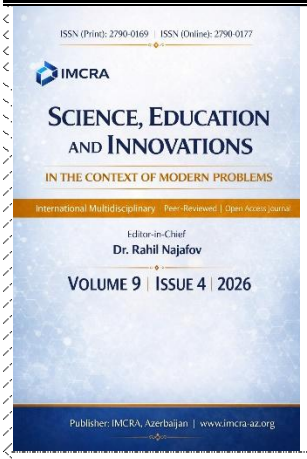

Science, Education and Innovations in the Context of Modern Problems
Issue 5, Vol. 9, 2026

RESEARCH ARTICLE

Domestic Legal Operationalization of the International Health Regulations (2005): A Doctrinal and Institutional Analysis of Algeria's Compliance within Global Health Governance

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Keywords
International Health Regulations (2005); Global Health Governance; Domestic Legal Implementation; Algeria; Public Health Law; World Health Organization; Joint External Evaluation.

Abstract

This article provides a comprehensive doctrinal analysis of the domestic implementation of the International Health Regulations (2005) (IHR) within the Algerian legal system, focusing on the dynamic interaction between binding international obligations and their operational realization at the national level. The study conceptualizes the IHR as a hybrid regulatory instrument situated at the intersection of public international law and domestic administrative law, imposing enforceable obligations in areas such as surveillance, preparedness, notification, intersectoral coordination, and health control at points of entry. Drawing on a qualitative legal methodology, the article examines Algeria's legislative and regulatory framework governing public health emergencies and evaluates its effectiveness through a critical interpretation of the findings of the 2022 World Health Organization Joint External Evaluation (JEE). The analysis demonstrates that while Algeria has formally incorporated the IHR into its domestic legal order through explicit normative instruments and institutional mechanisms, significant challenges persist in ensuring procedural coherence, regulatory harmonization, and effective coordination across sectors. The study argues that the effectiveness of global health governance is contingent not merely upon the existence of binding international norms, but upon their capacity to be translated into coherent, operational, and enforceable domestic legal frameworks. It concludes by proposing targeted legal and institutional reforms aimed at strengthening regulatory clarity, enhancing intersectoral integration, and consolidating the normative alignment between international obligations and domestic implementation practices.

Citation

Boudjema, M., Boukeffa, A. (2026). Domestic Legal Operationalization of the International Health Regulations (2005): A Doctrinal and Institutional Analysis of Algeria's Compliance within Global Health Governance. *Science, Education and Innovations in the Context of Modern Problems, 9*(5), 1–15. https://doi.org/10.56334/sei/9.5.16

Received: December 11, 2025 | **Accepted:** March 11, 2026 | **Published Online:** April 10, 2026

Introduction

In the contemporary landscape of public international law, global health security has emerged as a central normative and institutional concern, driven by the increasing frequency and intensity of transboundary health threats. The expansion of international mobility, trade networks, and global interconnectedness has rendered purely national responses insufficient, thereby necessitating coordinated legal frameworks capable of ensuring collective preparedness, early detection, and rapid response to public health emergencies of international concern. Within this evolving architecture, the International Health

Regulations (2005) (IHR), adopted under the auspices of the World Health Organization, constitute the foundational legal instrument governing the prevention and control of the international spread of disease.

The global outbreak of COVID-19 exposed critical structural deficiencies in national and international health systems, revealing that the principal challenge does not lie in the absence of binding international norms, but rather in the difficulty of translating these norms into effective domestic legal and institutional practices. The pandemic thus reoriented scholarly and policy attention toward the question of implementation, shifting the analytical focus from the formal validity of international obligations to the practical conditions under which they are internalized and operationalized within domestic legal systems.

In this regard, the IHR represent a paradigmatic example of a hybrid legal regime whose effectiveness depends fundamentally on domestic incorporation. While the Regulations are legally binding upon States Parties, their execution is structurally decentralized, relying on national legal frameworks, administrative capacities, and institutional coordination mechanisms. This configuration places domestic law at the core of global health governance, transforming national legal systems into the primary arena in which international health obligations acquire concrete legal effect.

The Algerian case provides a particularly instructive context for examining these dynamics. As a State Party to the IHR (2005), Algeria has undertaken formal steps to integrate the Regulations into its domestic legal order through a range of legislative and regulatory instruments addressing public health emergencies, surveillance systems, and border health controls. However, the findings of the 2022 WHO Joint External Evaluation reveal the persistence of structural, procedural, and normative challenges affecting the operational effectiveness of these arrangements. This duality—between formal legal incorporation and uneven practical implementation—renders Algeria a compelling case study for analyzing the relationship between international legal obligations and their domestic realization.

Against this backdrop, the present study seeks to provide a rigorous doctrinal examination of the mechanisms through which the Algerian legal system operationalizes the IHR, with particular emphasis on key domains such as points of entry, intersectoral coordination, and emergency preparedness. The analysis is strictly legal in orientation, focusing on normative structures, institutional arrangements, and procedural frameworks rather than on epidemiological outcomes or policy performance.

By situating domestic implementation at the center of global health governance, this article contributes to the broader scholarly debate on the effectiveness of international law, highlighting the critical role of national legal systems in bridging the gap between normative commitment and practical compliance.

Literature Review

The scholarly discourse on the International Health Regulations (2005) (IHR) is situated at the intersection of public international law, global health governance, and domestic legal implementation. Existing literature has progressively shifted from a normative focus on the legal architecture of the IHR toward a more critical examination of their operationalization within national legal systems.

Early doctrinal analyses emphasize the legal significance of the IHR as a binding regulatory framework governing the international spread of disease. In this regard, David P. Fidler (2005) conceptualizes the IHR as a transformative instrument in global health law, marking a departure from state-centric sovereignty toward a model of shared international responsibility. This perspective is further reinforced by Lawrence O. Gostin (2014), who situates the IHR within a broader framework of global health law, highlighting their role in promoting collective security through legally binding obligations related to surveillance, notification, and response.

Subsequent scholarship expands this normative foundation by examining the institutional and governance dimensions of the IHR. Studies by Rebecca Katz and Lawrence O. Gostin (2016) argue that the IHR constitute the principal governing framework for global health security, yet their effectiveness remains contingent upon the political will and administrative capacity of States. Similarly, Ilona Kickbusch and K. Srinath Reddy (2015) underline the evolving nature of global health governance, emphasizing the increasing complexity of multilevel coordination between national and international actors.

A central strand of the literature focuses on the challenges of domestic implementation. The hybrid nature of the IHR—binding at the international level but executed through domestic legal systems—has generated significant scholarly attention. Kumanan Wilson et al. (2008) demonstrate that federal and decentralized governance structures present particular difficulties in harmonizing national and subnational responsibilities. This issue is further explored by Lucia Mullen and Adam Kamradt-Scott (2018), who identify institutional fragmentation and coordination deficits as persistent obstacles to effective implementation.

Empirical and evaluative studies provide additional insights into the operational performance of the IHR. A systematic review by A. B. Suthar et al. (2018) highlights recurring gaps in surveillance systems, reporting mechanisms, and intersectoral coordination across multiple jurisdictions. These findings are corroborated by World Health Organization assessments, particularly through the Joint External Evaluation (JEE) framework, which identifies structural and procedural deficiencies in national preparedness capacities.

The COVID-19 pandemic has further intensified scholarly scrutiny of the IHR, exposing critical weaknesses in their practical enforcement. Rebecca Katz et al. (2014) and S. J. Hoffman and J. A. Røttingen (2015) argue that global health security frameworks require institutional reform to ensure greater accountability and scientific independence. In a similar vein, Roojin Habibi et al. (2020), in a widely cited contribution published in *The Lancet*, warn against the erosion of IHR compliance during global crises and call for stricter adherence to international legal obligations.

Another critical dimension addressed in the literature concerns transparency and decision-making within global health institutions. Mark Eccleston-Turner and Adam Kamradt-Scott (2019) highlight the need for greater procedural transparency in the emergency committee mechanisms established under the IHR. Their analysis underscores the importance of legitimacy and accountability in maintaining trust in international health governance systems.

From a human rights perspective, scholars such as Lisa Forman and Jillian Clare Kohler (2020) emphasize the tension between public health measures and individual rights, particularly during emergency responses. This perspective broadens the analytical scope of IHR implementation by integrating legal, ethical, and normative considerations.

Despite the richness of the existing literature, a notable gap persists in the systematic legal analysis of domestic implementation within specific national contexts, particularly in developing legal systems. While general frameworks and comparative studies are well developed, detailed doctrinal examinations of how individual States internalize and operationalize IHR obligations remain relatively limited. This gap is especially evident in the case of Algeria, where the interaction between international legal commitments and domestic regulatory structures has not been extensively explored in the academic literature.

Accordingly, this study contributes to the field by providing a focused doctrinal and institutional analysis of Algeria's domestic implementation of the IHR. By situating national legal mechanisms within the broader framework of global health governance, it seeks to bridge the gap between normative theory and practical application, thereby advancing scholarly understanding of the conditions under which international health law becomes operationally effective.

Research Problem, Methodology, and Structure

Against the evolving landscape of global health governance, this study addresses the following central research question: to what extent does the Algerian legal system effectively internalize and operationalize the binding obligations arising from the International Health Regulations (2005), and with what degree of legal and institutional effectiveness in key domains such as points of entry, intersectoral coordination, and public health emergency preparedness, particularly in light of the structural deficiencies identified by the World Health Organization Joint External Evaluation?

From a methodological perspective, the article adopts a doctrinal and analytical legal approach, grounded in the systematic interpretation of international and domestic legal norms. The study conceptualizes the IHR as a binding regulatory instrument within public international law and examines their implications for domestic legal systems through a normative analysis of Algerian legislative and regulatory frameworks. This approach is consistent with established methodologies in global health law scholarship, which emphasize the role of legal structures in shaping the effectiveness of international health governance (Gostin, 2014; Fidler, 2020).

The analysis relies exclusively on primary legal sources and authoritative institutional documents, including the WHO Constitution, the IHR (2005), Algerian legislation and executive decrees, and the WHO Joint External Evaluation. This reliance on normative materials reflects a deliberate analytical focus on the legal and institutional dimensions of implementation, rather than on epidemiological or policy outcomes (Burci & Vignes, 2004; Negri, 2018).

Structurally, the article is divided into two interrelated parts. Part I examines the IHR as an international legal framework for global health security, focusing on their legal nature, normative authority, and material scope. Part II evaluates their domestic implementation within the Algerian legal system, assessing the coherence and effectiveness of national legal and institutional mechanisms in light of international obligations and empirical evaluation findings.

Discussion

The findings of this study confirm that the domestic implementation of the International Health Regulations (2005) (IHR) within the Algerian legal system reflects a dual dynamic of formal legal integration and uneven operational effectiveness. While Algeria has established a relatively comprehensive normative framework incorporating international health obligations into domestic law, the effectiveness of this framework remains conditioned by structural, procedural, and institutional limitations.

From a formal legal perspective, Algeria demonstrates a high degree of normative alignment with international health law. The incorporation of the IHR through Presidential Decree No. 13-293 and their subsequent integration into national legislation, particularly Law No. 18-11 of 2018, illustrates a clear commitment to internalizing binding international obligations. This approach is consistent with the doctrinal understanding that effective compliance with global health law requires the transformation of international norms into domestically enforceable legal standards (Gostin, 2014; Burci & Vignes, 2004).

However, as emphasized in the literature, formal incorporation alone is insufficient to ensure effective implementation. The IHR operate within a functional paradigm in which the realization of obligations depends on the existence of operational capacities and institutional coherence (Gostin & Katz, 2016; Suthar et al., 2018). In the Algerian context, this gap between legal formalism and practical functionality is evident in the fragmentation of coordination mechanisms and the uneven integration of sectoral responsibilities.

A central challenge concerns intersectoral coordination, which constitutes a cornerstone of the IHR framework. Although Algeria has established institutional mechanisms such as the intersectoral committee under Executive Decree No. 15-210, the effectiveness of these bodies appears constrained by overlapping competencies, administrative segmentation, and limited procedural harmonization. This finding aligns with comparative studies demonstrating that coordination failures represent one of the most persistent barriers to effective IHR implementation, particularly in systems characterized by complex governance structures (Wilson et al., 2008; Mullen & Kamradt-Scott, 2018).

Moreover, the regulatory framework governing points of entry and border health control illustrates both progress and limitations. The establishment of specialized sanitary control services and the designation of competent authorities reflect compliance with IHR requirements. However, the effectiveness of these measures depends on the integration of surveillance, reporting, and response mechanisms across institutional boundaries. As noted in global health scholarship, points of entry constitute critical nodes in the management of transboundary health risks, yet they often suffer from coordination gaps and resource constraints (Katz et al., 2014; Gostin & Katz, 2016).

The findings also highlight the importance of surveillance and notification systems, particularly in light of Executive Decree No. 22-250 establishing mandatory disease reporting. While this represents a significant step toward fulfilling IHR obligations, the effectiveness of such systems depends on data reliability, timeliness, and institutional interoperability. Empirical studies have consistently shown that deficiencies in surveillance and reporting remain widespread, undermining the early detection and management of public health threats (Suthar et al., 2018; Moon et al., 2015).

The experience of the COVID-19 further reinforces these observations. The pandemic exposed systemic vulnerabilities in global and national health governance, demonstrating that even formally compliant legal systems may encounter significant operational challenges in crisis situations (Habibi et al., 2020; Forman & Kohler, 2020). In this context, Algeria's legal framework can be understood as normatively robust but functionally constrained, reflecting broader global patterns identified in the literature.

Another critical dimension concerns legal coherence and procedural clarity. The coexistence of multiple legislative and regulatory instruments, while indicative of comprehensive legal coverage, may generate interpretative ambiguities and implementation inconsistencies. As highlighted in global health law scholarship, effective implementation requires not only the existence of legal norms but also their systematic integration into a coherent and accessible regulatory framework (Fidler, 2020; Negri, 2018).

Furthermore, the analysis underscores the importance of institutional capacity and administrative effectiveness as determinants of compliance. The IHR impose obligations that extend beyond formal legal adoption, requiring sustained investments in infrastructure, human resources, and governance mechanisms. In this regard, the Algerian case reflects a broader structural reality: the effectiveness of international health law is ultimately contingent upon the capacity of domestic institutions to translate normative commitments into operational practice (Hoffman & Røttingen, 2015; Lee & Kamradt-Scott, 2014).

Finally, the findings highlight the inherently decentralized yet interdependent nature of global health governance. The IHR establish a legal framework that is formally universal but substantively dependent on national implementation. This model creates a tension between international legal uniformity and domestic institutional diversity, requiring continuous alignment between global standards and local capacities. As emphasized in the literature, this tension constitutes one of the defining challenges of contemporary global health law (Kickbusch & Reddy, 2015; Gostin, 2014).

Synthesis

In light of the above, the domestic implementation of the IHR in Algeria can be characterized as legally structured but operationally incomplete. While the State has successfully established a formal legal framework aligned with international obligations, the effectiveness of this framework is limited by challenges related to coordination, coherence, and institutional capacity.

These findings confirm the central argument advanced in global health law scholarship: the effectiveness of international legal instruments depends not on their normative strength alone, but on their capacity to be operationalized within complex domestic legal and administrative systems (Gostin & Katz, 2016; Suthar et al., 2018).

Part I: The International Health Regulations as a Legal Framework for Global Health Security

I. The Legal Nature and Normative Scope of the International Health Regulations

The International Health Regulations (2005) constitute a binding and universally applicable instrument of international law, adopted pursuant to Articles 21 and 22 of the Constitution of the World Health Organization. Unlike traditional

treaty-based obligations, the IHR derive their legal force from a mechanism of tacit acceptance, whereby regulations adopted by the World Health Assembly enter into force automatically for all Member States unless expressly rejected or subjected to reservations (Burci & Vignes, 2004; Fidler, 2005).

This distinctive adoption mechanism situates the IHR within a hybrid category of international legal instruments, combining elements of binding hard law with procedural features characteristic of institutional regulation. As noted in the literature, this "atypical" normative status reflects the evolution of international law toward more flexible and functionally oriented regulatory frameworks in response to globalized risks (Fidler, 2020; Negri, 2018).

From a doctrinal perspective, the IHR cannot be strictly classified as either conventional treaties or non-binding soft law instruments. Rather, they represent a specialized form of secondary legislation adopted by an international organization, endowed with direct legal effect upon Member States (Gostin, 2014; Burci & Vignes, 2004). Their binding character is reinforced by the absence of optional participation in core obligations, subject only to limited reservations mechanisms, thereby establishing a high degree of normative universality and legal obligation (Fidler, 2005).

The object and purpose of the IHR, as articulated in Article 2, reflect a paradigmatic shift in global health law from disease-specific regulation toward a risk-based and event-driven framework. The Regulations aim to prevent, detect, and respond to the international spread of disease while minimizing unnecessary interference with international traffic and trade, thereby balancing public health protection with economic and mobility considerations (Gostin & Katz, 2016; Katz et al., 2014).

This shift toward a functional and flexible regulatory model has been widely recognized in the literature as a defining feature of contemporary global health governance, enabling the IHR to address emerging and unpredictable threats, including those exemplified by the COVID-19 crisis (Habibi et al., 2020; Moon et al., 2015). At the same time, this flexibility introduces challenges in terms of interpretation, implementation, and enforcement at the domestic level (Suthar et al., 2018).

Materially, the scope of the IHR is both broad and multidimensional, encompassing surveillance systems, notification procedures, response capacities, and coordination mechanisms. States Parties are required to develop and maintain core capacities for detecting, assessing, reporting, and responding to public health risks, thereby embedding international obligations within domestic administrative and legal structures (Wilson et al., 2008; Mullen & Kamradt-Scott, 2018).

A central institutional requirement under the IHR is the establishment of a National IHR Focal Point, which serves as the primary interface between national authorities and the WHO. This requirement reflects the broader emphasis on institutional integration and intersectoral coordination, which are essential for effective implementation but often represent a source of operational difficulty in practice (Eccleston-Turner & Kamradt-Scott, 2019).

Furthermore, the IHR apply to a wide range of material and spatial domains, including points of entry such as ports, airports, and land crossings, as well as to travelers, goods, cargo, and conveyances. This expansive scope underscores the comprehensive nature of the regulatory framework and its capacity to address the complex pathways through which health risks may cross national borders (Gostin & Katz, 2016).

Structurally, the IHR integrate substantive obligations, procedural duties, and institutional mechanisms into a coherent regulatory system. These include notification and information-sharing requirements, capacity-building obligations, and cooperation frameworks between States and the WHO. The annexes to the Regulations, which possess equal legal force, provide detailed technical guidance, thereby enhancing the operational precision of the legal framework (Negri, 2018).

Taken together, the International Health Regulations (2005) represent a comprehensive and legally binding framework for global health security, characterized by their normative authority, institutional embeddedness, and functional adaptability. However, as consistently emphasized in the literature, their effectiveness ultimately depends not on their formal legal status, but on the extent to which they are effectively internalized and operationalized within domestic legal systems (Gostin, 2014; Suthar et al., 2018; Hoffman & Røttingen, 2015).

II. Domestic Legal Implementation of International Health Obligations

The effective functioning of the International Health Regulations (2005) (IHR) presupposes their systematic translation into domestic legal and institutional frameworks, notwithstanding their formally binding character at the international level. While the IHR impose obligations directly upon States Parties, their practical realization is inherently mediated through national legal systems, administrative capacities, and institutional coordination mechanisms (Gostin, 2014; Fidler, 2020; Negri, 2018).

This structural dependence reflects the hybrid nature of the IHR, which combine international legal normativity with operational public health functions executed at the domestic level. As emphasized in the literature, global health law increasingly relies on such hybrid governance models, where international obligations are inseparable from national implementation capacities (Lee & Kamradt-Scott, 2014; Kickbusch & Reddy, 2015).

Unlike classical treaty regimes that primarily regulate inter-State conduct, the IHR establish a dense network of positive obligations requiring continuous internal action by States, including the development of surveillance systems, notification mechanisms, verification procedures, and emergency response capacities (Gostin & Katz, 2016; Wilson et al., 2008). These

obligations operate through a model of indirect implementation, whereby States act as the principal agents responsible for transforming international legal commitments into operational domestic norms (Fidler, 2005; Burci & Vignes, 2004).

From a doctrinal standpoint, the IHR do not impose a uniform model of domestic incorporation. Instead, they adopt a functionalist and result-oriented approach, allowing States discretion in selecting constitutional, legislative, and administrative techniques for implementation (Negri, 2018; Suthar et al., 2018). This flexibility accommodates the diversity of legal systems while preserving the binding nature of the obligations themselves, thereby reinforcing the principle that effectiveness—not formal uniformity—constitutes the central criterion of compliance (Gostin, 2014; Hoffman & Røttingen, 2015).

A paradigmatic illustration of this logic is the requirement to establish a National IHR Focal Point, which institutionalizes international obligations within domestic administrative structures and ensures permanent communication with the World Health Organization (Mullen & Kamradt-Scott, 2018; Eccleston-Turner & Kamradt-Scott, 2019). This mechanism exemplifies the internalization of international law within national governance systems, thereby blurring the traditional distinction between external and internal legal spheres (Fidler, 2020).

More broadly, the IHR embed domestic implementation within a framework of continuous capacity-building and intersectoral coordination, requiring States to maintain functional systems for risk detection, assessment, reporting, and response. These capacities are not merely policy objectives but legally grounded obligations, whose fulfillment is subject to international monitoring and evaluation, notably through mechanisms such as the WHO Joint External Evaluation (Suthar et al., 2018; Habibi et al., 2020).

At the same time, the IHR situate domestic implementation within a broader normative framework emphasizing international cooperation, proportionality, necessity, and respect for human rights (Forman & Kohler, 2020; Gostin & Katz, 2016). This dimension underscores that national legal measures must align not only with technical public health requirements but also with fundamental legal principles governing the exercise of public authority.

Consequently, domestic implementation under the IHR cannot be conceived as a purely internal legal process. Rather, it constitutes the central interface through which global health obligations acquire concrete legal, institutional, and administrative reality, reflecting a decentralized yet normatively structured model of international law implementation (Moon et al., 2015; Katz et al., 2014).

Part II: Assessing the Domestic Implementation of the IHR in the Algerian Legal System

Building upon the international legal framework outlined above, this section examines the extent to which Algeria has translated the binding obligations of the IHR into coherent domestic legal and institutional arrangements, and evaluates their operational effectiveness in light of international standards and empirical assessments.

I. National Legal and Institutional Arrangements for Implementing the IHR in Algeria

The domestic implementation of the IHR within the Algerian legal system is grounded in a multi-layered normative architecture, combining formal incorporation, legislative alignment, regulatory operationalization, and institutional coordination across sectors. This architecture reflects a deliberate effort to integrate international health obligations into domestic law, while simultaneously revealing structural fragmentation in their practical execution (Gostin, 2014; Wilson et al., 2008).

At the foundational level, the incorporation of the IHR into the Algerian legal order was effected through Presidential Decree No. 13-293 of 4 August 2013, which formally published the Regulations in the Official Journal. This act confers direct internal legal force upon the IHR and situates them within the domestic hierarchy of norms as binding regulatory instruments, thereby ensuring their applicability without the need for further ratification procedures (Burci & Vignes, 2004; Fidler, 2005).

This formal incorporation is further reinforced by Law No. 18-11 of 2 July 2018 relating to health, which establishes an explicit normative linkage between international obligations and domestic public health law. By directly referencing the IHR in its provisions, the law transforms them from external legal commitments into internal normative standards governing national health policy and administrative action (Gostin & Katz, 2016).

In particular, the law provides for the implementation of preventive and protective measures against diseases with international propagation, mandates intersectoral coordination mechanisms, and establishes institutional responsibilities for sanitary control at points of entry. These provisions reflect the core functional requirements of the IHR, including surveillance, response, and border health measures (Wilson et al., 2008; Suthar et al., 2018).

Beyond the legislative framework, the operationalization of the IHR is ensured through a series of executive regulatory instruments, which translate general legal obligations into specific administrative mechanisms. Among these, Executive Decree No. 15-210 of 10 August 2015 plays a central role by establishing the intersectoral committee responsible for managing public health threats and emergencies of international concern.

This committee represents a key institutional mechanism for horizontal coordination across sectors, including health, transport, security, and environmental authorities. Its functions—ranging from information collection and risk assessment to policy coordination and monitoring—are directly aligned with the operational requirements of the IHR (Mullen & Kamradt-Scott, 2018; Eccleston-Turner & Kamradt-Scott, 2019).

Additional regulatory instruments further reinforce this framework. Executive Decree No. 22-250 of 2022 establishes the system of mandatory notification for communicable diseases, thereby strengthening surveillance and reporting capacities, while Executive Decree No. 24-277 of 2024 defines the organization and functioning of sanitary control services at border points. These measures reflect the centrality of points of entry control and early detection mechanisms within the IHR framework (Gostin, 2014; Katz et al., 2014).

Taken together, these legislative and regulatory instruments demonstrate that Algeria has developed a comprehensive formal framework for the domestic implementation of the IHR, characterized by explicit incorporation, sectoral integration, and institutionalization of coordination mechanisms. However, as emphasized in comparative studies and WHO evaluations, the existence of formal legal structures does not necessarily guarantee effective operational implementation, which depends on coherence, coordination, and administrative capacity (Suthar et al., 2018; Habibi et al., 2020; Moon et al., 2015).

Table 1. Mapping of IHR (2005) Core Obligations and Corresponding Algerian Legal Framework

IHR Core Domain	Key International Obligations	Relevant Algerian Legal Instruments	Institutional Mechanisms	Level of Formal Compliance	Observed Implementation Gaps
Surveillance & Detection	Establish early warning systems; continuous monitoring of public health risks	Executive Decree No. 22-250 (2022); Law No. 18-11 (2018)	National health surveillance system; reporting units	High	Fragmentation in data integration; limited real-time interoperability
Notification & Reporting	Timely notification of events to WHO; verification procedures	Law No. 18-11 (Arts. 42–44); Decree No. 22-250 (2022)	Ministry of Health; national reporting channels	Moderate–High	Delays in reporting; procedural inconsistencies across sectors
Points of Entry (PoE)	Health control at ports, airports, and land crossings	Executive Decree No. 24-277 (2024); Law No. 18-11 (2018)	Border sanitary control services; designated medical authority	High	Coordination gaps between border agencies; resource constraints
Intersectoral Coordination	Establish coordination mechanisms across sectors	Executive Decree No. 15-210 (2015)	Intersectoral committee for health emergencies	Moderate	Overlapping mandates; limited operational coherence
Emergency Preparedness & Response	Develop national response plans and core capacities	Law No. 18-11 (2018); national emergency frameworks	Ministry of Health; crisis response units	Moderate–High	Capacity limitations; uneven preparedness across regions
International Cooperation	Share information; collaborate with WHO and other States	WHO Constitution (1946); IHR (2005)	National IHR Focal Point	Moderate	Limited transparency and procedural standardization
Human Rights Compliance	Ensure proportionality, necessity, and respect for rights	Law No. 18-11 (2018); constitutional guarantees	Judicial and administrative oversight	Moderate	Lack of explicit procedural safeguards in emergency contexts

Table 2. Analytical Assessment of Domestic Implementation Effectiveness in Algeria (Based on IHR Requirements and WHO Evaluation Framework)

Assessment Dimension	Indicators of Effectiveness	Strengths Identified	Weaknesses / Constraints	Comparative Insight (Literature-Based)	Overall Evaluation

Legal Incorporation	Formal adoption of IHR; integration into domestic law	Direct incorporation via Presidential Decree; legislative alignment (Law No. 18-11)	Fragmented regulatory layering	Consistent with global practices of formal compliance (Gostin, 2014; Fidler, 2005)	Strong
Institutional Coordination	Functionality of intersectoral mechanisms	Existence of permanent coordination bodies	Overlapping competencies; weak procedural harmonization	Coordination deficits widely reported in federal/multi-sector systems (Wilson et al., 2008)	Moderate
Operational Capacity	Surveillance, response, and infrastructure readiness	Established reporting and response frameworks	Capacity gaps; uneven regional implementation	Capacity constraints are global challenge (Suthar et al., 2018; Moon et al., 2015)	Moderate
Regulatory Coherence	Consistency across legal instruments	Comprehensive legal coverage	Normative duplication; interpretative ambiguity	Legal fragmentation reduces effectiveness (Negri, 2018; Fidler, 2020)	Moderate
Points of Entry Management	Border health control effectiveness	Dedicated sanitary services; legal clarity	Inter-agency coordination challenges	PoE identified as critical vulnerability globally (Katz et al., 2014)	Moderate–High
Transparency & Reporting	Timeliness and openness of reporting systems	Formal reporting obligations established	Delays and procedural inconsistencies	Transparency gaps highlighted in WHO governance (Eccleston-Turner & Kamradt-Scott, 2019)	Moderate
Human Rights Integration	Safeguards during emergency measures	General legal recognition of rights	Limited operationalization in emergency context	Rights vs public health tension widely noted (Forman & Kohler, 2020)	Moderate
Overall System Effectiveness	Alignment between law and practice	Strong normative foundation	Implementation gaps across key domains	Confirms global pattern: law ≠ practice (Gostin & Katz, 2016)	Moderate (Structurally Robust, Functionally Constrained)

Institutional and Operationalization Framework of IHR Obligations in Algeria

The composition and institutional design of the intersectoral committee established under Algerian law reflect a comprehensive and legally embedded multisectoral governance model, consistent with the systemic logic of the International Health Regulations (2005). The inclusion of representatives from a wide spectrum of ministerial sectors—ranging from health, defense, and foreign affairs to agriculture, transport, environment, and education—alongside key national institutions such as the Pasteur Institute of Algeria, civil protection authorities, and veterinary and nuclear regulatory bodies, demonstrates an explicit attempt to translate the IHR requirement of intersectoral coordination into a formalized legal obligation rather than a discretionary administrative practice.

This institutional architecture reflects broader trends in global health governance, where the effectiveness of international legal obligations is increasingly contingent upon the integration of heterogeneous sectors within coordinated national frameworks (Kickbusch & Reddy, 2015; Lee & Kamradt-Scott, 2014). However, as highlighted in comparative scholarship, the mere existence of multisectoral bodies does not guarantee functional coherence, as coordination challenges often persist due to institutional fragmentation and overlapping mandates (Wilson et al., 2008; Mullen & Kamradt-Scott, 2018).

The operationalization of IHR obligations at points of entry (PoE) is further reinforced through Executive Decree No. 24-277 of 2024, which constitutes a detailed regulatory framework governing border health control. This instrument explicitly integrates core IHR concepts—including public health risk, public health emergency of international concern, quarantine, and isolation—into domestic administrative law, thereby ensuring normative continuity between international standards and national regulatory practice (Gostin & Katz, 2016; Negri, 2018).

The decree confers extensive powers upon sanitary authorities, including inspection of travelers and conveyances, verification of vaccination requirements, imposition of quarantine measures, and issuance of sanitary certifications. These provisions demonstrate a high degree of functional alignment with IHR operational requirements, particularly in relation to border control and risk management (Katz et al., 2014; Fidler, 2020). At the same time, the effectiveness of these measures remains dependent on the coordination between multiple agencies, including customs, security forces, and veterinary authorities, reflecting a broader challenge of institutional interoperability (Suthar et al., 2018).

Beyond border control, the domestic implementation framework extends to laboratory capacity and disease surveillance systems, which constitute essential components of IHR core capacities. Algeria maintains a relatively extensive laboratory infrastructure, encompassing public and private laboratories, reference institutions, and high-biosafety facilities. This infrastructure operates within sectoral networks supported by accreditation mechanisms and standardized procedures, thereby providing the technical foundation for detection and verification obligations under the IHR (Gostin, 2014; Moon et al., 2015).

Similarly, the surveillance system is structured around both indicator-based and event-based mechanisms, operating across multiple administrative levels and supported by regulatory instruments governing mandatory disease notification. These arrangements reflect an effort to institutionalize surveillance obligations within domestic law, aligning national practices with international requirements (Suthar et al., 2018; Wilson et al., 2008). Nevertheless, as emphasized in global health literature, surveillance effectiveness depends not only on legal formalization but also on data integration, interoperability, and continuous system coordination, which remain persistent challenges across jurisdictions (Habibi et al., 2020).

The notification dimension of IHR implementation is anchored through the designation of a National IHR Focal Point within the Ministry of Health, supported by formal administrative decisions and rapid response mechanisms. Parallel notification structures within the veterinary sector further illustrate the sectoral differentiation of reporting systems, consistent with the "One Health" approach to global health governance. However, the coexistence of multiple notification channels without fully harmonized coordination procedures highlights the complexity of translating international reporting obligations into coherent domestic legal frameworks (Eccleston-Turner & Kamradt-Scott, 2019; Fidler, 2020).

Finally, the implementation framework is supported by human resource development and capacity-building measures, including the deployment of trained personnel, epidemiological services, and continuous training programs. Although these elements are not always codified within a single legislative instrument, they constitute an essential component of the broader legal and institutional environment required for effective IHR implementation (Hoffman & Røttingen, 2015).

Taken together, the Algerian system reveals a normatively structured yet functionally dispersed implementation model, characterized by formal legal incorporation, sector-specific regulatory elaboration, and institutionalized coordination mechanisms. While this framework provides a solid legal foundation for compliance with international health obligations, it simultaneously exposes persistent challenges related to coherence, integration, and operational effectiveness, which are widely recognized in global health governance scholarship (Gostin & Katz, 2016; Suthar et al., 2018).

II. The WHO Joint External Evaluation as a Legal Diagnostic Tool

From a strictly legal perspective, the WHO Joint External Evaluation (JEE), although not legally binding, functions as a quasi-normative diagnostic instrument capable of assessing the degree to which international obligations are effectively internalized within domestic systems. Its analytical value lies in its capacity to reveal discrepancies between formal normative incorporation and practical operationalization, thereby providing an indirect measure of compliance with the International Health Regulations (2005) (Suthar et al., 2018; Habibi et al., 2020).

1. Normative Incorporation versus Operational Effectiveness

The findings of the JEE in the Algerian context reveal a recurrent pattern of strong formal alignment with IHR requirements accompanied by uneven operational performance. Across multiple core capacities, the evaluation acknowledges the existence of legal frameworks, institutional structures, and sectoral strategies, while simultaneously identifying persistent deficiencies in coordination, integration, and implementation effectiveness.

In the domain of laboratory systems, the JEE confirms the presence of an extensive and technically advanced infrastructure, including accredited laboratories and biosafety facilities. However, it highlights the absence of centralized coordination mechanisms and insufficient integration across sectors, indicating that technical capacity does not automatically translate into institutional coherence (Moon et al., 2015; Gostin, 2014).

A similar pattern is observed in the field of surveillance, where the existence of comprehensive indicator-based systems is accompanied by shortcomings in event-based surveillance, data-sharing platforms, and private-sector integration. These findings suggest that the primary challenge lies not in the absence of legal obligations, but in the procedural and institutional mechanisms required to ensure their effective and continuous implementation (Suthar et al., 2018; Wilson et al., 2008).

From a legal-analytical standpoint, this duality reflects a broader structural feature of international health law: the gap between normative commitment and operational realization. As emphasized in the literature, the effectiveness of global health governance depends not merely on the existence of binding legal instruments, but on their capacity to be translated into coherent, integrated, and functionally effective domestic systems (Gostin & Katz, 2016; Fidler, 2020).

Intersectoral Coordination and Notification Mechanisms

Intersectoral coordination constitutes a foundational pillar of the International Health Regulations (2005), particularly in relation to the detection, assessment, and notification of public health events. The Joint External Evaluation (JEE) confirms that Algeria has established the core institutional components required under the IHR, notably the intersectoral coordination committee and the designation of a National IHR Focal Point within the Ministry of Health. These elements demonstrate a high level of formal compliance with the institutional architecture prescribed by international health law (Gostin & Katz, 2016; Burci & Vignes, 2004).

However, the effectiveness of these arrangements is constrained by the absence of fully formalized procedural frameworks governing intersectoral communication and information exchange. In particular, the lack of standardized protocols between human health authorities and corresponding focal points in the animal health sector—especially those linked to international reporting systems—reveals a fragmentation of notification pathways. From a legal perspective, this fragmentation undermines the integrated and systemic logic of the IHR, which presupposes coordinated and interoperable governance structures across sectors (Lee & Kamradt-Scott, 2014; Eccleston-Turner & Kamradt-Scott, 2019).

The JEE further highlights that, although Algeria has demonstrated effective notification practices in past public health events, the underlying procedural framework governing validation, authorization, and transmission of notifications remains insufficiently codified. This reliance on ad hoc administrative practices, rather than legally stabilized procedures, introduces a degree of uncertainty and variability that may affect the predictability and timeliness of compliance with international obligations (Fidler, 2020; Suthar et al., 2018).

Accordingly, the Algerian case illustrates a broader structural issue identified in global health governance: the existence of parallel functional systems without adequate legal integration, resulting in a gap between operational capacity and procedural formalization (Wilson et al., 2008; Mullen & Kamradt-Scott, 2018).

3. Preparedness, Human Resources, and Sustainability of Implementation

In the domain of preparedness and human resources, the Algerian framework demonstrates a relatively advanced level of capacity development, supported by national training strategies, epidemiological services, and the implementation of field epidemiology training programs. The presence of trained personnel across the national territory and the establishment of multisectoral response teams constitute significant strengths, aligning with the core capacity requirements of the IHR (Gostin, 2014; Moon et al., 2015).

Nevertheless, the JEE identifies several structural vulnerabilities that may affect the long-term sustainability of these capacities. These include workforce ageing, uneven geographical distribution of qualified personnel, and the absence of formally institutionalized multidisciplinary response teams in all regions. From a legal standpoint, these challenges underscore the distinction between de facto capacity and its de jure stabilization within durable regulatory frameworks (Hoffman & Røttingen, 2015).

Furthermore, the evaluation emphasizes the need for continuous and legally embedded training mechanisms specifically tailored to public health emergencies of international concern. This finding reflects a broader principle in global health law: that preparedness is not a static condition, but a dynamic and legally structured process requiring continuous adaptation and institutional reinforcement (Habibi et al., 2020; Forman & Kohler, 2020).

4. Legal Significance of the JEE Findings

Although the WHO Joint External Evaluation does not constitute a legally binding instrument, it performs a crucial function as a quasi-normative diagnostic tool capable of assessing the operationalization of international obligations within domestic systems. Its analytical relevance lies in its ability to reveal discrepancies between formal legal incorporation and practical implementation, thereby providing an empirical basis for evaluating compliance with the IHR (Suthar et al., 2018; Gostin & Katz, 2016).

The findings in the Algerian context reveal a pattern of strong normative alignment combined with operational fragmentation, particularly in areas such as coordination, surveillance, and human resources. This duality reflects a broader structural feature of international health law, wherein binding legal norms depend for their effectiveness on complex and often imperfect domestic implementation processes (Fidler, 2005; Negri, 2018).

From a legal-analytical perspective, the JEE thus serves as an evidentiary mechanism that bridges the gap between normative commitments and empirical realities, enabling a more nuanced understanding of the conditions under which international legal obligations are effectively realized.

Conceptual Model Framework

Building upon the doctrinal and institutional analysis of the International Health Regulations (2005) (IHR), this study develops a conceptual legal-operational framework for assessing domestic implementation within national systems. The model is grounded in the premise that the effectiveness of global health governance depends on the interaction between normative incorporation, institutional translation, and operational performance (Gostin, 2014; Fidler, 2020).

1. Theoretical Structure of the Model

The proposed framework conceptualizes IHR implementation as a three-layered system:

(1) Normative Incorporation Layer

This layer captures the formal integration of international obligations into domestic law through constitutional, legislative, and regulatory instruments. It reflects the transformation of international norms into binding domestic legal standards, ensuring their legal enforceability (Burci & Vignes, 2004; Negri, 2018).

(2) Institutional Translation Layer

At this level, legal norms are operationalized through the establishment of administrative structures, coordination bodies, and sectoral mechanisms, including National IHR Focal Points, intersectoral committees, and regulatory authorities. This layer embodies the transition from legal abstraction to institutional functionality (Mullen & Kamradt-Scott, 2018; Wilson et al., 2008).

(3) Operational Effectiveness Layer

This layer reflects the practical performance of the system, including surveillance, notification, preparedness, and response capacities. It captures the extent to which legal and institutional arrangements produce timely, coordinated, and effective public health outcomes, as evaluated through mechanisms such as the WHO Joint External Evaluation (Suthar et al., 2018; Habibi et al., 2020).

2. Dynamic Interaction Mechanism

The model emphasizes that implementation is not linear but interactional and feedback-driven:

- Normative incorporation enables institutional design
- Institutional structures condition operational performance
- Operational outcomes generate feedback for legal and regulatory reform

This cyclical relationship reflects the broader evolution of global health law toward adaptive and performance-oriented governance systems (Gostin & Katz, 2016; Kickbusch & Reddy, 2015).

3. Core Analytical Dimensions

The framework identifies four cross-cutting dimensions:

- Legal Coherence – consistency and clarity of domestic legal instruments
- Institutional Coordination – effectiveness of intersectoral governance
- Operational Capacity – functionality of surveillance and response systems
- Procedural Formalization – existence of standardized and legally codified processes

These dimensions collectively determine the degree of effective compliance with IHR obligations (Fidler, 2005; Lee & Kamradt-Scott, 2014).

Findings

Applying the conceptual framework to the Algerian case reveals a complex and differentiated implementation profile, characterized by strong normative alignment but uneven operational consolidation.

1. Strong Normative Incorporation

The findings demonstrate that Algeria has achieved a high level of formal compliance with the IHR through:

- Direct incorporation via Presidential Decree No. 13-293
- Legislative integration through Law No. 18-11 (2018)
- Extensive regulatory elaboration across multiple domains

This confirms that the Algerian legal system has successfully internalized international health obligations as binding and operationally relevant domestic norms (Gostin, 2014; Burci & Vignes, 2004).

2. Institutional Expansion with Fragmentation Risks

At the institutional level, Algeria has developed a broad and multisectoral governance architecture, including:

- Intersectoral coordination committees
- National IHR Focal Point
- Sector-specific regulatory bodies

However, the findings indicate that this expansion is accompanied by fragmentation and coordination challenges, including:

- Overlapping institutional mandates
- Weak procedural harmonization
- Parallel but insufficiently integrated notification systems

This reflects a common pattern identified in global health governance, where institutional proliferation does not necessarily result in functional coherence (Wilson et al., 2008; Mullen & Kamradt-Scott, 2018).

3. Operational Capacity: Functional but Uneven

The analysis confirms the existence of substantial operational capacities, particularly in:

- Laboratory infrastructure
- Surveillance systems
- Human resource development

Nevertheless, significant constraints persist:

- Limited interoperability of data systems
- Gaps in event-based surveillance
- Uneven regional preparedness
- Dependence on ad hoc coordination mechanisms

These findings align with global empirical evidence indicating that capacity gaps and coordination failures remain central challenges in IHR implementation (Suthar et al., 2018; Moon et al., 2015).

4. Procedural Informality as a Key Structural Weakness

One of the most significant findings concerns the lack of procedural formalization, particularly in:

- Intersectoral information exchange
- Notification validation and transmission
- Coordination between human and animal health sectors

This reliance on informal or ad hoc practices undermines the predictability, consistency, and legal certainty required for effective compliance with international obligations (Eccleston-Turner & Kamradt-Scott, 2019; Fidler, 2020).

5. Normative–Operational Gap

The study identifies a persistent normative–operational gap, characterized by:

- Strong legal frameworks

- Functionally incomplete implementation

This gap confirms a central insight of global health law: legal obligation does not automatically translate into operational effectiveness, particularly in complex and multi-level governance systems (Gostin & Katz, 2016; Lee & Kamradt-Scott, 2014).

6. Transition to a Consolidation Phase

The findings suggest that Algeria has moved beyond the initial phase of legal incorporation into a second-stage "implementation consolidation phase", where the key challenge is not the creation of new norms but the integration, harmonization, and stabilization of existing mechanisms.

This transition reflects a broader shift in international law toward performance-based compliance, where effectiveness is measured in terms of system functionality rather than formal adherence (Fidler, 2020; Hoffman & Røttingen, 2015).

Conclusion

This study has examined the domestic implementation of the International Health Regulations (2005) within the Algerian legal system through a doctrinal and analytical lens, focusing on the relationship between the binding nature of international health obligations and their operational realization at the national level.

The analysis demonstrates that Algeria has adopted a legally explicit and institutionally structured approach to the internalization of the IHR, characterized by formal incorporation, legislative alignment, and the establishment of specialized regulatory and institutional mechanisms. This framework reflects a clear recognition of the IHR as binding international norms requiring permanent and structured domestic implementation (Gostin, 2014; Burci & Vignes, 2004).

However, the findings also reveal that normative incorporation alone does not ensure effective implementation. The principal challenges identified relate to procedural formalization, intersectoral coordination, and institutional coherence, rather than to deficiencies in legal commitment. This confirms the central thesis advanced in global health law scholarship: that the effectiveness of international legal instruments depends on their capacity to be operationalized within integrated and functionally coherent domestic systems (Gostin & Katz, 2016; Suthar et al., 2018).

The Algerian case thus represents an advanced stage of implementation, in which the core legal question shifts from the existence of obligations to the quality of their institutionalization and execution. This transition reflects a broader evolution in international law, where compliance is increasingly assessed in terms of operational effectiveness rather than formal adherence (Fidler, 2020; Lee & Kamradt-Scott, 2014).

Policy and Legal Recommendations

In light of the findings, the study proposes the following recommendations:

- Enhance regulatory clarity in intersectoral coordination by codifying standardized operating procedures governing information exchange and decision-making processes, thereby reducing fragmentation and improving legal predictability (Wilson et al., 2008).

- Strengthen the legal integration of the "One Health" approach by explicitly embedding coordination mechanisms between human and animal health sectors within existing regulatory instruments, ensuring alignment with international best practices (Habibi et al., 2020).

- Formalize notification procedures through the adoption of clear and binding protocols governing validation, authorization, and transmission processes, thereby reinforcing compliance with international reporting obligations (Eccleston-Turner & Kamradt-Scott, 2019).

- Institutionalize preparedness and response capacities by embedding multidisciplinary response teams and continuous training programs within stable legal frameworks, ensuring sustainability and resilience (Moon et al., 2015; Hoffman & Røttingen, 2015).

- Utilize the WHO Joint External Evaluation as a regulatory benchmarking tool, guiding targeted legal reforms and institutional adjustments aimed at enhancing coherence, interoperability, and long-term effectiveness (Suthar et al., 2018).

Ethical Considerations

This study is conducted in accordance with internationally recognized standards of research integrity and publication ethics. The research is based exclusively on the analysis of publicly available legal texts, official documents, and institutional reports, including materials issued by the World Health Organization. As such, it does not involve human participants, personal data, clinical experimentation, or animal subjects, and therefore does not require ethical approval from an institutional review board. The study adheres to the principles of transparency, academic honesty, and responsible scholarship, ensuring accurate representation and citation of all sources in line with international academic standards.

Conflict of Interest

The authors declare that there is no conflict of interest regarding the publication of this article.

The research was conducted independently and without any commercial, financial, institutional, or personal relationships that could be construed as influencing the results or interpretations presented in this study.

Funding Statement

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

The authors confirm that the study was conducted without external financial support that could have influenced its design, analysis, or conclusions.

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Data Availability Statement

The data supporting the findings of this study are fully derived from publicly accessible sources, including international legal instruments, national legislation, and official institutional reports.

No new datasets were generated or analyzed during the current study.

AI Use Statement

The authors declare that no artificial intelligence (AI) tools were used in the conceptualization, legal analysis, or interpretation of the research findings presented in this manuscript.

AI-assisted tools may have been used solely for language editing and formatting purposes, without influencing the intellectual content, arguments, or conclusions of the study. The authors take full responsibility for the originality, accuracy, and integrity of the work.

Acknowledgements

The authors express their appreciation to the academic and institutional community whose publicly available legal and policy materials contributed to this research.

Special acknowledgment is extended to the World Health Organization for providing access to authoritative reports and evaluation frameworks that informed the analytical dimension of this study.

Consent to Publish

All authors have given their **explicit consent** for the publication of this manuscript and confirm that the work has not been published previously and is not under consideration elsewhere.

Compliance with Ethical Standards

This article complies with the ethical standards of academic publishing, including guidelines established by international bodies such as the Committee on Publication Ethics (COPE), and adheres to best practices in legal and interdisciplinary research.

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