

NEW INTERNATIONAL HEALTH REGULATIONS: PLATFORM FOR GLOBAL HEALTH GOVERNANCE

*Guillermo J. Avilés Mendoza**

“The purpose and scope of these Regulations are to prevent, protect against, control and provide with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade (Article 2 - International Health Regulations 2005)”.

Introduction

In May 2005, the World Health Assembly (WHA) ratified the new International Health Regulations (“IHR 2005” or “Regulations”). The revised IHR empowers the World Health Organization (WHO) and Member States to meet the 21st Century global health challenges affecting international traffic and trade. The IHR is a key global governance instrument for the protection of international spread of disease, and in order to obtain its intended goals it must be administrated under ethical governance principles promoting the cooperation among Member States, WHO, intergovernmental organizations, international bodies, corporations and non-government organizations. The importance of the IHR is evidenced by the fact that, in light of the recent pandemic risk posed by the avian influenza, the fifty-ninth WHA called for its immediate voluntary compliance. The IHR will be binding to all the Member States starting in June 15, 2007 and calls for fundamental changes to the health surveillance systems and as a result, generates challenges and opportunities for the 21st Century global health governance (Fidler & Gostin 2006:93).

The broader scope of the IHR introduces obligations at local, national and international levels, which in turn call for an analysis of the new Regulations. Accordingly, this article provides an overview of the IHR within the global health perspective and analyses important Articles for the implementation of the Regulations.

*The views expressed in this article are the author’s and should not be attributed to the U.S. Department of Health and Human Services.

Second, the IHR empowers Member States and the WHO by opening the channels of collaboration with intergovernmental organizations and/or international bodies. The IHR provides the World with a unique global platform for the creation of interdisciplinary collaborative mechanisms that will facilitate the flow of information, technical and operational, between the multiple relevant actors of the new IHR system. Thus, in order for the IHR to be the effective global health governance instrument, the components of the system must work under the similar governance principles. As a result, this public policy analysis should be a useful tool for governments, non-government organizations, international organizations, corporations, media, and other local, national and international entities interested in the successful application of the IHR and its implications in global public health security.

The new IHR global health surveillance framework has been explained by a variety of exponents that inspired this paper (Baker & Fidler 2006, Fidler & Gostin, 2006, Fidler 2005). Therefore, this paper also intends to promote policy analysts to continue identifying and addressing constrains for the implementation of the new IHR. I want to encourage analysts from non-traditional publishing geographical areas to share their views with the broader audience. After all, the World is a global village that regardless of differences (political, cultural, geographical, economical, etc.) is united by the pursuit of healthier and safer generations. The global village will benefit from the fruits of multi-interdisciplinary policy analyses leading to a holistic viewpoint that will guide the public health leadership of the 21st Century to an efficient administration of the IHR.

In sum, in this article I share an international law and global governance analysis of the new IHR and support their implementation and integration into State Members' political and economical platforms, as within the Regulations' framework. In doing so, I encourage States Parties to collaborate through multiple channels to create partnerships that will mobilize financial resources to facilitate implementation of their obligations under the IHR. States Parties should take advantage of the unique unprecedented opportunity the IHR offers for global health governance (Fidler & Gostin, 2006:93).

I. Glance at the World Health Organization and International Law

World Health Organization

The World Health Organization was established in April 1948 as a specialized health agency for the United Nations (UN). The main objective of the WHO is the achievement of the highest possible level of health to all the people (Article 1 WHO Constitution). All Member States of the United Nations may become Member States of WHO by ratifying the Constitution of the WHO (Article 4 WHO Constitution). The WHA is the WHO's policy-making governing body in charge of the revision of the International Health Regulations and is currently composed by 192 Member States.

The WHA has the authority to write recommendations, make treaties and legally binding regulations to Member States with regards to any matter within the competence of the WHO. First, under Article 23 of the WHO Constitution the WHA has the authority to write recommendations to Member States. The recommendations are non-binding but are a resourceful guidance tool to Member States. Second, under Article 19 of the WHO Constitution grants the WHA the...

“...authority to adopt conventions and agreements with respect to any matter within the competence of the Organization”.

International legal scholars highlight the under usage of treaty-making power by the WHO as compared to the pre-WHO era where international sanitary conventions played important roles in the evolution of international public health law (Fidler 2005: 331 & Aginam 2004: 62). The international law dormancy period at the WHO was attributed to the organization's embedded culture of non-international legal experts (Fidler 1996:80). The analysis of the reasoning behind the lack of the WHO international law strategies is beyond the scope of this article. However, the fact that in 2003 the WHO negotiated the Framework Convention on Tobacco Control marks the beginning of public health treaties under Article 19 of the WHO Constitution.

Second, under Article 21 of the WHO Constitution the WHA has the authority to adopt legally binding regulations concerning five public health areas¹. Member States are bound to comply

with the adopted regulations unless they exercise their right to “contract-out” as stipulated in WHO Constitution Article 22. Under the principles of the Vienna Convention on the Law of Treaties the regulations enacted under Article 21 of the WHO Constitution are a treaty because they are a written manifesto where States agree to be legally bound to the regulations.

In July 1951 the WHA exercised its power under Article 21 and approved the International Sanitary Regulations, which in 1969 became the International Health Regulations (IHR). The old IHR are a regulatory mechanism for the sharing of epidemiological information on the international spread of cholera, plague and yellow fever. In 1995, after two minor revisions in 1973 and 1981, the WHA recognized the need for the enactment of a new IHR and ordered the WHO Director General to revise the Regulations. Once again we observe a period of international law dormancy by the WHO which can be regarded as a contributing factor to the non-compliance by some Members States and to the overall ineffectiveness of the IHR as shown by the outbreaks of cholera in Perú, plague in India, Ebola hemorrhagic fever in Zaire and the Severe Acute Respiratory Syndrome (SARS) in China (Gostin, 2004: 2624). Moreover, the increased concern in the proliferation of biological weapons and their bioterrorism implications, particularly after the sarin gas attack in Tokyo subway in 1995 and the anthrax attacks in the United States in 2001, demonstrated the need for a global public health surveillance system that encompasses more than the three reportable diseases under the old IHR.

The outbreak of SARS in 2003 was the turning point that speeded up the revision process of the IHR. The Chinese Ministry of Health on February 11, 2003, informed the WHO Director General of an outbreak of acute respiratory syndrome with three hundred reported cases. The disease was detected as early as November 2002 and when reported to the WHO was in its way to twenty-four countries and thousands of SARS cases. The SARS outbreak was the judgment call for the WHA to act on the IHR revision. The accelerated IHR revision process had one proposed text publication in January 2004 and three intergovernmental negotiations in November 2005, February 2005 and May 2005 (Fidler & Gostin, 2006: 85). The IHR (2005) was adopted by the WHA on May 23, 2005 and will be legally binding as of June 15, 2007. In summary, the WHO has two international law instruments to achieve the highest possible level of health for all the people. The

active role of the WHO in global health governance was reaffirmed with the recent exercise of their treaty-making power and the revision of the International Health Regulations.

International Trade Law and Public Health

International trade law has also been a contributing driving force in the global public health agenda. The 1947 General Agreement on Tariffs and Trade (GATT) made public health a trade-related international concern. Recognizant of the effects of public health measures on trade the international community, through the GATT, established trade-restricting health measures that addressed the threats posed by the spread of diseases (Fidler, 2005: 336). Moreover, the creation of the World Trade Organization (WTO) in 1995 and its new agreements made it clear that the globalization of the markets had created a stronger interdependent bond between public health and international trade law. Of particular importance is WTO's Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS). The TRIPS narrowed the international public health agenda by restricting governments' capabilities to protect and promote public health. However, the growing international concern of the imbalance between international trade and the health interests generated a twenty-first century momentum where the WTO affirmed its supports for the protection of public health. The integration between international trade and public health will continue to be driven by the globalization of markets and the new IHR is the platform for the global surveillance system that will secure international trade.

II. International Health Regulations (2005)

Purpose and Scope

The new IHR covers all public health threats or risks that may interfere with international traffic and trade. This is an all-inclusive scope, incorporates a new public health surveillance and response system build upon core capacities at the local, national and international level. The broader scope of the IHR (2005) makes the Regulations one of the most ambitious global health projects. The scope of the IHR is emphasized by the broad definition of "disease". Under the IHR "disease" is an illness or medical condition, irrespective of origin or source that presents or could present significant harm to humans (Article 1.1 IHR 2005). The broadness of the definition relies on the fact that the IHR

applies to any medical condition that may pose a risk of interfering with international traffic and trade. The expansion of the IHR scope overlaps with other international legal regimes and created unprecedented challenges for the WHO that requires co-operation among the different international organizations for the successful global health governance (Fidler 2005: 364). In the last section of this article I expand on the importance of cooperative frameworks for the successful application of the IHR as the platform for global health governance.

The IHR calls for the implementation of the Regulations with “full respect for the dignity, human rights and fundamental freedoms of persons”. The IHR is silent as to penalties for States that implement the Regulations against these principles of dignity, human rights and fundamental freedom. However, this should not deter other States from reporting a State that disregards the fundamental principles protected under the IHR.

The importance and the need for the new IHR were reaffirmed on May 2006 at the fifty-ninth WHA when Member States were called to comply immediately, in a voluntary basis without prejudice, with the relevant provisions of the IHR. The voluntary immediate compliance and accelerated implementation process is based on the possible emergence of a pandemic arising from the current outbreaks of avian influenza, caused by the highly pathogenic H5N1 strain of *Influenza virus A*. The broader scope of the IHR requirements introduces constraints at local, national and international levels, which in turns call for an analysis of the new Regulations. The following look at the Regulations provides: 1) important dates for the implementation of the requirements; 2) administrative mechanisms for rejection and/or reservations and dispute settlement procedures; and 3) brief description of the global public health surveillance system under the IHR.

A Date to Remember: June 15, 2007 Entry into Force of the New IHR

As stated above, the IHR (2005) were ratified on May 2005 and will be legally binding starting June 15, 2007. The Regulations grant a one-year extension to State Parties with proper notice of compliance problems before December 15, 2006 (Article 59.3 IHR 2005). Given the broader scope and core capacity obligations of the IHR it is foreseeable that Member States with economies in transition will face compliance problems and request the extension. The Ministry of Health from each State has the governmental

responsibility to inform their respective government officials the importance of the compliance with the Regulations. The Ministries of Health are responsible for advocating the adjustment of the legislative and administrative agendas to promote compliance. The Regulations call for designation of the authorities responsible for the implementation of the Regulations implying that the responsibility is not only on the Ministries of Health. Therefore, the IHR are a call for health diplomacy at the local, national and international governmental levels. In order to have a successful compliance rate we need diplomatic exercises advocating the formulation of laws and administrative provisions implementing the IHR.

Rejection/Reservation of the IHR (2005) by Member States

As stipulated in Article 22 of the WHO Constitution Member States can reject or make reservations to legally-binding regulations promulgated by the WHA under Article 21 of the WHO Constitution. The IHR provides Member States with 18 to reject or make reservations (Article 59 IHR 2005). Member States had until December 15, 2006 to reject or make reservations to the Regulations. If a Member State partially rejects the Regulations it will be considered a reservation and administered under Article 62 of the IHR. The reservation processes under the Regulations is complicated and deserves a brief description. A reservation is accepted when more than two-thirds of Member States do not object to the reservation. On the other hand, when one-third of the States object to the reservation the Director General provides 3 months to the reserving State to consider the withdrawal of the reservation. If the reserving State decides to move forward, the reservation is taken to a vote at the WHA. The IHR Review Committee provides a recommendation to the WHA on the State's reservation. Since the majority vote of the WHA will probably be the same view of the States that objected the reservation; as result, there is no independent appeal process for an objected reservation. State Parties are bound to comply with the Regulations to the full extent even when they have raised reservations objected by the majority. The reservation approval process should be governed by the ethical standards calling for transparency and fairness.

Settlement of Disputes Developing from the Interpretation and/or Application of the Regulations

Article 56 of the Regulations governs the mechanisms States Parties can use for the settlement of disputes that might arise from the interpretation and/or application of the Regulations. First, the dispute resolution processes require that the States Parties engage in good faith negotiations or...

“...any other peaceful means of their own choice, including good offices, mediation or conciliation” (Article 56.1 IHR 2005).

This is an important clause because many times States start the dispute in an adversarial mode, seeking tribunals for the resolution of instances where a negotiation in a neutral venue or the assistance of a third neutral party can resolve the dispute. Alternative Dispute Resolution (ADR) allows States Parties in disagreement to use “any other peaceful means of their own choice”. Once again, the implementation of the Regulations will be a challenge to States Parties and multiple disputes may arise from their interpretation and/or application. Non-adversarial ADR as the first process to settle disputes decentralizes the enforcement and makes State Parties the main decision makers in the implementation of the Regulations. Furthermore, requiring the use of non-adversarial processes as the first step for the resolution of disputes is also a call for the collaborative scheme that the Regulations want to promote (Article 44 IHR 2005).

On the other hand, the Regulations do not describe the way the information generated during the non-adversarial dispute settlement processes will be administered. Is the settlement information confidential? According to the Regulations there is no requirement to file documentation if the dispute is settled. This might create more disputes than the ones intended to reduce. Let me explain my point with a hypothetical of a dispute between two States Parties that mediate their dispute and reached an amicable agreement with a confidentiality clause. Let's assume for this hypothetical that the Parties' interpretation of the IHR is erroneous and as a result their agreement goes against the applicability of the requirements of the Regulations. Therefore, the lack of a review mechanism for agreements reached by non-adversarial ADR processes is a flaw that might create more disputes than the ones intended to reduce. One alternative to prevent this possible flaw is to create a repository of agreements with a filing requirement with

the Director General. Another option is to have a WHO certified third neutral party review the settlement agreement.

If the State Parties in dispute fail to settle the dispute via the non-adversarial ADR processes they need to inform the Director General, “who should make any effort to settle” the dispute (Article 56.2 IHR 2005). It is unclear whether the Director General will continue to advocate the non-adversarial processes or will require the Parties to proceed to arbitration as stipulated under Article 56.3. Moreover, the IHR arbitration clause stipulates that State Parties may opt to accept compulsory arbitration as the dispute settlement mechanism for specific disputes or to all the disputes concerning the interpretation or application of the IHR. States Parties that accept arbitration as compulsory must accept the arbitral award as binding and final. States parties should be aware that arbitration is a process that requires allocation of resources and might take months before a resolution is achieved. On the other hand, non-adversarial ADR processes are most of the time simpler and quicker. State Parties should take advantage of the non-adversarial ADR processes to settle the disputes concerning the interpretation or application of these Regulations.

Compulsory arbitration bypasses the non-adversarial processes and it should be used in a case-by-case basis. The Regulations work under the assumption that, Parties that failed to settle their disputes will agree to utilize arbitration as the dispute settlement mechanism. However, the Regulations are silent as to what happens when one of the Parties in dispute declines to participate in the voluntary arbitration. International trade agreements are known for their compulsory arbitration clauses and enforceable mechanisms. The IHR non-adversarial processes are a great first step to settle disputes; however, the lack of compulsory enforcement mechanism makes the compliance an option rather than a requirement. As globalizations integrate international trade law with public health, the best practices of disputes settlements should be promulgated.

Core Capacity Assessment by 2009

Each State Party must conduct, before June 15, 2009, the assessment of their existing national structures and resources to meet the minimum capacity requirements with regards to: 1) surveillance; 2) reporting; 3) notification; 4) verification; 5) response; and 6) collaboration (Annex 1 IHR 2005). The WHA in May 2006 urged States Parties to initiate a process of identifying and addressing administrative and legal constraints that might affect

the timely implementation of the Regulations. States Parties are required under paragraph 1 of Article 5 to comply with the minimum capacity requirements by June 15, 2012.

Baker and Fidler analysis of the IHR (2005) under the U.S. Centers for Disease Control and Prevention (CDC) evaluation guidelines for an effective public health surveillance system is a great resource for the assessment requirement (2006:1059). Under the CDC guidelines an effective public health surveillance system will have 10 key attributes: usefulness, sensitivity, timeliness, stability, simplicity, flexibility, acceptability, data quality, positive predictive value, and representativeness.

Implementation Plans and Extensions to the 2012 Core Capacity Obligations

Each State Party must also develop plans of action before June 15, 2009. The plans of action, also referred as implementation plans, are a key instrument for the application of the Regulations and State Parties must be aware of that fact. If a State Party, after conducting the initial assessment, determines that is incapable of complying with the minimum requirements by June 2012, the Party can request an extension of two years to fulfill the obligation (Article 5.2 IHR 2005). The request for extension must be supported with the implementation plan. Moreover, under “exceptional circumstances, and supported by a new implementation plan”, the Director General with the advice of IHR Review Committee can grant a second extension until June 2016. The implementation plans will guide States Parties in the development, strengthening and maintenance of the minimum capacity requirements of the Regulations and are the mandatory supporting evidence for the extensions. As a result, is in the best interest of the States Parties to commence their assessment of their national structures and resources, and establish elaborated implementation plans as soon as possible. In Table 1, I share an example of a matrix that States Parties can use as model for their implementation plans.

Table 1. Sample Implementation Matrix of Core Capacity Requirements for Surveillance and Response as Described in Annex 1 of the IHR (2005).

ASSESSMENT OF NATIONAL STRUCTURES & RESOURCES FOR:	2006	JUNE 2007	JUNE 2009	2010 - 2011	JUNE 2012
Surveillance	Voluntary Compliance	IHR (2005) Entry into Force	Assessment due with Plans of Action (AP) (2009-2012)	Plans of Action Implementation	Full Compliance
Reporting	Voluntary Compliance	IHR (2005) Entry into Force	Assessment due with Plans of Action (AP) (2009-2012)	Plans of Action Implementation	Full Compliance
Notification	Voluntary Compliance	IHR (2005) Entry into Force	Assessment due with Plans of Action (AP) (2009-2012)	Plans of Action Implementation	Full Compliance
Verification	Voluntary Compliance	IHR (2005) Entry into Force	Assessment due with Plans of Action (AP) (2009-2012)	Plans of Action Implementation	Full Compliance
Response	Voluntary Compliance	IHR (2005) Entry into Force	Assessment due with Plans of Action (AP) (2009-2012)	Plans of Action Implementation	Full Compliance
Collaboration	Voluntary Compliance	IHR (2005) Entry into Force	Assessment due with Plans of Action (AP) (2009-2012)	Plans of Action Implementation	Full Compliance

National IHR Focal Point

Each State Party is responsible for identifying or establishing the National IHR Focal Point, a national center that must be accessible at all times for communications with the WHO IHR Contact Points (Article 1.1 IHR 2005). The WHA urged States to establish immediately the National IHR Focal Point with the delegated authority to communicate official information. State Parties must understand the relevance of the National IHR Focal Point in the information-sharing system of the IHR and identify a center capable to work in a 24 hours schedule the seven days of the week. States Parties are encouraged to ask for guidance from the WHO for the establishment of their National IHR Focal Point. The ideal center serving as the National IHR Focal Point should have an interdisciplinary team of experts that will channel all the IHR communications with the WHO. The communications between the National IHR Focal Point and the WHO should be enhanced with technology. For instance, each National IHR Focal Point should have access to telephone lines, fax machine, computers, scanners, access to Internet and other technologies that facilitate the transfer of surveillance information with the WHO Contact Points.

Without a center serving as the National IHR Focal Point the State Party will face many challenges in the implementation of the Regulations and weaken the global health surveillance system that prevents and reduces the international spread of disease and minimizes the interference with international traffic. Therefore, it is in the best interest of the global village for each State Party to obtain endorsement from the highest political officers within their respective jurisdictions for the establishment of the National IHR Focal Point and the implementation of the Regulations. States Parties should provide their governmental cabinets a clear definition of the roles and responsibilities of the National IHR Focal Point within the State's organizational and communication structures. Establishment of a reliable National IHR Focal Point is an imperative under the Regulations in which the long terms benefits outweighs the short terms burdens that State Parties will face.

Public Health Emergency of International Concern

The IHR global public health surveillance system is based on time-sensitive communication procedures that the States Parties and the WHO must follow to determine whether an event constitutes a public health emergency of international concern. A public health emergency of international concern is an extraordinary manifestation of a disease, which is determined to constitute a public health risk to other States through the international spread of disease and might require a coordinated international response (Article 1.1 IHR 2005). The new IHR departs from the disease-specific reporting and covers any disease event that might interfere with international traffic and trade. The lessons learned from the SARS outbreak showed us the importance of having a system that allows the international community for rapid preventive responses rather than restorative actions. The IHR promotes the sharing of accurate and sufficiently detailed public health information in assisting the verification, assessment and assistance processes.

Global Public Health Decision-Making Instrument

Annex 2 of the Regulations provides States Parties with one page decision-making instrument that guides the State's responsible authorities in the determination of whether a disease event may constitute a public health emergency of international concern. Familiarity with the global decision-making instrument in Annex 2 can't be taken for granted. States should make every

effort to provide technical assistance at the community, local and national level to ensure that the decision instrument is used for the determination of a public health emergency of international concern. This innovative public health decision-making instrument is the base of the global surveillance system and all States shall promote its application for the detection of health events that may constitute a public health emergency of international concern and interfere with international traffic and trade.

Notification & Verification

Once the State's responsible authorities determine the event may constitute a public health emergency of international concern, the National IHR Focal Point must provide notice to the WHO within 24 hours. The Regulations are flexible as to the way notice should be provided to the WHO as long as is done via the most efficient means of communication available (Article 6.1 IHR 2005). Another source of surveillance information is reports from sources other than State's notifications or consultations. A major advancement in international public health surveillance is Article 9 of the Regulations that will permit the WHO to accept reports from other sources than States and interpret them according to epidemiological principles. The official use of third party non-governmental surveillance reports are a great tool for the WHO to commence the verification communications with the State Party in whose territory the event is allegedly occurring. Non-governmental international organizations, intergovernmental organizations and other State Members can be sources of the reports. Once the State Party is notified of the alleged event it must provide within 24 hours the available public health information on the status of events been verified (Article 10.3). In the event the State Party refuses to collaborate the WHO may share the alleged information with other States Parties.

Temporary and Standing Recommendations

Under the IHR the WHO has the authority to circulate temporary recommendations with respect to a public health emergency of international concern or standing recommendations with specific health measures (Articles 15 and 16). The Regulations provide detail criteria for the issuance of recommendations and a list of the possible public health measures needed to avoid the interference with international traffic and trade (Articles 17 and 18). Although the recommendations are not legally binding is in

the best interest of governments to familiarize themselves with the list of health measures the WHO may issue and make the necessary legislative arrangements to establish processes that will allow them to enforce the WHO standing recommendations.

Public Health Measures: Balancing Act between State's Sovereign Right to Apply Protective Measures and Minimization of Interference with Human Rights and International Traffic

As stated above, the Regulations are to be applied with full respect for the dignity, human rights and fundamental freedoms of persons at all times. This article will not discuss the health measure procedures under the Regulations, but States are reminded that in order to implement the measures they must have evidence of a public health risk and the measures shall be the least intrusive and invasive ones with the express consent of the traveler. Article 45 governs the confidentiality of personal health information collected under the Regulations. States are called to keep the information confidential and to proceed anonymously as required by their respective national laws. This is a critical balancing act between States' sovereign right to apply protective measures and interference with human rights. Many States do not have laws that govern the confidentiality of health information for their own territories and now are facing a legal requirement for the collection, interpretation and dissemination of personal information of health information in a confidential and anonymously fashion. Experts in the field called for the enactment of public health information privacy laws that protect the information from been used for non-public health surveillance purposes (Gostin 2006:1700). Once again the IHR present challenges to the States parties that call for a coordinated collaborative implementation effort.

III. Global Health Governance under the IHR (2005)

Globalization, Driving Force for the Integration Between Trade and Public Health

Globalization drives the world's economic, technological, political and cultural integration. Global trade in goods is currently enhanced by the WTO, which encourages the reduction of trade barriers and the disappearance of borders. Open markets as results of trade agreements between countries, expanded the range and efficiency of the travel industry. The integration driven

by globalization has no sings of stopping as more trade agreements continue to open ports for the trade purposes. As discussed above the WTO's agreements have integrated public health into the globalization movement. Globalization has brought the world closer together but it has also created new challenges for the twenty-first century. The WTO Director General listed the growing shortage of energy resources, the destruction of the biosphere, spread of pandemics, the volatility of financial markets, and the migratory movements provoked by insecurity, poverty or systemic political instability as product of impeding consequences of globalization. Therefore, with the progress associated with globalization the twenty-first century society must be prepared for the risks associated with the amalgamate trend. The IHR provides the world with a unique opportunity for the establishment of a safer and secure global network that will protect international traffic and trade and reduce the health related risks associated with globalization.

IHR (2005) Platform for Global Governance of Healthier and Secure Channels of Trade

With the reduction in trade barriers, people and goods are free to move among States, augmenting the chances for the occurrence of a public health emergency of international concern. The SARS outbreak is the perfect example of globalization's contribution to the spread of diseases. In less than 4 months twenty-four countries had reported thousands of SARS cases. The possible emergence of a pandemic arising from the current outbreaks of avian influenza makes of the IHR an imperative global agenda for the preservation of healthier and secure channels of trade. The WHO with the IHR provides States with an instrument that protects them from public health risks and prevents the unnecessary interference with international traffic and trade.

Global governance occurs when States, international bodies, intergovernmental organizations, public and private non-government organizations, in sum all relevant international actors, work together for a common goal. The IHR is the platform of global health governance for the preservation of healthier and secure channels of trade in the 21st century. Unlike the previous IHR the new IHR provides an all-inclusive approach that calls for the integration of sectors that benefit from safer international traffic and trade. The IHR integrates public health in multiple areas of global policy such as trade, security, and human rights.

The IHR clarifies the role of public health in its global integration with economical, social, and political interests. The IHR global governance platform invites non-government entities to participate in the development, implementation and enhancement of the new public health surveillance system. The participation of non-government actors is one of the landmarks for the IHR global health governance platform. For example, as explained above, the IHR grants the WHO the official authority to use non-governmental epidemiological information in the assessment of a public health emergency of international concern, shifting the reporting system from a bilateral to the multilateral framework where all relevant actors work together for the preservation of healthier and secure channels of international traffic and trade.

Article 14 and 44 of the IHR (2005) are the Pillars of the Platform for Global Health Governance

Article 14 of the IHR calls for the WHO to work closely with intergovernmental organizations and international bodies in the...

“...implementation of these Regulations, including through the conclusion of agreements and other similar arrangements”.

The WHA decided that for the purposes of Article 14, the WHO is expected to co-operate with at least eleven intergovernmental organizations and international bodies:

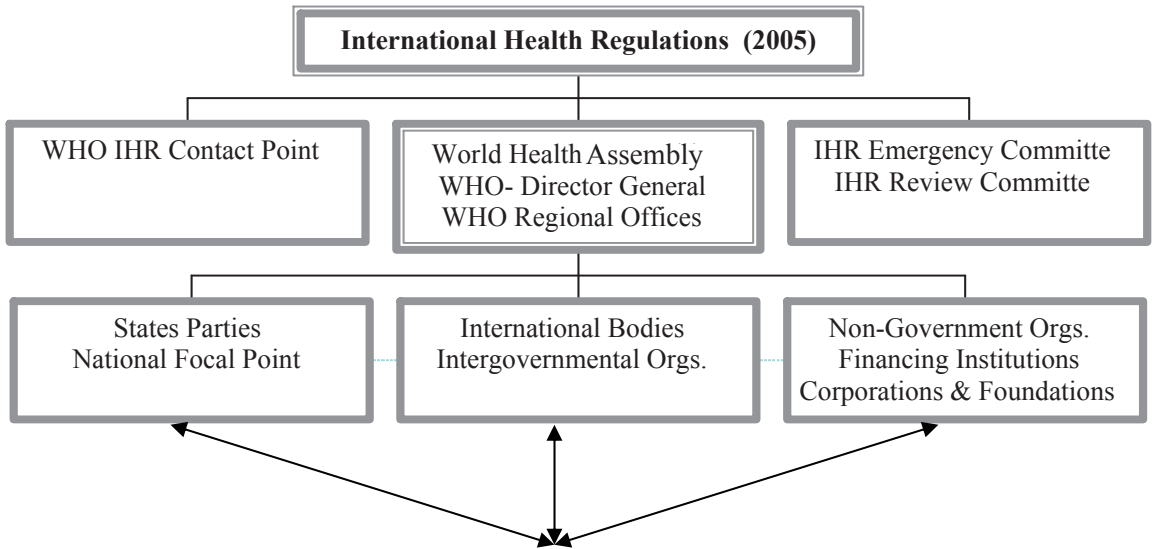
1. United Nations
2. International Labor Organization
3. Food and Agriculture Organization
4. International Atomic Energy Agency
5. International Civil Aviation Organization
6. International Maritime Organization
7. International Committee of the Red Cross
8. International Federation of Red Cross and Red Crescent Societies
9. International Air Transport Association
10. International Shipping Federation
11. Office International des Epizooties.

The co-operative scheme under the IHR Article 14 calls for the inclusion of global governance bodies and for the recognition of the IHR as the platform for global health governance. The WHO faces unprecedented challenges with the IHR, which calls for the establishment of closer working relations with non-

traditional partners. The same all-inclusive scope for disease surveillance should apply to the establishment of partnerships for the implementation of the Regulations.

Article 44 of the IHR is cardinal in the execution of the global health governance platform. Article 44 is simply titled “Collaboration and assistance” and calls for States to work together in mobilizing financial resources to facilitate implementation of their obligations under the Regulations. Collaboration for the mobilization of resources is necessary for the success of the IHR as many States with economies in transition don’t have the financial resources for making the infrastructure changes in route to the fulfillment of the core capacities required for surveillance, reporting, notification, verification, and response under the IHR (Gostin, 2006: 1700). Therefore, financial mechanisms are necessary for the implementation of the platform for global health governance. States parties are encouraged to create multiple channels of collaboration leading to a united front that will assist them in negotiating lower prices for the goods or services necessary for the implementations of the Regulations. In Figure 1, I share the conceptualization of Article 44 as the collaborative platform leading to the global health governance of the twenty-first century.

GLOBAL HEALTH GOVERNANCE



IHR (2005) - ARTICLE 44: MULTIPLE CHANNELS OF COLLABORATION

Figure 1. IHR's collaborative platform leading to global health governance.

Under Article 44, States Parties should establish multiple channels of collaboration with multilateral development banks, corporations and philanthropic entities for the implementation of the new IHR. First, Multilateral Development Banks institutions provide financial support and professional advice for economic and social activities to States with economies in transition. The Multilateral Development Banks typically refers to the World Bank Group and the four regional development banks: African Development Bank, Asian Development Bank, European Bank for Reconstruction and Development and the Inter-American Development Bank Group. Second, States parties should open the channels of collaboration with private corporations. The growing number of corporations searching for tangible initiatives to fulfill their corporate responsibility makes the partnering with private corporations a win-win enterprise as all parties will benefit from the fruits of a successful IHR. Finally, States should reach out to philanthropic organizations working closely in the global health agenda. For example, the Bill and Melinda Gates Foundation works extensively in the global health projects. In summary, States with economies in transition will benefit from the multiple channels of collaboration for the mobilization of financial

resources that will reduce the financial burden they will face in the implementation of their obligations under the new Regulations.

The IHR channels of collaborations also call for technical, logistical, operational and legal support among States for the development, strengthening and maintenance of the public health capacities required under the Regulations. States parties are to assist among themselves in the development of the public health capacities and legal and administrative provisions. The multi-levels (local, national, international) channels of collaborations make the IHR the platform for the global health governance. The global platform is the stage for the creation of interdisciplinary collaborative mechanisms that will facilitate the flow of information between the multiple relevant actors of the new IHR system.

Conclusion

Globalization has brought the world closer together but it has also created new challenges for the twenty-first century. Globalization reduces trade barriers and augments the risk of a public health emergency of international concern. The broader scope of the new IHR introduces a new surveillance system for the protection of international traffic and trade. The new Regulations are a unique global platform for global health governance where States, intergovernmental organizations and non-governmental actors are given an active role in public health security. The IHR establishes collaborative mechanisms that will facilitate the flow of information, technical and operational, between the multiple relevant actors of the global public health surveillance system. The Regulations are the latest integration of international law and public health and prepare us to face the twenty-first century challenges posed by globalization. Implementation of the IHR obligations is a public health imperative in which the long terms benefits outweighs the short terms burdens. The world as the global village will be safer and healthier with the IHR. The blue prints for the new global health governance platform are in place for all relevant actors to take action.

Acknowledgements

The author wishes to thank Professor Lawrence Gostin and Professor David Fidler for providing literature on the IHR (2005). He also wishes to thank Dr. Joxel García and Yanka Epstein at the

Pan American Health Organization for the valuable support they provided.

NOTE

1. WHA has the authority to adopt legally binding regulations concerning five public health areas including “sanitary and quarantine requirements and other procedures designed to prevent the international spread of disease” (Article 21 WHO Constitution).

REFERENCES

- Aginam, Obiofor. 2004. “Globalization of Infectious Disease, International Law and the World Health Organization: Opportunities for Synergy in Global Governance of Epidemics”. *New Eng. J. Int’l Law & Comp. Law* 11, no. 1: 59–73.
- Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS). Accessed on August 3, 2006 at http://www.wto.org/english/thewto_e/minist_e/min01_e/mindecl_trips_e.htm.
- Baker, Michel G. and Fidler, David P. 2006. “Global Public Health Surveillance under the New International Health Regulations”. *Emerging Infectious Diseases* 12, no. 7: 1058.
- Centers for Disease Control and Prevention. Updated guidelines for evaluating public health surveillance systems: recommendations from the guidelines working group. *MMWR Morb Mortal Wkly Rep.* 2001; 50:1–36. Accessed on August 10, 2006 at <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5030a5.htm>
- Fidler, David P. 1996. “Globalization, International Law, and Emerging Infectious Diseases”. *Emerging Infectious Diseases* 2, no. 2: 77- 84. Accessed on August 4, 2006 at <ftp://ftp.cdc.gov/pub/EID/vol2no2/adobe/vol2no2.pdf>.
- Fidler, David P. 2005. “From International Sanitary Conventions to Global Health Security: the New International Health Regulations”. *Chinese Journal of International Law* 4, no. 2: 325-392.
- Fidler, David P. and Lawrence O. Gostin. 2006. “The New International Health Regulations: an Historic Development for International Law and Public Health”. *Journal of Law, Medicine and Ethics.* Spring 2006: 85-94.
- Gostin, Lawrence O. 2004. “International Infectious Disease Law, Revision of the World Health Organization’s International health Regulations”. *Journal of American Medical Association* 291, no. 21: 2464.
- Gostin, Lawrence O. 2006. “Public Health Strategies for Pandemic Influenza”. *Journal of the American Medical Association* 295, no. 14: 1700.
- IHR (2005) Article 14 and 44
- International Sanitary Regulations. 1951
- Vienna Convention on the Law of Treaties. 1969. Accessed on July 31, 2006 at <http://www.worldtradelaw.net/misc/Viennaconvention.pdf>.
- World Health Organization. 1995. Forty-eight World Health Assembly. Resolution 48.7. Revision and updating of the International Health Regulations.

- World Health Organization. 2003. WHO Framework Convention on Tobacco Control. Accessed on July 31, 2006 at http://www.who.int/tabacco/fctc/text/en/fctc_en.pdf.
- World Health Organization. 2005. Third Report of Committee A. Fifty-eight World Health Assembly. Agenda item 13.1. International Health Regulations.
- World Health Organization. 2005. Fifty-six World Health Assembly. Provisional Agenda Item 14.6. Revision of the International Health Regulations: Severe Acute Respiratory Syndrome (SARS).
- World Health Organization. 2006. Fifty-ninth World Health Assembly. Agenda item 11.1—Application of the International Health Regulations (2005).
- World Health Organization. 2006. About WHO. Accessed on July 28, 2006 at <http://www.who.int/abn/>.
- WHO Constitution Article 1
- WHO Constitution Article 4
- WHO Constitution Article 23
- WHO Constitution Article 19
- WHO Constitution Article 21
- WHO Constitution Article 22
- World Trade Organization. 2001. Declaration on the TRIPS agreement and public health. Accessed on August 10, 2006 at http://www.wto.org/english/thewto_e/minist_e/min01_e/mindecl_trips_e.htm.
- World Trade Organization. Director General Remarks at the Master of Public Affairs Inaugural Lecture at the Institut d'Etudes Politiques de Paris. October 2005. Accessed on August 3, 2006 at http://www.wto.org/english/news_e/sppl_e/sppl12_e.htm.

ABOUT THE AUTHOR

Guillermo J. Avilés Mendoza has a degree in Genetics and Cell Biology from the College of Biological Sciences at the University of Minnesota. He worked at the National Human Genome Research Institute where he published his findings on pre-clinical stem cells gene therapy. He completed a law degree with emphasis in international alternative dispute resolution at Hamline University School of Law. He is the recipient of the gold medal as the most effective arbitrator at the International Competition for Online Dispute Resolution. He served as coordinator of the international environmental public health partnership between the Pan American Health Organization, the U.S. Environmental Protection Agency and the U.S. Centers for Disease Control and Prevention. He serves as Ombudsman for the National Institutes of Health. He is a board member of a non-profit organization focusing on international negotiations.