

Monique van Alphen Fyfe

**WHATE'ER IS BEST ADMINISTERED IS BEST:
GLOBAL ADMINISTRATIVE LAW,
EMERGENCY POWERS AND THE WORLD
HEALTH ORGANIZATION**

Submitted for the LLB (Honours) Degree
LAWS523: Current Issues in International Law and Politics

Faculty of Law



2016

Abstract: *The World Health Organization is uniquely placed to lay claim to normative legitimacy. It is the key centralised agency for international health law, and has almost universal state membership. Yet its powers of emergency contained in the International Health Regulations – to declare a public health emergency of international concern and determine the necessary response – are subject to considerable critique. The Organization’s legitimacy is potentially undermined. One way to reinforce legitimacy is through the use of Global Administrative Law principles such as transparency, participation and review. This paper examines the use of emergency power in the cases of SARS, H1N1 and Ebola to see if Global Administrative Law principles are present. It then considers whether using Global Administrative Law to constrain and review the use of emergency power is sufficient in itself, or whether it shrouds broader issues that ought to be raised regarding the World Health Organisation, the International Health Regulations, and the architecture of the international order.*

Key words: *World Health Organization, International Health Regulations, Global Administrative Law, emergency power, legitimacy, international law*

Word count: *Excluding the cover page, abstract, contents, footnotes and bibliography, this paper consists of exactly 14,944 words.*

I	“THE DREAMS OF MEN, THE SEED OF COMMONWEALTHS, THE GERMS OF EMPIRES”	4
II	ASSEMBLING A COMMON HEALTH: WHO AND ITS EMERGENCY POWERS	6
	A Structure of the World Health Organization	6
	B Historical Movements and Moments	8
	C Development of Emergency Powers	10
III	AILMENTS OF EMPIRE: PROBLEMS RAISED BY EMERGENCY POWERS	14
	A Legitimacy, Accountability and Emergency Powers	14
	1 <i>Democratic principles</i>	15
	2 <i>Expertise</i>	16
	3 <i>Efficacy</i>	17
	B Securitisation and the (Imaginary) Emergency Trap	18
IV	TRIALING A REMEDY: GLOBAL ADMINISTRATIVE LAW	20
	A GAL: Definitions and Foundations	20
	B Finding GAL in WHO’s Emergency Powers	22
	1 <i>Transparency</i>	23
	2 <i>Participation</i>	26
	3 <i>Reasoned decisions</i>	29
	4 <i>Review</i>	32
V	TAKING AIM AT THE HEART: DISSECTING GLOBAL ADMINISTRATIVE LAW	36
	A A Balance of Transparency and Participation	37
	B Proceduralising the Political	41
	C Hot and Cold: the Effects of Review	44
	D Re-Birthing the Clinic: The Architecture of Emergency Governance	48
	1 <i>The disorders of GAL</i>	48
	2 <i>The emergency imaginary</i>	50
	3 <i>An anatomy of WHO in the international order</i>	52
VI	A CONCLUSION, A BEGINNING, A NEVER ENDING DEFEAT	55
VII	BIBLIOGRAPHY	58

I “THE DREAMS OF MEN, THE SEED OF COMMONWEALTHS, THE GERMS OF EMPIRES”¹

Outbreaks of infectious disease have had a persistent and considerable influence on the shape of international law. Historically, measures to halt the spread of disease operated at national borders and were instigated by individual states against threats of “Asiatic diseases”.² Disordered and dangerous bodies emerging from unfamiliar worlds were simply excluded. A significant feature of disease, however, is its failure to observe the authority of sovereign borders, rendering these measures ineffective.³ Another feature is its intimate connection with, and ability to disrupt, international trade. These features highlight states’ mutuality of vulnerability—shared exposure to risk and shared interest in protecting against it.⁴ They also suggest that global cooperation through a centralised body is a more effective international law tool than traditional state-based quarantine measures.

Yet, and despite the near-universal World Health Organization (WHO) membership, questions of legitimacy arise from the centralisation of power. This is particularly true of emergency powers used when WHO declares a public health emergency of international concern.⁵ These powers comprise significant discretion, are bound by limited substantive controls, and are subject to little oversight or legal review. They give rise to concerns of accountability and the continued consolidation of unchecked power. If “[s]overeign is he who decides on the exception”,⁶ then states have little sovereignty in international health. Other mechanisms to constrain emergency powers, and strengthen claims to their legitimate use, might be needed.

Global Administrative Law (GAL) is one such mechanism. GAL promotes accountability and thus legitimacy through principles and practices such as transparency, participation and review. It provides procedural limits that, when utilised coherently, can limit fears of exceptionalism and improve both the quality

¹ Joseph Conrad *Heart of Darkness* (Penguin Books, Harmondsworth, 1973) at 29.

² David P Fidler *International Law and Infectious Diseases* (Oxford University Press, Oxford, 1999) at 28–35; and N Howard-Jones “Origins of International Health Work” [1950] *Br Med J* 1032 at 1032–1035.

³ Fidler, above n 2, at 5.

⁴ For an argument that mutuality of vulnerability is key to reigniting cooperation in the field of global health see Obijiofor Aginam *Global Health Governance: International Law and Public Health in a Divided World* (University of Toronto Press, Toronto, 2005) at ch 3.

⁵ See for example the concerns raised by J Benton Heath “Global Emergency Power in the Age of Ebola” (2016) 57 *Harv Intl LJ* 1; and Tine Hanrieder and Christian Kreuder-Sonnen “WHO decides on the exception? Securitization and emergency governance in global health” (2014) 45 *Security Dialogue* 331.

⁶ Carl Schmitt *Political Theology: Four Chapters on the Concept of Sovereignty* Georg Schwab (trans) (University of Chicago press, Chicago, 2005) at 5.

of decisions and the likelihood of decisions being accepted. However, because GAL is primarily procedural, it runs the risk of adding a legitimising veil over international legal systems that deserve deeper critique. When combined with the fear of global health threats, the othering of states that harbour disease, and the palimpsest of imperialism, the GAL veil takes on a starkly fragile quality.

This paper explores whether GAL provides adequate limitations to the exercise of WHO's emergency powers. There is considerable scholarship examining the exercise of power at WHO, including its emergency powers. GAL analyses of WHO tend to take a broad and empirical frame, looking at WHO's processes in general rather than emergency mechanisms, and focusing on specific aspects of GAL. Research reveals no in-depth critique of WHO's emergency powers through a GAL lens, something this paper seeks to rectify. It argues that in emergencies, WHO demonstrates some adherence to GAL principles, but such adherence is undermined by inconsistent or shallow application. It further argues that GAL itself may not be a comprehensive remedy for the ills of emergency governance at WHO, instead hindering appropriate use, review and development of emergency powers. These arguments are supported firstly by an investigation into WHO's use of emergency power associated with SARS, H1N1 and Ebola which demonstrate GAL in action and inaction. Support is drawn secondly from critical approaches to both GAL and the architecture of WHO and its emergency powers. This exercise evaluates key sources of legitimacy for WHO, how GAL helps or hinders those sources, and how WHO's emergency power best ought to develop.

Four substantive Parts provide the structure for this paper. Part II provides context by outlining WHO's structure and emergency powers. Part III describes commonly raised concerns about the exercise and ramifications of these powers. Part IV defines GAL and locates its elements within WHO's emergency powers. Finally, Part V explores the benefits and pitfalls of GAL, comparing elements to other international organisations and assessing it as a solution to the problems raised in Part III.

Emile Ouamouno contracted Ebola at the age of two and died on 28 December 2013.⁷ His death, along with so many of the more than 11,000 deaths that followed, was largely preventable.⁸ It is to Emile and to each of those that lost their lives that this paper is dedicated.

⁷ Jakaya Mrisho Kikwete and others *Protecting Humanity from Future Health Crises: Report of the High-level Panel on the Global Response to Health Crises* (United Nations, 25 January 2016) at 21.

⁸ At 20–24.

II ASSEMBLING A COMMON HEALTH: WHO AND ITS EMERGENCY POWERS

WHO is one of several United Nations specialised agencies established during the post-World War II period to engender global cooperation regarding matters of global concern.⁹ Although it retains its original structure, which itself incorporated pre-existing regional bodies, significant health events and changes in the global political milieu have produced new pressures to which WHO, and its operations, has had to respond with what WHO's legal counsel Gian Luca Burci calls "adaptation without reform".¹⁰

This Part sets the context for later analyses. It begins with an outline of the basic structure of WHO, its organs and their various roles. This is followed by a brief discussion of two key issues—decolonisation and globalisation—and their effect on the organisation. Finally, it ends with an introduction to the development of health-related emergency power, from WHO's inception to the revolutionary reform embodied in the 2005 International Health Regulations.

A Structure of the World Health Organization

The Constitution of WHO was adopted by the International Health Conference in 1946 and entered into force in 1948 with a broad mandate: the "attainment by all peoples of the highest possible level of health".¹¹ It was one of several contemporaneous international organisations (IOs) to show an increasing concern for the welfare of the individual, and their combined set of rules was seen as "an agent of progress and evolution".¹² It was something of a watershed moment in the history of international law relating to health: WHO was the first truly international health organisation (it now has 194 Member States) and was conferred unprecedented powers to make binding international health law. WHO's establishment represented an emphatic shift from fragmented quarantine to universal surveillance. The powers were an indication of an increasing

⁹ Others include the Food and Agriculture Organization established in 1945, the International Monetary Fund established in 1945, the United Nations Educational, Scientific and Cultural Organization established in 1946, the International Civil Aviation Organization established in 1947, the International Maritime Organization established in 1947, and the World Meteorological Organization established in 1950. For a discussion of cooperation in international law immediately following the second world war see Wolfgang Friedmann *The Changing Structure of International Law* (Columbia University Press, Cambridge (Mass), 1964).

¹⁰ Gian Luca Burci "Institutional Adaptation without Reform: WHO and the Challenges of Globalization" (2005) 2 IOLR 437 at 437.

¹¹ Constitution of the World Health Organization 14 UNTS 185 (opened for signature 22 July 1946, entered into force 7 April 1948) [WHO Constitution], art 1.

¹² Friedmann, above n 9, at 40–41 and 58.

tendency for technical decisions to prevail over divided national interests. WHO portended an era of true international cooperation.

WHO is made up of three principal organs: the World Health Assembly, the Executive Board, and the Secretariat. The Assembly is the plenary policy-making body.¹³ It meets annually and is made up of state delegates who are qualified in the field of health.¹⁴ The Assembly has the “authority to adopt conventions or agreements”¹⁵ and to “make recommendations ... with respect to any matter within the competence of the Organization”.¹⁶ The Constitution afforded the Assembly “revolutionary normative powers” from the outset: the ability to adopt, via a simple majority, International Health Regulations (IHR) that bind states.¹⁷ Although states may avoid being bound by registering objection, the underlying principle reverses the international law orthodoxy of opt-in to one of opt-out. The Assembly is thus a powerful centralised international organisation, the first to be conferred authority to make binding international health law.¹⁸

The Executive Board is tasked with, inter alia, giving effect to Assembly policy, providing answers to questions arising out of its own initiative or put to it by the Assembly, and authorising emergency action by the Director-General.¹⁹ The Assembly, taking into account “equitable geographic distribution”, elects states who then delegate individuals as members of the Board.²⁰ Each of the 34 members serves for three years.²¹

The Secretariat, headed by the Director-General, is the decentralised administrative and technical body of WHO. It administers policy decisions of the Assembly through its Geneva headquarters, six Regional Offices and various WHO policy arms.²² Regional Offices have considerable discretion over regional activities and can often be politicised by their respective domestic governments.²³

¹³ WHO constitution, above n 11, art 18.

¹⁴ Article 11.

¹⁵ Article 19.

¹⁶ Article 23.

¹⁷ Gian Luca Burci “International Law and Infectious Disease Control” United Nations Audiovisual Library of International Law; WHO Constitution, arts 21 and 22; and Friedmann above n 9, at 279–280.

¹⁸ Burci, above n 17.

¹⁹ WHO constitution, above n 11, art 28.

²⁰ Article 24.

²¹ Article 24.

²² Article 30. The Regional Offices structure allowed the incorporation of pre-existing regional health organisations, such as the Pan American Sanitary Bureau.

²³ See Javed Siddiqi *World Health and World Politics: the World Health Organization and the UN System* (University of South Carolina Press, Columbus, 1995) at 60–82; Fiona Godlee “Change at last at WHO:

One 1995 study found that WHO policy “mainly reflects and is influenced by the initiatives of the staff, supported by the technical advisory bodies and the scientific community”.²⁴ Many of the Secretariat’s activities do not require input or approval of the Assembly, nor do states have any straightforward process to rein in this work. Thus parties other than states have considerable input into the shape of WHO policy, risking politicisation and unaccountability. For all its strengths and weaknesses, this tripartite structure remains in place today, and yet broader political and economic contexts have wrought significant change on the organisation.

B Historical Movements and Moments

Global politics has had an inevitable impact on WHO’s membership and thus its policy direction. Two issues are of considerable importance: the mid-century global moment of decolonisation and the late twentieth-century movement towards globalisation.

The first meeting of the Assembly was attended by 46 of WHO’s then 48 Member States. At the end of ten years, WHO had 85 states.²⁵ At 20, it had 126.²⁶ Decolonisation saw a considerable “[h]orizontal expansion of membership of the family of nations”,²⁷ leading to a considerable expansion of WHO membership. That membership moved from predominantly developed to predominantly developing countries, and brought with it the attendant loss of homogeneity of values.²⁸ With the Assembly’s one state, one vote principle,²⁹ developing countries became a source of rising power within WHO, a power used to try to

but will the regions play ball?” (1998) 317(7154) *BMJ* 296; Ruth Levine “Open Letter to the Incoming Director general of the World health Organization: Time to Refocus” (2006) 333(7576) *BMJ* 1015; and Kelley Lee *The World Health Organization* (Routledge, London, 2009) at 32.

²⁴ J Patrick Vaughan and others *Cooperation for Health Development: Extrabudgetary Funds in the World Health Organization* (Australian Agency for International Development, Royal Ministry of Foreign Affairs, Norway and Overseas Development Administration, United Kingdom, London: Overseas Development Administration, 1995) at 56.

²⁵ The World Health Organization *The First Ten Years of the World Health Organization 1948–1957* (Geneva, 1958) at 473.

²⁶ The World Health Organization *The Second Ten Years of the World Health Organization 1958–1967* (Geneva, 1968) at 317.

²⁷ Friedmann, above n 9, at 5.

²⁸ Whilst there is disagreement about whether these differences in values are based on inherent cultural values, economic interests or political views, and what ought to be the appropriate response, the general point is made in for example Friedman, above n 9, at 6–7; Antony Anghie *Imperialism, Sovereignty and the Making of International Law* (Cambridge University Press, Cambridge, 2005) at 196–244; and Richard A Falk “The New States and International Legal Order” (1966) II(118) *Recueil des Cours* 1 at 34–43.

²⁹ This in itself has theoretical legitimacy problems: see Daniel Bodansky “The Legitimacy of International Governance: A Coming Challenge for International Environmental Law?” (1999) 93 *AJIL* 596 at 614.

shift policy priority to improvement of basic health care and prevention over post-event protective mechanisms.³⁰

The priorities of developing countries conflicted with those of powerful developed countries following neo-liberal economic philosophies.³¹ WHO's regulation of breastmilk substitute marketing and introduction of essential medicine lists to assist developing countries against exploitative international trade exacerbated tensions.³² This led to serious discontent for several powerful states, culminating in the 1982 capping of states' compulsory contributions driven by the United States.³³ WHO's legitimacy crisis led to the World Bank becoming a major actor in world health initiatives during the 1980s.³⁴ The funding freeze largely remains in place and WHO relies heavily on voluntary contributions from states, NGOs and private corporations, which made up some 81 per cent of funding that totalled US\$2.6 billion in 2014–2015.³⁵ The funding issue is a symptom of what Stewart calls “structural disregard”, where international bodies not concerned with trade and investment are under-resourced, leaving gaps in regulatory regimes.³⁶ WHO operates at middle ground, enjoying an inbuilt incentive for all states to continue at least a bare minimum of cooperation, particularly in light of globalisation.³⁷

Globalisation causes states to have less control over phenomena within their borders.³⁸ It comprises the intensification, multiplication and increased interdependency of networks of exchange.³⁹ These networks, along with liberalisation of international trade laws, have permitted vastly increased volumes

³⁰ See for example Nitsan Chorev *The World Health Organization between North and South* (Cornell University Press, Ithaca, 2012); and WHO initiatives such as the *Global Strategy for Health for All by the Year 2000* GA Res 36/43, A/RES/36/43 (1981).

³¹ For the conflict apparent in the General Assembly see for example RP Anand *Confrontation or Cooperation? International Law and the Developing Countries* (Marinus Nijhoff, Dordrecht (The Netherlands), 1987) at 103–125 and 129–146.

³² *International Code of Marketing of Breast-milk Substitutes* (World Health Organization, 1981) adopted by the Thirty-fourth World Health Assembly *International Code of Marketing of Breast-milk Substitutes* WHO WHA Res WHA34.22 (1981); and The selection of essential drugs: Report of a WHO Expert Committee (World Health Organization Technical Report Series 615, Geneva, 1977).

³³ Lee, above n 23, at 87–91.

³⁴ At 99–101; and Kamradt Abbasi “The World Bank and World Health: Changing Sides” (1999) 31 *BMJ* 865.

³⁵ World Health Organization *Annex to the Financial Report for the year ended 31 December 2014* (A68/INF/1, 1 May 2015).

³⁶ Richard B Stewart “Remedying Disregard in Global Regulatory Governance: Accountability, Participation, and Responsiveness” (2014) 108 *AJIL* 211 at 213.

³⁷ David P Fidler “The Globalization of Public Health: Emerging Infectious Diseases and International Relations” (1993) 5 *Ind J Global Legal Studies* 11 at 16–17.

³⁸ At 14.

³⁹ Manfred Steger *Globalization: A Very Short Introduction* (Oxford University Press, Oxford, 2009) at 14.

of trade and travel.⁴⁰ Distinctions between national and international public health become even less relevant because globalisation exacerbates the social and economic factors that enable the global spread of disease with “unprecedented speed”.⁴¹ It can also cause unprecedented financial harm.⁴² Reduced state-level control of economic factors weakens states’ ability to address other factors that contribute to disease spread, such as urbanisation, poverty and environmental issues.⁴³ Particularly for impoverished states, this is compounded by neoliberal restructuring of public health systems tied to international loans.⁴⁴ The result is a developing world that remains a “giant reservoir of microbial threats”;⁴⁵ a situation not dissimilar to that which engendered international cooperation on health in the 19th century.⁴⁶

C Development of Emergency Powers

Although WHO’s emergency powers have recently expanded, for some time they remained as per WHO’s originating Constitution. At inception, WHO’s emergency powers were within the sole purview of the Executive Board, which could instruct the Director-General to “combat epidemics, to participate in the organization of health relief to victims of a calamity and to undertake [urgent] studies and research”.⁴⁷ These powers were exercised with some regularity, particularly in the early years of WHO, such as in providing basic emergency assistance to Palestinian refugees from 1948 and to the Democratic Republic of Congo in 1960.⁴⁸ Despite this, no centralised, broad-based emergency powers were initiated until substantial reform of the IHR was undertaken in 2005.

Very narrow emergency powers were contained in the regulations originally adopted by the Assembly. The first regulations of 1951 (revised in 1969) were based on the rather conflicting objectives of maximum security and minimum

⁴⁰ David P Fidler *SARS governance and the globalization of disease* (Palgrave Macmillan, New York, 2004) at 45.

⁴¹ Fidler, above n 37, at 12 and 33; and Kikwete and others, above n 7, at 25.

⁴² Kikwete and others, above n 7, at 26–27.

⁴³ Fidler, above n 37, at 33.

⁴⁴ Alexander Kentikelenis, Lawrence King, Martin McKee and David Stuckler “The International Monetary Fund and the Ebola outbreak” (2015) 3 *Lancet Glob Health* e69.

⁴⁵ Fidler, above n 37, at 34.

⁴⁶ Fidler, above n 37, at 17–18.

⁴⁷ WHO constitution, above n 11, art 28(i).

⁴⁸ See for example *The First Ten Years of the World Health Organization 1948–1957*, above n 25, at 60 (Cholera epidemic in Egypt, dealt with by the interim commission), 127 (emergency action in the Eastern Mediterranean region), 135–136 (Palestinian refugees), and 376–378; and *The Second Ten Years of the World Health Organization 1958–1967*, above n 26, at 19, 44–45 (Democratic Republic of Congo), and 281 (Palestinian refugees).

interference.⁴⁹ They employed an approach that relied on states surveying and reporting to WHO on a specific list of historically significant “quarantinable diseases”,⁵⁰ and on a set of maximum border control measures only able to be applied in the case of those specific diseases.⁵¹ The list of diseases was reduced in various amendments.⁵² Beyond the powers of the Executive Board, in 1951, WHO’s emergency powers were limited to delimiting the affected zone for any reported yellow fever outbreak.⁵³ The 1969 regulations gave WHO (although which organ is unclear) the power to investigate outbreaks on its own initiative, but only with state consent.⁵⁴ These regulations were widely regarded as ineffective, “marginal and largely unobserved”,⁵⁵ and developed states became complacent regarding infectious disease despite continued outbreaks in developing countries.⁵⁶

Significant outbreaks of the quarantinable diseases since the 1990s,⁵⁷ combined with the transnational threats of HIV/AIDS, emerging infectious diseases and increased fear of bioterrorism, engendered increased attention on global health risks and protective mechanisms.⁵⁸ Severe acute respiratory syndrome (SARS) in particular, highlighted the IHR’s inadequacies.⁵⁹ Of particular concern were the limited list of diseases that required reporting to WHO (SARS was not one of them), delayed reporting by states reluctant to risk their economic interests, and states’ non-compliance with various capacity and surveillance obligations. In response to SARS, the Director-General authorised actions that were beyond WHO’s mandate.⁶⁰ Global alerts, travel advisories and statements admonishing China’s inaction were issued, and a global network to research and share

⁴⁹ International Sanitary Regulations 175 UNTS 214 (1951) [ISR 1951]; International Health Regulations 764 UNTS 1 (1969) [IHR 1969]; and Fidler, above n 2, at 61–65.

⁵⁰ ISR 1951, above n 49, art 1 definition of “quarantinable diseases”; and IHR 1969, above n 49, art 1 definition of “diseases subject to the Regulations”.

⁵¹ ISR 1951, above n 49, arts 23–94; and IHR 1969, above n 49, arts 24–88.

⁵² In 1951, quarantinable diseases included cholera, plague, typhus, smallpox, relapsing fever and yellow fever. By 1995, the list included only cholera, plague and yellow fever.

⁵³ ISR 1951, above n 49, art 70(1).

⁵⁴ IHR 1969, above n 49, art 11(2).

⁵⁵ See the comments of Gian Luca Burci as reported in “Shifting Norms in International Health Law” (2004) 98 *Am Soc’y Int’l L Proc* 13 at 17.

⁵⁶ Lawrence O Gostin *Global Health Law* (Harvard University Press, 2014) at 180. See also Fidler above n 37, at 26–28.

⁵⁷ Gostin, above n 56, at 180.

⁵⁸ Burci, above n 55, at 16.

⁵⁹ See Fidler, above n 40, at 71–105; and David P Fidler “Germs, governance, and global public health in the wake of SARS” (2004) 113 *The Journal of Clinical Investigation* 799.

⁶⁰ Fidler, above n 40, at 137; and Burci, above n 55, at 17.

information about the disease was initiated.⁶¹ The “Chernobyl factor”—that emergencies often accelerate reform—is an apt analogy:⁶² SARS had a significant influence in the reformation of WHO’s rules of engagement in health emergencies.⁶³

The adoption of the 2005 IHR has been described as a “revolution in the governance of global infectious disease”.⁶⁴ Of the many changes that were made, several are of particular importance in the context of emergency powers. The revised IHR do away with a prescribed list of diseases, instead requiring states to report any event that could have international health ramifications based on risk assessment criteria—an “all-hazards approach”.⁶⁵ Any kind of event may now be a potential health concern. In addition, states are now required to report not only potential public health risks in their own jurisdiction, but also in jurisdictions of another state where that state has failed to report.⁶⁶ WHO may also rely on non-state supplied evidence of health risks, enabling WHO to obtain necessary information from media reports, non-governmental organisations (NGOs) and so on.⁶⁷ As a result, states have reduced control over the ability of WHO to gather information regarding health risks within their jurisdiction. The theory resembles a global health panopticon: if states are subject to surveillance by all-seeing independent parties, they will be more likely to report themselves.⁶⁸ The observer in Foucault’s account enjoys a degree of anonymity, but global health observers do not: WHO must inform the state of the information’s source and refrain from disclosure “only where it is duly justified”.⁶⁹

Also included are significant emergency powers. The IHR authorise the Director-General, after hearing the advice of a committee of experts, to exercise emergency power without any mandatory substantive involvement of states or other WHO

⁶¹ Fidler, above n 40, at 96; Fidler “Germs, governance, and global public health in the wake of SARS”, above n 59; and J Benton Heath “SARS, the ‘Swine Flu’ Crisis and Emergency Procedures in the WHO” in Sabino Cassese and others (eds) *Global Administrative Law: The Casebook* (3rd ed, IRPA–IILJ, Rome and New York, 2012) 147 at 149–150.

⁶² “China and SARS: China’s Chernobyl?” *The Economist* (online ed, 24 April 2003).

⁶³ World Health Organization Sixty-Fourth World Health Assembly Resolutions and Decisions Annex WHA58/2005/REC/1 *Revision of the International Health Regulations* WHA58.3.

⁶⁴ Fidler “Germs, governance, and global public health in the wake of SARS”, above n 59.

⁶⁵ Gian Luca Burci and Jakob Quirin “Introductory Note to World Health Organization and United Nations Documents on the Ebola Outbreak in West Africa” (2015) 54 *ILM* 532 at 532; and see International Health Regulations 2509 UNTS 134 (2005) [IHR 2005], art 9 and annexe 2.

⁶⁶ IHR 2005, above n 65, arts 6 and 9.

⁶⁷ Articles 9(1) and 10.

⁶⁸ Gostin, above n 56, at 192–193.

⁶⁹ IHR 2005, above n 65, art 9(1).

organs.⁷⁰ The Director-General has broad discretion to determine whether an event is a PHEIC, and to determine the necessary elements of any temporary recommendations.⁷¹ A PHEIC is an “extraordinary event” which constitutes a “public health risk to other States through the international spread of disease” and potentially requires a “coordinated international response”.⁷² Temporary recommendations that accompany or follow the declaration of a PHEIC are defined as “non-binding advice”.⁷³ However, their issue facilitates enormous global pressure to comply, such as where states are reluctant to provide information (for example, China in the case of SARS),⁷⁴ or engage in prohibited behaviour (for example, the unnecessary trade and travel restrictions against Mexico during the H1N1 crisis).⁷⁵

These powers were first exercised in 2009, when H1N1 influenza was declared a PHEIC.⁷⁶ The aftermath of the crisis—revealed to be far less threatening than WHO had anticipated—highlights a number of accountability concerns with the exercise of emergency powers in global health. The Ebola response, criticised for delay and poor coherence, further emphasised these concerns.

As J Benton Heath notes, the 2005 IHR mean that:⁷⁷

Emergency power is no longer the sole province of states, or even of international assemblies or executive councils, and instead is spread among the bureaucratic components of international organizations ...

The IHR are integrally linked to globalisation: they resolve situations where there is potential for global impact and potential disruption of global trade and movement. States have high levels of interest in all of these matters. How such emergency powers, now substantially divorced from any measure of state control, might be held to account is the subject of the remainder of this paper.

⁷⁰ WHO constitution, above n 11, arts 12–17 and 48–49. See generally Benton Heath, above n 5, at 21–26.

⁷¹ The Director-General’s emergency powers stem from the IHR 2005, above n 65, arts 12–17 and 48–49.

⁷² Article 1, definition of “public health emergency of international concern”.

⁷³ Article 1, definition of “temporary recommendations”.

⁷⁴ Fidler, above n 40, at 73–75, 80, 85–86 and 93–98.

⁷⁵ David P Fidler “The Swine Flu Outbreak and International Law” (2009) 13 ASIL Insights (online ed).

⁷⁶ Margaret Chan “Swine influenza” (Statement by WHO Director-General, 25 April 2009); and Margaret Chan “World now at the start of 2009 influenza pandemic” (Statement to the press by WHO Director-General, 11 June 2009).

⁷⁷ Benton Heath, above n 5, at 10.

III AILMENTS OF EMPIRE: PROBLEMS RAISED BY EMERGENCY POWERS

Emergency powers in international law come with complications. In domestic legal systems their exercise raises the possibility of unchecked authority, rights violations, and the persistent expansion of such power. WHO's emergency powers are no different. A perceived lack of accountability, no mechanisms for formal review, and the institutionalisation of previously non-mandated power give rise to questions of legitimacy: how can emergency powers, without the checks and balances available at a municipal level, be acceptable on the international plane? This Part seeks to define the problems raised by emergency powers. It begins by looking at the ways legitimacy might be achieved by an international organisation generally, and ends by looking at the specific problems inherent in WHO's emergency power framework.

A Legitimacy, Accountability and Emergency Powers

Centralisation of emergency power puts pressure on perceptions of legitimacy. IOs with weak powers do not tend to generate critique, but powerful organisations do.⁷⁸ Where reliance is placed on decisions of non-elected bodies, this critique amplifies.⁷⁹ But what is legitimacy, and how do IOs gain it?

Legitimacy, the “justification of authority”,⁸⁰ has both sociological and normative aspects.⁸¹ Franck defines legitimacy in its sociological sense as “the capacity of a rule to pull those to whom it is addressed toward consensual compliance”.⁸² WHO enjoys popular acceptance of its authority over global health matters, even in emergency governance, as evidenced by its wide membership, continued state participation in its processes and general adherence to its rules.⁸³ Despite this, and although they are to some extent intertwined,⁸⁴ more pertinent is normative legitimacy. In this sense, “legitimate authority is precisely that which *ought* to be obeyed, ... which deserves obedience and consent, ... to which consent can be

⁷⁸ Bodansky, above n 29, at 597.

⁷⁹ Eric Stein “International Integration and Democracy: No Love at First Sight” (2001) 95 AJIL 489 at 531.

⁸⁰ Bodansky, above n 29, at 601.

⁸¹ Allen Buchanan and Robert O Keohane “The Legitimacy of Global Governance Institutions” in Rüdiger Wolfrum and Volker Röben (eds) *Legitimacy in International Law* (Springer, Berlin, 2008) 25 at 25.

⁸² Thomas M Franck “The Power of Legitimacy and the Legitimacy of Power: International Law in an Age of Power Disequilibrium” (2006) 100 AJIL 88 at 93.

⁸³ But see World Health Organization “Statement on the 4th meeting of the IHR Emergency Committee regarding the 2014 Ebola outbreak in West Africa” (21 January 2015), noting that more than 40 countries defied the temporary recommendations associated with Ebola; and Kikwete and others, above n 7, at 66 noting that 500 restrictions were in place in 70 countries in excess of WHO recommendations.

⁸⁴ Bodansky, above n 29, at 601–602.

justified”.⁸⁵ This legitimacy can be gained in various ways. Three are of particular significance in the context of WHO. One is via the application of a set of generally accepted governing principles, for example consent or democracy;⁸⁶ another is legitimacy via expertise. These fall under what Weiler calls “process” or “input” legitimacy.⁸⁷ Third is legitimacy via efficacy, also called “result” or “output” legitimacy.⁸⁸

1 Democratic principles

The definition of democracy is highly contested, as is whether it is indeed an “emerging” right in international law.⁸⁹ Nevertheless, it remains a key source of legitimacy. Eric Stein notes the models of democratic states need adapting to the requirements of specific IOs.⁹⁰ Robert Howse identifies several definitions of democracy, two of which—representative and deliberative—apply best in the context of WHO.⁹¹

Representative democracy is somewhat self-explanatory: a constituency (states) nominate or elect individuals to represent their views. In its most simplistic form, the normative legitimacy of IOs stems from prior state acquiescence to their rules; a version of the social contract theory.⁹² However, representative democracy at the international plane is fraught with difficulty. Substantial elements of domestic legal systems are lacking. Disputes arise regarding who or what makes up the electorate—the demos not necessarily present at international law.⁹³

⁸⁵ Hanna Pitkin “Obligation and Consent II” (1966) 60 *Am Pol Sci Rev* 39 at 39.

⁸⁶ Beginning with the social contract theories of John Locke and Jean-Jacques Rousseau.

⁸⁷ JHH Weiler “In the Face of Crisis: Input Legitimacy, Output Legitimacy and the Political Messianism of European Integration” (2012) 34 *Journal of European Integration* 825 at 828.

⁸⁸ At 828. These three legitimacies have also been called source-, process- and results-based legitimacy. See Rüdiger Wolfrum “Legitimacy of International Law from a Legal Perspective: Some Introductory Considerations” in Rüdiger Wolfrum and Volker Röben (eds) *Legitimacy in International Law* (Springer, Berlin, 2008) 1 at 6–7.

⁸⁹ See Susan Marks *The Riddle of All Constitutions: International Law, Democracy and the Critique of Ideology* (Oxford University Press, Oxford, 2000).

⁹⁰ Stein, above n 79, at 531.

⁹¹ Robert Howse “How to Begin to Think About the ‘Democratic Deficit’ at the WTO” in Robert Howse *The WTO System: Law, Politics & Legitimacy* (Cameron May, London, 2007) 57 at 57; and Robert Howse “Transatlantic regulatory cooperation and the problem of democracy” in George A Bermann, Matthias Herdegen and Peter L Lindseth (eds) *Transatlantic Regulatory Cooperation: Legal Problems and Political Prospects* (Oxford University Press, Oxford, 2000) 469.

⁹² Bodansky, above n 29, at 597 and 609; and Howse “How to Begin to Think About the ‘Democratic Deficit’ at the WTO”, above n 91, at 57.

⁹³ See for example Samantha Besson “Whose Constitution(s)? International Law, Constitutionalism, and Democracy” in Jeffrey L Dunhoff and Joel P Trachtman (eds) *Ruling the World: Constitutionalism, International Law and Global Governance* (Cambridge University Press, Cambridge, 2009) 381; and JHH Weiler “European Democracy and Its Critique” (1995) 18 *W Eur Pol* 4; and Bodansky, above n 29, at 614.

Putting aside the broader problem of global democracy, WHO itself does have representative elements. The Assembly is representative—being made up of state delegates. However, given the Assembly has limited ability to influence or develop policy, and only blunt voting and budgetary tools to constrain the Secretariat, it is difficult to see it as sufficient to allay general concerns of a democratic deficit at WHO. It is harder still to see this as effective brake on emergency powers when the Assembly has no direct input into emergency decisions. Even if the Assembly had such input, “informational asymmetries” of the principal/agent relationship mean delegates may not act in ways anticipated by their constituency.⁹⁴ Representative democracy is thus not strong in emergency health governance.

Deliberative democracy is a more appropriate concept. Its legitimising power “depends on a conception of public justification and deliberative reason”.⁹⁵ This is, in effect, an argument for transparency and participation. Such an argument is supported by the preamble of WHO’s Constitution that reads, in part: “Informed opinion and active co-operation on the part of the public are of the utmost importance in the improvement of the health of the people.”⁹⁶ Participation or cooperation might be more limited, that is not extending to direct decision-making or decision-making by some sort of electorate, but rather partial input by affected parties that ensures decision-makers are alive to the parties’ preferences. Whether the emergency powers of WHO cater for such input, and thus acquire legitimacy via democratic principles is discussed below.

2 *Expertise*

Legitimacy stemming from expertise recognises that authority over technical and scientific matters might be best left with experts rather than an electorate. This is of clear significance in WHO: health is a highly technical and scientific matter. Individuals who make up the Assembly and various decision-making bodies within WHO are required to be experts in the field of health.⁹⁷ Because of their expertise, they are entrusted with making decisions within their competence.

⁹⁴ Howse “How to Begin to Think About the ‘Democratic Deficit’ at the WTO”, above n 91, at 60–61.

⁹⁵ Robert Howse “Democracy, Science, and Free Trade: Risk Regulation on Trial at the World Trade Organization” (2000) 98 Mich L Rev 2329 at 2334. See also Jürgen Habermas *Between facts and norms: contributions to a discourse theory of law and democracy* (William Rehg (trans), Polity Press, Cambridge, 1996) at 287–328.

⁹⁶ WHO Constitution, above n 11, preamble.

⁹⁷ For example Assembly delegates should be “most qualified by their technical competence in the field of health”: WHO Constitution, above n 11, art 11. Executive Board members should be “technically qualified in the field of health”: WHO Constitution, above n 11, art 24. Members of the Emergency Committee are selected “on the basis of the expertise and experience required” for the particular committee: IHR 2005, above n 65, art 48(2).

Where decisions require overlapping expertise—such as economic, cultural and logistical—highlights the spaces in which this basis for legitimacy may be flawed.

Expertise is steeped in assumptions. Three internal assumptions arise:⁹⁸

... first, the decisions in question have better and worse answers; second, certain people possess special knowledge (expertise) about what those answers are; and third, we (the non-experts) can identify the people with this special knowledge ...

In the context of environmental law, Bodansky points to difficulties in the first and last of these assumptions.⁹⁹ Identifying the right experts can be difficult—are states' delegates really the most qualified in health, and how is this assessed? More importantly, whether or not decisions are better or worse will often involve numerous variables, including questions of value that ultimately require policy, rather than technical or scientific, decisions. Are those who are most qualified in health also qualified to make decisions interfacing with, for example, human rights, economic concerns and environmental issues?¹⁰⁰ A broader assumption is that the role of experts is to trump democratic process with expert decisions. Perhaps a more appropriate role of technical expertise is to ensure decisions are made in an appropriately structured process, that is with the best information.¹⁰¹ Whether WHO's emergency processes adequately address these assumptions is considered below.

3 *Efficacy*

Legitimacy from efficacy puts aside concern for process or expertise, focusing on a decision's outcome. Its logic considers that if the outcome is effective, the decision-maker, irrespective of process, is perceived as legitimate: there is, after all, "no better way to legitimate a war than to win it".¹⁰² WHO reaps accolades when the spread of disease is halted effectively, but considerable criticism when it is not. As a legitimating technique, efficacy is extremely risky: "If success breeds legitimacy, failure, even if wrongly allocated, leads to the opposite."¹⁰³ Efficacy also needs a clear standard against which outcomes can be measured. Yet

⁹⁸ Bodansky, above n 29, at 620.

⁹⁹ At 620–622.

¹⁰⁰ See William Onvizu "International Environmental Law, the Public's Health, and Domestic Environmental Governance in Developing Countries" (2006) 21 *Am U Int'l L Rev* 597 discussing the interrelation between environmental and health law.

¹⁰¹ Howse, above n 95, at 2335. See also Cass R Sunstein and Richard Pildes "Experts, Economists, and Democrats" in Cass R Sunstein *Free Markets and Social Justice* (Oxford University Press, New York, 1997) 128.

¹⁰² Weiler, above n 87, at 828.

¹⁰³ At 831.

emergency health strategies and outcomes are not necessarily black and white, and involve multitudes of parties with overlapping mandates. Even if clear standards could be deduced, measuring and attributing success is difficult. Further, efficacy requires a trusted body to measure WHO's success. Establishing WHO's legitimacy in using emergency powers with efficacy alone is challenging and risky.

These sources of legitimacy are not necessarily independent of each other. This indicates the need to understand the nuances of where legitimacy stems from and how that might be achieved at WHO. Emergency decisions pose more specific risks to perceptions of legitimacy via the exercise of autocratic and unaccountable powers.

B Securitisation and the (Imaginary) Emergency Trap

Hanrieder and Kreuder-Sonnen illustrate one of the particular problems with emergency decisions: that of securitisation and what they call the “emergency trap”.¹⁰⁴ Securitisation is the process of taking a politicised issue (an infectious disease, for example) and turning it into an existential threat (death) to a referent object (a particular population).¹⁰⁵ Securitisation of health issues can confer political priority on combating disease, honing the focus of the global body politic. It also allows governing bodies “to use extraordinary means or break normal rules for reasons of security”.¹⁰⁶ These extraordinary means can weaken civil liberties, undermine fundamental rules and infringe on human rights.¹⁰⁷ Illiberal measures used in the context of an emergency can then self-perpetuate through the institutionalisation of extraordinary powers, which then become normalised and thus more frequently used in less deserving circumstances.¹⁰⁸ It is this process of institutionalisation of the extraordinary that constitutes an emergency trap.

Securitisation and the emergency trap can be seen in action at WHO in the development and deployment of the 2005 IHR. Non-mandated powers used

¹⁰⁴ Hanrieder and Kreuder-Sonnen, above n 5.

¹⁰⁵ Barry Buzan, Ole Wæver and Jaap de Wilde *Security: A New Framework for Analysis* (Lynne Rienner Boulder, CO, 1998) at 21, 36 and 40.

¹⁰⁶ Barry Buzan and Ole Wæver *Regions and Powers: The Structure of International Security* (Cambridge University Press, Cambridge, 2003) at 6.

¹⁰⁷ Buzan, Wæver and de Wilde, above n 105; and Stefan Elbe “Should HIV/AIDS Be Securitized? The Ethical Dilemmas of Linking HIV/AIDS and Security” (2006) 50 *International Studies Quarterly* 119.

¹⁰⁸ Hanrieder and Kreuder-Sonnen, above n 5, at 335; and Oren Gross and Fionnuala Ní Aoláin *Law in Times of Crisis: Emergency Powers in Theory and Practice* (Cambridge University Press, New York, 2006) at 228.

during the SARS pandemic were subsequently institutionalised via IHR reform, conferring on the Director-General a mandate to use such powers in future emergencies. The premature use of these powers in the H1N1 crisis completes the trap, pointing to a tendency to expand emergency powers and invoke them more frequently. Further evidence of a tendency to securitise global health concerns can be seen in the Security Council’s unanimous adoption of Resolution 2177, which determined that the 2014 Ebola outbreak constituted a “threat to international peace and security”,¹⁰⁹ the first time it had found such a threat stemming from disease.¹¹⁰

Despite the troubling nature of the emergency trap, there are possible mitigating factors. The use of emergency power is not the “suspension of the entire existing order”,¹¹¹ and is thus vulnerable to legal limitation, such as substantive and procedural limits on the powers themselves and ex-post review of their exercise.¹¹² Moreover, the IHR emergency trap itself may not be as concerning as some suggest. Kingsbury and Casini argue that the 2005 IHR provided WHO with less power to be exercised in more constrained conditions than that employed during the SARS crisis.¹¹³ The 2005 IHR, then, are a recognition by the Assembly that while some of WHO’s actions were acceptable, others were not and ought to be limited in their application by various means, including input from states.¹¹⁴ Seen this way, the reform was less of an emergency trap and more a form of ex-post review of previous emergency action that determined some ex-ante limits and set the conditions for further ex-poste review.

However, the problem of big emergencies redefining “normal” remains. This retains the strength of arguments for limitation of emergency powers, lest the global health law mimic the error of classical times where the “despotism of Augustus prepared the Romans for Tiberius”.¹¹⁵ What many scholars and critics have in common is an emphasis on (predominantly procedural) checks to ensure emergency powers are appropriately restrained from running rampant but still able to be exercised effectively. The same could be said for the values underlying the

¹⁰⁹ *Security Council Resolution 2177 [on the outbreak of the Ebola virus in, and its impact on, West Africa]* SC Res 2177 S/RES/2177 (2014).

¹¹⁰ Burci and Quirin, above n 65, at n 8.

¹¹¹ Schmitt, above n 6, at 12.

¹¹² Hanrieder and Kreuder-Sonnen, above n 5, at 340–344; and Gross and Aoláin, above n 108, at 169–170.

¹¹³ Benedict Kingsbury and Lorenzo Casini “Global Administrative Law Dimensions of International Organizations Law” (2009) 6 IOLR 319.

¹¹⁴ Benton Heath, above n 61, at 150.

¹¹⁵ John Stuart Mill *Three Essay – On Liberty, Representative Government, The Subjection of Women* (Oxford University press, Oxford, 1975) at 185.

concepts of legitimacy. These checks have been grouped under the moniker Global Administrative Law.

IV TRIALLING A REMEDY: GLOBAL ADMINISTRATIVE LAW

For Forms of Government let Fools contest;
Whate'er is best administered is best.¹¹⁶

Whether GAL provides adequate legal limits to the exercise of WHO's emergency powers to avoid the emergency trap and consolidate WHO's legitimacy is the focus of this Part. It begins by defining GAL, acknowledging its strengths and weaknesses, and locating its international law foundations. Key principles of GAL are examined in WHO's use of emergency power during H1N1 and Ebola. In doing so, areas of conformity and resistance in the use of GAL principles are identified to tease out whether GAL currently is or could be an effective legal limit to emergency decisions.

A GAL: Definitions and Foundations

GAL is the application to global institutions of administrative law stemming from the domestic legal systems of western liberal democracies. Proponents of GAL contend that IOs have become more than "simple instruments" of states:¹¹⁷

... they set their own norms and regulate their own field(s) of activity; they generate and follow their own legal proceedings; and they have the power to grant participatory rights to the (public and private) actors affected by their activities. As a result, they have emerged as genuine global public administrations.

Due to exercising something akin to a discretionary public power, IOs ought to exercise that power with a level of compliance with administrative law principles.¹¹⁸ In their seminal work, Kingsbury, Krisch and Stewart define GAL as:¹¹⁹

... comprising the mechanisms, principles, practices, and supporting social understandings that promote or otherwise affect the accountability of global administrative bodies, in particular by

¹¹⁶ Alexander Pope *An Essay on Man, in Epistles to a Friend: Epistle III* (J Wilford, London, 1733) at 54.

¹¹⁷ Lorenzo Casini "Beyond drip-painting? Ten years of GAL and the emergence of a global administration" (2015) 13 *ICON* 473 at 474.

¹¹⁸ Benedict Kingsbury and Nico Krisch "Introduction: Global Governance and Global Administrative Law in the International Legal Order" (2006) 17 *EJIL* 1 at 2.

¹¹⁹ Benedict Kingsbury, Nico Krisch and Richard B Stewart "The Emergence of Global Administrative Law" (2005) 68 *LCP* 15 at 17.

ensuring that they meet adequate standards of transparency, participation, reasoned decision, and legality, and by providing effective review of the rules and decisions they make.

A link can here be made to normative legitimacy: the standards listed above lend support to legitimacy's sources. Participation and transparency, for example, support deliberative democracy. Reasoned decisions and effective review are necessary to determine if an organisation is effective. Expertise based legitimacy is supported by transparency, reasoned decisions and review, ensuring decision-makers are indeed experts.

Kingsbury and Casini suggest that in the context of multiple overlapping globally regulatory bodies, an "administrative perspective on the work of IOs enables analysis of practices already occurring" which in turn enables these practices to be framed in legal terms—something they consider to be somewhat lacking.¹²⁰ Theirs is an empirical as well as a normative proposition,¹²¹ with the potential for GAL principles, built on objectives of "publicness", to provide legitimacy:¹²²

... typically, compliance with publicness considerations becomes more and more important in determining weight (perhaps even rising to be requirements of validity) the less the established sources criteria are met, the more doubt there is about recognition [in the Hartian sense], the greater the levels of resistance, and the greater the extent to which individuals or other private actors and their basic rights and welfare are affected.

There are competing theories of the legal foundation for GAL, each giving rise to various complications. One theory is that of inter-regime accountability, akin to an ultra vires or rule of law argument. This emphasises regime integrity, aiming to "secure the cohesion and sound functioning of an institutional order", the legitimacy of which is justified independently via delegation by sovereign states.¹²³ GAL principles would merely police compliance with rule and the limits of delegation.¹²⁴ This narrow conception of GAL best suits an international order that has little to no consensus on substantive norms and little independent action taken by IOs—not something that applies particularly well to WHO.

¹²⁰ Kingsbury and Casini, above n 113, at 320 and 332.

¹²¹ Richard B Stewart "The normative dimensions and performance of global administrative law" (2015) 13 *ICON* 499.

¹²² Benedict Kingsbury "The Concept of 'Law' in Global Administrative Law" (2009) 20 *EJIL* 23 at 31 and 32.

¹²³ Kingsbury, Krisch and Stewart, above n 119, at 43 and 44.

¹²⁴ At 44.

Another theory is protecting the rights of individuals “through their participation in administrative procedures and through the availability of review to ensure legality”.¹²⁵ This is based on the centrality of individuals over collectives, and requires considerable agreement regarding the existence and content of protected rights. It requires stronger rights-based procedural elements such as prior hearings, reasoned decisions and access to review.¹²⁶ Limited substantive elements might also be incorporated. For an IO that grapples with competing rights of individuals and states, this is an appealing middle ground.

The final theory is a desire for democracy. A democratic deficit in international law, and the lack of appropriate structures to implement it,¹²⁷ indicates that other accountability mechanisms are needed to ensure democratic principles are given effect. It “invites development of institutional procedures, principles, and remedies with objectives short of building a full-fledged ... global democracy”.¹²⁸ This theory makes the strongest case for a wide definition of GAL, incorporating strong transparency and participation rights, and access to review. It is also the hardest to justify, not only because democracy is a “hugely contested concept”,¹²⁹ but also in light of a lack of global consensus on the democratic project.¹³⁰

These foundations place different emphasis on different aspects of GAL. They also interface differently with the various conceptions of legitimacy. What impact this has on finding GAL in operation at WHO and how it can give rise to legitimacy is explored below.

B Finding GAL in WHO’s Emergency Powers

Elements of GAL can be found in WHO governance and its use of emergency powers. WHO, like many other international bodies, is subject to an increasing expectancy of accountability, transparency, participation, and review—an expectancy engendered by both internal and external actors. Although such increased expectancy is identifiable within WHO, its bureaucratic nature can make it difficult to determine where procedural processes are sourced and who

¹²⁵ At 44.

¹²⁶ At 46.

¹²⁷ See for example Robert Dahl “Can International Organizations Be Democratic? A Skeptic’s View” in Ian Shapiro and Casiano Hacker-Cordon (eds) *Democracy’s Edges* (Cambridge University Press, Cambridge, 1999) 19; Buchanan and Keohane, above n 81, at 38–39; and in the context of the European Union Weiler, above n 87.

¹²⁸ Kingsbury, Krisch and Stewart, above n 119, at 27.

¹²⁹ Marks, above n 89, at 2.

¹³⁰ See generally Marks, above n 89, for an overview of the arguments either way and a consideration of their implications.

determines their content. Calls for increased transparency in particular have been met with preliminary receptiveness, and yet implementation remains an issue, leaving hanging the recommendations of multiple review bodies.

1 Transparency

International law, built on foundations of diplomacy, is not always automatically associated with transparency. Transparency is, however, described as having “attained quasi-religious significance in debate over governance and institutional design”.¹³¹ It is related to the “intimate connections between information and power”, one of the fundamental planks of GAL.¹³² The UN makes plain its commitment to transparency, noting that “[f]reedom of information is a fundamental human right and is the touchstone of all the freedoms to which the United Nations is consecrated”.¹³³ Various bodies that have assessed WHO’s emergency action have highly valued transparency. There is, however, a need to be circumspect of transparency practices: “If ‘democracy deficit’ is a global governance catchphrase, then ‘transparency’ is its buzzword solution”.¹³⁴ Any use of transparency to counter illegitimacy arguments cannot simply be a label applied to ineffective practices, but must provide effective support to whatever conception of legitimacy is being used.

Transparency—both “[d]ecisional transparency and access to information”¹³⁵—can be considered either intrinsically or instrumentally valuable. In other words, it is either desirable in its own right or because it leads to better outcomes. The former, aligning more with a democratic conception of legitimacy, accepts compromise only when it conflicts with certain other principles. The latter, aligning with efficacy legitimacy, more readily accepts limitations, but requires more rigorous and defined assessment criteria based on expected outcomes.

The rhetoric around transparency at WHO seems to fall into the instrumentally valuable or efficacy camp. The Director-General has stated that transparency is an

¹³¹ Christopher Hood “Transparency in Historical Perspective” in Christopher Hood and David Heald (eds) *Transparency: The Key to Better Governance?* (Oxford University Press, Oxford, 2006) 3 at 4. See also Andrea Bianchi “On Power and Illusion: The Concept of Transparency in International Law” in Andrea Bianchi and Anne Peters (eds) *Transparency in International Law* (Cambridge University Press, Cambridge, 2013) 1 at 3–5.

¹³² Megan Donaldson and Benedict Kingsbury “Power and the Public: The Nature and Effects of Formal Transparency Policies in Global Governance Institutions” in Andrea Bianchi and Anne Peters (eds) *Transparency in International Law* (Cambridge University Press, Cambridge, 2013) 502 at 533.

¹³³ *Calling of an International Conference on Freedom of Information* GA Res A/59, I (1946).

¹³⁴ Thomas N Hale “Transparency, Accountability, and Global Governance” (2008) 14 *Global Governance* 73 at 73.

¹³⁵ Kingsbury, Krisch and Stewart, above n 119, at 39.

integral part of ensuring effective control of disease.¹³⁶ The 2007 *World Health Report* noted that “[t]rust is built through transparency, and trust is necessary for international cooperation in health and development”.¹³⁷ Further, distrust leads to delayed reporting, which in turn leads to greater health risks.¹³⁸ Nevertheless, there is an intrinsic element to the arguments for transparency at WHO—an assumption that transparency is fundamentally desirable.

There is a high degree of general transparency at WHO: reports of the Director-General and the Executive Board, and records of the Assembly are readily available online. Changes within the organisation have attempted to improve internal transparency, for example the introduction of cabinet-style decision-making within the Secretariat in 1999,¹³⁹ and proposed public scrutiny of state implementation reports.¹⁴⁰ Some transparency propositions are not taken up, often lost in the murky depths of Secretariat policy development.¹⁴¹ The Secretariat in particular, despite having significant influence on policy, is one of the more opaque parts of WHO.

In an emergency context, transparency is more convoluted. The 2005 IHR instruct the Director-General to communicate to states all decisions relating to a PHEIC “with the views of the Emergency Committee”.¹⁴² Such information must “subsequently” be made available to the public.¹⁴³ “Subsequently” is undefined, but in practice decisions are released immediately. The IHR are silent on whether Committee members identities should be made public. During H1N1, WHO employed rules of procedure for non-emergency committees, where anonymity is highly valued to prevent lobbying from the pharmaceutical industry.¹⁴⁴ This strategy “notoriously backfired” by fuelling concerns that Committee members—some of whom had declared potential conflicts of interest due to industry links—were artificially inflating the level of risk for the benefit of pharmaceutical

¹³⁶ World Health Organization *The World Health Report 2007: Global Public Health Security in the 21st Century* (2007) at vii.

¹³⁷ At xiii.

¹³⁸ At xii–xiii.

¹³⁹ See World Health Organization *The World Health Report: Making a Difference* (May 1999) at xviii.

¹⁴⁰ See for example World Health Organization *WHO Code of Practice on the International Recruitment of Health Personnel: Draft Guidelines on Monitoring the Implementation of the WHO Global Code* (March 2011); and Emily A Bruemmer and Allyn L Taylor “Institutional Transparency in Global Health Law-making: The World Health Organization and the Implementation of the International Health Regulations” in Andrea Bianchi and Anne Peters (eds) *Transparency in International Law* (Cambridge University Press, Cambridge, 2013) 271 at 283.

¹⁴¹ Bruemmer and Taylor, above n 140, at 283.

¹⁴² IHR 2005, above n 65, art 49(6).

¹⁴³ Article 49(6).

¹⁴⁴ Benton Heath, above n 61, at 151.

companies.¹⁴⁵ Some states had pending vaccine contracts that were automatically triggered by the declaration of a PHEIC.¹⁴⁶ Of particular concern was that, in not declaring conflicts of interest, WHO was in violation of its own internal policies.¹⁴⁷ Some transparency was retrospectively applied: the identities of the H1N1 Emergency Committee members are now available online.¹⁴⁸ Deliberations concerning their appointment and conflicts of interest remain undisclosed. These transparency steps have not prevented some states from removing PHEIC triggers from contracts with pharmaceutical companies.¹⁴⁹

Substantial criticism regarding transparency has been levelled at WHO's emergency powers. Following the H1N1 crisis, the commentators took issue with transparency of the Emergency Committee membership and perceived conflicts of interest,¹⁵⁰ and the Parliamentary Assembly of the Council of Europe commissioned reports and made resolutions criticising WHO's lack of transparency.¹⁵¹ This unprecedented criticism called into question WHO's credibility and efficacy,¹⁵² risking trust in the organisation in terms of its ability to exercise emergency powers without political or industry influence over its experts.

In response, WHO's Review Committee (established to report on the effectiveness of the 2005 IHR following H1N1) took a very serious approach to transparency. The H1N1 IHR Report stated that the Committee itself "aimed to be thorough, systematic, open and objective".¹⁵³ Although its deliberative sessions

¹⁴⁵ At 151.

¹⁴⁶ See Health Protection Agency *Assessment Report on EU-wide Pandemic Vaccine Strategies* (25 August 2010) at 41–42; and Deborah Cohen and Philip Carter "WHO and the Pandemic Flu 'Conspiracies'" (2010) 340 *BMJ* 1274.

¹⁴⁷ Cohen and Carter, above n 146.

¹⁴⁸ "List of Members of, and Advisor to, the International Health Regulations (2005) Emergency Committee concerning Influenza Pandemic (H1N1) 2009" (1 October 2010) World Health Organization <www.who.int>.

¹⁴⁹ See for example Deirdre Hine *The 2009 Influenza Pandemic: An Independent Review of the UK Response to the 2009 Influenza Pandemic* (Department of Health (UK), July 2010), at 155 as cited in Abigail C Dushman "Horizontal Review between International Organizations: Why, How, and Who Cares about Corporate Regulatory Capture" (2011) 22 *EJIL* 1089 at 1112.

¹⁵⁰ See for example Cohen and Carter, above n 146; and Fiona Godlee "Conflicts of Interest and Pandemic Flu" (2010) 340 *BMJ* 1256.

¹⁵¹ Social Health and Family Affairs Committee *The Handling of the H1N1 Pandemic: More Transparency Needed* (Council of Europe Parliamentary Assembly, Doc 1228, 4 June 2010); *Extra-institutional actors in the democratic system* Council of Europe Res 1749 (June 2010); and *Handling of the H1N1 pandemic: more transparency needed* Council of Europe Rec 1929 (June 2010).

¹⁵² Bruemmer and Taylor, above n 140, at 283.

¹⁵³ World Health Organization *Strengthening Response to Pandemics and Other Public-Health Emergencies: Report of the Review Committee on the Functioning of the International Health Regulations (2005) and on Pandemic Influenza (H1N1) 2009* (2011) [*H1N1 IHR Report*] at xiv.

were private, plenary sessions were open to states, NGOs and the media; everyone present could hear what the Committee heard.¹⁵⁴ The Report was also released to the general public rather than just to states. Its criticisms reflected those of the Parliamentary Assembly and are discussed under *Review* below.

WHO navigated a middle ground during the Ebola crisis. The identities of the Emergency Committee members, along with short biographies, were made public.¹⁵⁵ Further, the separate panel convened by the Director-General to advise on the ethics of using unregistered medication against Ebola disclosed from the outset their identities and conflicts of interest.¹⁵⁶ Yet, for both the Committee and the panel, the process for appointment and conflict of interest disclosure procedures were not published in any substantive detail.

Transparency in emergency decisions at WHO is variable. Although specific transparency actions are required or prohibited by the 2005 IHR, other transparency actions are voluntarily undertaken. This has led to inconsistency, which undermines transparency's usefulness to WHO claims to legitimacy via efficacy and expertise: without evidence, the expertise of decision-makers and the efficacy of their decisions are in doubt.

2 *Participation*

Participation, one of the “classical elements of administrative law” is also a recurring theme in descriptions of GAL.¹⁵⁷ Participation is broadly divisible between decisional participation (partaking in the decision itself), and non-decisional participation (making submissions to decision-making bodies). Both build on the foundation of an increasing desire for democratic participation at international law,¹⁵⁸ and have strong links to legitimacy framed in terms of democratic principles. Participation may also influence whether WHO's power is effective by ensuring those who are affected are heard and are thus more likely to desire to comply (or be able to comply) with emergency decisions.

¹⁵⁴ At vii–viii and xiv.

¹⁵⁵ “List of Members of, and Advisers to, the International Health Regulations (2005) Emergency Committee regarding Ebola” World Health Organization <www.who.int>; and “Biographies of the members of, and advisers to, the IHR Emergency Committee regarding the Ebola outbreak in West Africa” World Health Organization <www.who.int>.

¹⁵⁶ “Ethical considerations for use of unregistered interventions for Ebola viral disease: Report of an advisory panel to WHO” (World Health Organization, August 2014) at 4 and 8–9.

¹⁵⁷ Kingsbury, Krisch and Stewart, above n 119, at 38 and 39.

¹⁵⁸ For entitlement to democracy generally see for example Stein, above n 79, at 490. For entitlement to democracy at a state level from the perspective of the international community see Thomas M Franck “The Emerging Right to Democratic Governance” (1992) 86 AJIL 46.

In the emergency context at WHO, participation is generally limited to non-decisional participation by state delegates. There are some opportunities for affected states and very limited opportunities for other international actors to have input into emergency decisions.¹⁵⁹ One way is via the IHR Roster of Experts. All states and other interested parties (IGOs, for instance) may nominate experts for the Roster, and the Director-General is also able to appoint additional experts.¹⁶⁰ There is no guarantee, however, that a state's preferred expert will be on the Emergency Committee. The Director-General selects members of the Emergency Committee from the Roster (or, where appropriate, other expert advisory panels) to provide advice in particular emergencies.¹⁶¹ The Director-General does not have unlimited discretion—he or she is limited by the requirement to select appropriate experts for the specific event and to have due regard for equitable geographic distribution.¹⁶² Whatever the process of selection, and despite its very important influence in practice, the Committee has little legal power: it provides its views only at the request of the Director-General.¹⁶³ Participation in emergency decisions by parties other than the affected states is thus limited by the convoluted paths of input, the significant discretion afforded to the Director-General in selecting Committee members, and the advisory nature of the Committee's views.

Affected states have slightly more capacity for input via the Emergency Committee. Affected states may nominate at least one member of the Emergency Committee directly,¹⁶⁴ which ensures representation (and thus participation), and emphasises claims to legitimacy via democracy and efficacy. During Ebola, although several affected states had representatives on the Committee from their own country, others—Guinea, Liberia, Senegal and Mali—did not.¹⁶⁵ This may be due to not having anyone from their country on the Roster, nominating an expert from another country, or merely a product of procedural necessity: swift changes to disease spread may have made it impractical to add members to the Committee for temporarily affected states. Due to poor adherence to transparency, reasons for this departure are unavailable. Given that participation rights are limited;

¹⁵⁹ IHR 2005, above n 65, arts 12(1)–12(4).

¹⁶⁰ Article 47.

¹⁶¹ Articles 48(2)–(3).

¹⁶² Article 48(2).

¹⁶³ Article 48.

¹⁶⁴ Article 48(2).

¹⁶⁵ “List of Members of, and Advisers to, the International Health Regulations (2005) Emergency Committee regarding Ebola”, above n 155.

departures from these rights ought to be justified. Despite an increased ability for participation by affected states, there is no guarantee states' views will be heeded.

As noted above, the Director-General is required to have regard for equitable geographical representation in selecting the Committee. Equitable representation ensures a level of participation and cultural expertise that might otherwise be diluted. Even without members for Guinea, Liberia, Senegal and Mali, the Emergency Committee for Ebola was somewhat geographically diverse.¹⁶⁶ Although seven of the 22 members were from Africa, 13 could be classed as coming from western or developed countries. For a disease that disproportionately affected Africa and had the potential to travel worldwide, an emphasis on western countries seems counter-productive. Combined with a paucity of transparency around deliberations, the ability to assess influences on decisions is limited.

One further procedural element permits affected state participation: the Director-General must invite an affected state to present its views to the Committee.¹⁶⁷ Although there is no substantive right to participation (that is, states that are unable to attend the meeting will miss out), states do take the opportunity to participate. The Ebola Emergency Committee met via video conference in August 2014, with the participation of the then affected states: Guinea, Liberia, Sierra Leone, and Nigeria.¹⁶⁸ Affected states continued their involvement in later sessions.¹⁶⁹ The information they provided was acknowledged by the Committee, which noted in its first meeting the specific challenges raised by affected states, particularly capacity and resources, misperceptions of the disease, and population mobility.¹⁷⁰ However, critical nuances appear to have been missed. The UN Panel

¹⁶⁶ "List of Members of, and Advisers to, the International Health Regulations (2005) Emergency Committee regarding Ebola", above n 155.

¹⁶⁷ IHR 2005, above n 65, art 49(4).

¹⁶⁸ World Health Organization "Statement on the 1st meeting of the IHR Emergency Committee on the 2014 Ebola outbreak in West Africa" (8 August 2014) at 1.

¹⁶⁹ See World Health Organization "Statement on the 2nd meeting of the IHR Emergency Committee regarding the 2014 Ebola outbreak in West Africa" (22 September 2014); World Health Organization "Statement on the 3rd meeting of the IHR Emergency Committee regarding the Ebola outbreak in West Africa" (23 October 2014); World Health Organization "Statement on the 4th meeting of the IHR Emergency Committee regarding the 2014 Ebola outbreak in West Africa" (21 January 2015); World Health Organization "Statement on the 5th meeting of the IHR Emergency Committee regarding the 2014 Ebola outbreak in West Africa" (10 April 2015); World Health Organization "Statement on the 6th meeting of the IHR Emergency Committee regarding the Ebola outbreak in West Africa" (7 July 2015); World Health Organization "Statement on the 7th meeting of the IHR Emergency Committee regarding the Ebola outbreak in West Africa" 5 October 2015; World Health Organization "Statement on the 8th meeting of the IHR Emergency Committee regarding the Ebola outbreak in West Africa" (18 December 2015); and World Health Organization "Statement on the 9th meeting of the IHR Emergency Committee regarding the Ebola outbreak in West Africa" (29 March 2016).

¹⁷⁰ "Statement on the 1st meeting of the IHR Emergency Committee on the 2014 Ebola outbreak in West Africa", above n 168, at 1–2.

considered that initial responses to the crisis did not adequately take into consideration local cultural contexts, fostering distrust and poor communication between the parties.¹⁷¹ Greater consideration of the views of affected states would generate understanding of the need for culturally appropriate guidelines or policy. Greater participation, combined with greater transparency, could enhance the Committee's inclination to consider these views.

Irrespective of state participation and the views of the Emergency Committee, whether an event is a PHEIC and what type of response is appropriate are ultimately discretionary decisions of the Director-General.¹⁷² In practice, and possibly because the Director-General is required to communicate the Committee's views alongside emergency decisions,¹⁷³ consensus is a priority. The Committee was unanimous in its recommendation that Ebola constituted a PHEIC, advice that the Director-General promptly followed.¹⁷⁴ To what extent the Committee heeded the input from affected states is uncertain.

3 *Reasoned decisions*

Participation might go some way to justify the delegation of decision-making authority, but does not necessarily justify the decisions themselves.¹⁷⁵ The principle that decisions should be accompanied by reasons is founded on the rule of law, particularly the principle of equality and avoiding arbitrariness.¹⁷⁶ Decisions rendered without reasons and subject to few accountability mechanisms risk being perceived as arbitrary and autocratic uses of power lacking legitimacy.

Giving reasons is instrumental and necessary to the proper functioning of other aspects of GAL. Harlow notes the standard justification for reasoned decisions "stresses the control function of judicial review but also extends to an embryonic public principle of transparency".¹⁷⁷ The principle supports the goal of transparency, it can provide evidence of appropriate participation and, finally, reasoned decisions can facilitate review of those decisions by providing bases on

¹⁷¹ Kikwete and others, above n 7, at 38.

¹⁷² IHR 2005, above n 65, art 48(5).

¹⁷³ Article 49(6).

¹⁷⁴ "Statement on the 1st meeting of the IHR Emergency Committee on the 2014 Ebola outbreak in West Africa", above n 168.

¹⁷⁵ Bodansky, above n 29, at 619.

¹⁷⁶ Marco Macchia "The rule of law and transparency in the global space" in Sabino Cassese (ed) *Research Handbook on Global Administrative Law* (Edward Elgar Publishing, Cheltenham, 2016) 261 at 269.

¹⁷⁷ Carol Harlow *Accountability in the European Union* (Oxford University Press, Oxford, 2002) at 160. See also Richard B Stewart "Accountability and the Discontents of Globalization: US and EU Models for Regulatory Governance" (paper presented at New York University Law School Hauser Colloquium on Globalization and its Discontents, 20 September 2006) at 22.

which challenges or defences can be mounted. Reasons are particularly important where other accountability mechanisms are lacking.¹⁷⁸ Even without the threat of legal review, having to give reasoned decisions encourages a decision-maker to act within their powers, reference relevant norms, justify deviations from those norms and develop “decisional consistency”.¹⁷⁹ An underlying implication is that the reasons must be worthy—in other words, it “entails substantive commitments”.¹⁸⁰

Decisions made under WHO’s emergency powers can be broadly divided between appointment decisions and decisions of substance. Only the latter could be said to be often accompanied by reasons. These tend to be summaries of Emergency Committee meetings regarding PHEICs. The reasons accompanying PHEIC decisions during Ebola, for instance, catalogue the affected states that made presentations, provide a broad overview of matters raised, and bullet point matters of particular concern.¹⁸¹ They outline what the Emergency Committee considered (and the Director-General agreed) to be the necessary temporary recommendations for affected and other states in light of those concerns. Each document rarely exceeds 2,000 words. The reasons for appointment decisions remain cloaked in mystery. Although there is considerable transparency in the procedure for appointment to the Committee, such transparency does not extend into the Director-General’s reasons for choosing particular members.

Neither of these two examples is particularly effective in fulfilling the reasoned decisions requirement. Appointment decisions lack reasons entirely, perhaps because they are perceived as less controversial—a disputed perception in the case of H1N1.¹⁸² Decisions regarding PHEICs provide bare reasons in support and give the appearance of a competent appraisal of the issues. However, the reasons given do not adequately support the various rationales behind requiring reasons. Transparency is compromised—albeit possibly to protect free and frank debate within the Committee. It is not clear to what extent states participated, the substance of the matters they raised, and to what extent these matters were considered. The ability to use Committee statements as tools for review is

¹⁷⁸ John Ferejohn “Accountability in a Global Context” (2007) IILJ Working Paper 2007/5 (Global Administrative Law Series) at 9.

¹⁷⁹ Stewart, above n 177, at 22–23. See also David Dyzenhaus, Murray Hunt and Michael Taggart “The Principle of Legality in Administrative Law: Internationalisation as Constitutionalisation” (2001) 1 OJCLJ 5 at 6 and 28.

¹⁸⁰ Dyzenhaus, Hunt and Taggart, above n 179, at 29.

¹⁸¹ See the various Statements of the IHR Emergency Committee regarding Ebola, above n 168 and n 169.

¹⁸² *Strengthening Response to Pandemics and Other Public-Health Emergencies*, above n 153, at 115; Benton Heath, above n 61, at 151; and Cohen and Carter, above n 146; and Godlee, above n 150.

undermined by their brevity: decisions emphasise reasons that justify PHEICs and associated temporary recommendations; any analysis of reasons pointing away from declaring a PHEIC is absent. Moreover, the few mandatory procedural limits on emergency decisions contained in the 2005 IHR are not discussed. For instance, it is not clear if the Director-General has considered scientific principles or advice from relevant committees.¹⁸³ It unclear if the measures are no more “restrictive of international traffic and trade and ... intrusive to persons than reasonably available alternatives”.¹⁸⁴ Nor is it clear whether other areas of international law, such as fundamental human rights, have been considered,¹⁸⁵ or whether departures from those norms are justified by “urgent circumstances”.¹⁸⁶

Decisions of substance involving more controversial matters tend to attract more detailed reasoning. The report of the advisory panel on the use of unregistered medicines focused on one issue, discussed it in detail, and provided its reasons in greater depth.¹⁸⁷ Still criticisms remain: the meeting was a mere three hours long,¹⁸⁸ the process failed to include affected states and a consideration of their values,¹⁸⁹ and the recommendations were generic and provided definitions considered too loose for many practitioners to employ.¹⁹⁰ The document does not “approve” the use of any medicines, but WHO’s seeming endorsement of a process to use unregistered medicines had significant normative value. Inadequate reasons take on a particularly ominous tone in light of the chequered history of western pharmaceutical use in Africa.¹⁹¹ This example also does not adequately fulfil the rationales behind reasoned decisions.

WHO’s approach to reasoned decisions does not appear to have been modified greatly in more recent times. The decision declaring Zika a PHEIC contains little

¹⁸³ IHR 2005, above n 65, art 17(a)–(c).

¹⁸⁴ Article 17(d).

¹⁸⁵ Article 17(e)–(g).

¹⁸⁶ Article 17.

¹⁸⁷ “Ethical considerations for use of unregistered interventions for Ebola viral disease: Report of an advisory panel to WHO”, above n 156.

¹⁸⁸ Udo Schuklenk “Bioethics and the Ebola Outbreak in West Africa” (2014) 14(3) *Developing World Bioethics* ii at ii.

¹⁸⁹ Angus J Dawson “Ebola: what it tells us about medical ethics” (2015) 41 *J Med Ethics* 107 at 108; Udo Schüklenk “WHO Ebola ethics panel excluded those most affected” (13 August 2014) *The Conversation* <www.theconversation.com>; and Schuklenk, above n 188, at ii.

¹⁹⁰ Dawson, above n 189, at 108; and Philippe Calain “The Ebola clinical trials: a precedent for research ethics in disasters” (2016) *J Med Ethics* 1.

¹⁹¹ See for example Benjamin Mason Meier “International Protection of Persons Undergoing Medical Experimentation: Protecting the Right of Informed Consent” (2003) 20 *Berk J Intl L* 513; and Marcia Angell “Ethical imperialism? Ethics in international collaborative clinical research” (1988) 319 *NEJM* 1081.

reasoning,¹⁹² and does not have Emergency Committee representatives from affected countries.¹⁹³ Sensing a need to clarify its position as to why the decision was made, the Emergency Committee for Zika published more extensive reasons in the *Lancet*, just days following the PHEIC decision.¹⁹⁴ Along with the decisions discussed above, this decision falls short of providing strong support for claims of legitimacy via democracy, efficacy and expertise.

4 Review

Reviews come in many types with many variables. They can be legal or political in nature, and undertaken by ad hoc or standing bodies either external or internal to the decision-making body. Review can extend to a right of legal review by affected parties.¹⁹⁵ Review goes some way to ensure decisions are consistent with predetermined criteria,¹⁹⁶ and—along with reasoned decisions—can operate as a substitute for democratic participation and transparency.¹⁹⁷ WHO has been subject to extensive review following severe disease outbreaks.

WHO's Constitution does not create or designate an independent or internal body that has standing jurisdiction to determine the legality of emergency responses. Nor are there any concrete proposals for such a body. However, several ad hoc mechanisms have been employed to review emergency responses. These mechanisms have been both internal and external. Internally, ad hoc review committees can be convened by the Director-General to review emergency action,¹⁹⁸ and the Executive Board can itself undertake reviews, make proposals and issue resolutions.¹⁹⁹ Externally, WHO has been subject to review by the UN,²⁰⁰ the Parliamentary Assembly of the Council of Europe,²⁰¹ and various

¹⁹² World Health Organization “WHO statement on the first meeting of the International Health Regulations (2005) (IHR 2005) Emergency Committee on Zika virus and observed increase in neurological disorders and neonatal malformations” (1 February 2016).

¹⁹³ France and El Salvador participated in the Emergency Committee deliberations but did not have members on the Emergency Committee: see “List of Members of, and Advisers to, the International Health Regulations (2005) Emergency Committee on Zika virus and observed increase in neurological disorders and neonatal malformations” (14 June 2016) World Health Organization <www.who.int>.

¹⁹⁴ David L Heymann and others “Zika virus and microcephaly: why is this situation a PHEIC?” (2016) 387 *The Lancet* 719.

¹⁹⁵ Kingsbury, Krisch and Stewart, above n 119, at 39–40 discussing the World Bank Inspection Panel and the WTO Appellate Body decision *United States–Import Prohibition of Certain Shrimp and Shrimp Products* WT/DS58/AB/R Doc No 98-3899 (12 October 1998).

¹⁹⁶ Macchia, above n 176, at 272.

¹⁹⁷ John Ferejohn's remarks at Global Administrative Law Conference, New York University School of Law April 2005 as cited in Stewart, above n 177, at 16.

¹⁹⁸ IHR 2005, above n 65, arts 50–52.

¹⁹⁹ Art 28(e).

²⁰⁰ Kikwete and others, above n 7.

NGOs.²⁰² Although none necessarily have binding power on WHO, their combined influence is extremely strong.

The Director-General called a special session of the Executive Board following the Ebola outbreak. The outcome, betraying international pressure for “profound organizational changes”,²⁰³ has resulted in change. In its recommendations, the Board made multiple references to improving transparency of information and decision-making.²⁰⁴ The Board also emphasised the need for decisions to be taken within the parameters of WHO’s “principles and objectives”.²⁰⁵ These points suggest both procedural and substantive limits on emergency decision-making are desirable. Transparency requires dissemination of information to at least the affected parties (and affected parties might extend to the public in a PHEIC). Suggested substantive limits on the Director-General’s discretion can be found in WHO’s constitution: for instance, equality principles, the provision of aid only on request or acquiescence, the right to attaining the highest possible levels of health, and the principle of openness and cooperation.²⁰⁶

The Board also made recommendations regarding review. Firstly, it asked the Director-General to commission an independent expert assessment of WHO’s response to Ebola.²⁰⁷ It recommended that the Director-General establish a committee to review the effectiveness of the 2005 IHR in facilitating emergency responses, and options for improving transparency and efficiency for future responses.²⁰⁸ Finally, the Board recommended establishing an ad hoc advisory group to “provide advice on administrative and logistical support” to the Director-General in the case of future outbreaks.²⁰⁹

The Board is highly attuned to the need for legitimacy, and its recommendations align with GAL goals: calls for transparency, the need for substantive limits on

²⁰¹ *The Handling of the H1N1 Pandemic: More Transparency Needed*, above n 151; Council of Europe Res 1749, above n 151; and Council of Europe Rec 1929, above n 151.

²⁰² For example Médecins Sans Frontières *Pushed to the Limit and Beyond: A year into the largest ever Ebola outbreak* (23 March 2015); Médecins Sans Frontières *Epidemics: Neglected emergencies?* (Médecins Sans Frontières Operational Centre Geneva, October 2015); and Marc DuBois, Caitlin Wake, Scarlett Sturridge and Christina Bennett *The Ebola response in West Africa: Exposing the politics and culture of international aid* (Humanitarian Policy Group, Overseas Development Institute, 2015).

²⁰³ Burci and Quirin, above n 65, at 533.

²⁰⁴ *Executive Board Special Session on the Ebola Emergency* WHO EBSS3.R1 EBSS/3/2015/REC/1 (2015) at [10], [25], [27] and [51].

²⁰⁵ At [36].

²⁰⁶ WHO Constitution, above 11, preamble.

²⁰⁷ *Executive Board Special Session on the Ebola Emergency*, above n 204, at [52].

²⁰⁸ At [53].

²⁰⁹ At [54].

decision-making via WHO principles, expert advisory groups, and the desirability of independent review of decisions. Several recommendations have been implemented. Independent reviews of the Ebola response (the Ebola Panel) and the efficacy of the 2005 IHR (resulting in the Ebola IHR Report) were undertaken.²¹⁰ Transparency, however, remains something of a sticking point. While the Board emphasised transparency in decision-making, echoed by the speeches of Assembly delegates,²¹¹ it appears transparency is translated into solely financial transparency to donors through Secretariat policy development processes.²¹² Selective interpretation within the bureaucratic component of WHO has left a key GAL principle without an avenue for implementation. WHO's system of internal review works to some degree, but it is not without flaws.

This is further emphasised when comparing this outcome with the outcome of the IHR review commissioned after the 2009 H1N1 crisis (H1N1 IHR Report). The Report identified confidentiality of the Emergency Committee as a key problem as it fed suspicions that WHO had "something to hide".²¹³ Some Committee members had declared potential conflicts of interest that were deemed insufficient to exclude them from the decision-making process.²¹⁴ Lack of transparency, particularly because it extended over the 17-month period of the PHEIC, fuelled concerns regarding the veracity of the PHEIC decision. Recommendation six of the H1N1 IHR Report concluded that WHO needed to "adopt more transparent procedures" for appointing Committee members,²¹⁵ and develop clear guidelines for assessing the severity of outbreaks.²¹⁶ Although applying hard and fast rules is

²¹⁰ World Health Organization *Report of the Ebola Interim Assessment Panel* (7 July 2015); and *Implementation of the International Health Regulations (2005): Report of the Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response – Report by the Director-General Sixty-Ninth World Health Assembly A69/21* (13 May 2016) [Ebola IHR Report].

²¹¹ See for example *World Health Organization Sixty-Eighth World Health Assembly Summary Records of Committees, Geneva, 18–26 May 2015 WHA68/2015/REC/3* the speeches of Mr Dikmen (Turkey) at 12, Dr Roa Rodriguez (Panama) at 44, Ms Alarcón Mayorga (Colombia) at 45–46 and 62, Mr Kuemmel (Germany) at 56, Mr Jehangir (Pakistan) at 289, Ms Ching (International Baby Food Action Network) at 338.

²¹² See for example the commentary around financial transparency regarding the Contingency fund in "WHA68(10) 2014 Ebola virus disease outbreak and follow-up to the Special Session of the Executive Board on the Ebola Emergency" *World Health Organization Sixty-Eighth World Health Assembly Geneva, 18–26 May 2015 Resolutions and Decisions Annexe WHA68/2015/REC/1* (2015) at 89; and *2014 Ebola virus disease outbreak and follow-up to the special session of the Executive Board on Ebola: options for a contingency fund to support WHO's emergency response capacity – Report by the Director-General WHO WHA A68/26* (2015) at [28]–[31].

²¹³ *H1N1 IHR Report*, above n 153, at 115.

²¹⁴ At 115.

²¹⁵ *World Health Organization Sixty-Fourth World Health Assembly WHA64/2011/REC/1 Annexe 1: Implementation of the International Health Regulations (2005) Report of the Review Committee on the Functioning of the International Health Regulations (2005) in relation to Pandemic (H1N1) 2009 A64/10* at 66–67.

²¹⁶ At 67.

difficult in emergencies, a “basket of indicators” would provide benchmarks for decision-makers, and for those assessing the legitimacy of the decision. Decisions could be thus streamlined, more reliable and reasoned, and seen as more authoritative if made by experts without vested interests. Neither of these recommendations from the H1N1 IHR Report has been implemented. In fact the Ebola Panel, the UN Panel and the Ebola IHR Report found that implementation of the H1N1 IHR Report recommendations could have mitigated the Ebola crisis.²¹⁷ Clearly, the ad hoc bodies deployed to review WHO emergency action have not shied from critical appraisals. WHO’s responsiveness to their appraisals, however, leaves something to be desired.

The H1N1 crisis also begat another type of review. In what is a rare instance of horizontal review by another public body,²¹⁸ the Parliamentary Assembly of the Council of Europe criticised the lack of transparency and shortcomings of the decision to declare H1N1 a PHEIC.²¹⁹ Described by one member of the Parliamentary Assembly as “brave” and “difficult”,²²⁰ horizontal review is complicated by a lack of clear inter-institution hierarchies and the potential for transgressing norms of international relations—specifically the principle of comity.²²¹ It carries political risks of upsetting states with specific interests in the critiqued IO.²²² A lack of universal standards compounds the questionable veracity of the review.²²³ Despite these pitfalls, the Parliamentary Assembly made strong criticisms of WHO’s emergency management.

The UN also undertook a review of WHO following Ebola.²²⁴ Broad terms framed the review, but its recommendations focused on compliance with the 2005 IHR: states must urgently adhere to core capacity obligations;²²⁵ support must be provided so they can;²²⁶ and WHO must provide leadership and ensure state

²¹⁷ *Report of the Ebola Interim Assessment Panel*, above n 210, at 10; Kikwete and others, above n 7, at 5; and *Ebola IHR Report*, above n 210, at 50.

²¹⁸ Dushman, above n 149, at 1090 and 1099–1101.

²¹⁹ *The Handling of the H1N1 Pandemic: More Transparency Needed*, above n 151; Council of Europe Res 1749, above n 151; and Council of Europe Rec 1929, above n 151.

²²⁰ Translated comments of Agramunt Font de Mora (Spain) Parliamentary Assembly, Report of the Third Part of the 2010 Ordinary Session, 26th sitting, AA10CR26, AS (2010) CR 26, 24 June 2010 as cited in Dushman, above n 218, at 1101.

²²¹ Dushman, above n 218, at 1101–1102.

²²² At 1102.

²²³ At 1102.

²²⁴ Kikwete and others, above n 7.

²²⁵ At 11–13 and 32–43, Recommendations 1–5.

²²⁶ At 15–17, 56–58 and 64–65, Recommendations 10–12 and 18–20.

compliance.²²⁷ These are not new criticisms, which suggest a “high-level political mechanism is needed to monitor the implementation”.²²⁸ To this end, the UN recommended a global council reporting to the UN and a summit on “Global Public Health Crises”.²²⁹

The most recent review of WHO’s emergency response is the Ebola IHR Report, instigated at the recommendation of the Executive Board. This report ultimately considers problems did “not result from failings of the IHR themselves, but rather from a lack of implementation”.²³⁰ It advises against IHR revision, but recommends augmentation to help improve implementation: the introduction of a standing advisory committee to oversee WHO’s PHEIC decisions and communications.²³¹

GAL principles make various appearances to varying degrees in WHO’s emergency governance. Transparency has been heavily criticised, yet convoluted and potentially ineffective participation has not garnered similar disapproval. Reasoned decisions, which might otherwise relieve pressure on transparency and participation, are lacking. Review processes are robust, but their effectiveness is undermined by lack of implementation. Whether these limitations to GAL principles can be justified or if they point to more structural problems is the subject of the final Part of this paper.

V TAKING AIM AT THE HEART: DISSECTING GLOBAL ADMINISTRATIVE LAW

This Part extends the examination of GAL in relation to WHO’s emergency powers. The use of GAL at WHO appears, on the face of it, to be promising but ultimately lacking. But are there justifications for varying GAL principles? And what of GAL’s own internal limitations? This Part first engages in analyses of specific aspects of GAL, making comparisons to methods employed by other IOs where appropriate. It then embarks on a broader enquiry, addressing risks of applying GAL uncritically, and problems associated with concepts of emergencies. It ends by grappling with the question: is it best, whatever is best

²²⁷ At 13–18 and 45–54, 60–64 and 66–68, Recommendations 6–9, 13–17 and 22–24.

²²⁸ At 19 and 69–70.

²²⁹ At 19 and 70, Recommendations 26 and 27.

²³⁰ *Ebola IHR Report*, above n 210, at 9.

²³¹ At 11 and 63–64, Recommendation 6.

administered, or should a critique take aim at the architecture of global health governance?

A A Balance of Transparency and Participation

Transparency is inconsistently and inadequately applied at WHO. Despite rhetoric proclaiming its importance, it is only one of many competing principles in play in emergency contexts. As with any IO, there is a need to “consider transparency’s costs in order to structure mechanisms that preserve other important values”.²³² For instance, optimal transparency may be less than full transparency in health matters due to considerations such as confidentiality and privacy.²³³ This is borne out in the 2005 IHR. WHO is supplied health information by states in confidence, divulging to other states only in certain circumstances, such as when it is necessary to protect against health concerns.²³⁴ Public dissemination is allowed only when the information is already in the public domain and there is a need to supply authoritative statements.²³⁵ However, these restrictions are considerably reduced in the context of a PHEIC, thus eliminating confidentiality concerns regarding state provided information.²³⁶ Health data identifying individuals must be protected by states according to their own privacy laws, and by WHO according to strict privacy rules in the IHR, even during a PHEIC.²³⁷ Confidentiality of state supplied information and protection of individuals’ privacy cannot justify WHO’s lack of transparency in its PHEIC decisions as it requires no breach of personal data, and confidentiality is a subordinated concern.

Transparency is claimed to facilitate better decisions. It can provide for better scrutiny by the public, NGOs and other interested parties.²³⁸ It can expose, and thus disempower, attempts at lobbying or appearances of corporate capture. Targeted funding has considerable impact on the shape and direction of WHO policy, and can lend itself to the argument that WHO is vulnerable to lobbying by blocks of states or other interests.²³⁹ The successful use of transparency to sanitise

²³² Bruemmer and Taylor, above n 140, at 274.

²³³ At 273; and Lawrence O Gostin and Benjamin E Berkman “Pandemic Influenza: Ethics, Law, and the Public’s Health” (2007) 59 Ad L Rev 121 at 156.

²³⁴ IHR 2005, above n 65, art 11(1)–(2).

²³⁵ Article 11(4).

²³⁶ Article 11(2)(a).

²³⁷ Article 45.

²³⁸ Donaldson and Kingsbury, above n 132, at 528–530.

²³⁹ See Siddiqi, above n 23, at 84 regarding the “Geneva states” that contribute over half of WHO’s funding and have a “strong voice in setting limits to certain WHO programmes”; and Lee, above n 23, at 40–41 and 119 describing the impact of targeted funding and political trade-offs; and Dushman, above n 218, at 1093–1094 regarding tobacco industry and scientific lobbying.

this is illustrated by WHO's use of public hearings to thwart the power of the tobacco lobby when developing international law on tobacco regulation.²⁴⁰

In emergency contexts, however, some level of opacity may lead to better decisions and justify transparency limitations. Confidentiality could promote better quality inputs. For example, states might more readily proffer relevant information.²⁴¹ Confidentiality could also promote better deliberation in matters involving a delicate balance of technical, economic and political concerns. For example, it can prevent counterproductive political grandstanding by decision-makers to satisfy other constituencies,²⁴² and it can promote free and candid discussion valuable to contested subjects,²⁴³ which would balance public safety, political and economic considerations.²⁴⁴ It can also prevent the exposure of poor decisions—inevitable in a large organisation—that might unnecessarily risk the authority of its expertise.²⁴⁵ Evidently, neither outright confidentiality nor complete transparency is a panacea; the solution vacillates somewhere in between.

Other IOs guide where the balance might lie. From a traditional starting point of opacity due to being extensions of the diplomatic process,²⁴⁶ some IOs are becoming more open to transparency and participation.²⁴⁷ The World Bank has made concrete efforts, shifting policy from a limited list of matters on which disclosure is expected to a default presumption of transparency with specific

²⁴⁰ See World Health Organization *Tobacco Industry Strategies to Undermine Tobacco Control Activities at the World Health Organization: Report of the Committee of Experts* (July 2000); World Health Organization “WHO Director-General’s Response to the Tobacco Hearings” (13 October 2000); and WHO Framework Convention on Tobacco Control, 21 May 2003, 2302 UNTS 166 (opened for signature 16 June 2003, entered into force 27 February 2005).

²⁴¹ Donaldson and Kingsbury, above n 238, at 527.

²⁴² Bruemmer and Taylor, above n 140, at 273; Buchanan and Keohane, above n 81, at 430–431; and Kingsbury, above n 122, at 50.

²⁴³ See Luis Miguel Hinojosa Martínez “Transparency in International Financial Institutions” in Andrea Bianchi and Anne Peters (eds) *Transparency in International Law* (Cambridge University Press, Cambridge, 2013) 77 at 84–90 and 99–102.

²⁴⁴ Bruemmer and Taylor, above n 140, at 273. See also S Rushton “Global Governance Capacities in Health: WHO and Infectious Diseases” in A Kay and OD Williams (eds) *Global Health Governance: Crisis, Institutions and Political Economy* (Palgrave MacMillan, London, 2009) 75; and Gabrielle Marceau “IGOs in Crisis? Or New Opportunities to Demonstrate Responsibility?” (2011) 8 *Int’l Org L Rev* 1 at 4–5 for discussions of the negotiations with Indonesia regarding influenza sharing. See S Vezzani “Preliminary Remarks on the Envisaged World Health Organization Pandemic Influenza Preparedness Framework for the Sharing of Viruses and Access to Vaccines and Other Benefits” (2010) 13 *The Journal of World Intellectual Property* 678 at 680–681 for the resulting equitable sharing and vaccine development framework agreed.

²⁴⁵ Donaldson and Kingsbury, above n 238, at 529.

²⁴⁶ Stein, above n 79, at 502.

²⁴⁷ See for example Robert Howse “How to Begin to Think About the ‘Democratic Deficit’ at the WTO” in Robert Howse *The WTO System: Law, Politics & Legitimacy* (Cameron May, London, 2007) 57 at 73 regarding the WTO.

exceptions.²⁴⁸ Closed deliberations with publicly disclosed decisions are common,²⁴⁹ but the World Trade Organization (WTO) now allows open hearings if all parties consent.²⁵⁰ However, the specific context of emergency health decisions provides additional challenges to these models. The risks of default disclosure permeate WHO's Constitution and the 2005 IHR. Transparency could create chilling effects on state reporting, encourage potential overreactions with harsh trade and travel embargoes, risk public panic, and risk personal privacy and security—the very issues WHO is charged with protecting against. Given the type of information and potential risks of premature disclosure, the current presumption of confidentiality with certain exceptions might best be maintained.

Competing considerations in these exceptions might be reconciled with a tiered approach. First, decisions regarding PHEICs are themselves public by default and ought to remain so. From there, distinctions can be drawn between access to information and proactive publication,²⁵¹ and between procedural and substantive matters.²⁵² Procedural matters—such as who is chosen for Emergency Committees and why—ought to be robust enough to withstand default transparency.²⁵³ Where competing considerations arise around substantive matters, providing access to substantive information only to those affected by the decision may be justified. In a globalised world, however, this begs the question as to who is considered “affected”.

Given that complete transparency is counterproductive, other GAL principles—particularly participation—might need to pick up the slack. Harlow suggests committees on the one hand obstruct transparency, but on the other facilitate greater participation by affected parties, interested parties and experts.²⁵⁴ Importantly, participation is not about consensus or the discovery of ultimate

²⁴⁸ World Bank “Bank Policy: Access to Information” (1 July 2015) at s 3(b)(1); Martínez, above n 243, at 94; and Macchia, above n 176, at 271.

²⁴⁹ Martínez, above n 243, at 99; and Sarah Joseph *Blame it on the WTO? A Human Rights Critique* (Oxford University Press, Oxford, 2011) at 65.

²⁵⁰ Panagiotis Delimatsis “Institutional Transparency in the WTO” in Andrea Bianchi and Anne Peters (eds) *Transparency in International Law* (Cambridge University Press, Cambridge, 2013) 122 at 131–132; and Kingsbury, above n 122, at 49.

²⁵¹ Alan Boyle and Kasey McCall-Smith “Transparency in International Law-making” in Andrea Bianchi and Anne Peters (eds) *Transparency in International Law* (Cambridge University Press, Cambridge, 2013) 419 at 434.

²⁵² International Law Association *Report of the Seventy-first Conference held in Berlin, 16-21 August, 2004* (International Law Association, London, 2004) at 164 and 172–175.

²⁵³ Bruemmer and Taylor, above n 140, at 274.

²⁵⁴ Harlow, above n 177, at 33.

truth,²⁵⁵ but rather ensuring diverse concerns are presented to decision-makers. Decisions become more legitimate: decided by well-informed experts, likely to be effective, and seen as more democratic. Participation encourages continued cooperation and acceptance of decisions, even without agreement on its substantive content.²⁵⁶ Participation by affected states via Emergency Committees is relatively modest considering potential infringements on freedom of movement and impacts on trade and economies. The principal factor that justifies this limit is the need for timely decisions.

Early intervention often presents the best opportunity to prevent disease spread and reduce large-scale harm. This rationalises both limiting the breadth of parties with rights to be heard (affected states) and limiting the types of rights (procedural rather than substantive). One problem regarding the first limitation is that explored by Third World Approaches to International Law (TWAIL) scholars Bhupinder Chimni and Antony Anghie: recognition of the authoritarian violence some Third World states use against individuals within their borders.²⁵⁷ Individuals from the Third World are often on the front-line of emergencies—whether it be environmental crises,²⁵⁸ political crises,²⁵⁹ or disease outbreaks.²⁶⁰ States refusing to address individuals’ participation at a domestic level illustrate an ongoing need to address individuals’ participation at the international level.²⁶¹ States refusing to comply with international obligations to the detriment of their population’s health also supports such rights. Although a lack of individual or civil society participation is not critical to expertise- or efficacy-based legitimacy, it is important to democratic legitimacy, or to bolster other claims to legitimacy where transparency is lacking.²⁶²

²⁵⁵ Compare Jürgen Habermas *The Postnational Constellation: Political Essays* (MIT Press, Cambridge, 2001); and Amy Gutmann and Dennis Thompson *Why Deliberative Democracy?* (Princeton University Press, Princeton, 2004).

²⁵⁶ Stewart, above n 177, at 28.

²⁵⁷ Antony Anghie and BS Chimni “Third World Approaches to International Law and Individual Responsibility in Internal Conflicts” (2003) *Chinese JIL* 77 at 82–83.

²⁵⁸ See Onvizu, above n 100; and Usha Natarajan “Symposium: Third World Approaches to International Law (TWAIL) Conference: Capitalism and the Common Good: TWAIL and the Environment: The State of Nature, the Nature of the State, and the Arab Spring” (2012) 14 *ORIL* 177.

²⁵⁹ See Natarajan, above n 258.

²⁶⁰ World Health Organization *The World Health Report 1996 – Fighting Disease, Fostering Development* (Geneva, 1996) at 9.

²⁶¹ See Natarajan, above n 258, at 196–198.

²⁶² Boyle and McCall-Smith, above n 251, at 428.

Although participation of individuals is rare in IOs, there are examples of representative participation through civil society organisations.²⁶³ The WTO allows NGOs to submit amicus curie briefs during disputes.²⁶⁴ The World Bank is increasingly inclusive of civil society via consultation.²⁶⁵ The UN, too, is increasing its interface with NGOs,²⁶⁶ with some NGOs obtaining consultative status.²⁶⁷ NGO participation can be seen to enhance the efficacy and democratic legitimacy of global governance decisions. TWAIL scholars, however, raise questions about the use of NGOs as representatives of Third World individuals. Inequality in individual access to or influence over NGOs combined with NGOs having greater access to IOs is at times contrary to the interests of Third World countries or individuals.²⁶⁸ With respect to WHO, and its emphasis on technical expertise, these issues might be best solved outside of participation in decision-making in a review setting, an option discussed further below.

B Proceduralising the Political

GAL is founded on the premise that following particular procedures brings benefits to administrative decisions, but such procedures may also have the effect of limiting flexibility that would otherwise be available to emergency decision-makers. The emergency decisions in SARS, H1N1 and Ebola show that proceduralisation has not uniformly improved their quality or veracity.

Under previous IHR, procedural guides were extremely limited. During SARS, WHO undertook many actions that were not subject to formal procedural limits. The Secretariat, for example, issued and prematurely recalled its advice against non-essential travel to Toronto.²⁶⁹ The recall materialised without the provision of

²⁶³ Regarding contested meanings of civil society see Laura Pedraza-Fariña “Conceptions of Civil Society in International Lawmaking and Implementation: A Theoretical Framework” (2013) 34 *Mich J Intl L* 605; and Francesca Bignami “Theories of civil society and Global Administrative Law: the case of the World Bank and international development” in Sabino Cassese (ed) *Research Handbook on Global Administrative Law* (Edward Elgar Publishing, Cheltenham, 2016) 325.

²⁶⁴ *United States–Import Prohibition of Certain Shrimp and Shrimp Products* WT/DS58/AB/R Doc No 98-3899 (12 October 1998) at [88]–[91]. See Delimatsis, above n 250, at 130.

²⁶⁵ Bignami, above n 263, at 326.

²⁶⁶ Alan Boyle and Christine Chinkin *The Making of International Law* (Oxford University Press, Oxford, 2007) at 53.

²⁶⁷ Boyle and McCall-Smith, above n 251, at 425; and *Arrangements for Consultation with Non-Governmental Organizations* ESC Res 1296 E/RES/1296(XLIV) (1968).

²⁶⁸ Jagdish N Bhagwati “The Question of Linkage” (2002) 96 *AJIL* 126; and Donaldson and Kingsbury, above n 238, at 526.

²⁶⁹ “WHO extends its SARS-related travel advice to Beijing and Shanxi province in China and to Toronto, Canada” (23 April 2003) World Health Organization <www.who.int>; and “World Health Organization lifts Toronto travel advisory, maintains advice for areas of China” (30 April 2003) World Health Organization <www.who.int>.

reasons, raising questions of political interference by Canadian delegates.²⁷⁰ Under the 2005 IHR, the Director-General issues such recommendations along with Emergency Committee views, which goes some way to allay fears of repeat performance. And yet the decision to declare H1N1 a PHEIC, despite accompanying reasons, was extremely poorly received. Are more reasons needed? One criticism of reasoned decisions is that the work of technical experts is hindered if their reasoning is scrutinised by those with vested interests: “NGO agitators or self-serving industrialists”.²⁷¹ However, this argument does not fit with the Millian justifications of freedom of expression,²⁷² nor with the experience of WHO during the development of tobacco regulations discussed above.

Taking the criticism of proceduralisation further, the need to take a decision in a particular manner may itself hinder good decisions. This arguments might apply to WHO’s ill-judged use of emergency power during H1N1. The criticism WHO received:²⁷³

... stands in stark contrast to the widespread praise heaped on the WHO for stopping SARS in 2003. In this light, it might be important to ask whether a formalized emergency powers regime actually serves the goal of placing reasonable constraints on the action of a secretariat, or whether an informal regime might be preferred.

WHO may have been more cautious if the choice had not been so stark between emergency and non-emergency.²⁷⁴ Without formal powers, its decisions could have been political, although this may have required more effort to justify to the international community. Proceduralisation has played a part in the heavy-handed use of emergency power.

Similar criticisms can be made in the context of delayed decisions. States, particularly developing ones, are extremely vulnerable to potentially damaging economic and social effects of PHEICs.²⁷⁵ This explains why some are reluctant to engage with the PHEIC framework. The UN Panel noted that prior to the Ebola PHEIC declaration, some affected states requested WHO’s help without one—to

²⁷⁰ Fidler, above n 40, at 92–93.

²⁷¹ Kingsbury, above n 122, at 49 and n 68.

²⁷² John Stuart Mill *On Liberty* (Cambridge University Press, Cambridge, 2011) at 33.

²⁷³ Benton Heath, above n 61, at 152.

²⁷⁴ At 152.

²⁷⁵ Kikwete and others, above n 7, at 26–27.

effect political rather than legal solutions.²⁷⁶ WHO was sensitive to these concerns, but did not proceed to help in the way requested.²⁷⁷ The IHR, while not expressly prohibiting such action, dampens motivations to step outside their parameters. Other factors may have been at play, such as reluctance stemming from H1N1 critiques. Nevertheless, proceduralisation assisted the delay of WHO-backed help arriving in Guinea and Liberia for almost eight months. Review can mitigate this to some degree: the Ebola IHR Review recently recommended instigating an “International Public Health Alert” category to enable international responses while avoiding the detrimental effects of a PHEIC declaration.²⁷⁸ This does not, however, entirely address affected states’ fears of unwarranted embargoes.

Conversely, lack of procedure has detrimental effects. The IHR do not indicate how WHO determines whether PHEIC decisions need to be taken. In practice, the Director-General makes the determination based on information required to be reported under the 2005 IHR. In the case of Ebola, various parties had signalled to the Secretariat that Guinea was not able to cope as early as March 2014.²⁷⁹ Médecins Sans Frontières made SOS calls to WHO in June as the disease spread to neighbouring countries.²⁸⁰ However, unlike H1N1 or MERS, Ebola was not a novel infectious disease and experts disagreed over whether the epidemiology and geographical spread was unusual, a problem exacerbated by little reliable data.²⁸¹ WHO preferred to treat it as a standard outbreak, following informal proceduralised methods balancing novelty and severity, neither of which were considered out of the ordinary—a conclusion based on insufficient information.

A PHEIC is an extraordinary public health event that poses an international risk potentially requiring an international response.²⁸² Ebola might have fitted this description early on, but for the blanks being filled in with additional procedural steps. The PHEIC declaration was not made until August, at which point more than 1,000 people had died and NGO capacity had moved well beyond crisis

²⁷⁶ At 37. Nigeria, Senegal and Mali took swift action declaring a crisis. By implication, it appears Liberia, Sierra Leone and Guinea did not.

²⁷⁷ At 47.

²⁷⁸ *Ebola IHR Report*, above n 210, at 63–64, Recommendation 6.

²⁷⁹ “Ebola virus disease in Guinea” (23 March 2014) World Health Organization Regional Office for Africa <www.afro.who.int>; Médecins Sans Frontières, above n 202, at 5–7.

²⁸⁰ Médecins Sans Frontières, above n 202, at 9–10.

²⁸¹ Kikwete and others, above n 7, at 37.

²⁸² IHR 2005, above n 65, art 1, definition of “public health emergency of international concern”.

point.²⁸³ The UN Panel, somewhat frugal in its condemnation on this point, described the declaration as “late”.²⁸⁴ The fact that some affected states were reluctant to cooperate is an important political concern. Expert disagreement creates difficult technical issues. But neither of these factors is unexpected in the context of emergency health situations. A lack of formal procedure to follow when confronted with precursory disagreements and insufficient data led to a massive failure in ensuring WHO’s constitutional purpose was fulfilled. Perhaps procedural triggers that require the convening of something similar to an Emergency Committee in contested situations are necessary.

C Hot and Cold: the Effects of Review

Review is one of the stronger GAL principles apparent in the exercise of WHO’s emergency power. Legal review is lacking. Political reviews have had mixed success in effecting changes to the exercise of emergency power. WHO has been receptive to both internal and external review, particularly when recommendations are in unison. Nevertheless, reform has not always resulted, which suggests legal review might be an appropriate addition to WHO’s GAL assemblage.

Again potential models can be found in the operation of other IOs. The WTO has one of the heaviest hitting examples of adjudicatory oversight, with impartial panels that determine disputes, a Dispute Settlement Body that can overturn panel decisions by “reverse consensus”, and a standing Appellate Body that hears appeals from panel decisions on matters of law only.²⁸⁵ The Appellate Body enjoys an institutional independence to make decisions that conflict with trade-friendly policy.²⁸⁶ Howse notes that such judicialisation means the fragmentation of international law for some and for others the promotion of an “institutional thickness that [international law] traditionally lacked when tethered to diplomatic or political arrangements”.²⁸⁷ The Appellate Body process counters criticisms of other organs at the WTO: it incorporates a certain level of participation, pluralism and transparency.²⁸⁸ However, the WTO process is expensive, time consuming, and the Appellate Body’s role in review is criticised as “largely perfunctory”.²⁸⁹

²⁸³ “Statement on the 1st meeting of the IHR Emergency Committee on the 2014 Ebola outbreak in West Africa”, above n 168; and Médecins Sans Frontières, above n 202, at 9–11.

²⁸⁴ Kikwete and others, above n 7, at 46.

²⁸⁵ See generally Robert Howse *The WTO System: Law, Politics & Legitimacy* (Cameron May, London, 2007).

²⁸⁶ Robert Howse “The World Trade Organization 20 Years On: Global Governance by Judiciary” (2016) 27 *EJIL* 9 at 12, 25 – 27 and generally.

²⁸⁷ At 10.

²⁸⁸ Howse “How to Begin to Think About the ‘Democratic Deficit’ at the WTO”, above n 91, at 72–73.

Despite its benefits, in the context of emergency decisions where applicants might be countries or individuals lacking in funds that want to prevent or review measures with some haste, a judicialisation option may simply be too heavy.

Although legal review might bring substantial legitimacy and accountability benefits, further problems associated with this kind of review pose not insignificant risks to the effectiveness of emergency powers. Strict legal review of decisions tends to lock in predetermined criteria against which decisions are judged and requires the giving of reasons which are measured against the criteria. These effects give rise to demands that decision-makers act consistently with previous reasoning.²⁹⁰ However, precedents are problematic in emergencies as predetermined criteria may not adequately address unanticipated contingencies. There is tension between the desire for at least procedural consistency and the need to tailor decisions to the current emergency.

There is also potential for legal review to engender chilling effects on the use of emergency powers due to risk of liability.²⁹¹ Risks of “mission creep” by legal reviewers hindering action and bureaucratic turf wars between bodies distracting from the response are also potential hazards.²⁹² The decision regarding the ethical use of unregistered medications during the Ebola crisis was extremely quick, made in consultation with 12 medical ethics experts, and subject to a significant number of qualifications.²⁹³ Despite the safeguards of expertise and caveated advice, the prospect of legal liability makes such decisions unlikely. Perhaps, in light of the particularly intense criticism of unregistered medicine decision, a chilling effect is a desirable outcome, but the ability to act quickly and take risky decisions is nonetheless an important one.

Legal review needs to address the fact that WHO negotiates diplomatic and technical categories of institutional composition, the former seeking political resolution of conflicts; the latter more formalised modes of conflict resolution.²⁹⁴

²⁸⁹ Howse “How to Begin to Think About the ‘Democratic Deficit’ at the WTO”, above n 91, at 61–63, referring to Ernst-Ulrich Petersmann “European and International Constitutional Law: Time for Promoting ‘Cosmopolitan Democracy’ in the WTO” in Gráinne de Búrca and Joanne Scott (eds) *The EU and the WTO: Legal and Constitutional Issues* (Hart Publishing, Oxford, 2001) 81; and John H Jackson and Alan Sykes (eds) *Implementing the Uruguay Round* (Clarendon Press, Oxford 1997).

²⁹⁰ Stewart, above n 177, at 16.

²⁹¹ Kingsbury and Casini, above n 113, at 338.

²⁹² See Jochen von Bernstorff “Procedures of Decision-Making and the Role of Law in International Organizations” (2008) 9 *German LJ* 1939 at 1945–1951; and Kingsbury and Casini, above n 113, at 337.

²⁹³ “Ethical considerations for use of unregistered interventions for Ebola viral disease: Report of an advisory panel to WHO”, above n 156..

²⁹⁴ For the two compositions and various ramifications see Gráinne de Búrca, Robert O Keohane and Charles Sabel “New Modes of Pluralist Global Governance” (2013) 45 *NYU.J Int’l Law & Pol* 723.

Further, the need to be open and responsive to a wide range of parties suggests review by something other than judicial means is appropriate.²⁹⁵ Eric Stein suggests that an “inspection panel (such as that created by the World Bank) and an ombudsman should be appointed to receive citizen complaints of maladministration”.²⁹⁶ The World Bank Inspection Panel is accessible to individuals to defend their interests against development projects to hold the Bank to its commitment to alleviating poverty in its projects.²⁹⁷ It is subject to limitations: it can only investigate actions by the Bank; and the Bank, rather than the Panel, ultimately determines appropriate responses.²⁹⁸ Implications of deference to the Bank are addressed by ensuring Panel members cannot thereafter work for the Bank.²⁹⁹ Although the Panel initially had limited effectiveness,³⁰⁰ it has since become a powerful legitimising force, remedying various accountability deficits, particularly participation.³⁰¹

Another quasi-judicial option is the position of Ombudsperson to the Security Council’s 1267 Sanctions Committee, created in response to criticisms of the Sanction Committee’s lack of accountability in decisions concerning entries on the ISIL (Da’esh) and Al-Qaida Sanctions List.³⁰² The Ombudsperson is an “independent and impartial” party who reviews delisting requests from individuals, groups or entities who are currently on the List. The Ombudsperson operates as an advisor, adopting flexible and diplomatic problem-solving approaches.³⁰³ States have individual agreements or arrangements with the Office of the Ombudsperson to access confidential material necessary to review listing

²⁹⁵ Devika Hovell *The Power of Process: The Value of Due Process in Security Council Sanctions Decision-Making* (Oxford University Press, Oxford, 2016) at 143.

²⁹⁶ Stein, above n 79, at 532.

²⁹⁷ Dana Clark “Understanding the World Bank Inspection Panel” in Dana Clark, Jonathan Fox and Kay Treakle (eds) *Demanding Accountability: Civil-society Claims and the World Bank Inspection Panel* (Rowman & Littlefield, Lanham, 2003) at 1.

²⁹⁸ Clark, above n 297, at 10; Benedict Kingsbury “Introduction: Global Administrative Law in the Institutional Practice of Global Regulatory Governance” in Hassane Cissé, Daniel D Bradlow and Benedict Kingsbury (eds) *International financial institutions and global legal governance* (World Bank Legal Review 3, World Bank, Washington, DC, 2012) 3 at 17–19.

²⁹⁹ See Clark, above n 297.

³⁰⁰ See the various case studies in Dana Clark, Jonathan Fox and Kay Treakle (eds) *Demanding Accountability: Civil-society Claims and the World Bank Inspection Panel* (Rowman & Littlefield, Lanham, 2003).

³⁰¹ Stewart, above n 36.

³⁰² *Continuation of measures imposed against the Taliban and Al-Qaida* SC Res 1904, S/RES/1904 (2009); *Extension of the mandate of the Office of the Ombudsperson and the implementation of measures relating to the Al-Qaida sanctions list* SC Res 2083, S/RES/2083 (2012) at [19]; and *Extension of the mandate the Office of the Ombudsperson for a period of 24 months from the date of expiration of its current mandate* SC Res 2253, S/RES/2253 (2015) at [54].

³⁰³ Macchia, above n 176, at 273; and Hovell, above n 295, at 139.

decisions.³⁰⁴ Although critiqued by courts as being of a non-judicial character,³⁰⁵ Hovell suggests the Ombudsperson is more appropriate to a context without strict separation of legal and political authority.³⁰⁶ The Ombudsperson engages with and is responsive to not only states, but also individuals, NGOs, and academics: a level of transparency and participation crucial to countering the opacity inherent in Sanction Committee decisions.³⁰⁷ The Ombudsman’s review operates de novo, meaning it is able to respond to present circumstances, rather than limited to those that influenced the original decision.³⁰⁸ Although it is not technically binding, it has something akin to a “bounded discretion” in that the Sanctions Committee must agree unanimously in order to override the Ombudsperson’s recommendations.³⁰⁹ The process can take anywhere from eight to 14 months;³¹⁰ not particularly lengthy by international law standards.

Both options have significant appeal, but the Ombudsperson is more likely to balance the diplomatic and technical categories of WHO. It allows much greater levels of participation by different parties which could go some way to address TWAIL concerns of representation and provide a platform for affected parties other than states to influence decisions. Depending on the stage in which it was initiated, the Ombudsperson process could provide for more nuanced political negotiations with states, but also preserve a technical component to ensure efficacy is maintained. It has enough of a binding character to address the problem of non-implementation of review recommendations, but enough flexibility to avoid building unhelpful precedent.

There are difficulties. The ability of the decision-maker to overturn an Ombudsperson’s recommendation is problematic in the case of WHO—at present this would require just the opinion of the Director-General rather than unanimity of a panel. Perhaps the creation of an Ombudsperson could drive deeper change to emergency governance and require that the PHEIC decision be made by the Emergency Committee that then retains the power to overturn Ombudsperson decisions. Further difficulties arise from enforcement. The Security Council

³⁰⁴ See “Access to Classified Information” Office of the Ombudsperson of the Security Council’s 1267 Committee <www.un.org>.

³⁰⁵ See for example *Her Majesty’s Treasury v Ahmed* [2010] UKSC 2, [2010] 2 AC 534 at [145]–[156] per Lord Phillips, [184]–[185] per Lord Rodger and [246] per Lord Mance; and Case T-85/09 *Kadi v European Commission* [2010] ECR II-5177 at [28].

³⁰⁶ Hovell, above n 295, at 143.

³⁰⁷ At 146–148.

³⁰⁸ At 149–150.

³⁰⁹ SC Res 2253, above n 302, at [56]; and Hovell, above n 295, at 151.

³¹⁰ SC Res 2253, above n 302, at annex II.

Ombudsperson is imbued with all of the political persuasiveness associated with that particular institution. WHO enjoys somewhat lower levels of persuasiveness and other methods of compliance have an unsavoury aspect in the field of health: sanctions or tying relief to compliance mean poor health outcomes, suffering and death. Instead of making non-compliance undesirable, the aim ought to be making compliance and cooperation desirable. This requires a broader examination of GAL and the international context.

D Re-Birthing the Clinic: The Architecture of Emergency Governance

Each individual principle of GAL can be improved upon and adapted for the particularities of WHO and emergency decisions. However, there are deeper questions of GAL's pedigree and its overall effect. Still deeper questions arise from the context of emergencies and the structure of international health law. The way emergencies are conceived affects the applied response, and the way international law is structured affects how emergencies are imagined.

1 The disorders of GAL

The microbe is nothing; the terrain, everything.³¹¹

Despite not expressly making normative claims, GAL has predictable normative consequences: decisions subject to GAL principles are “good”. They obtain a sense of legitimacy not because of their substantive content but because of the process followed. Casini warns that GAL might be powerful, but its normative claim must not be overstated—there is too much diversity in the global legal space for a singular answer.³¹² This diversity calls for thorough examinations of GAL's pedigree, the legitimacy of which is often taken for granted,³¹³ and an accounting of who or what sets GAL standards.³¹⁴ This pedigree is sourced in the administrative rules of democratic states,³¹⁵ which are themselves built on the value systems particular to the “Global North”.³¹⁶ Concerns are raised by scholars associated with the “Global South” and TWAIL.

³¹¹ Louis Pasteur as cited in Paul Farmer *Infections and Inequalities: The Modern Plagues* (University of California Press, Berkeley, 2001) at 37.

³¹² Casini, above n 117, at 477.

³¹³ Christoph Möllers “Constitutional foundations of global administration” in Sabino Cassese (ed) *Research handbook on Global Administrative Law* (Edward Elgar Publishing Limited, Cheltenham, 2016) at 109.

³¹⁴ Mario Savino “What if global administrative law is a normative project?” (2015) 13 *ICON* 492 at 494.

³¹⁵ Howse “How to Begin to Think About the ‘Democratic Deficit’ at the WTO”, above n 91, at 59.

³¹⁶ Rene Urueña “GAL and the Domestic Regulatory State: Challenges from the South” in Sabino Cassese and others (eds) *Global Administrative Law: The Casebook* (3rd ed, IRPA-IILJ, Rome and New York, 2012) 52 at 56.

Chimni sees GAL's definition as too narrow: it is merely procedural, not substantive.³¹⁷ This is problematic, particularly in light of the western origin of GAL principles. Purely procedural definitions would, for instance, fail to acknowledge the relative (in)abilities of various parties to participate effectively,³¹⁸ and fail to recognise that GAL is:³¹⁹

... an integral part of international law and institutions that have an imperial character. ... GAL is today being shaped by a transnational capitalist class that seeks to legitimize unequal laws and institutions and deploy it to its advantage.

Kingsbury acknowledges this, noting "GAL can and frequently does serve the interests of powerful actors—a central reason for the rapid uptake of GAL norms".³²⁰ Applying GAL unquestioningly fails to consider the interests of parties other than the powerful.

Bodansky suggests GAL provides "necessary rather than sufficient conditions for legitimacy".³²¹ Chimni's blunt critique concurs. He prefers a broader definition of GAL that does not draw strict separations between administrative and substantive law.³²² His definition would instead incorporate human rights dimensions, rights to information, requirements for effective participation and substantive review.³²³ Perhaps substantive limits are already incorporated into WHO's emergency powers: the participation of affected states is made as easy as possible via video links;³²⁴ and all decisions under the IHR must be implemented with "full respect for the dignity, human rights and fundamental freedoms of persons",³²⁵ and "guided by" the Charter of the UN and WHO's Constitution.³²⁶ These must be balanced with other concerns: equal and universal protection of all people from disease,³²⁷ the scientific creditability of threats,³²⁸ and minimal interference with

³¹⁷ BS Chimni "Cooption and Resistance: Two Faces of Global Administrative Law" (2005) 37 NYU J Int'l L & Pol 799 at 803–804, referring to Kingsbury, Krisch and Stewart, above n 119, at 17.

³¹⁸ Chimni, above n 317, at 805 and 813–816.

³¹⁹ At 806.

³²⁰ Kingsbury, above n 298, at 32.

³²¹ Daniel Bodansky "The Concept of Legitimacy in International Law" in Rüdiger Wolfrum and Volker Röben (eds) *Legitimacy in International Law* (Springer, Berlin, 2008) 309 at 315.

³²² Chimni, above n 317, at 804.

³²³ At 827.

³²⁴ "Statement on the 1st meeting of the IHR Emergency Committee on the 2014 Ebola outbreak in West Africa", above n 168.

³²⁵ IHR 2005, above n 65, art 3(1).

³²⁶ Article 3(2).

³²⁷ Article 3(3).

³²⁸ Article 12(4)(d).

trade and travel.³²⁹ Emergency decisions require at least a small window of discretion to enable such balancing, alongside concerns of timeliness and efficacy.

The definition of GAL is not the only problem, even if it does incorporate substantive aspects. By subjecting decisions to a set of procedural principles, GAL has a tendency to lend legitimacy to underlying decision-making processes. The Ebola IHR Report, for instance, intimated that the 2005 IHR are sound, only their implementation requires addressing.³³⁰ This assertion relieves pressure on finding solutions to deeper structural problems. These structural problems can be found both in the emergencies themselves and the broader structure of international law relating to health.

2 *The emergency imaginary*

Violent deaths are natural deaths here. He died of his environment.³³¹

How emergencies are conceived is integral to the shape of the response. “[B]right-line distinctions between normalcy and emergency are frequently untenable”,³³² and yet this is the premise on which PHEIC decisions operate. An “emergency” implies sudden, unpredictable events that have no agent and entail a turning point: it will get better improve from here.³³³ It calls for immediate or short-term humanitarian responses, not political or economic analyses, and a managerialism that “focuses on restoring the existing order, not changing it”.³³⁴ The mere act of categorising events as emergencies has the tacit effect of othering them from the normal, systemised, managed world.³³⁵ Regularising the response also (contradictorily) normalises emergencies: the focus on extraordinary cases hides how emergency governance embeds smaller emergencies as normal.³³⁶

Yet emergencies often refer to prolonged or repeated events resulting from global indifference to extreme poverty, political instability and environmental degradation. Often the “disorder” described is the result of prolonged

³²⁹ Article 12(4)(e).

³³⁰ *Implementation of the International Health Regulations (2005)*, above n 210, at 9.

³³¹ Graham Greene *The Comedians* (Random House, London, 2004) at 94.

³³² Gross and Aoláin, above n 108, at 171.

³³³ Craig Calhoun “The Idea of Emergency: Humanitarian Action and Global (Dis)Order” in Didier Fassin and Mariella Pandolfi (eds) *Contemporary States of Emergency: The Politics of Military and Humanitarian Interventions* (Zone Books, New York, 2010) 29 at 30–31.

³³⁴ At 30 and 55; and Craig Calhoun “A World of Emergencies: Fear, Intervention, and the Limits of Cosmopolitan Order” (2004) 41 *CRSA* 373 at 384.

³³⁵ Calhoun, above n 334, at 393.

³³⁶ Kim Lane Scheppele “Small Emergencies” (2006) 40 *Ga L Rev* 835 at 840; and Calhoun, above n 334, at 388.

mistreatment or disregard via colonisation or economic exploitation.³³⁷ The way emergencies are conceived and how they are dealt with contributes further to this disregard, increasing the likelihood of future emergencies.³³⁸ Ebola, for instance, has been a frequent visitor to the African continent since its emergence in the 1970s. Paul Farmer asks:³³⁹

If certain populations have long been afflicted by these disorders, why are the diseases considered “new” or “emerging”? Is it simply that they have come to affect more visible—read more “valuable”—persons?

Emergency interventions are not solutions because they treat symptoms, not causes; to ignore these limits is to “forfeit opportunities to make responses more effective”.³⁴⁰ Ebola is one of 18 “neglected tropical diseases” that have affected over 1.4 million people in 149 countries in repeated outbreaks over 40 years.³⁴¹ Yet Ebola does not enjoy the benefit of private research and development funding due to poverty of potential markets for pharmaceutical solutions.³⁴² Although the pandemic provided short-lived commercial incentives to develop these solutions, the inevitable lag in testing, approval and production left sufferers without specific treatment options.³⁴³ The small amounts of experimental drugs available were used in the United States, not Africa.³⁴⁴ Critics point out that focusing on pharmaceutical measures diverts attention from the more important issues of infection control and the provision of human resources and infrastructure.³⁴⁵ What infrastructure was provided was not only under-resourced, but also temporary and unintegrated into existing systems.³⁴⁶ It could have provided long-term improvement and enabled prevention of future outbreaks for countries struggling to cater for the healthcare needs, but was instead rendered worthless beyond the immediate crisis. This is not to say WHO’s involvement ceases once the PHEIC is

³³⁷ Calhoun, above n 333, at 40.

³³⁸ Calhoun, above n 334, at 387 and n 18.

³³⁹ Farmer, above n 311, at 39.

³⁴⁰ Calhoun, above n 334, at 389.

³⁴¹ Kikwete and others, above n 7, at 58. Note it is not currently listed as a neglected tropical disease by WHO: “Neglected Tropical Diseases” World Health Organization <www.who.int>.

³⁴² Kikwete and others, above n 7, at 58.

³⁴³ “Ethical considerations for use of unregistered interventions for Ebola viral disease: Report of an advisory panel to WHO”, above n 156, at 4.

³⁴⁴ Sarah Boseley “Ebola patients in west Africa will not have access to experimental drugs used in US” *The Guardian* (online ed, London, 7 August 2014).

³⁴⁵ Christian A Gericke “Ebola and ethics: autopsy of a failure” (2015) 350 *BMJ* h2105; and L Claire Hooker and others “Don’t be scared, be angry: the politics and ethics of Ebola” (2014) 201 *Med J Aust* 352.

³⁴⁶ Médecins Sans Frontières, above n 202, at 14.

declared over—its coordination and advisory role remained³⁴⁷—but a PHEIC’s end immediately dissipates the potentially productive intensification of international pressure. Emergencies temporarily overcome commercial and capacity problems, but they do nothing to address underlying inequality of access to well-funded pharmaceutical solutions or basic infrastructure.

Fidler alludes the limits of WHO’s emergency governance saying the IHR are “rules for global triage rather than global disease prevention”.³⁴⁸ But even this is not true of emergency health decisions in practice: Ebola was only declared a PHEIC after the disease had escaped the confines of the “dark continent” to the United States and Spain.³⁴⁹ African nations had suffered for months without WHO’s intervention. Further, by focusing on PHEICs, WHO and the global community are not focusing on the fact that two-thirds of states report non-compliance with capacity and preparedness requirements of the IHR, mostly due to severe lack of financial ability to do so.³⁵⁰ The UN Panel, along with countless critics, point to the preventative benefits in the global community providing urgent financial support to states struggling to implement preparedness requirements.³⁵¹ The continued lack of emphasis on such support betrays a focus on the health of developed countries over the developing, and a neglect of human rights concerns of the humanitarian side of WHO’s purpose.

3 *An anatomy of WHO in the international order*

Open up some corpses: you will dissipate at once the darkness that observations alone could not dissipate.³⁵²

WHO itself deserves scrutiny; its own internal structure is not blameless. Responsibility for the needs of states rests with Regional Offices, a hangover from pre-WHO arrangements.³⁵³ However, much specialist expertise is located at WHO’s Geneva Headquarters.³⁵⁴ Médecins Sans Frontières specialist Armand

³⁴⁷ WHO response in severe, large-scale emergencies: Report of the Director-General WHO WHA A69/26 (2016) at [19]–[20].

³⁴⁸ David Fidler “From International Sanitary Conventions to Global Health Security: The New International Health Regulations” (2005) 4 Chinese JIL at 389.

³⁴⁹ Kikwete and others, above n 7, at 23.

³⁵⁰ At 32.

³⁵¹ At 33–34, and 36–37.

³⁵² Marie François Xavier Bichat as cited in Michel Foucault *The Birth of the Clinic: An Archaeology of Medical Perception* (AM Sheridan (trans), Routledge, New York, 2003) at 180.

³⁵³ WHO Constitution, above n 11, art 51. See also Siddiqi, above n 23, at 60–82; and Lee, above n 23, at 32.

³⁵⁴ Armand Spreecher “Challenges in the Management of the West African Ebola Outbreak” in Nicholas G Evans, Tara C Smith and Maimuna S Majumder (eds) *Ebola’s Message: Public Health and Medicine in the Twenty-First Century* (MIT Press, Cambridge, 2016) 73 at 80.

Spreecher considers the long-standing poverty of communication between these two components of WHO a key reason the Ebola PHEIC delay.³⁵⁵ This arrangement is well-overdue for reform—a position supported by the Ebola review panel’s recommendation that in a PHEIC reporting lines should bypass the head of the Regional Office and instead be channelled directly to WHO headquarters.³⁵⁶

But the problems are deeper still. The foundations of international health law are embedded in a diplomacy that “did not have its origins in humanitarian concerns about health conditions in poor, non-European countries”.³⁵⁷ The earliest Sanitary Conventions protected Europe and North America from threats from Asia, the Middle East and India.³⁵⁸ The original IHR and quarantinable diseases reflected threats perceived by and to the trading interests of powerful countries, not the public health concerns that seriously affected outcomes in other countries.³⁵⁹ This trade emphasis is still apparent in the 2005 IHR. Lakoff locates the problem in WHO’s straddling of the “two regimes of global health”: global health security (involving the securitisation of and preparedness for disease), and humanitarian biomedicine (involving infrastructure development and prevention).³⁶⁰ The IHR and emergency governance are part of the security regime,³⁶¹ yet WHO’s work in pandemics forces it to engage with the humanitarian side of its role in emergency contexts.

Ebola “vividly demonstrated the difference between the impacts of an epidemic in countries with strong versus countries with weak health systems”.³⁶² Lack of preparedness is the problem, but this is caused by enormous structural inequalities and the complicity of powerful states in the economic and social conditions that prevent preparedness. Countries hardest hit had been subject to International Monetary Fund “structural adjustment policies”, which along with civil war had dismantled local health systems and thus exacerbated the disease’s spread and

³⁵⁵ At 80.

³⁵⁶ *Report of the Ebola Interim Assessment Panel*, above n 210, at 18.

³⁵⁷ Fidler, above n 40, at 44.

³⁵⁸ See for example the International Sanitary Convention 1894 Great Britain Treaty Series no 4 (15 April 1893), pt II “Special Provisions for the Countries of the East and Far East” and pt III “Special Provisions Regarding Pilgrimages”; Fidler, above n 2, at 28–35; Howard-Jones, above n 2 at 1032–1035; and Nermin Ersoy, Yuksel Gungor and Aslihan Akpinar “International Sanitary Conferences from the Ottoman perspective (1851–1938)” (2011) 10 *Hygiea Internationalis* 53.

³⁵⁹ Fidler, above n 40, at 47–48.

³⁶⁰ Andrew Lakoff “Two Regimes of Global Health” (2010) 1 *Humanity* 59 at 59–60.

³⁶¹ At 62.

³⁶² Kikwete and others, above n 7, at 28.

mortality rate.³⁶³ Ebola illustrates the interconnectedness of international law, a cautionary tale against institutional silos.

Like most administrative solutions, GAL fails to answer the questions of why the world remains so unequal, how those on the periphery of power can pursue change, and what the relationship of law, politics and economics ought to be.³⁶⁴ Improved administrative procedures “may remake management of the regime but not the politics of the globe”.³⁶⁵ Review after review has pointed to lack of adherence to IHR core capacities and preparedness, and encourages states to provide assistance to enable this. These reviews fail to pull aside the veil to question how the IHR are inequitably policed.³⁶⁶ Developing countries are criticised for not being prepared, but financial backing is not forthcoming.³⁶⁷ Developed countries are criticised for imposing non-mandated trade barriers during PHEICs, but few sanctions are proposed.³⁶⁸ Plenty of political will and financial backing is found for virus sharing agreements and vaccines marketed in developed countries—matters that disproportionately benefit developed states.³⁶⁹ It is, as David Kennedy states:³⁷⁰

... disheartening that while the world fractures so many of our debates about global governance are content merely to embroider the habits of the technical class, decorating their management with intellectual filigree.

Any emergency response is “structurally inseparable from the political and economic determinants of the outbreak”.³⁷¹ Emergency decision-makers and GAL proponents ought to take note.

³⁶³ Kentikelenis, King, McKee and Stuckler, above n 44.

³⁶⁴ David Kennedy “The Mystery of Global Governance” in Jeffrey L Dunhoff and Joel P Trachtman (eds) *Ruling the World: Constitutionalism, International Law and Global Governance* (Cambridge University Press, Cambridge, 2009) 37 at 59.

³⁶⁵ At 66.

³⁶⁶ See the comments of an anonymous West African Health Minister *Ebola IHR Report*, above n 210, at 55.

³⁶⁷ See for instance *Ebola IHR Report*, above n 210, at 10–11, 56 and 67–70, Recommendations 1, 8 and 10.

³⁶⁸ But see at 11 and 66, Recommendation 7 which recommends WHO may publish on its website any travel restriction measure taken by a state in contravention of the IHR.

³⁶⁹ See at 11 and 70–71, recommendation 11, and the table at 53 which outlines progress made on various recommendations of other review reports.

³⁷⁰ Kennedy, above n 364, at 59.

³⁷¹ Hooker and others, above n 345, at 353.

VI A CONCLUSION, A BEGINNING, A NEVER ENDING DEFEAT

... what we learn in time of pestilence: that there are more things to admire in men than to despise.³⁷²

The World Health Organization is uniquely placed to lay claim to normative legitimacy. With virtually unequalled state membership, it has via the Assembly near universal participation in decisions on significant global health matters. WHO's 2005 IHR emergency powers, however, are not subject to the same level of participation and oversight. These emergency powers are revolutionary, influential and controversial. Despite appearing somewhat unconstrained legally, they are nevertheless exercised, to some degree, in accordance with key principles of GAL. Although some principles, such as transparency, participation and reasoned decisions are underdeveloped, ex-post review is particularly strong. Through these principles and their development, emergency decisions regain something of their legitimacy.

Although GAL principles can provide enhanced legitimacy where standard accountability mechanisms are weak, there is an ever-present risk that this legitimising effect hides deeper problems. GAL principles need to be truly pluralistic, with substantive aspects that mitigate broader inequalities between the beneficiaries of emergency health decisions. Moreover, they ought not to operate so as to obscure underlying structural problems associated with the IHR, with WHO, and with international law generally.

International emergency health law has flaws. Historical rationales and compromises continue to influence both the structure of WHO and its operations. It was and is predicated primarily on protecting trading interests and developed states. The emergency context can have the effect of prolonging deleterious effects of disease outbreaks: PHEICs engender a focus on immediate emergencies rather than finding solutions to ongoing and underlying issues. Why do PHEICs not address maternal health issues when these kill 830 women every day, 99 per cent of whom lived in developing countries?³⁷³ Could not an Ebola vaccine have been available to two-year old Emile in Guinea in 2013, nearly 40 years after the first appearance of the disease?

³⁷² Albert Camus *The Plague* (Stuart Gilbert (trans), Vintage, New York, 1991) at 308.

³⁷³ World Health Organization "Maternal mortality: Fact sheet No 348" (November 2015).

Emergencies (and their effect on trade) can have a constructive effect on the development of health law. Bouts of fecund cooperation tend to follow global health emergencies: the original International Sanitary Conferences following cholera and the industrial revolution, the WHO Constitution following World War II, and the IHR following SARS and globalisation are all products of grave health dangers.³⁷⁴ Ebola, too, may yet have a similarly productive effect if the UN follows through on its proposal to take control over emergency responses if WHO fail to improve.³⁷⁵ However, the fact that much reform takes place after emergencies can also provide a shroud for the darker, more difficult issues: the structural underfunding within WHO of preventative initiatives such as health infrastructure, the complicity of financial institutions in dismantling existing public health systems, and complacency regarding the disproportionate effects of PHEICs on countries with weak health systems exacerbated by globalisation.

GAL ought not to be applied merely as a “filigreed” shroud over ills of the international order. The risk of GAL—and it is a real one—is in its convincing the majority of parties that it is in itself enough. It is not. As Kennedy argues, enough might be:³⁷⁶

... to multiply the sites at which decisions could be seen and contested, rather than condensing them at a center, in the hope for a heterogeneity of solutions and approaches and a large degree of experimentation, rather than an improved constitutional process or more stable settlement.

The Ebola IHR Report notes that development of international law for health emergencies is a “cycle of continuous improvement”.³⁷⁷ That much is true. It is not, however, a cycle that ought to be predicated on the maintenance of existing structures where they perpetuate the more sinister aspects of global health law. To paraphrase Dr Rieux, that we may suffer a never ending defeat, that our victories may not be lasting, are not reasons to give up the struggle.³⁷⁸

³⁷⁴ International Sanitary Convention, above n 358, preamble; Siddiqi, above n 23, at 14; Lee, above n 23, at 12–16; and Fidler, above n 40, at 45.

³⁷⁵ Kikwete and others, above n 7, at 4.

³⁷⁶ Kennedy, above n 364, at 67.

³⁷⁷ *Ebola IHR Report*, above n 210, at 9.

³⁷⁸ Camus, above n 372, at 128.

VII BIBLIOGRAPHY

Cases

Case T-85/09 *Kadi v European Commission* [2010] ECR II-5177.

Her Majesty's Treasury v Ahmed [2010] UKSC 2, [2010] 2 AC 534.

WTO Appellate Body decision *United States–Import Prohibition of Certain Shrimp and Shrimp Products* WT/DS58/AB/R Doc No 98-3899 (12 October 1998).

Treaties and Regulations

Constitution of the World Health Organization 14 UNTS 185 (opened for signature 22 July 1946, entered into force 7 April 1948).

Global Strategy for Health for All by the Year 2000 GA Res 36/43, A/RES/36/43 (1981).

International Code of Marketing of Breast-milk Substitutes WHA Res WHA34.22 (1981).

International Health Regulations 764 UNTS 1 (1969).

International Health Regulations 2509 UNTS 134 (2005).

International Sanitary Convention 1894 Great Britain Treaty Series no 4 (15 April 1893).

International Sanitary Regulations 175 UNTS 214 (1951).

WHO Framework Convention on Tobacco Control, 21 May 2003, 2302 UNTS 166 (opened for signature 16 June 2003, entered into force 27 February 2005).

Resolutions

Council of Europe Resolution *Extra-institutional actors in the democratic system* Council of Europe Res 1749 (June 2010).

Council of Europe Recommendation *Handling of the H1N1 pandemic: more transparency needed* Council of Europe Rec 1929 (June 2010).

Economic and Social Council Resolution *Arrangements for Consultation with Non-Governmental Organizations* ESC Res 1296 E/RES/1296(XLIV) (1968).

Security Council Resolution *On the outbreak of the Ebola virus in, and its impact on, West Africa* SC Res 2177 S/RES/2177 (2014).

Security Council Resolution *Continuation of measures imposed against the Taliban and Al-Qaida* SC Res 1904, S/RES/1904 (2009).

Security Council Resolution *Extension of the mandate of the Office of the Ombudsperson and the implementation of measures relating to the Al-Qaida sanctions list* SC Res 2083, S/RES/2083 (2012).

Security Council Resolution *Extension of the mandate the Office of the Ombudsperson for a period of 24 months from the date of expiration of its current mandate* SC Res 2253, S/RES/2253 (2015).

General Assembly Resolution *Calling of an International Conference on Freedom of Information* GA Res A/59, I (1946).

World Health Organization Executive Board Resolution *Executive Board Special Session on the Ebola Emergency* WHO EBSS3.R1 EBSS/3/2015/REC/1 (2015).

Official Reports and Documents

Margaret Chan “Swine influenza” (Statement by WHO Director-General, 25 April 2009).

Margaret Chan “World now at the start of 2009 influenza pandemic” (Statement to the press by WHO Director-General, 11 June 2009).

Marc DuBois, Caitlin Wake, Scarlett Sturridge and Christina Bennett *The Ebola response in West Africa: Exposing the politics and culture of international aid* (Humanitarian Policy Group, Overseas Development Institute, 2015).

Deirdre Hine *The 2009 Influenza Pandemic: An Independent Review of the UK Response to the 2009 Influenza Pandemic* (Department of Health (UK), July 2010).

International Law Association *Report of the Seventy-first Conference held in Berlin, 16-21 August, 2004* (International Law Association, London, 2004).

Jakaya Mrisho Kikwete and others *Protecting Humanity from Future Health Crises: Report of the High-level Panel on the Global Response to Health Crises* (United Nations, 25 January 2016).

Médecins Sans Frontières *Pushed to the Limit and Beyond: A year into the largest ever Ebola outbreak* (23 March 2015).

Médecins Sans Frontières *Epidemics: Neglected emergencies?* (Médecins Sans Frontières Operational Centre Geneva, October 2015).

Office of the Ombudsperson “Access to Classified Information” Office of the Ombudsperson of the Security Council’s 1267 Committee <www.un.org>.

Parliamentary Assembly of the Council of Europe *Report of the Third Part of the 2010 Ordinary Session, 26th sitting AA10CR26, AS* (2010).

Social Health and Family Affairs Committee *The Handling of the H1N1 Pandemic: More Transparency Needed* (Council of Europe Parliamentary Assembly, Doc 1228, 4 June 2010).

J Patrick Vaughan and others *Cooperation for Health Development: Extrabudgetary Funds in the World Health Organization* (Australian Agency for International Development, Royal Ministry of Foreign Affairs, Norway and Overseas Development Administration, United Kingdom, London: Overseas Development Administration, 1995).

World Bank “Bank Policy: Access to Information” (1 July 2015).

World Health Organization *The selection of essential drugs: Report of a WHO Expert Committee* (World Health Organization Technical Report Series 615, Geneva, 1977).

World Health Organization *The World Health Report 1996 – Fighting Disease, Fostering Development* (Geneva, 1996).

World Health Organization *The World Health Report: Making a Difference* (May 1999).

World Health Organization *Tobacco Industry Strategies to Undermine Tobacco Control Activities at the World Health Organization: Report of the Committee of Experts* (July 2000).

World Health Organization “WHO Director-General’s Response to the Tobacco Hearings” (13 October 2000).

World Health Organization “WHO extends its SARS-related travel advice to Beijing and Shanxi province in China and to Toronto, Canada” (23 April 2003) World Health Organization <www.who.int>.

World Health Organization “World Health Organization lifts Toronto travel advisory, maintains advice for areas of China” (30 April 2003) World Health Organization <www.who.int>.

World Health Organization *The World Health Report 2007: Global Public Health Security in the 21st Century* (2007).

World Health Organization “List of Members of, and Advisor to, the International Health Regulations (2005) Emergency Committee concerning Influenza Pandemic (H1N1) 2009” (1 October 2010) World Health Organization <www.who.int>.

World Health Organization *WHO Code of Practice on the International Recruitment of Health Personnel: Draft Guidelines on Monitoring the Implementation of the WHO Global Code* (March 2011).

World Health Organization *Strengthening Response to Pandemics and Other Public-Health Emergencies: Report of the Review Committee on the Functioning of the International Health Regulations (2005) and on Pandemic Influenza (H1N1) 2009* (2011).

World Health Organization *Sixty-Fourth World Health Assembly WHA64/2011/REC/1 Annexe 1: Implementation of the International Health Regulations (2005) Report of the Review Committee on the Functioning of the International Health Regulations (2005) in relation to Pandemic (H1N1) 2009 A64/10* (2011).

World Health Organization Regional Office for Africa “Ebola virus disease in Guinea” (23 March 2014) World Health Organization Regional Office for Africa <www.afro.who.int>.

World Health Organization “List of Members of, and Advisers to, the International Health Regulations (2005) Emergency Committee regarding Ebola” World Health Organization <www.who.int>.

World Health Organization “Biographies of the members of, and advisers to, the IHR Emergency Committee regarding the Ebola outbreak in West Africa” World Health Organization <www.who.int>.

World Health Organization “Ethical considerations for use of unregistered interventions for Ebola viral disease: Report of an advisory panel to WHO” (World Health Organization, August 2014).

World Health Organization “Statement on the 1st meeting of the IHR Emergency Committee on the 2014 Ebola outbreak in West Africa” (8 August 2014).

World Health Organization “Statement on the 2nd meeting of the IHR Emergency Committee regarding the 2014 Ebola outbreak in West Africa” (22 September 2014).

World Health Organization “Statement on the 3rd meeting of the IHR Emergency Committee regarding the Ebola outbreak in West Africa” (23 October 2014).

World Health Organization “Statement on the 4th meeting of the IHR Emergency Committee regarding the 2014 Ebola outbreak in West Africa” (21 January 2015).

World Health Organization “Statement on the 5th meeting of the IHR Emergency Committee regarding the 2014 Ebola outbreak in West Africa” (10 April 2015).

World Health Organization *Annex to the Financial Report for the year ended 31 December 2014 (A68/INF/1, 1 May 2015)*.

World Health Organization “Maternal mortality: Fact sheet No 348” (November 2015).

World Health Organization *2014 Ebola virus disease outbreak and follow-up to the special session of the Executive Board on Ebola: options for a contingency fund to*

support WHO's emergency response capacity – Report by the Director-General WHO WHA A68/26 (2015).

World Health Organization *Sixty-Eighth World Health Assembly Summary Records of Committees, Geneva, 18–26 May 2015 WHA68/2015/REC/3 (2015).*

World Health Organization *Sixty-Eighth World Health Assembly Geneva, 18–26 May 2015 Resolutions and Decisions Annex WHA68/2015/REC/1 (2015).*

World Health Organization *Report of the Ebola Interim Assessment Panel (7 July 2015).*

World Health Organization “Statement on the 6th meeting of the IHR Emergency Committee regarding the Ebola outbreak in West Africa” (7 July 2015).

World Health Organization “Statement on the 7th meeting of the IHR Emergency Committee regarding the Ebola outbreak in West Africa” 5 October 2015.

World Health Organization “Statement on the 8th meeting of the IHR Emergency Committee regarding the Ebola outbreak in West Africa” (18 December 2015).

World Health Organization “WHO statement on the first meeting of the International Health Regulations (2005) (IHR 2005) Emergency Committee on Zika virus and observed increase in neurological disorders and neonatal malformations” (1 February 2016).

World Health Organization “Statement on the 9th meeting of the IHR Emergency Committee regarding the Ebola outbreak in West Africa” (29 March 2016).

World Health Organization *Implementation of the International Health Regulations (2005): Report of the Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response – Report by the Director-General Sixty-Ninth World Health Assembly A69/21 (13 May 2016).*

World Health Organization *WHO response in severe, large-scale emergencies: Report of the Director-General WHO WHA A69/26 (2016).*

World Health Organization “List of Members of, and Advisers to, the International Health Regulations (2005) Emergency Committee on Zika virus and observed increase in neurological disorders and neonatal malformations” (14 June 2016) World Health Organization <www.who.int>.

World Health Organization *Sixty-Fourth World Health Assembly Resolutions and Decisions Annex WHA58/2005/REC/1 Revision of the International Health Regulations WHA58.3.*

World Health Organization “Neglected Tropical Diseases” World Health Organization <www.who.int>.

_____*Health Protection Agency Assessment Report on EU-wide Pandemic Vaccine Strategies (25 August 2010).*

Books and Chapters in Books

Obijiofor Aginam *Global Health Governance: International Law and Public Health in a Divided World* (University of Toronto Press, Toronto, 2005).

RP Anand *Confrontation or Cooperation? International Law and the Developing Countries* (Marinus Nijhoff, Dordrecht, 1987).

Antony Anghie *Imperialism, Sovereignty and the Making of International Law* (Cambridge University Press, Cambridge, 2005).

J Benton Heath “SARS, the ‘Swine Flu’ Crisis and Emergency Procedures in the WHO” in Sabino Cassese and others (eds) *Global Administrative Law: The Casebook* (3rd ed, IRPA–IILJ, Rome and New York, 2012) 147.

Samantha Besson “Whose Constitution(s)? International Law, Constitutionalism, and Democracy” in Jeffrey L Dunhoff and Joel P Trachtman (eds) *Ruling the World: Constitutionalism, International Law and Global Governance* (Cambridge University Press, Cambridge, 2009) 381.

Andrea Bianchi “On Power and Illusion: The Concept of Transparency in International Law” in Andrea Bianchi and Anne Peters (eds) *Transparency in International Law* (Cambridge University Press, Cambridge, 2013) 1.

Francesca Bignami “Theories of civil society and Global Administrative Law: the case of the World Bank and international development” in Sabino Cassese (ed) *Research Handbook on Global Administrative Law* (Edward Elgar Publishing, Cheltenham, 2016) 325.

Daniel Bodansky “The Concept of Legitimacy in International Law” in Rüdiger Wolfrum and Volker Röben (eds) *Legitimacy in International Law* (Springer, Berlin, 2008) 309.

Alan Boyle and Christine Chinkin *The Making of International Law* (Oxford University Press, Oxford, 2007).

Alan Boyle and Kasey McCall-Smith “Transparency in International Law-making” in Andrea Bianchi and Anne Peters (eds) *Transparency in International Law* (Cambridge University Press, Cambridge, 2013) 419.

Emily A Bruemmer and Allyn L Taylor “Institutional Transparency in Global Health Law-making: The World Health Organization and the Implementation of the International Health Regulations” in Andrea Bianchi and Anne Peters (eds) *Transparency in International Law* (Cambridge University Press, Cambridge, 2013) 271.

Allen Buchanan and Robert O Keohane “The Legitimacy of Global Governance Institutions” in Rüdiger Wolfrum and Volker Röben (eds) *Legitimacy in International Law* (Springer, Berlin, 2008) 25.

Barry Buzan, Ole Wæver and Jaap de Wilde *Security: A New Framework for Analysis* (Lynne Rienner Boulder, CO, 1998).

Barry Buzan and Ole Wæver *Regions and Powers: The Structure of International Security* (Cambridge University Press, Cambridge, 2003).

Craig Calhoun “The Idea of Emergency: Humanitarian Action and Global (Dis)Order” in Didier Fassin and Mariella Pandolfi (eds) *Contemporary States of Emergency: The Politics of Military and Humanitarian Interventions* (Zone Books, New York, 2010) 29.

Albert Camus *The Plague* (Stuart Gilbert (trans), Vintage, New York, 1991).

Dana Clark “Understanding the World Bank Inspection Panel” in Dana Clark, Jonathan Fox and Kay Treakle (eds) *Demanding Accountability: Civil-society Claims and the World Bank Inspection Panel* (Rowman & Littlefield, Lanham, 2003) 1.

Nitsan Chorev *The World Health Organization between North and South* (Cornell University Press, Ithaca, 2012).

Joseph Conrad *Heart of Darkness* (Penguin Books, Harmondsworth, 1973).

Robert Dahl “Can International Organizations Be Democratic? A Skeptic’s View” in Ian Shapiro and Casiano Hacker-Cordon (eds) *Democracy’s Edges* (Cambridge University Press, Cambridge, 1999) 19.

Panagiotis Delimatsis “Institutional Transparency in the WTO” in Andrea Bianchi and Anne Peters (eds) *Transparency in International Law* (Cambridge University Press, Cambridge, 2013) 122.

Megan Donaldson and Benedict Kingsbury “Power and the Public: The Nature and Effects of Formal Transparency Policies in Global Governance Institutions” in Andrea Bianchi and Anne Peters (eds) *Transparency in International Law* (Cambridge University Press, Cambridge, 2013) 502.

Paul Farmer *Infections and Inequalities: The Modern Plagues* (University of California Press, Berkeley, 2001).

David P Fidler *International Law and Infectious Diseases* (Oxford University Press, Oxford, 1999).

David P Fidler *SARS governance and the globalization of disease* (Palgrave Macmillan, New York, 2004).

Wolfgang Friedmann *The Changing Structure of International Law* (Columbia University Press, Cambridge (Mass), 1964).

Michel Foucault *The Birth of the Clinic: An Archaeology of Medical Perception* (AM Sheridan (trans), Routledge, New York, 2003).

Lawrence O Gostin *Global Health Law* (Harvard University Press, 2014).

Graham Greene *The Comedians* (Random House, London, 2004).

Amy Gutmann and Dennis Thompson *Why Deliberative Democracy?* (Princeton University Press, Princeton, 2004).

Oren Gross and Fionnuala Ní Aoláin *Law in Times of Crisis: Emergency Powers in Theory and Practice* (Cambridge University Press, New York, 2006).

Jürgen Habermas *Between facts and norms: contributions to a discourse theory of law and democracy* (William Rehg (trans), Polity Press, Cambridge, 1996).

Jürgen Habermas *The Postnational Constellation: Political Essays* (MIT Press, Cambridge, 2001).

Carol Harlow *Accountability in the European Union* (Oxford University Press, Oxford, 2002).

Christopher Hood “Transparency in Historical Perspective” in Christopher Hood and David Heald (eds) *Transparency: The Key to Better Governance?* (Oxford University Press, Oxford, 2006) 3.

Devika Hovell *The Power of Process: The Value of Due Process in Security Council Sanctions Decision-Making* (Oxford University Press, Oxford, 2016).

Robert Howse “Transatlantic regulatory cooperation and the problem of democracy” in George A Bermann, Matthias Herdegen and Peter L Lindseth (eds) *Transatlantic Regulatory Cooperation: Legal Problems and Political Prospects* (Oxford University Press, Oxford, 2000) 469.

Robert Howse “How to Begin to Think About the ‘Democratic Deficit’ at the WTO” in Robert Howse *The WTO System: Law, Politics & Legitimacy* (Cameron May, London, 2007) 57.

John H Jackson and Alan Sykes (eds) *Implementing the Uruguay Round* (Clarendon Press, Oxford 1997).

Sarah Joseph *Blame it on the WTO? A Human Rights Critique* (Oxford University Press, Oxford, 2011).

David Kennedy “The Mystery of Global Governance” in Jeffrey L Dunhoff and Joel P Trachtman (eds) *Ruling the World: Constitutionalism, International Law and Global Governance* (Cambridge University Press, Cambridge, 2009) 37.

Benedict Kingsbury “Introduction: Global Administrative Law in the Institutional Practice of Global Regulatory Governance” in Hassane Cissé, Daniel D Bradlow and Benedict Kingsbury (eds) *International financial institutions and global legal governance* (World Bank Legal Review 3, World Bank, Washington, DC, 2012) 3.

Kelley Lee *The World Health Organization* (Routledge, London, 2009).

Marco Macchia “The rule of law and transparency in the global space” in Sabino Cassese (ed) *Research Handbook on Global Administrative Law* (Edward Elgar Publishing, Cheltenham, 2016) 261.

Susan Marks *The Riddle of All Constitutions: International Law, Democracy and the Critique of Ideology* (Oxford University Press, Oxford, 2000).

Luis Miguel Hinojosa Martínez “Transparency in International Financial Institutions” in Andrea Bianchi and Anne Peters (eds) *Transparency in International Law* (Cambridge University Press, Cambridge, 2013) 77.

John Stuart Mill *Three Essay – On Liberty, Representative Government, The Subjection of Women* (Oxford University press, Oxford, 1975).

John Stuart Mill *On Liberty* (Cambridge University Press, Cambridge, 2011).

Christoph Möllers “Constitutional foundations of global administration” in Sabino Cassese (ed) *Research handbook on Global Administrative Law* (Edward Elgar Publishing Limited, Cheltenham, 2016) 109.

Ernst-Ulrich Petersmann “European and International Constitutional Law: Time for Promoting ‘Cosmopolitan Democracy’ in the WTO” in Gráinne de Búrca and Joanne Scott (eds) *The EU and the WTO: Legal and Constitutional Issues* (Hart Publishing, Oxford, 2001) 81.

Alexander Pope *An Essay on Man, in Epistles to a Friend: Epistle III* (J Wilford, London, 1733).

S Rushton “Global Governance Capacities in Health: WHO and Infectious Diseases” in A Kay and OD Williams (eds) *Global Health Governance: Crisis, Institutions and Political Economy* (Palgrave MacMillan, London, 2009) 75.

Carl Schmitt *Political Theology: Four Chapters on the Concept of Sovereignty* Georg Schwabb (trans) (University of Chicago press, Chicago, 2005).

Javed Siddiqi *World Health and World Politics: the World Health Organization and the UN System* (University of South Carolina Press, Columbus, 1995).

Armand Sprecher “Challenges in the Management of the West African Ebola Outbreak” in Nicholas G Evans, Tara C Smith and Maimuna S Majumder (eds) *Ebola’s Message: Public Health and Medicine in the Twenty-First Century* (MIT Press, Cambridge, 2016) 73.

Manfred Steger *Globalization: A Very Short Introduction* (Oxford University Press, Oxford, 2009).

Cass R Sunstein and Richard Pildes “Experts, Economists, and Democrats” in Cass R Sunstein *Free Markets and Social Justice* (Oxford Univesrity Press, New York, 1997) 128.

Rene Urueña “GAL and the Domestic Regulatory State: Challenges from the South” in Sabino Cassese and others (eds) *Global Administrative Law: The Casebook* (3rd ed, IRPA–IILJ, Rome and New York, 2012) 52.

Rüdiger Wolfrum “Legitimacy of International Law from a Legal Perspective: Some Introductory Considerations” in Rüdiger Wolfrum and Volker Röben (eds) *Legitimacy in International Law* (Springer, Berlin, 2008) 1.

World Health Organization *The First Ten Years of the World Health Organization 1948–1957* (Geneva, 1958).

World Health Organization *The Second Ten Years of the World Health Organization 1958–1967* (Geneva, 1968).

Journal Articles

Kamradt Abbasi “The World Bank and World Health: Changing Sides” (1999) 31 *BMJ* 865.

Marcia Angell “Ethical imperialism? Ethics in international collaborative clinical research” (1988) 319 *NEJM* 1081.

Antony Anghie and BS Chimni “Third World Approaches to International Law and Individual Responsibility in Internal Conflicts” (2003) *Chinese JIL* 77.

J Benton Heath “Global Emergency Power in the Age of Ebola” (2016) 57 *Harv Intl LJ* 1.

Jagdish N Bhagwati “The Question of Linkage” (2002) 96 *AJIL* 126.

Daniel Bodansky “The Legitimacy of International Governance: A Coming Challenge for International Environmental Law?” (1999) 93 *AJIL* 596.

Gráinne de Búrca, Robert O Keohane and Charles Sabel “New Modes of Pluralist Global Governance” (2013) 45 *NYU.J Int’l Law & Pol* 723.

Gian Luca Burci “Shifting Norms in International Health Law” (2004) 98 *Am Soc’y Int’l L Proc* 13.

Gian Luca Burci “Institutional Adaptation without Reform: WHO and the Challenges of Globalization” (2005) 2 *IOLR* 437.

Gian Luca Burci and Jakob Quirin “Introductory Note to World Health Organization and United Nations Documents on the Ebola Outbreak in West Africa” (2015) 54 *ILM* 532.

Philippe Calain “The Ebola clinical trials: a precedent for research ethics in disasters” (2016) *J Med Ethics* 1.

Craig Calhoun “A World of Emergencies: Fear, Intervention, and the Limits of Cosmopolitan Order” (2004) 41 *CRSA* 373.

Lorenzo Casini “Beyond drip-painting? Ten years of GAL and the emergence of a global administration” (2015) 13 *ICON* 473.

BS Chimni “Cooption and Resistance: Two Faces of Global Administrative Law” (2005) 37 *NYU J Int’l L & Pol* 799.

Deborah Cohen and Philip Carter “WHO and the Pandemic Flu ‘Conspiracies’” (2010) 340 *BMJ* 1274.

Angus J Dawson “Ebola: what it tells us about medical ethics” (2015) 41 *J Med Ethics* 107.

Abigail C Deshman “Horizontal Review between International Organizations: Why, How, and Who Cares about Corporate Regulatory Capture” (2011) 22 *EJIL* 1089.

David Dyzenhaus, Murray Hunt and Michael Taggart “The Principle of Legality in Administrative Law: Internationalisation as Constitutionalisation” (2001) 1 *OUCLJ* 5.

Stefan Elbe “Should HIV/AIDS Be Securitized? The Ethical Dilemmas of Linking HIV/AIDS and Security” (2006) 50 *International Studies Quarterly* 119.

Nermin Ersoy, Yuksel Gungor and Aslihan Akpınar “International Sanitary Conferences from the Ottoman perspective (1851–1938)” (2011) 10 *Hygiea Internationalis* 53.

Richard A Falk “The New States and International Legal Order” (1966) II(118) *Recueil des Cours* 1.

David P Fidler “The Globalization of Public Health: Emerging Infectious Diseases and International Relations” (1993) 5 *Ind J Global Legal Studies* 11.

David P Fidler “Germs, governance, and global public health in the wake of SARS” (2004) 113 *The Journal of Clinical Investigation* 799.

David Fidler “From International Sanitary Conventions to Global Health Security: The New International Health Regulations” (2005) 4 *Chinese JIL* 389.

David P Fidler “The Swine Flu Outbreak and International Law” (2009) 13 *ASIL Insights* (online ed).

Thomas M Franck “The Emerging Right to Democratic Governance” (1992) 86 *AJIL* 46.

Thomas M Franck “The Power of Legitimacy and the Legitimacy of Power: International Law in an Age of Power Disequilibrium” (2006) 100 *AJIL* 88.

Christian A Gericke “Ebola and ethics: autopsy of a failure” (2015) 350 *BMJ* h2105.

Fiona Godlee “Change at last at WHO: but will the regions play ball?” (1998) 317(7154) *BMJ* 296.

Fiona Godlee “Conflicts of Interest and Pandemic Flu” (2010) 340 *BMJ* 1256.

Lawrence O Gostin and Benjamin E Berkman “Pandemic Influenza: Ethics, Law, and the Public’s Health” (2007) 59 *Ad L Rev* 121.

Thomas N Hale “Transparency, Accountability, and Global Governance” (2008) 14 *Global Governance* 73.

Tine Hanrieder and Christian Kreuder-Sonnen “WHO decides on the exception? Securitization and emergency governance in global health” (2014) 45 *Security Dialogue* 331.

David L Heymann and others “Zika virus and microcephaly: why is this situation a PHEIC?” (2016) 387 *The Lancet* 719.

L Claire Hooker and others “Don’t be scared, be angry: the politics and ethics of Ebola” (2014) 201 *Med J Aust* 352.

N Howard-Jones “Origins of International Health Work” [1950] *Br Med J* 1032.

Robert Howse “The World Trade Organization 20 Years On: Global Governance by Judiciary” (2016) 27 *EJIL* 9.

Benedict Kingsbury “The Concept of ‘Law’ in Global Administrative Law” (2009) 20 *EJIL* 23.

Benedict Kingsbury and Lorenzo Casini “Global Administrative Law Dimensions of International Organizations Law” (2009) 6 *IOLR* 319.

Benedict Kingsbury and Nico Krisch “Introduction: Global Governance and Global Administrative Law in the International Legal Order” (2006) 17 *EJIL* 1.

Benedict Kingsbury, Nico Krisch and Richard B Stewart “The Emergence of Global Administrative Law” (2005) 68 *LCP* 15.

Alexander Kentikelenis, Lawrence King, Martin McKee and David Stuckler “The International Monetary Fund and the Ebola outbreak” (2015) 3 *Lancet Glob Health* e69.

Andrew Lakoff “Two Regimes of Global Health” (2010) 1 *Humanity* 59.

Gabrielle Marceau “IGOs in Crisis? Or New Opportunities to Demonstrate Responsibility?” (2011) 8 *Int’l Org L Rev* 1.

Benjamin Mason Meier “International Protection of Persons Undergoing Medical Experimentation: Protecting the Right of Informed Consent” (2003) 20 *Berk J Intl L* 513.

Usha Natarajan “Symposium: Third World Approaches to International Law (TWAIL) Conference: Capitalism and the Common Good: TWAIL and the Environment: The State of Nature, the Nature of the State, and the Arab Spring” (2012) 14 *ORIL* 177.

William Onvizi “International Environmental Law, the Public’s Health, and Domestic Environmental Governance in Developing Countries” (2006) 21 *Am U Int’l L Rev* 597.

Laura Pedraza-Fariña “Conceptions of Civil Society in International Lawmaking and Implementation: A Theoretical Framework” (2013) 34 *Mich J Intl L* 605.

Robert Howse “Democracy, Science, and Free Trade: Risk Regulation on Trial at the World Trade Organization” (2000) 98 *Mich L Rev* 2329.

Ruth Levine “Open Letter to the Incoming Director general of the World health Organization: Time to Refocus” (2006) 333(7576) *BMJ* 1015.

Hanna Pitkin “Obligation and Consent II” (1966) 60 *Am Pol Sci Rev* 39.

Mario Savino “What if global administrative law is a normative project?” (2015) 13 *ICON* 492.

Kim Lane Scheppelle “Small Emergencies” (2006) 40 *Ga L Rev* 835.

Eric Stein “International Integration and Democracy: No Love at First Sight” (2001) 95 *AJIL* 489.

Udo Schuklenk “Bioethics and the Ebola Outbreak in West Africa” (2014) 14(3) *Developing World Bioethics* ii.

Richard B Stewart “Remedying Disregard in Global Regulatory Governance: Accountability, Participation, and Responsiveness” (2014) 108 *AJIL* 211.

Richard B Stewart “The normative dimensions and performance of global administrative law” (2015) 13 *ICON* 499.

Jochen von Bernstorff “Procedures of Decision-Making and the Role of Law in International Organizations” (2008) 9 *German LJ* 1939.

JHH Weiler “European Democracy and Its Critique” (1995) 18 *W Eur Pol* 4.

JHH Weiler “In the Face of Crisis: Input Legitimacy, Output Legitimacy and the Political Messianism of European Integration” (2012) 34 *Journal of European Integration* 825.

Other

Sarah Boseley “Ebola patients in west Africa will not have access to experimental drugs used in US” *The Guardian* (online ed, London, 7 August 2014).

Gian Luca Burci “International Law and Infectious Disease Control” United Nations Audiovisual Library of International Law.

John Ferejohn “Accountability in a Global Context” (2007) IILJ Working Paper 2007/5 (Global Administrative Law Series).

Udo Schüklenk “WHO Ebola ethics panel excluded those most affected” (13 August 2014) *The Conversation* <www.theconversation.com>.

Richard B Stewart “Accountability and the Discontents of Globalization: US and EU Models for Regulatory Governance” (paper presented at New York University Law School Hauser Colloquium on Globalization and its Discontents, 20 September 2006).

S Vezzani “Preliminary Remarks on the Envisaged World Health Organization Pandemic Influenza Preparedness Framework for the Sharing of Viruses and Access to Vaccines and Other Benefits” (2010) 13 *The Journal of World Intellectual Property* 678.

____ “China and SARS: China’s Chernobyl?” *The Economist* (online ed, 24 April 2003).