THE 2005 INTERNATIONAL HEALTH REGULATIONS: TAIWAN, COMPLIANCE AND THE EXCLUSION PARADOX

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ABSTRACT

Question of compliance continues to puzzle and generate intellectual interest in the global legal discourse; in particular, the worldwide implementation gap in the 2005 International Health Regulations (hereinafter "2005 IHR") as exposed by the COVID-19 pandemic again has renewed attention on the question. The article focuses on Taiwan as a case study to explore endogenous and exogenous factors underpinning the voluntary compliance of the 2005 IHR. Arguably, Taiwan's relatively success at containing the pandemic at the one-year mark since the emergence of SARS-CoV-2 first identified in China in 2020 is partly due to public health reforms in the aftermath of 2003 Severe Acute Respiratory Syndrome (SARS). As the world largely fall short of pandemic preparedness as a function of the wide-spread non-compliance of the 2005 IHR, examining the factors underpinning Taiwan's voluntary compliance offers a more nuanced understanding of compliance where the diffusion of norms occurs absent of enforceable mechanism. Such would contribute to the broader discourse as securing 2005 IHR compliance is a shared challenge. Taiwan's voluntary compliance is striking as it indirectly reaffirms

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the central importance of the World Health Organization (hereinafter "WHO") as a norms-generating global health agency more broadly: as Taiwan's public health reform has drawn extensively from the WHO norms.

KEYWORDS: *2005 International Health Regulations, World Health Organization, Taiwan, compliance, COVID-19, pandemic, pandemic preparedness*

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I. INTRODUCTION

The COVID-19 epidemic critically exposes the global health landscape is as fractured as it is fragmented. As the pandemic now recognized as the worst global health crisis since World War Two,[1] the ability of the World Health Organization (hereinafter "WHO") to lead is under close scrutiny. Among the identified institutional weaknesses, the maligned agency also finds itself embroiled in an unfamiliar territory of the geopolitical battlefield, where its credibility as a normative and technical agency is on the line. Taiwan, with its relative success in the containing the COVID-19 pandemic, the country's notable exclusion from the WHO also has drawn unsought publicity for the agency.[2] Insofar as geopolitics have overshadowed the operations of the WHO's global response, the global legal architecture for international disease control, the 2005 International Health Regulations (hereinafter "2005 IHR"),[3] is also largely sidelined. As the world turned its attention on WHO's governance weaknesses, overlooked in the global health discourse is that Taiwan builds parts of its pandemic success upon the IHR norms and WHO recommendations despite decades of exclusion. Investment in public health core capability has yielded clear health dividends for Taiwan: coupled with swift political and public health actions, the island has a markedly low record of 890 cases and seven deaths as of January 27, 2021.[4] Yet, Taiwan's voluntary compliance with the IHR is puzzling from an international law perspective; particularly as the implementation rate for WHO member states remain markedly low.[5] Why—and how—Taiwan, a non-member to the WHO, would internalize IHR norms voluntarily? How do capability-building and learning occur when Taiwan remains an outsider to the international health regime? While it is too early to draw bold conclusions about Taiwan's overall COVID-19 response, it is worth noting that investment in domestic public health systems and a culture of self-reliance bore out of necessity lay the cornerstone to Taiwan's responsive COVID-19 response. Coupled with swift and decisive political actions as SARS-CoV-2 first emerged in China, the relative success of the self-governing island is widely reported. Taiwan's voluntary compliance is

[1] Edith M. Lederer, *UN Chief Says COVID-19 Is Worst Crisis Since World War II*, ABC NEWS (Apr. 1, 2020, 4:48 AM), https://abcnews.go.com/US/wireStory/chief-covid-19-worst-crisis-world-war-ii-69905340.

[2] Helen Davidson, *Senior WHO Adviser Appears to Dodge Question on Taiwan's Covid-19 Response*, GUARDIAN (Mar. 30, 2020, 5:29 AM), https://www.theguardian.com/world/2020/mar/30/senior-who-adviser-appears-to-dodge-question-on-taiwans-covid-19-response.

[3] International Health Regulations (2005), May 23, 2005, 2509 U.N.T.S. 79 [hereinafter 2005 IHR].

[4] *CECC Confirms 1 More Imported COVID-19 Case; Case Returns to Taiwan from Guatemala*, TAIWAN CENTERS FOR DISEASE CONTROL (June 25, 2020), https://www.cdc.gov.tw/En/Bulletin/Detail/DkxPUCdSuDNYk2nVAvQDnQ?typeid=158.

[5] *See, e.g.*, World Health Org. [hereinafter WHO], *Annual Report on the Implementation of the International Health Regulations (2005)*, at 8-9, WHO Doc. A73/14 (May 12, 2020).

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striking as it indirectly reaffirms the central importance of the WHO as the global health agency more broadly: Taiwan's public health reform has drawn extensively from the WHO norms.

While Taiwan is a unique case study by virtue of its status under international law: the self-governing island has been a footnote in the global health discourse largely as a function of geopolitics. An extensive body of literature encapsulates the cross-strait relationships, its bilateral and regional agreements with major economies, Taiwan's relationship with the WHO, but little has focused on the various pathways in which international health norms, specifically the 2005 IHR norms, are internalized in Taiwan. Although the eruption of the COVID-19 pandemic on the global stage has engendered a burgeoning literature that examines Taiwan's pandemic responses which offers a critical look at the role of government during health emergencies, this body of literature engages with the growing body of legal literature on the role of government in the COVID-19 pandemic more broadly. Overlooked in the literature is the engagement of Taiwan with the international health norms, despite and in spite of its exclusion from the international community. Focusing on Taiwan through the lens of international law shed light on how various drivers align domestic public health needs with international health commitments. Examining various processes of health norms internalization in Taiwan provides a pragmatically useful lens that contributes to the understanding of IHR implementation and state behaviors specifically, and the linkage between national security and infectious disease control more broadly.

Insofar as Taiwan's status under international law remains an open question, what has emerged from Taiwan's engagement in the global health security regime is a phenomenon of what I termed as "compliance without compliance"—voluntary compliance occurs as a result of various entwined endogenous factors and implementation occurs in spite, and because of, continual exclusion from the international health community. Without drawing generalized conclusions, Taiwan's conformity with international norms suggests that voluntary compliance occurs when: a catastrophic health event which embeds the vital link between national security and infectious diseases control onto national consciousness, and when WHO norms offer promising allure to cure domestic public health inadequacies.

This article proceeds as follows: Part II provides an overview on the 2005 IHR and the challenges relating to compliance, Part III provides a brief background on the peculiarity of Taiwan's international status, Part IV examines the relationships between Taiwan and WHO which informs the self-reliance culture prominently on display during the COVID-19 pandemic. Part V distills the domestic, endogenous factors and identifies the components of compliance without compliance. Part VI concludes.

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II. GENERAL OVERVIEW OF 2005 IHR

The 2005 IHR, which entered into force on 15 June 2007, provides the global legal architecture for international infectious diseases control. The 2005 IHR has dual aims: "To prevent, protect against control, and provide a public health response to international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade."[6] International cooperation of infectious diseases control has its origin in the International Sanitary Regulations, adopted in 1851, which standardized quarantine measures for cholera, plague and yellow fever,[7] and established the principle that health as a subject of international cooperation.[8] After the establishment of the WHO in the aftermath of World War Two, the World Health Assembly (hereinafter "WHA") adopted the IHR in 1969 which covered six diseases and then in 1981, reduced to three diseases: cholera, yellow fever and plague. Substantial revision took place in 1995 and the scope of diseases was extended to account for biological, chemical, radiological, or nuclear in origin that might have international concerns. The most recent revision of the IHR occurred after the 2003 Severe Acute Respiratory Syndrome (hereinafter "SARS"), which led to significant overhauls of the IHR including obligations for State Parties to develop eight minimal core public health capacities to prevent, detect, and respond to specific health hazards, adopt legislation and policy regarding infectious diseases control, enhance state capabilities in coordination, surveillance, response, preparedness, risk communication, human resources, and laboratory. The 2005 IHR also includes obligation for State Parties to notify WHO of events that may constitute a public health emergency of international concern (Article 6 and 7), empowering the WHO to consider unofficial reports of public health events and obtain verification from concerned State Parties (Article 9 and 10), procedures for determining a public health emergency of international concerns, and issuing temporary recommendations, obligation to protect travelers' human rights (Article 12), and establishing national IHR focal points. It was widely believed that these provisions would enhance collective global health security.

Significantly, while the 2005 IHR is legally binding for all WHO State Parties, within the 2005 IHR provisions differ in their legal nature, ranging from legally binding to non-legally binding obligations. The use of "shall"

[6] 2005 IHR, *supra* note 3, art. 2.
[7] NORMAN HOWARD-JONES, THE SCIENTIFIC BACKGROUND OF THE INTERNATIONAL SANITARY CONFERENCES 1851-1938, at 12 (1975), https://apps.who.int/iris/handle/10665/62873.
[8] *Id.* at 16.

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is indicative of legally binding nature, for instance, Article 54 on reporting obligation where WHO and State Parties are required to report to the annual WHA on progress made in implementing the IHR; Article 43 on implementation of additional health measures in the context of international travel restrictions which prohibits State Parties from taking measures "more restrictive of international traffic".[9] On the other hand, the use of "should" in provisions reflects in an agreement by the State Parties in certain circumstances of what would constitute as appropriate actions, for instance, Article 21 on the ground crossing. Lastly, provisions containing the term "may" afford discretion to the State Parties and WHO to take steps, for instance Article 9 where "WHO may take into account reports from sources other than notifications or consultations . . ." in considering public health event. These provisions with varying legal effects reflect the tension between zealously guarded sovereignty and the recognition for a collective effort in safeguarding global health security.

In general, the compliance rate with IHR remains unsatisfactorily low and is generally credited as a key reason for the lack of national pandemic preparedness worldwide.[10] More specifically, legal scholars and practitioners have attributed the lack of enforcement mechanism in the 2005 IHR as an underlying reason for the world's lack of pandemic preparedness. The preference for soft managerial tools—such as persuasion, public opinion, technical assistance, financial support—as means to encourage individual member states to implement their treaty obligations is ubiquitous in the international health regime. Such an approach reflects the culture of global health more broadly, where the international health regime aims to build upon cooperation instead of coercion. It is generally believed that by avoiding "naming and shaming" as a governance mechanism the WHO would facilitate a culture of openness and transparency. It is also generally assumed that a culture of openness is an essential component for encouraging information sharing when a novel pathogen emerges. These partly explain the preference for soft, managerial techniques in the international health regime. Additionally, the lack of enforcement mechanism in the IHR can be explained by the notable reluctance of State Parties to concede their sovereignty and subject themselves to external scrutiny. This is evident in the requirement of developing and maintain minimum core capabilities in the IHR, where the WHO is without the necessary enforcement power to ensure State Parties comply with their treaty obligations. Instead, WHO secures compliance by relying on annual self-assessment reporting by State Parties at the World Health Assembly meetings and through the voluntary joint evaluation process.

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[9] 2005 IHR, *supra* note 3, art. 43.

[10] Simon Chesterman, *Covid-19 and the Global Legal Disorder*, SIMON CHESTERMAN, https://simonchesterman.com/blog/2020/05/01/covid-19/ (last visited Feb. 25, 2021).

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Accordingly, the lack of enforcement mechanism has been identified as one of the structural shortcomings of the IHR, which has undermined the overall effectiveness of the instrument as exposed by the COVID-19 pandemic. At the inception of the WHO, it was assumed that the technical allure of the agency would suffice for coordinating global health problems, where countries would put aside politics and follow the lead of WHO in times of global health crises.[11] Where, unlike other international organization, WHO requires expertise in public health for the position of director-general. Likewise, it was assumed that self-interest would be sufficient to propel compliance. However, insofar as improving each identified core capability requires substantial resources and investment from State Parties, as the threat of a pandemic remained in abstraction prior to the emergence of SARS-CoV-2, it has been observed that State Parties were reluctant to invest in public health infrastructure because investment does not always yield political gain for the ruling elite.

As identified above, the WHO and the 2005 IHR are by design, without "teeth". Instead, the operation of the 2005 IHR relies on soft, managerial techniques to secure voluntary compliance. However, relying on the self-interest of State Parties and the technocratic allure of WHO as tools of securing compliance have proven disastrous.[12] The institutional design of WHO reflects a constant tug-of-war between sovereignty and global health security.

The lack of meaningful monitoring and enforcement tools, compounded by the unwillingness of State Parties to concede their sovereignty, proved to be detrimental to the world. At the end of 2020, SARS-CoV-2 has penetrated 218 countries and territories, the Independent Panel for Pandemic Preparedness and Response concluded that the world simply was not prepared for a global pandemic.[13]

Notably, as WHO now embroils in the largest governance crisis since the organization's inception, under intense scrutiny is the role of the WHO in managing the pandemic which reflects a diminishing trust in the institution's ability in safeguarding global health security more broadly. Accordingly, WHO's institutional crisis also has engendered an unparalleled proliferation of legal scholarship in global health law. Previous international infectious diseases outbreaks have exposed governance weaknesses of the

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[11] Eyal Benvenisti, *The WHO—Destined to Fail?: Political Cooperation and the COVID-19 Pandemic*, 114(4) AM. J. INT'L L. 588, 592-93 (2020).

[12] José E. Alvarez, *The WHO in the Age of the Coronavirus*, 114(4) AM. J. INT'L L. 578, 582-83 (2020).

[13] THE INDEP. PANEL FOR PANDEMIC PREPAREDNESS & RESPONSE FOR THE WHO EXEC. BD., SECOND REPORT ON PROGRESS 5 (2021), https://theindependentpanel.org/wp-content/uploads/2021/01/Independent-Panel_Second-Report-on-Progress_Final-15-Jan-2021.pdf.

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WHO, but the sheer magnitude of the COVID-19 pandemic and its unimaginable human sufferings have again put the limelight on the widespread non-compliance as a function of politics and tug-of-war between states and WHO.[14] Scholars offer a rich body of diagnostic accounts of failings of WHO in the current pandemic: the IHR provisions are crafted in such a way that are difficult to facilitate political cooperation,[15] an overdependence on states and bureaucratic nature of WHO hinders the operations of the agency,[16] the failure of State Parties to strengthen core capacities and among others.

While institutionalizing a strong enforcement mechanism within the IHR remains highly desirable, insofar as introducing such a mechanism would require amendments to the IHR text and major commitments from State Parties, it remains questionable if State Parties would be willing to concede their national sovereignty. To that end, encouraging norm diffusion in the absence of enforceable mechanisms might not be desirable but remains a likely path forward. In the context of the COVID-19 pandemic response, the relative success of Taiwan in containing the spread of the virus is remarkable in light of its contentious legal and political status in the realm of international law. Taiwan, an outlier in terms of its contentious political and legal status, its exclusion from the WHO, the island's voluntary compliance with the 2005 IHR tend to be overlooked in the discussion vis-à-vis its relative success of the pandemic response.

In the ensuing sections, the article examines Taiwan's voluntary compliance with the 2005 IHR as a lens to understand how norms are internalized despite its exclusion from the international health regime. The article argues that compliance occurs chiefly as underpinned by an acute sense of the self-governing island's external and internal vulnerabilities to public health emergencies. While it is too early to make bold conclusions about Taiwan's voluntary compliance with the 2005 IHR in relation to its response to the COVID-19 pandemic, it is worthwhile noting that pandemic preparedness remains an essential component of pandemic containment. The article does not claim the causal relationship between IHR compliance and the relative success of the COVID-19 pandemic response nor does the article claim that Taiwan's experience is reproducible elsewhere. Instead, the article uncovers and identifies the various pathways in which IHR norms are internalized. Admittedly, there are limitations: Taiwan's unique political circumstance makes Taiwan's experience difficult to be generalized; its contentious legal and political status precludes the self-governing island from reporting at the WHA. As such, in terms of the narrowest sense of

[14] Lawrence O. Gostin et al., *The Legal Determinants of Health: Harnessing the Power of Law for Global Health and Sustainable Development*, 393 LANCET 1857, 1863 (2019).
[15] Benvenisti, *supra* note 11, at 596.
[16] Alvarez, *supra* note 12, at 586.

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compliance, the exclusion of Taiwan from the annual reporting at the WHA cast doubts over its compliance. However, in terms of internalizing IHR norms—through incorporating international health norms through domestic legislation and enhancing public health core capabilities—the self-governing island follows closely the IHR and WHO recommendations. In this context, the article makes a modest aim of highlighting an overlooked aspect to offer a more nuanced understanding of drivers underpinning compliance pull in Taiwan.

III. TAIWAN'S INTERNATIONAL STATUS AND THE CULTURE OF SELF-RELIANCE

On December 31, WHO had picked up a disturbing thread about a potential novel pathogen through a US-based open-access platform on infectious disease outbreaks.[17] On the same day, Taiwan's Centers for Disease Control (hereinafter "Taiwan CDC") also detected the thread through social media. The thread included a screenshot from a group chat with Dr Li Wenliang, warning that "seven cases of SARS have been confirmed" in Wuhan city, home to 19 million people. Chinese news media also reported an outbreak of atypical pneumonia occurring in Wuhan. Based on the assumption of possible human-to-human transmissions,[18] the Taiwan CDC enhanced border control and quarantine measures for inbound flights from Wuhan beginning on December 31.[19] The Taiwan CDC also sent an email to the WHO focal point,[20] which forwarded the email to the WHO China Office for follow-up with Chinese Authorities.[21]

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[17] FOREIGN AFFAIRS COMM., THE ORIGINS OF THE COVID-19 GLOBAL PANDEMIC, INCLUDING THE ROLES OF THE CHINESE COMMUNIST PARTY AND THE WORLD HEALTH ORGANIZATION 7-9 (2020), https://www.hsdl.org/?view&did=846088.

[18] Sophia Yang, *Evidence of Taiwan Health Official Learning About Wuhan Virus Human-to-Human Transmission in Dec*, TAIWAN NEWS (Apr. 16, 2020), https://www.taiwannews.com.tw/en/news/3917429.

[19] *In Response to Pneumonia Outbreak in Wuhan, China, Taiwan CDC Advises Travelers Visiting Outbreak Area to Take Relevant Precautions Throughout Trip and After Returning to Taiwan*, TAIWAN CENTER FOR DISEASE CONTROL (Jan. 6, 2020), https://www.cdc.gov.tw/En/Bulletin/Detail/Dbg1J9leIDoxseqTHMiaxQ?typeid=158; *Prevention and Control of COVID-19 in Taiwan*, TAIWAN CENTER FOR DISEASE CONTROL (July 9, 2020), https://www.cdc.gov.tw/en/category/page/0vq8rsAob_9HCi5GQ5jH1Q.

[20] I-chia Lee, *Virus Outbreak: Chen Reveals Taiwan's E-mail to WHO*, TAIPEI TIMES (Apr. 12, 2020), https://www.taipeitimes.com/News/front/archives/2020/04/12/2003734453.

[21] WHO, COVID-19 VIRTUAL PRESS CONFERENCE—20 APRIL, 2020 (Apr. 20, 2020), https://www.who.int/docs/default-source/coronaviruse/transcripts/who-audio-emergencies-coronavirus-press-conference-20apr2020.pdf (remarks by Michael Ryan, Executive Director of the WHO Health Emergencies Programme, noting that a formal request from the WHO to China was sent on January 1 under Article 6 of the IHR).

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The Taiwan CDC had sound reasons to react proactively. Taiwan is 180 kilometers away from China with a close tie of trade and economic activities. These conditions also eerily mirrored the circumstancing surrounding the 2003 SARS outbreak, where the self-governing island nation had the highest mortality in the world with 346 cases and 37 deaths, of which 7 were health workers.[22] Like all nations, Taiwan is vulnerable to the sudden emergence of infectious disease outbreaks. Further, Taiwan's peculiar status under international law makes the island nation more vulnerable: during the SARS outbreak, Taiwan had no access to real-time information, diagnostic reagents and virus sample as it has no formal relationship with the WHO. Due to various factors, Taiwan was initially predicted to be the second worst-hit country as the novel coronavirus SARS-CoV-2 emerges.[23]

With the memory of the devastation of the SARS outbreak looms, many of the technocrats who were closely involved in the SARS response now occupy senior positions in the Taiwan CDC. The circumstances surrounding the virus prompted the Taiwan CDC to take several swift actions.[24] Decades of isolation from the international health community has seen Taiwan exercising independent judgment as the SARS-CoV-2 emerges, [25] particularly as Taiwan's communication channel with the WHO is significantly humped by a supposedly secrete—albeit widely circulated—Memorandum of Understanding between the WHO and China which regulates interactions between Taiwan and the WHO.[26]

Taiwan's contentious international status again overshadows the island as the COVID-19 pandemic unfolds: a large gap exists between law and reality. On the one hand, Taiwan can be considered as a non-state as it lacks formal diplomatic relations with most states and has no membership in the United Nations (hereinafter "UN") in the traditional sense of international law. On the other hand, since 1971, Taiwan has functioned as a *de facto* independent state, fulfilling international law requirements as an

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[22] *Summary of Probable SARS Cases with Onset of Illness from 1 November 2002 to 31 July 2003*, WHO, https://www.who.int/csr/sars/country/table20040421/en/ (last visited Feb. 22, 2021).

[23] C. Jason Wang et al., *Response to COVID-19 in Taiwan: Big Data Analytics, New Technology, and Proactive Testing*, 323(14) JAMA 1341, 1342 (2020).

[24] *Id.*

[25] *Meeting No. 30 HESA—Standing Committee on Health*, PARLVU (June 23, 2020), https://parlvu.parl.gc.ca/Harmony/en/PowerBrowser/PowerBrowserV2/20200623/-1/33508?Language=English&Stream=Video.

[26] BJÖRN ALEXANDER LINDEMANN, CROSS-STRAIT RELATIONS AND INTERNATIONAL ORGANIZATIONS: TAIWAN'S PARTICIPATION IN IGOS IN THE CONTEXT OF ITS RELATIONSHIP WITH CHINA 243-45 (2014). *See also* Matt Yu & Joseph Yeh, *WHO-China MOU a Hurdle to Taiwan's WHA Participation: FM*, CHINA POST (May 11, 2020), https://chinapost.nownews.com/20200511-1234405.

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independent sovereign state:[27] a permanent population, a defined territory, a government and the capacity to conduct international relations. Although Taiwan considers itself a member of the international community but has not sought such recognition internationally.[28] This is in part because Taiwan claims as to be the legitimate government of all territory currently under China, but only exercises jurisdiction over Taiwan; likewise, China claims Taiwan as part of its territory but has never exercised control over the island nation.[29] As the second-largest economy, China often dwarfs Taiwan's international presence: China is 233 times the size of Taiwan, and a leading trading partner to the US, European Union (EU), Japan and other major economies.

Yet, because of Taiwan's economic importance, the self-governing island is a member of the Asian Development Bank, the World Trade Organization, the Pacific Economic Cooperation Council, the Pacific Basin Economic Council and the Asia-Pacific Economic Cooperation.[30] In 2019, Taiwan's GDP per capita is US$24,828, with a foreign reserve of US$469.49 billion. China is Taiwan's top trading partner, followed by the US, Hong Kong and Japan.[31] With a population of 23.5 million, Taiwan has a population larger than three-quarters of the UN member states. Despite the cross-strait political tension, Taiwan and China enjoy a close trade and economic relationship. From 2009-2019 Taiwan attended the annual WHA meetings as an observer as the cross-strait relationship warmed. However, as the cross-strait relationship cools Taiwan has been excluded from the WHA since.

IV. TAIWAN AND THE WHO

Taiwan, officially the Republic of China, was a founding member of the WHO when the agency was created in 1948, but later lost the seat to its

[27] *See* Ralph N. Clough, *The Status of Taiwan in the New International Legal Order in the Western Pacific*, 87 AM. SOC'Y INT'L L. PROC. 73, 73-77 (1993). For a historical account on the cross-strait relationship, see, e.g., Jonathan I. Charney & J. R. V. Prescott, *Resolving Cross-Strait Relations Between China and Taiwan*, 94(3) AM. J. INT'L L. 453, 460 (2000). Insofar as the legal status of Taiwan is undetermined, terms such as nation, country, state, or island are used interchangeably.

[28] LINDEMANN, *supra* note 26, at 214.

[29] In its reservation to the 2005 IHR, China again declared that Taiwan is part of its territory, a claim which is consistently rejected by Taiwan. *See, e.g.*, Ben Blanchard, *Taiwan Rejects China's Main Condition for WHO Participation*, REUTERS (May 15, 2020, 12:24 PM), https://www.reuters.com/article/us-health-coronavirus-taiwan-idUSKBN22R0HM.

[30] *International Convention and Customs Procedures of Taiwan*, NORDEA (Mar., 2021), https://www.nordeatrade.com/no/explore-new-market/taiwan/customs.

[31] *Top Trading Partners—December 2019*, U.S. CENSUS BUREAU, https://www.census.gov/foreign-trade/statistics/highlights/top/top1912yr.html (last visited Feb. 22, 2021).

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rivalry, People's Republic of China (PRC) at the UN in 1972.[32] UN Resolution 2758, which later replicated in the WHA resolution, recognizes PRC as the legitimate representative of China.[33] After the expulsion, Taiwan's participation in international organizations became aught. It was not until 1997 when domestic democratization process reignited Taiwan's desire to rejoin the UN. It is widely believed that participation in UN agencies would enhance Taiwan's international status. The WHO was chosen partly because of the agency's health aspirations which imply universality. It was believed that the agency would be less resistant to Taiwan's participation as compared to other UN agencies. However, what was originally politically motived soon shifted to focus on the domestic's public health needs, defined by the emergence of the SARS outbreak and the COVID-19 pandemic respectively.

Within Taiwan, public demands for engagement in international activities also featured prominently in domestic elections, in part because of a growing acute public awareness that diplomatic isolation was undermining the country's efforts in health security. Within the first decade of democratization, Taiwan experienced three public health crises which shaped public perception on the imperative of rejoining WHO. In 1998, type 71 enterovirus outbreak infected over 1.8 million individuals and resulted in forty deaths, in the ensuing year, Taiwan experienced one of the most serious earthquakes, measured at 7.6 on the Richter Scale, which resulted in 2,400 deaths, injured 11,000, and left 100,000 homeless; in 2003 Taiwan experienced national devastation again with the SARS epidemic which left the country with the highest death toll per capita worldwide. Public health and medical officials soon realized that decades of absence from the global health realm have had dire health consequences as the country found itself without direct contact with WHO during public health crises.

A. The 2003 SARS Outbreak

The 2003 SARS originated in China's Guangdong province, resulted in 8,422 cases spreading across over thirty countries, resulting in 916 deaths. Taiwan first detected the virus within its territory on March 14 and reached out immediately to the WHO for assistance. However, due to China's persistent objections, the WHO could not directly engage with Taiwan.[34] Instead, the WHO turned to the US Centers for Disease Control (hereinafter

[32] LINDEMANN, *supra* note 26, at 190.
[33] *See generally* G.A. Res. 2758 (XXVI), U.N. Doc. A/RES/2758(XXVI) (Oct. 25, 1971).
[34] Donald G. McNeil Jr., *The SARS Epidemic: The Outbreak; Number of Cases in Taiwan May Be More Than Reported*, N.Y. TIMES (May 16, 2003), https://www.nytimes.com/2003/05/16/world/sars-epidemic-outbreak-number-cases-taiwan-may-be-more-than-reported.html.

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"US CDC") in Atlanta, a WHO collaborating Centre and asked the US CDC to dispatch a team of experts to Taiwan. By April, a cluster of cases appears in Taipei's Ho-Pin Hospital, a major hospital in the capital city of Taiwan. It soon became apparent that a shortage of surgical masks and personal protective gears have paralyzed Taiwan's SARS response where 94% of infections were transmitted inside hospitals.[35] Taiwan's inadequate response in Ho-Pin Hospital had also attributed to the spread of the virus to the South of Taiwan.

It soon became clear that Taiwan's epidemiological vulnerabilities had largely stemmed from its peculiar political situation: case definition on the publicly accessible WHO website was lagging behind the latest development, as not all of WHO's diagnosis criteria were made available to Taiwan such that doctors in the Ho-Pin Hospital missed identifying the first case in the hospital as it appeared. Likewise, Singapore had received warning that a mysterious disease was emerging in China on March 6, Taiwan learnt of the outbreak only through WHO's official alert on March 12.[36]

As the situation in Taiwan worsened, WHO dispatched a two-person team to Taiwan on May 3, seven weeks after Taiwan first reported its first case, and after obtaining approval from China which granted the visit on the understanding that the mission would not violate the "one-China principle" as a face-saving attempt.[37] A strict protocol had to be observed—the WHO team was instructed to intact with working doctors only and not with Taiwanese health minister or senior officials.[38] Conscious of the political implication of the visit, WHO experts refrained from exchanging business cards with their Taiwanese counterparts.[39] Likewise, Taiwan refrained from politicalize the WHO visit, a first in the thirty-four years since Taiwan was expelled from the UN, and kept it a low-key event away from the public's eye.

Excluding Taiwan from WHO was detrimental for the island and continues to pose a loophole in the global defense against emerging infectious diseases. Taiwan's engagement with WHO was momentarily improved after the SARS outbreak, as Taiwan's exclusion from the international community was evidently harmful to the collective interest as international cooperation was essential in infectious disease control.

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[35] Donald G. McNeil Jr., *SARS Fears Shake Taiwan Medical Staffs*, N.Y. TIMES (May 21, 2003), https://www.nytimes.com/2003/05/21/world/sars-fears-shake-taiwan-medical-staffs.html.
[36] Donald G. McNeil Jr., *SARS Furor Heightens Taiwan-China Rift*, N.Y. TIMES (May 19, 2003), https://www.nytimes.com/2003/05/19/world/sars-furor-heightens-taiwan-china-rift.html.
[37] LINDEMANN, *supra* note 26, at 229.
[38] Lee, *supra* note 20.
[39] LINDEMANN, *supra* note 26, at 204. *See also* Legislative Yuan (2003), Weiyuanhui Jilu [Committee Report], 26, 93 (2003) (Taiwan).

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International support for integrating Taiwan into the global health security regime had seen the midsize island enjoying fleeting victories: Taiwan successfully lobbied for the inclusion of "universal application" in Article 3:3 of the 2005 IHR—which would become a legal basis for Taiwan's future engagement[40]—as well as "all requests" in the SARS WHA Resolution, an indirect, subtle reference to Taiwan.[41]

A point of contact was established in 2009 for direct communication between the WHO Secretariat and Taiwan after the 2003 SARS outbreak.[42] For the WHO, integrating Taiwan into the IHR framework was a practically necessary, but politically sensitive endeavor. WHO had proceeded with notable caution: instead of using "national focal point" as commonly used for WHO member states—the usage would have implied sovereignty from the perspectives of the WHO and China: Article 1 of the IHR provides that a national focal point as "designated by each State Party"[43]—the WHO Secretariat designated the Taiwan CDC as a "contact point" where the agency could access the password-protected IHR Event Information Site.[44] However the access remains limited: Taiwan cannot share information with other WHO member states via the platform, nor can other member states access Taiwan's epidemiological information from the website.[45]

Acting in the absence of real-time information is a recurring challenge for Taiwan which persist after the 2003 SARS outbreak: in 2007, WHO had detected infections linked to the consumption of imported raw baby corn from Thailand, and suspected that Taiwan might also have been receiving the contaminated shipment from Thailand, which by then had been detected in Denmark and Australia. WHO sent the information to China, but China did not pass the information immediately to Taiwan until ten days had passed since the official notification from the WHO.[46] During the H1N1, a WHO member state had detected a Taiwanese passenger who came into contact with a confirmed case while traveling on the same flight, the information

[40] LINDEMANN, *supra* note 26, at 221.
[41] *Id.* at 220-21. *See also* WHO, *Fifty-Eighth World Health Assembly, Geneva, 16-25 May 2005: Resolutions and Decisions: Annex*, WHA58/2005/REC/1 (2005).
[42] *WHO Agrees to Include Taiwan in the Implementation of IHR*, TAIWAN CENTER FOR DISEASE CONTROL (Jan. 23, 2009), https://www.cdc.gov.tw/En/Bulletin/Detail/ijDOgFLf8UnPhkPCa7yYeg?typeid=158.
[43] 2005 IHR, *supra* note 3, art. 1.
[44] Sigrid Winkler, *Taiwan in International Organizations: New Road Ahead or Dead-End?*, *in* POLITICAL CHANGES IN TAIWAN UNDER MA YING-JEOU 247, 255 (Jean-Pierre Cabestan & Jacques deLisle eds., 2014).
[45] *MOFA Calls on WHO to Take Neutral, Professional Stance Facilitating Taiwan's Full Participation and Contributions*, MINISTRY FOREIGN AFF. REPUBLIC CHINA (TAIWAN) (Mar. 30, 2020), https://www.mofa.gov.tw/en/News_Content.aspx?n=1EADDCFD4C6EC567&s=506FD04141AAC6DD.
[46] LINDEMANN, *supra* note 26, at 231.

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was rallied to the WHO Western Pacific Region (WPRO), the WPRO sent the information to China's IHR national focal point, then the information was passed from China to Taiwan CDC.[47] After the IHR entered into force in 2007, WHO has sent out 232 health-related communications to national focal points worldwide, but only sixteen were transmitted from China to the Taiwan CDC.[48] In the same year, Taiwan sent nearly sixty communications to WHO Contact Point, but all went unanswered.[49] While these incidents did not result in fatalities but were significant enough for Taiwan to be mindful of. In many ways, these incidents have attributed to a culture of self-reliance and explain the proactive approach taken by the government during the initial stage of the COVID-19 pandemic.

V. THE LOGICS OF COMPLIANCE

Conventionally, legal scholars and political scientists have argued that Taiwan obeys international law partly as an attempt to increase its international space, and partly because obeying international law adds the credibility of Taiwan's commitments to treaty-based regimes.[50] However, as scholars now beginning to grapple with the legal implications of the COVID-19 pandemics on international legal order, a more nuanced understanding of Taiwan's behavior in the global health regime offers a useful lens to understanding IHR compliance, particularly as the IHR generally exerts little compliance pull across countries.

An examination of the relevant legislative amendments to the CDC Act, a central piece of legislation to Taiwan infectious diseases control legal architecture, reveals what I term as "compliance without compliance": adherence occur in spite—and because of—Taiwan's unique international status. The 2003 SARS outbreak catalyzed Taiwan's public health reform, where strengthening its core public health capabilities as defined by the IHR became imperative for the government. In this sense, implementation occurs both as a reaction and a resistance to the perceived and actual diplomatic isolation. An acute sense of self-awareness on the vital link between national security and infectious disease control thus become embedded in the national consciousness in the post-SARS period.

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[47] *Taiwan's Lack of State Party Status Under the International Health Regulations Leads to Notification Concerning a Taiwanese National's Inflight Exposure to Tuberculosis Being Sent to China*, TAIPEI ECON. & CULTURAL CTR. INDIA (Apr. 21, 2018), https://www.roc-taiwan.org/inen/post/3138.html.

[48] LINDEMANN, *supra* note 26, at 231.

[49] *Id*.

[50] *See generally* Jacques deLisle, *"All the World's a Stage": Taiwan's Human Rights Performance and Playing to International Norms*, *in* TAIWAN AND INTERNATIONAL HUMAN RIGHTS: A STORY OF TRANSFORMATION 173 (Jerome A. Cohen et al. eds., 2019).

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While it requires further empirical studies to uncover the extent to which aligning domestic public health law with the IHR has facilitated Taiwan's responsive approach during the COVID-19 pandemic, documents and policy papers from the Taiwan government, and the legislative history of the CDC Act and other relevant public health regulations reveals three sets of factors are especially important that explain patterns of Taiwan's voluntary compliance in the post-SARS period:

First, as an outsider to the WHO, Taiwan has a strategical need to behave in a way consistent with the WHO norms; internalizing health norms adds creditability to Taiwan's commitment.[51] Voluntary compliance sends a strong signal to Taiwan's willingness to commit to the global health regime. Furthermore, as Professor Ian Hurd points out international law enables states to pursue collective interests that no single state is capable of achieving[52]—the production of public goods—voluntary compliance not only enhances Taiwan's international standing and reputation, it also makes clear of Taiwan's contribution to the production of global public goods. Taiwan makes a compelling case, where its arguments do not exist in abstraction, evidence of compliance provides a strong basis to assess Taiwan's actual and potential contribution to the production of global public goods.

Moreover, from a legal perspective, Taiwan arguably has a strong desire to adhere to the 2005 IHR because the text provides a (rare) legal basis for including an outsider in the global health security regime. In the period immediately after the 2003 SARS outbreak, Taiwan underwent an extensive domestic health reform which draws from WHO recommendations and guidelines on pandemic preparedness.[53] Domestic laws on infectious disease control were revised per the 2005 IHR: the CDC Act which entered into force in 1944, was revised considerably in 2007, shortly before the 2005 IHR entering into force. The 2005 IHR is cited several times as a basis for revisions.[54] For instance, Article 3 of the CDC Act was updated in conformity with the 2005 IHR, which broadens the categories of notifiable infectious diseases.[55] Article 5 of the CDC Act provides a legal basis for the

[51] Robert Howse & Ruti Teitel, *Beyond Compliance: Rethinking Why International Law Really Matters*, 1(2) GLOBAL POL'Y 127, 130 (2010) (noting that adhesion to international legal norms may be used as a basis for assessing admission).
[52] *See generally* IAN HURD, HOW TO DO THINGS WITH INTERNATIONAL LAW (2017).
[53] *See Zongtongfu Gongbao Chashun: Hsiucheng Chuanjanping Fangchih Fa* [*Laws, Regulations, and Decrees in the Office of President Gazette: Amendment of the Communicable Disease Control Act*], OFF. PRESIDENT REPUBLIC CHINA (TAIWAN) (July 18, 2007), https://www.president.gov.tw/Page/294/38708/%E4%BF%AE%E6%AD%A3%E5%82%B3%E6%9F%93%E7%97%85%E9%98%B2%E6%B2%BB%E6%B3%95-.
[54] *Id*.
[55] *Id*.

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central authority to "develop, strengthen and maintain . . . the capacity to detect, assess, notify and report events", echoing Article 5 and 13 of the 2005 IHR.[56] Article 5:1(5) further provides a legal basis for international collaboration on infectious disease controls which corresponds to Article 44 of the IHR.[57] Strengthening public health core capabilities is also mandated by the CDC Act: restructuring stockpile system for personal protective equipment,[58] reorganizing national laboratory system,[59] establishing a clear centralized commend system during health crises,[60] among other initiatives. These commitments reflect Taiwan's determination to be integrated into the global health security regime as provided in Annex I of the IHR.[61]

Second, irrespective of the international community's perception of Taiwan's voluntary compliance, insofar as Taiwan is largely on its own in the global infectious disease regime, self-resilience bore out necessity had seen the island nation adopting various public health measures and recommendations in line with the IHR. As the IHR provides a framework for the national pandemic response, meeting core requirements for disease detection, assessment, reporting and response was widely perceived by technocrats as necessary for Taiwan to strengthen its pandemic response capability.[62] Policymakers look to WHO norms as an authoritative source of scientific knowledge which provides a useful basis to inform domestic public health practices. For instance, it became clear that the lack of risk communication during the SARS outbreak had fuel public fear and distrust. Lack of trust in the public institutions had seen a sudden surge for face masks creating a market shortage,[63] aggravated by hoarding of supplies and price inflation by retailers. Public outcry and resentment were further exacerbated when the government's woeful response resulted in the deaths of health workers when the government introduced excessive quarantine measures.

After the 2003 SARS outbreak, the Taiwan CDC adopted various WHO guidelines on risk communications as domestic guidelines were lacking.[64] Taiwan turned to the WHO to fill the normative gap at the national level, recognizing that civic engagement and transparency would help the public in making informed decisions to protect themselves during an outbreak,

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[56] *Id*.
[57] *Id*.
[58] *Id*.
[59] *Id*.
[60] *Id*.
[61] *Id*.
[62] Yu-Chen Hsu et al., *Risk and Outbreak Communication: Lessons from Taiwan's Experiences in the Post-SARS Era*, 15(2) HEALTH SECURITY 165, 169 (2017).
[63] *Id*.
[64] WHO, WHO OUTBREAK COMMUNICATION GUIDELINES (2005), https://www.who.int/csr/resources/publications/WHOCDS200528/en/. *See generally* M.Y. Yen et al., *From SARS in 2003 to H1N1 in 2009: Lessons Learned from Taiwan in Preparation for the Next Pandemic*, 87(4) J. HOSP. INFECTION 185 (2014).

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Taiwan incorporated WHO recommended communication strategies. Drawing extensively from WHO's evidence-based guidance on risk communication, the government focused to provide timely, accurate information during the H1N1 influenza pandemic, the Ebola outbreak, the MERS-CoV outbreak, and most prominently, the COVID-19 pandemic. Willingness to embrace WHO norms have seen the government building a close relationship with the media, which has helped the government to win public support during the COVID-19 pandemic.

While membership in the WHO holds a certain allure for Taiwan, adopting WHO recommendation also provides direct benefits insofar as infectious disease control is strongly linked with national security. For Taiwan, investment in public health core capacity is much seen as an insurance against isolation from the international health community in times of public health emergencies. Equally, before the emergence of the COVID-19 pandemic, implementation of the IHR also reassures domestic constitutes that despite diplomatic isolation, domestic pandemic preparedness is on par with international norms. Faced with the bleak political reality where direct engagement with WHO is becoming less likely, Taiwan pursued a pragmatic route and seeks memberships in WHO affiliated technical networks, but with decimal successes.[65] Without direct access to the WHO, Taiwan looked to allies and actively engage in various international academic activities, develop professional networks, and undertake self-learning through open access materials on WHO platforms.[66]

Third, as the implementation of the IHR is largely seen as the province of technocrats, this also moves domestic public health reform away from the sphere of politics and into the sphere of public health. Importantly, as public health reform was led by technocrats with a clear public health mission, implementation of the IHR was seen as a prescription to cure domestic inadequacy instead of political rhetoric. While the world has turned its attention to the governance weaknesses of the WHO, in Taiwan, norms internalization had occurred partly because of the perceived and actual technical aura of WHO. Insofar as the public health reform is largely perceived as technical, public health reform also received less public resistance. Accordingly, WHO norms provide a roadmap for Taiwan to strengthen its public health legal preparedness, as well as a benchmark for Taiwan to measure its pandemic preparedness. IHR assessment tools further assure domestic constitutes that despite diplomatic isolation, Taiwan is well prepared to respond. This also explains the motivation underpinning the

[65] UPMC CTR. FOR HEALTH SECURITY, IHR JOINT EXTERNAL EVALUATION OF TAIWAN (JUNE 21-JULY 1, 2016) (2016), https://www.cdc.gov.tw/File/Get/5b8gmJMzQapsSv8YLgcyuA.
[66] *Id*.

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voluntary assessment using the IHR tool in 2016, conducted jointly with Johns Hopkins University.[67]

Compliance, therefore, occur as a result of key domestic actors' diverse interests are neatly woven together: diplomates consider compliance with the IHR as a demonstration of Taiwan's creditability of commitments to the international health regime. Technocrats generally perceive adherence with the IHR would improve internal health security and contribute to the overall global health security. Likewise, for legislatures, the IHR provides benchmarks for Taiwan's pandemic preparedness and a strong justification for sustained funding. These factors coupled with the increased cross-strait tension, diplomatic isolation, attributed to an acute sense of awareness that underpinned a culture of self-reliance and explains voluntary compliance with the IHR. In many ways, self-reliance by necessity has become one of the key drivers underpinning Taiwan's public health reform in the period immediately after the 2003 SARS epidemic and before the emergence of the COVID-19 pandemic.

VI. CONCLUSION

At a time where the WHO is under assaults from multifront, Taiwan's compliance with the IHR indirectly—and paradoxically—reaffirms the central importance of WHO both as a normative and technical agency. Decades of isolation have seen Taiwan cultivating a culture of self-reliance, where compliance with the 2005 IHR occurs as a result of exogenous and endogenous factors alignment. Despite initial success, no country is an island during a pandemic. In an interconnected world, Taiwan's compliance without compliance takes on a layered meaning: non-compliance in the strictest sense as Taiwan is not a member of the WHO, yet, Taiwan's compliance occurs in the broadest sense: as a member of the international community. Insofar as an effective pandemic response is both simultaneous domestic and international matters, collapsing the boundary of a nation-state, the picture that emergences from Taiwan bears contemporary relevancy as it offers a nuanced understanding of compliance, expounds complex interdependency across time and space.

[67] *Id.* at 2-4.

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