservations.[178] Politicians have also used fearmongering to discuss the pandemic treaty with the public, claiming that such a treaty will supersede U.S. national law, which would be true only if the treaty were ratified.[179] However, even with the United States refusing to ratify international treaties, these treaties are still influential in holding the government accountable to international law. For example, with the FCTC, both domestic and international advocacy have proven to be helpful in stimulating interventions and holding decision-makers accountable for the enforcement of the provisions of this convention on tobacco control.[180] International and domestic advocacy efforts will be crucial in holding the United States accountable for meeting the requirements of a pandemic treaty even if the United States signs the treaty but never ratifies it.

173. *See id.*

174. U.S. CONST., art. II, § 2.

175. DAVID SLOSS, DEATH OF TREATY SUPREMACY: AN INVISIBLE CONSTITUTIONAL CHANGE 287 (2016).

176. *Id.*

177. *Status of Ratification Interactive Dashboard*, UNITED NATIONS HUM. RTS.: OFF. HIGH COMM'R, https://indicators.ohchr.org [https://perma.cc/79UQ-LXMQ].

178. *See* SLOSS, *supra* note 175, at 322.

179. Adam Taylor, *Global Health Talks Clouded by Conspiracy Theories About Pandemic Treaty*, WASH. POST (May 22, 2022, 7:30 PM), https://www.washingtonpost.com/world/2022/05/22/wha-who-pandemic-treaty/ [https://perma.cc/Y97H-8N26 (dark archive)].

180. THOMAS E. NOVOTNY & HADII M. MAMUDU, PROGRESSION OF TOBACCO CONTROL POLICIES: LESSONS FROM THE UNITED STATES AND IMPLICATIONS FOR GLOBAL ACTION 38–39 (2008).

IV. A PANDEMIC TREATY SHOULD ADOPT EFFECTIVE ACCOUNTABILITY MECHANISMS TO STRENGTHEN GLOBAL SOLIDARITY AND REALIZE THE HUMAN RIGHT TO HEALTH

The negotiation process of drafting and adopting a pandemic treaty will allow the WHO to include certain policies that will help countries prevent and respond to future pandemics. With the COVID-19 pandemic exposing gaps in existing global health law—particularly the lack of meaningful accountability mechanisms to ensure the implementation of the IHR and the GHSA—the WHO is now in a prime position to create a comprehensive, binding source of international law that will fill these gaps and complement other global health doctrines.[181] Drafting a pandemic treaty to include effective accountability mechanisms will also give the WHO a unique opportunity to strengthen human rights obligations and global solidarity in global health law.[182]

A. *Implementing Meaningful Accountability Measures*

The lack of meaningful accountability measures ensuring state compliance is one of the most prevalent weaknesses in existing sources of global health law. This has been highlighted especially by the COVID-19 pandemic and other public health emergencies.[183] The pandemic revealed that many countries ignored the WHO's public health guidance because the organization lacked adequate compliance mechanisms to monitor, investigate, and remediate harmful state actions.[184] Even without forceful accountability measures, treaties can still be effective in ensuring compliance with global health obligations.[185]

One issue that arises in the context of a treaty is how it will bind member states. Will member states be able to opt out or signal reservations they have to certain provisions? To use the FCTC as an example, 180 member states have ratified this convention, showing that it has immense political support.[186] Article 19 of the WHO Constitution provides little guidance as to whether an opt-out mechanism exists. Rather, it states that the convention will "come into force for each Member when accepted by it in accordance with its constitutional

181. Lawrence O. Gostin, Sam F. Halabi & Kevin A. Klock, *An International Agreement on Pandemic Prevention and Preparedness*, 326 J. AM. MED. ASS'N 1257, 1257–58 (2021) [hereinafter Gostin et al., *An International Agreement*].

182. Benjamin Mason Meier & Sonam K. Shah, *Advancing Human Rights in Global Health Through the Pandemic Treaty*, MCGILL PERSPS. ON GLOB. HEALTH (Nov. 27, 2021), http://www.perspectivesmcgill.com/opinion/humanrightsandpandemictreaty [https://perma.cc/Y7ZM-568C].

183. Gostin et al., *Developing an Innovative Pandemic Treaty*, *supra* note 31, at 504.

184. *Id.*

185. Eric A. Friedman & Lawrence O. Gostin, *Imagining Global Health with Justice: In Defense of the Right to Health*, 23 HEALTH CARE ANALYSIS 308, 324 (2015) [hereinafter Friedman & Gostin, *Imagining Global Health*].

186. *Id.* at 323.

processes" and that member states can submit "reservations" if they disagree with provisions in the treaty.[187] While the creation of a treaty rather than a set of regulations provides an added level of legal accountability, the WHO, in creating a pandemic treaty, will need to determine how it will keep member states compliant with any obligations and what enforcement mechanisms it will implement against member states. However, member states could still be subject to reporting requirements despite not ratifying a pandemic treaty by virtue of their WHO membership, which will help hold them accountable for the implementation of pandemic treaty guidelines.[188]

In creating an accountability framework for a pandemic treaty, the WHO should consider using monitoring and review procedures as a foundation for accountability. In the human rights context, "there is limited evidence that state ratification of human rights treaties leads to meaningful human rights implementation."[189] However, monitoring and reviewing procedures have been found to ensure human rights implementation for public health promotion.[190] An example of such a system is the Human Rights Council's Universal Periodic Review, which monitors the human rights records of every UN member state, not just those that have ratified the specific human rights treaties.[191] In the absence of a police force to enforce decisions passed by an international body, reporting requirements can put pressure on countries to implement treaty standards through the court of public opinion, with heightened public awareness to hold them accountable.[192] Any reporting requirements implemented by a pandemic treaty should also allow other countries to comment on the progress of fellow member states so as to ensure mutual accountability of countries in implementing pandemic treaty requirements.[193]

In addition to reporting and monitoring requirements, it is important to note that incentives would not effectively hold many wealthy countries accountable to their pandemic treaty obligations. These countries can afford to skirt pandemic guidelines.[194] Relatedly, monetary sanctions likely would not work against high-income countries, with those countries being able to afford to pay any penalties incurred. Additionally, there should be more meaningful

187. WORLD HEALTH ORG., CONSTITUTION, *supra* note 29, at 7.

188. Article 61 of the WHO Constitution requires states to report annually to the WHO any "actions taken and process achieved in improving the health of its people." *Id.* at 14.

189. Meier et al., *Monitoring and Review*, *supra* note 11, at 155.

190. *Id.*

191. *See* Felice D. Gaer, *A Voice Not an Echo: Universal Periodic Review and the UN Treaty Body System*, 7 HUM. RTS. L. REV. 109, 139 (2007).

192. Harvard Law School Human Rights Program, *The International Court of Justice Case on Genocide in Myanmar*, YOUTUBE (Feb. 27, 2020), https://www.youtube.com/watch?v=gYJB-ZxRkK8&t=884s [https://perma.cc/US7N-WWUZ].

193. *Id.*

194. *See* Friedman & Gostin, *Imagining Global Health*, *supra* note 185, at 322–25 (explaining that countries are unlikely to agree to economic sanctions).

enforceability mechanisms beyond simply reporting states' progress toward meeting their treaty obligations. As shown by the JEE, passive reporting is not enough to ensure compliance with IHR guidelines, and a treaty will need to have additional mechanisms to track a state's progress toward meeting global health obligations.[195]

While there is some evidence that an external independent review panel can be effective, it will need to have additional authority.[196] Commissioning reports on state progress is a good first step in creating an accountability system.[197] The WHO can also strengthen authority in a pandemic treaty's accountability system by requiring reporting by states. Robust reporting requirements for member states can help identify problems encountered in implementing a treaty and can assist with independent reviews of these efforts.[198] The WHO can also impose sanctions on states that do not implement treaty obligations. If the WHO chooses to pursue this method of accountability, the organization will need to evaluate what sanctions it wishes to impose on countries. Sanctions and reporting can be monitored by an independent panel. In fact, an Independent Accountability Panel already exists that operates for women's, children's, and adolescent's health.[199] This panel includes remedying human rights violations in its accountability framework, going beyond merely requiring countries to report on their progress in achieving certain global health outcomes.[200] Sanctions, along with requirements for regular reporting on states' progress toward meeting pandemic treaty obligations, will improve on current accountability frameworks that exist in global health.

B. *Effective Accountability Can Promote Global Solidarity and Human Rights*

Including robust monitoring and reporting requirements in a pandemic treaty can help the WHO realize global solidarity and fulfill human rights obligations that will be necessary to prevent the next pandemic. The IPPPR's report on pandemic preparedness recommends that a legal instrument ensures maximum complementarity, cooperation, and collective action across the international system at all levels.[201] The report notes that while the WHO

195. THE INDEP. PANEL FOR PANDEMIC PREPAREDNESS & RESPONSE, *supra* note 122, at 16.

196. *See* Gostin et al., *The Normative Authority*, *supra* note 38, at 858–59.

197. *Id.* at 860.

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

199. *See* Lawrence O. Gostin & Eric A. Friedman, *Global Health: A Pivotal Moment of Opportunity and Peril*, 36 HEALTH AFFS. 159, 163 (2017).

200. *See IAP at a Glance*, INDEP. ACCOUNTABILITY PANEL, https://iapewec.org/about/iapataglance/ [https://perma.cc/WZT7-LPEC].

201. THE INDEP. PANEL FOR PANDEMIC PREPAREDNESS & RESPONSE, *supra* note 122, at 47.

should be the leading health organization in the international health system, it is imperative that the preparedness and response system created in a pandemic treaty be well-coordinated in support of countries where different actors' comparative advantages are maximized.[202] Norms in the pandemic treaty will only be effective if they are implemented at all governance levels (locally, nationally, or globally) and in a fully transparent and cooperative manner.[203] A pandemic treaty focused on global solidarity will require states to "overcome nationalist forces . . . with leaders embracing diplomacy across nations to prepare for new challenges."[204] In order for the WHO to achieve the right to health in alignment with the UN Secretary-General's call for global solidarity, it must recognize international assistance and cooperation as central to pandemic responses, requiring that all states in a position to assist share research, medical equipment, supplies, and best practices.[205] Global solidarity also requires that intellectual property regimes, particularly regarding vaccines, do not impede access to crucial resources.[206]

Global health law depends on strong governance; however, the WHO has not been able to rally global solidarity throughout the COVID-19 pandemic because it lacks the legal authority and financial resources to effectively coordinate public health efforts across nations.[207] This new pandemic treaty should use robust accountability mechanisms to affirm states' obligations to implement legal norms that seek to provide international assistance and cooperation and ensure global solidarity in response to health emergencies and pandemics. In conjunction with this treaty, states should refrain from taking any actions that thwart global solidarity, such as utilizing isolationist policies (like travel bans) to combat the spread of disease.

Effective accountability mechanisms in a pandemic treaty will also help protect human rights. The WHO Constitution states that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being," officially declaring that health is a human right.[208] This right was further emphasized in the UN Universal Declaration of Human Rights.[209] Countries' responses to COVID-19 led to many human rights violations, such as restrictions in movement and hording of vaccine supplies, and ultimately failed to uphold the right to health.[210] With the right to health firmly established in global health governance, the WHO should uphold its

202. *Id.* at 48.
203. Gostin et al., *An International Agreement*, *supra* note 181, at 1258.
204. Gostin et al., *Developing an Innovative Pandemic Treaty*, *supra* note 31, at 507.
205. Pūras et al., *supra* note 105, at 1889.
206. *Id.*
207. Gostin et al., *Developing an Innovative Pandemic Treaty*, *supra* note 31, at 505.
208. WORLD HEALTH ORG., CONSTITUTION, *supra* note 29, at 1.
209. G.A. Res. 217 (III) A, Universal Declaration of Human Rights (Dec. 10, 1948).
210. *See supra* Section II.A.

constitutional mandate by including human rights obligations in its pandemic treaty.

The WHO can affirm the right to health and other human rights in a pandemic treaty by using accountability mechanisms to require member states to "maintain core public health capacities; ensure the availability, accessibility, and quality of health services; and provide access to basic needs during lockdowns."[211] Mainstreaming human rights in a pandemic treaty will require the WHO to prioritize principles of equity, nondiscrimination, participation from affected communities, transparency in reporting and decision-making, and accountability for health outcomes.[212]

Additional human rights obligations come in the form of extraterritorial obligations that member states have with each other. Extraterritorial human rights obligations speak to state acts or omissions that affect human rights beyond their territory.[213] Codifying this obligation in a pandemic treaty will create a pathway to realize the right to health in global health governance by strengthening international cooperation and defining key human rights obligations for member states.[214] This human rights obligation also speaks to other essential elements that should be included in a pandemic treaty. In order to strengthen human rights in international law, "[m]ainstreaming extraterritorial obligations in the pandemic treaty would provide international commitments under global health law and facilitate, through proposed institutional oversight mechanisms, accountability and global solidarity."[215] In achieving this goal, the WHO should prioritize support for states in the Global South and facilitate accountability through monitoring and reviewing obligations under WHO and UN human rights systems.[216] By aligning global health law and human rights obligations, the WHO can create a treaty that will meet any pandemic challenges ahead.

CONCLUSION

While the COVID-19 pandemic has tested the world's preparedness to prevent, detect, and respond to disease outbreaks, the WHO is now in a

211. Meier & Shah, *supra* note 182.

212. *Id.*

213. ETO CONSORTIUM, MAASTRICHT PRINCIPLES ON EXTRATERRITORIAL OBLIGATIONS OF STATES IN THE AREA OF ECONOMIC, SOCIAL & CULTURAL RIGHTS 7 (2013), https://www.fidh.org/IMG/pdf/maastricht-eto-principles-uk_web.pdf [https://perma.cc/52J7-BWS7].

214. Benjamin M. Meier, Judith Bueno de Mesquita & Sharifah Sekalala, *The Pandemic Treaty as a Framework for Global Solidarity: Extraterritorial Human Rights Obligations in Global Health Governance*, HARV. L. SCH. PETRIE-FLOM CTR. (Oct. 31, 2021), https://blog.petrieflom.law.harvard.edu/2021/10/13/pandemic-treaty-extraterritorial-obligations/ [https://perma.cc/W4FT-FACH].

215. *Id.*

216. *Id.*

position to create a legally binding treaty to prevent and respond to future pandemic threats.[217] This treaty will be complementary to existing global health law doctrines, such as the IHR and the GHSA, filling gaps in these existing sources of global health law to prepare states to better detect and respond to disease outbreaks. A treaty is preferable to other legal instruments to prevent another pandemic because of its legally binding nature and the lengthy revision processes associated with other recommendations and regulations.

In creating this pandemic treaty, the WHO will be using an article in its constitution that has only been used once before—Article 19.[218] This article gives the WHO the ability to create legally binding covenants enforceable on member states. In creating this doctrine, the WHO will have to navigate lengthy negotiation processes and geopolitical conflicts to generate consensus on what pandemic treaty obligations should be.

Throughout the negotiation process, the WHO should ensure that the treaty sets up an effective accountability system with a focus on monitoring and reporting to ensure that member states implement pandemic treaty obligations, including obligations for global solidarity and respecting human rights. This treaty can be monumental in global health law and can better prepare member states and global health actors to respond to future public health threats and be prepared for the next pandemic.

SONAM K. SHAH**

217. *World Health Assembly Process*, *supra* note 6.

218. WORLD HEALTH ORG., CONSTITUTION, *supra* note 29, at 7.

** J.D. Candidate, University of North Carolina School of Law. M.P.H. Candidate, University of North Carolina Gillings School of Global Public Health. I would like to thank Professor Benjamin Meier for his guidance and expertise in developing this ongoing topic. I would also like to thank my editors, Christie Shaw & Aaron Harding, for their editorial support and valuable insight throughout the publication process. Lastly, I would like to thank my friends and family for their unwavering support.