Accountability of Member States for Achieving the IHR Core Capacities – A Coloniality Perspective

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26 Jan 2025

Summary

The 2005 revision of the International Health Regulation (IHRs) created a new set of obligations on member states, namely, to put in place a range of 'core capacities' (surveillance, laboratories, border inspection, etc) which, once implemented globally, would enhance 'global health security'.

From 2008 when the IHRs (2005) came into effect, there was a rising tide of criticism directed at countries – largely low-income countries – who had not implemented the required core capacities. From 2014 the criticism was superseded by moves to put in place external inspections, initially voluntary, as part of holding delinquents accountable.

In the first half of this paper we review the chronology of these events. In the second half we explore the power relations behind these events from a coloniality of global health perspective.

The accountability of countries to the 'international community' matters, in relation to global health security as in many other respects. However, assessing this history of finger-pointing and diplomatic pressure in relation to core capacities needs to take account of some wider issues. We discuss the opportunity costs of the core capacities, the lack of accountability of the global North for the rising threats to global health security, and the coloniality of global health.

Chronology

The 2003 SARS epidemic prompted the WHO to speed up the proposed revisions of the IHRs which had been underway but slowly.

The revised IHRs (finalised in 2005; in force from 2008) included several innovations which reflected the experience of SARS. One of these was empowering the DG to have regard to a range of sources of epidemic intelligence rather than wait for formal advice from countries regarding outbreaks. Another major innovation was the listing of 'core capacities' which countries needed to have in place as part of their response capacity. These included laboratory facilities, surveillance systems, and the monitoring of airports, ports and border crossings.

While implementing the core capacities was mandatory, the accountability of countries for fulfilling these obligations was weak, depending basically on self-reporting against a series of global indicators.

The Review Committee set up to review the experience of the 2009 H1N1 Pandemic reported in May 2011. The Report of the Review Committee was critical of countries which had not put in place the required core capacities and was pessimistic regarding the likelihood of full implementation by 2012, the four year period of grace after the IHRs (2005) came into effect.

The 2013-16 West Africa Ebola epidemic added to the concerns being raised regarding the failures to implement the core capacities.

In February 2014 the Global Health Security Agenda was launched with the support of the Obama Whitehouse. The GHSA comprises countries, intergovernmental organisations, the private sector (GHS Round Table), and private sector and NGOs (coming together as the Global Health Security Consortium). The GHSA proposed Country Assessments regarding their global health security levels based on 11 Action Packages. The Obama Press Release of 26 Sept 2014 refers to the action packages as providing the targets and indicators to be used to measure how national, regional, and global capacities are developed and maintained over the long-term. The US was at this stage providing funding to 30 countries to assist them in their health security arrangements. The GHSA is presently (June 2024) working towards the implementation of its GHSA 2028 Framework.

In November 2014 the Review Committee on Second Extensions reported. Second extensions here was a reference to countries seeking a second or third extension of the deadline for compliance. The Review Committee was critical again of those countries who were not making progress in the implementation of the required core capacities.

In October 2015 WHO held a Technical consultation on monitoring and evaluation of functional core capacity to implement the International Health Regulations (2005) (See WHO/HSE/GCR/2015.15 and WHO/HSE/CGR/2015.14.) The consultation was informed by the 2015 Concept Note, Development on monitoring and evaluation of functional core capacity for implementing the International Health Regulations (2005).

The Technical Consultation recommended a package of enhanced tools for monitoring and evaluation of IHR implementation, including joint external evaluations, after action reviews, and simulations as well as the self-report mechanism. These recommendations made their way through the governing bodies and were published in Jan 2018 as the International Health Regulations (2005): IHR monitoring and evaluation framework. Sodjinou and colleagues (2022) have published a useful review of 96 JEE reports drawing out the common 'major challenges'.

In 2018 the Global Preparedness Monitoring Board (WHO & WB) was established.

In May 2021 the Independent Panel published its main report, COVID-19: Make it the last pandemic. Amongst other recommendations, it argued for strengthening the accountability of countries for IHR implementation.

In May 2022 the WHA considered the Concept Note (A75/21) for a Universal Health and Preparedness Review mechanism to be established as part of the IHR monitoring and evaluation framework.

An inaugural Global Peer Review of Universal Health Emergency Preparedness was held in February 2024 and the Executive Board in Jan 2025 will consider EB156/21 which reports on lessons learned implications, benefits, challenges and options for the UHPR.

Analysis

The accountability of countries to the 'international community' matters, in relation to global health security as in many other respects. However, assessing this history of finger-pointing and diplomatic pressure in relation to core capacities needs to take account of some wider issues.

- Opportunity costs of the core capacities,
- Accountability for the rising threats to global health security, and
- The coloniality of global health.

Opportunity costs of the core capacities

The health risks (healthy years of life at risk) that are being abated by country investment in core capacities are largely the risks to people in other countries. The pressures on LICs to implement those core capacities are largely coming from the Global North.

The opportunity costs of investing in achieving core capacity standards are to be measured in terms of other uses of the same resources. For many LICs the healthy years of life gained from investing in antenatal care and safe delivery, or immunisation of children, or safe drinking water would far exceed the healthy years of life at risk saved domestically through investment in core capacities. The benefit of the investment being demanded is largely yielded beyond national borders.

Accordingly, the case for international financial assistance for implementing core capacities is strong. Some assistance is flowing but there is also strong pressure on delinquent countries to direct domestic resources into achieving the core capacities.

Accountability for the rising threats to global health security

The increasing pressure on L&MICs to comply with the IHRs mandate can be contrasted against the lack of accountability of the countries of the global North, in particular the US, for their contribution to global health risk through foot dragging on global warming, unrestrained extractivism including deforestation, and the pursuit of input dependent industrial agriculture, associated with unsustainable meat consumption in the global North.

Coloniality of global health

The sanitary conferences of the 19th century, the antecedents of the IHRs, were sponsored and attended by the colonial powers of Europe and North America. The broad purpose of the conferences was to protect the people of the colonising powers from contagion through exposure to colonised peoples while avoiding costly disruptions to trade. (See Aginam, O. (2003). "The Nineteenth Century Colonial Fingerprints on Public Health Diplomacy: A Postcolonial View." Law Social Justice and Global Development Journal **1**.)

When the IHRs were first codified, the international sanitary regulations, they were mandated by organisations dominated by the colonisers. The IHRs were born in the colonial relationship and continue to reflect the coloniality of power, dressed in the ideology of the racialised other. (See Richardson, E. T. (2019). "On the coloniality of global public heath." Med Anthropol Theory **6**(4): 101-118.)

Coloniality, the disregard of the objectified other, was alive and well during the COVID-19 pandemic, exemplified by the vaccine hoarding during the pandemic and the refusals by the global North of the TRIPS waiver, meanwhile insisting on the core capacities. (Quijano, A. (2000) "Coloniality of Power and Eurocentrism in Latin America." International sociology **15**(2): 215-232.)

The Global Health Security Agenda (GHSA) is a particularly clear expression of coloniality. Formed beyond the reach of the WHA, as a 'multistakeholder public private partnership', the GHSA has led the charge in terms of holding IHR delinquents to account and in pressing WHO to move towards mandatory external inspection through the UHPR, voluntary now but scheduled to be mandated.

Recognising the coloniality of global health in no sense denies the necessity of the IHRs or of accountability for implementing agreed preparedness provisions. However, in the context of economic inequality (which itself reflects the legacies of colonialism), the lack of solidarity from the global North (access to vaccines, adequate financial assistance to support health preparedness, support for local production) is stark and reflects the coloniality of power.