As I’ll be addressing the issue of nuclear weapons and international health law, a word of background first.

Since international health law is a regime which is not as well developed as other international law regimes, like international environmental law and -- the other IHL -- international humanitarian law, perhaps it’s worthwhile to step back very briefly and identify what international health law is.

International health law is, in a very narrow sense of international treaties, very limited. It’s composed of just three major instruments.

2. The International Health Regulations of 2005

And the, 3, the Convention on Tobacco Control of 2005 (Yes, 2005 was a busy year for international health lawyers!)

The last instrument, the tobacco convention, is the reason our restaurants and public places are smoke free, for example. You’ll probably not be surprised to hear that the tobacco convention isn’t relevant to nuclear weapons.

What you may be surprised to learn is that the first two treaties I mentioned may indeed be relevant in case of nuclear weapons detonation.

In particular, the potential role of the International Health Regulations with respect to a nuclear weapon detonation could be of critical importance.

In my presentation, I aim to hypothesize how the International Health Regulations, which I will refer to as “the IHR”, may be used in case of a nuclear weapon detonation.

For this hypothetical analysis, let us assume that Country X is a State Party to the IHR. 196 countries are so this is an easy assumption.

Imagine a scenario where a suitcase nuclear weapon is detonated in the capital city of “Country X”. For our analysis, it doesn’t matter who detonated the bomb or why.

We also assume that existing international arrangements for nuclear emergencies will be in effect. This means, for example, that WHO will play its role as described in the Joint Plan of International Organizations for Preparedness and Response to Radiological or Nuclear Emergencies (JPlan 2013).
For the sake of this discussion, we will only examine how the IHR could be used in response to the detonation.

So, at 12 p.m. in the Capital, the bomb is detonated. Upon hearing of the detonation, the Director-General, the “DG”, will begin a series of informal consultations.

The Director General will reach out to various leaders, including the Head of Country X, the Secretary General of the United Nations and other heads of state and health ministers.

During these high level discussions, the DG may raise the IHR as a framework for addressing the health effects of the detonation.

These leaders, like those of us here today, may be surprised to hear about the IHR in these circumstances.

They’ll be thinking: The IHR cover diseases like influenza and polio and ebola. Can the health effects of a nuclear blast be considered a disease?

The answer is yes.

Historically, the IHR focused only on specific infectious diseases, for example, plague, cholera, yellow fever and small pox.

However, in the 2005 redraft of the IHR, the definition of disease was expanded beyond particular infectious diseases. Today, “disease” is defined in the IHR as “an illness or medical condition, irrespective of origin or source, that presents or could present significant harm to humans.”

This definition encompasses what is known as an “all-hazards” approach and covers radio-nuclear events.

It is this concept of disease as a “medical condition, irrespective of origin or source” that is the key concept.

So these leaders might then ask, just because the health effects fall within the definition, does that mean the IHR automatically apply? And here the answer is no; there is no automatic application of the IHR.

A series of steps must take place before the IHR, and its special authorities, are brought to bear.

So here’s what would happen next.
After determination that the IHR could apply to this situation, Country X would assess the event occurring within its territory (i.e., the detonation) and formally notify WHO.

WHO, in turn, will notify IAEA. And, the Director General will convene an Emergency Committee of the IHR. The convening of the Emergency Committee is a necessary step for the DG to declare the event a so-called “Public Health Event of International Concern”, the designation that gives the DG special power to deal with the crisis.

The Emergency Committee is composed of experts selected by the Director General from the IHR Expert Roster. Currently, there are, in fact, experts on the IHR Roster with technical expertise in managing radiological or nuclear emergencies. So we are, in fact, prepared.

The Emergency Committee will provide its views whether the detonation is an event that constitutes a “public health emergency of international concern” or a “PHEIC”.

Afterwards, the Director General will determine and communicate to the State Parties whether the detonation is a PHEIC, and, if so, any temporary recommendations.

I should underscore that the power to determine a PHEIC and issue temporary recommendations are independent of the approval of WHO Member States. In other words, the IHR give an extraordinary degree of autonomy to the Director General in an emergency situation.

We imagine in this scenario that a PHEIC would be declared by the DG, that the DG would exercise her extraordinary authorities and issue temporary recommendations.

These recommendations would address a wide range of issues: from managing casualties with trauma, burns, acute radiation sickness, and psychological effects; to distribution of potassium iodide; to restrictions on food and drinking water for affected countries as well as for trade purposes.

In extreme circumstances, the temporary recommendations may limit travel to or from affected cities and ban the export of products originating from the affected areas.

Although temporary recommendations are non-binding, they cover multiple disciplines, could significantly impact and disrupt trade, and are viewed as authoritative by IHR State Parties.

Throughout the response to the PHEIC, the Director-General will continue with consultations, and regular meetings of the Emergency Committee.
Overall, the International Health Regulations would provide a framework for confirming and coordinating the public health response to this hypothetical event.

In closing, and to move the discussion back towards current real-life events, instead of the hypothetical, what I described today is the current state of the IHR. However this state is likely to evolve in the near term. Given the ongoing Ebola outbreak, countries have begun to critically analyse the IHR in response to the Ebola outbreak.

If the IHR are further strengthened as a result of the Ebola crises, as I believe they will be, we can look forward to an even more effective IHR regime to address the international spread of disease, irrespective of origin or source.

Thank you.