World view

By Rebecca Katz

Pandemic policy can learn from arms control

Ebola uncovered policy flaws. A bioweapons treaty might show a fix, says Rebecca Katz.

Last month, the World Health Organization (WHO) was reduced to the equivalent of playground pleading: 'But you promised!' Under an international treaty, some 195 countries are obliged to provide the WHO with information about disease outbreaks on request. So when Tanzania did not respond to queries about potential cases of Ebola, the WHO called the country out publicly in its official outbreak report. In bureaucratic circles, this 'naming and shaming' sent shock waves. The two have now made peace; on 18 October, the WHO lauded Tanzania for its cooperation and Ebola preparedness.

But the underlying problem is unsolved: the WHO has little recourse if countries do not meet their obligations to protect global health. Seven years ago, when Saudi Arabia was less than forthcoming about Middle East respiratory syndrome infections, the WHO thought its best option was to ask government officials for information, pretty pretty please. Its 'boldness' with Tanzania made up for past timidity.

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I think our best hope is to learn from the Biological Weapons Convention (BWC). This disarmament treaty, which entered into force in 1975, was the first to ban an entire class of weapons. Since then, signatory countries have continued to review technological developments and debate protection strategies; they meet up to twice a year and are mandated to hold a review conference once every five years. I supported the US delegation to the BWC from 2004 to 2019, and saw at first hand how an international agreement adapts to shifts in science, technology and politics. The most recent BWC review conference, for example, covered technological advances such as CRISPR–Cas and human-genome editing.

The current International Health Regulations (IHR) entered into force in 2007. They are a remarkable, hard-won achievement, forged from the fear of the 2002 emergence of severe acute respiratory syndrome (SARS) in Asia. Under the regulations, countries agreed to establish ways to prevent, detect and respond to public-health emergencies, including building surveillance, diagnosis and response capacities. They committed to notify the WHO within 24 hours of the emergence of potential public-health emergencies: cases of Ebola, yellow fever and new subtypes of influenza, for example. High-income countries agreed to support efforts in poorer areas.

The treaty has worked well: health systems have become much better at controlling infectious diseases. Witness the outbreaks that fizzled quickly. Monkeypox in Cameroon in May 2018. Nipah virus disease in India in June 2018.

> **"This is no way to protect the world from a global pandemic."**

But when obligations aren't met, it is unclear what to do.

The drawn-out, controversial process of deciding whether to declare a public-health emergency of international concern (PHEIC) has been most damaging. The declaration in July 2019 for the current Ebola outbreak was only the fifth in IHR history. The relevant committee had met and decided against making the declaration three times in 2018 and 2019, even though many (myself included) felt that the criteria for doing so had been reached.

The WHO provided a host of explanations: the declaration would do little to slow the spread of the outbreak, which has so far caused more than 2,000 deaths, and could harm nations in the outbreak region by prompting neighbouring countries to close borders and cease trade. In my view, that rationale went beyond what was written in the treaty and underscored a (reasonable) fear that nations would ignore the WHO's guidance on maintaining trade and border crossings. The subsequent controversy has undermined faith in the IHR and their ability to guide global health governance.

There is also the question of exactly what the IHR and WHO can take on: disease outbreaks put stress on systems beyond those for health care. In Ebola outbreaks in West Africa and the Democratic Republic of the Congo (DRC), the United Nations appointed its own entity, not the WHO, to lead a response that encompassed humanitarian and, in the DRC, security operations.

The answer is not to rewrite or dismantle the IHR. Instead, the global health community needs a way to help fill gaps in the regulations and prevent new ones from emerging. Here is where the BWC can serve as a model. As the former US representative to the BWC, Charles Flowerree, wrote, treaties "cannot be left simply to fend for themselves".

Like the parties to the bioweapons convention, the WHO member states should convene regular 'review conferences' to discuss developments and their implications for the IHR. Nothing prohibits this, except inertia, and perhaps not knowing what a path forwards would look like. I have, with a team of collaborators, formed a global group of regulatory and governance scholars, called the International Law Impact and Infectious Disease Consortium, that stands ready to help.

It is not hard to imagine PHEICs much worse than those for polio, Zika and even Ebola. High-level governance structures are hard to implement, and they might not be scintillating conversation for most, but they do enable us to be as prepared as possible for the next big threat.

This upcoming January, the WHO and its member states will meet to plan the World Health Assembly later in 2020. An IHR review conference, which can lay out a plan for future updates, should be on the agenda.

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