

Response to Call for Evidence from Ad Hoc Committee on Intergovernmental Organisations concerning “Acting through Intergovernmental Organisations to Control the Spread of Communicable Diseases”

from:

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This document contains responses to the Committee’s Call for Evidence on “Acting through Intergovernmental Organisations to Control the Spread of Communicable Diseases.” The Committee should be aware that I am an international lawyer and not a scientist, epidemiologist, or public health practitioner. My responses reflect my area of expertise as an international lawyer with experience working on global health issues, especially communicable disease threats, and working with intergovernmental organizations, particularly the World Health Organization. I have coded my responses to the questions set by the Committee (e.g., responses 1.1 and 1.2 address Question #1), but, for space reasons, I have not included the questions. I have limited my responses to the questions relevant to my expertise and to the 6-page (A4) limit set by the Committee, but I would be willing to provide further responses in writing or travel to London to answer questions from the Committee.

David P. Fidler
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Response to Call for Evidence from Ad Hoc Committee on Intergovernmental Organisations concerning “Acting through Intergovernmental Organisations to Control the Spread of Communicable Diseases”

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1.1 The UK Department of Health was correct to identify the unfounded nature of the post-war sense that industrialized societies had conquered communicable diseases. The reasons for this complacency are complex, but all countries, including developing countries, are now paying a heavy price for it. Despite the progress made since the mid-1990s in global health, the international system has not yet achieved change that is sustainable. To paraphrase Churchill, we have only reached the end of the beginning of mounting adequate national and international responses to the threat posed by communicable diseases.

1.2 Opining on whether the “global situation” is deteriorating is difficult because we have multiple “global situations” that reflect different levels of progress, inertia, and deterioration. For example, HIV/AIDS is a different kind of threat from avian influenza, so any progress on HIV/AIDS does not necessarily translate into progress against containing avian influenza and preparing for its possible genetic shift into a killing microbial menace. The Committee needs to disaggregate the global situation, examine the various types of communicable disease threats, the capabilities of intergovernmental organizations (IGOs) across these threats, and then reassemble the pieces to get the composite picture. Talking in terms of a crisis is not an exaggeration, and the scale and intensity of efforts over the past decade underscore that a sense of crisis has, and continues, to exist.

2.1 As an international lawyer, I am not trained in epidemiology, so I cannot comment on the reliability of data generated by national governments and IGOs. I can share some thoughts on the political and legal aspects of data generation and use concerning communicable diseases. From a public health perspective, data collection and analysis (e.g., as done in surveillance) forms the basis for formulating and implementing interventions (e.g., vaccination, quarantine). Public health strives for evidence-based measures, so reliable data gathered as frequently and comprehensively as possible are critical. The acceleration of globalization has made the need to accomplish this task domestically and internationally ever more important. Achieving this objective politically and legally in an international system of nearly 200 sovereign States has proved, however, a very difficult task.

2.2 Globalization has helped revolutionize the environment affecting communicable disease emergence and spread by facilitating convergences of disease “vectors,” such as trade and travel, migration, antimicrobial resistance, and social determinants of health (e.g., poverty). Globalization has not, however, had an equivalent impact on the structure and dynamics of international politics and international law. We are chasing the whirlwind of 21st century globalization with an international system still tethered to 19th century patterns of State behavior and cooperation. Caught in the middle are IGOs, such as WHO, which appreciate the disease trends but remain accountable to sovereign States and their interests.

3.1 The intergovernmental surveillance with which I am most familiar is the WHO’s Global Outbreak Alert and Response Network (GOARN). GOARN’s capabilities have grown impressively since its establishment in the early 21st century, and the progress made connects to WHO’s strategy of making GOARN a “network of networks,” including information sources beyond governments. Despite GOARN’s development, this intergovernmental surveillance capability remains inadequate because (1) WHO member States do not fund it properly, and (2) underlying national and sub-national surveillance systems on which GOARN ultimately relies, especially in developing countries, still remain in poor condition.

3.2 Intergovernmental surveillance systems exist at regional levels as well, such as in the EU, ASEAN, APEC, and the Americas. Efforts to strengthen these regional systems themselves, and how they integrate into GOARN, should be pursued by individual governments, these regional organizations, and WHO.

4.1 Without more funding and sustained political commitment from governments and IGOs, the development of global surveillance and intervention capabilities could easily stagnate and regress in the next 10 years. I already detect a growing sense in non-health foreign policy circles that enough, for the moment, has been done for global cooperation on communicable diseases, and that other pressing issues (e.g., global warming) deserve priority attention. So much progress has been made that people unfamiliar with global health's precarious evolution sometimes assume that the challenge has been adequately met, not realizing that the progress made does not get the international community where it needs to be with respect to the communicable disease threat.

4.2 One pattern already conspicuous is the growing gap between developed and developing countries in terms of public health capabilities to address communicable diseases. The likely continuation of this pattern will not only create epidemiological holes in global capacities but also stimulate tensions between rich and poor countries. We have seen these tensions arise in the controversy over Indonesia's stance on withholding avian influenza samples.

5.1 HIV/AIDS. Although some trends are positive (e.g., increasing numbers of persons infected with HIV in developing countries receiving antiretrovirals), the scale of the pandemic still beggars the imagination. The decrease in the rate of new infections (if the data is reliable), still means the international community has a massive, long-term problem on its hands. Looking ahead, I see a number of potential problems: (1) funding levels that plateau and begin declining; (2) continued lack of a breakthrough on an HIV vaccine; (3) continued or accelerated "brain drain" of health care personnel from developing to developed countries; and (4) the emergence and rapid spread of resistant strains of HIV.

5.2 Tuberculosis. I am most worried by the prospects of the increased and accelerated spread of MDR-TB and XDR-TB (still linked to the HIV/AIDS crisis) without development of new TB antibiotics that are affordable and accessible in developing countries.

5.3 Malaria. Potential obstacles to better malaria control and prevention include (1) continued development and spread of resistant forms of malaria; (2) lack of development of affordable and accessible anti-malarial drugs; (3) lack of sustained commitment to current effective initiatives, such as the increases in distribution and use of bed nets in Africa; and (4) multiplying challenges from other vector-borne diseases, such as dengue fever, that may divert resources from anti-malarial campaigns.

5.4 Avian influenza. Future challenges include (1) resolving the standoff on sharing virus strains for surveillance and vaccine development purposes; (2) continued weaknesses in cooperation between animal and human health agencies nationally and internationally; (3) tapering off of political interest in pandemic influenza preparedness; and (4) signs of genetic drift or shift causing countries to revert to narrow approaches to their self-interests, which would undermine global cooperation.

5.5 Better intergovernmental cooperation. "Better," "smarter," or "improved" intergovernmental cooperation and action is often prescribed for the challenges these four and other communicable diseases present. Strengthened intergovernmental cooperation is not, however, a panacea for these challenges. I doubt whether better or smarter intergovernmental cooperation will remove the obstacles mentioned above. The scale of these problems overwhelms intergovernmental capabilities, the priorities of member States are too diverse,

and the rise of non-state actors (e.g., Gates Foundation) may exacerbate the on-going fragmentation of global health diplomacy.

7.1 I have been an advocate for giving global health higher priority in States' foreign policies because communicable and other disease problems require political commitment from more than the public health sector. Without heightened political priority, strategies against the four diseases will tend to drift back towards technical, ad hoc, and reactive responses that will not address underlying causes of the emergence and spread of communicable diseases.

7.2 Intergovernmental action in non-health areas is important, but, to the surprise of many in public health not familiar with the history of intergovernmental efforts on poverty reduction, population control, or climate change, the track record of efforts on non-health issues is not typically impressive. Framing non-health problems as health crises, as happens more frequently today, only goes so far in generating greater political interest in tackling the issues. In addition, to address some underlying problems in an effective and sustainable fashion would require regime change for public health in many countries, a task that understandably makes foreign policy makers interested in global health select less ambitious objectives.

7.3 More trans-intergovernmental cooperation on communicable diseases occurs today than in the past, and this "joined-up" thinking and action has produced benefits. The elasticity of joined-up thinking within national governments and between IGOs is not, however, as high as anticipated. Breaking national ministries and IGOs out of their traditional policy "silos" remains fraught with difficulties that limit what "joined-up" governance can achieve. This low elasticity contributes to the proliferation of more initiatives rather than consolidation of activities into more centralized policy synergies within and between governments.

9.1 The growing global TB problem has multiple facets--the connection to the worldwide HIV/AIDS epidemic, the breakdown of public health and health care systems in many countries, the declining effectiveness of anti-TB drugs, and the failure of strategies pushed by WHO (e.g., DOTS) to be sustainable in many countries. These facets, viewed collectively, should call into question the assertion that TB is, in fact, a treatable disease. This assertion assumes that conditions prevalent in industrialized countries (e.g., available drugs, functioning public health and health care systems, social conditions that make sustained therapy regimens work) exist or can easily be created in countries struggling against TB.

9.2 Again, intergovernmental action is important, but intergovernmental approaches against TB should be more intense at the regional level, and not just at WHO. Diffusion of anti-TB activities across regional organizations will become even more important as regional spread of MDR-TB and XDR-TB occurs.

10.1 The impact of restrictions on the use of DDT on malaria's spread started before 2004 because donor countries and governments in malarial regions decreased funding and use of DDT for anti-malarial control before adoption of the Stockholm Convention. In addition, care must be taken in assigning causal effect to the non-use of DDT in malaria's spread because other factors have played significant roles as well (e.g., misuse of anti-malarials, failure to make effective use of bed nets, lack of funding for anti-malarial programs, climatic changes encouraging spread of mosquitoes to new areas). I am not aware of a risk assessment that specifically compares the dangers to human health from DDT use versus exposure to malaria.

11.1 WHO, in collaboration with FAO and OIE, has worked to improve early detection of the transmission of avian influenza from birds to humans. WHO has also worked with WHO member States to improve surveillance on any potential human-to-human transmission cases. Although not perfect, the extent of the surveillance that does exist is, historically speaking, impressive, and these IGOs should continue to deepen and broaden their collaborative efforts on avian influenza surveillance.

11.2 This emerging early warning system for avian influenza is not sufficient to prevent an influenza pandemic. In fact, most public health experts would agree that the chances of identifying and containing a pandemic virus with the current system are very poor, which makes the developing global surveillance system a resource for alerting national capabilities for the potential spread of a dangerous flu virus. This dynamic is what irks many developing countries--they share data that only help developed countries use their superior resources to protect themselves. The controversy over Indonesia's refusal to share samples of avian influenza strains reflects these underlying North-South tensions. More efforts need to address the lack of response capabilities in developing countries.

12.1 Antimicrobial resistance has been a major factor in the re-emergence of TB and malaria, but such resistance has not yet been as significant with respect to HIV/AIDS and avian influenza. Enough resistant strains of HIV and H5N1 have emerged, however, to make the antimicrobial resistance nightmare a real possibility with HIV/AIDS and avian influenza.

12.2 The problem of antimicrobial resistance has risen in importance on intergovernmental agendas in the past decade, and WHO supports a global effort against the threats posed by antimicrobial resistance. Data suggest, unfortunately, that intergovernmental efforts made to date have not had material impact on reducing the threat of antimicrobial resistance in these four diseases, and, worryingly, other diseases as well.

13.1 Intergovernmental efforts to address antimicrobial resistance globally include the problem of hospital-acquired infections. As illustrated by the problems with such infections in Britain and the United States, most attention generated on this issue has come from developed countries. Serious antimicrobial resistance problems in developing countries concerning HIV, TB, malaria, and avian influenza are not significantly related to the spread of resistant microbes through hospital treatment. IGOs have to set priorities on what antimicrobial resistance problems they should address.

13.2 Although WHO might need to prioritize antimicrobial resistance not related to hospital treatment, regional IGOs (e.g., EU, APEC, ASEAN) can improve their cooperation and information flows about hospital-acquired resistant infections. One stumbling block to this suggestion is the reluctance of countries to share such data because countries are trying to attract "health tourists" by offering cheaper, faster health and medical services to a growing global market of health consumers.

14.1 I do a significant amount of work with WHO on the relationship between health and trade. In this work, many controversies in this relationship (e.g., trade in health services, application of sanitary and phytosanitary measures) have settled down and given way to more constructive efforts at producing coherency between trade and health policies. The one area that remains contentious and unproductive involves intellectual property rights. Developments in international trade law, particularly the proliferation of regional and bilateral trade agreements containing TRIPS-plus provisions, ensure that the controversies over the impact of patents on access to medicines will continue unabated.

14.2 Despite the on-going controversies involving intellectual property rights, care should be taken in addressing just how much patents cause problems for global communicable disease threats. For example, of the four diseases of most interest to the Committee, patent concerns have arisen in HIV/AIDS (with respect to antiretrovirals) and avian influenza (with respect to patents and potential vaccine development), but not seriously with TB or malaria. Patent controversies have not, however, prevented massive increases in the availability of antiretrovirals in the developing world, nor have patents, to date, materially undermined treatment strategies for those infected with avian influenza. Development of the next

generation of drugs for TB and malaria through public-private partnerships will probably not be hampered by the kinds of intellectual property controversies that arose with antiretrovirals.

14.3 Whether more intergovernmental action on the patent issues is necessary depends on whether such future action can break stalemated patterns in IGOs already established over many years, in particular within WHO and WTO. More of the same is, well, more of the same. As indicated above, the proliferation of TRIPS-plus provisions in regional and bilateral trade agreements has reduced the policy traction WHO and WTO previously had in this area.

15.1 IGOs, especially the WHO, and national public health agencies, such as the U.S. CDC, engage in programs designed to improve the ability of transition and developing countries to identify disease events, diagnose specific diseases, and undertake effective interventions. I understand that more of these kinds of programs are envisioned as part of the implementation of the International Health Regulations 2005, thus ensuring robust intergovernmental activity in this area for the foreseeable future.

15.2 The biggest problem is the mismatch between the scale of the need for such improvements and the paucity of resources made available to undertake these capacity-building programs. WHO does not have sufficient resources to engage in these activities on a sustainable basis, and many developed countries have to expend serious resources to improve their own surveillance and response systems after decades of neglect. For example, the United States has spent much more on strengthening its own surveillance and response systems than it has allocated to international assistance for strengthening communicable disease surveillance and response. Seeking more intergovernmental activity does not usually equate to more resources for such activity, and IGOs, especially WHO, typically are tasked to do more without increased access to resources.

15.3 Some big influxes of money into global health have come from non-governmental sources, such as private foundations, and the activities funded by these non-state actors have not typically focused on building sustainable public health infrastructure. In fact, many experts are concerned that the non-governmental programs are cannibalizing public health systems in developing countries (e.g., through employing highly skilled medical and health personnel) and producing even weaker public health infrastructures in the very countries where stronger infrastructures are needed.

16.1 As my publications on the International Health Regulations 2005 (IHR 2005) indicate, I believe that the IHR 2005 are the most radical development in the history of the use of international law on global health problems. I refer the Committee to those writings for the details of why the IHR 2005 represent such a dramatic contribution to global health governance, and I can provide a list of these publications if needed. The global framework established by the IHR 2005 is impressive, but its effectiveness has yet to be tested or proven.

16.2 In fact, the first major communicable disease event implicating the IHR 2005--the Indonesian virus sharing controversy--revealed confusion about the IHR 2005's content and its relevance to this global health crisis. Attempts by WHO and others to argue that the IHR 2005 required Indonesia to share virus samples without conditions backfired because the IHR 2005 do not mandate such sharing, as properly interpreted under principles of treaty interpretation in international law.

16.3 In terms of future implementation of the IHR 2005, the radical new framework will not function effectively without significant improvements in national and sub-national surveillance and response capabilities. The IHR 2005 can easily end up as a piece of paper without more serious national and international efforts to build public health capacity to the point most countries can fulfill their obligations under the IHR 2005. Unfortunately, the IHR 2005 neither contains a strategy for achieving this capacity nor any mechanisms to fund

capacity building. WHO does not have access to the kind of resources needed, and non-governmental funding entities have tended to show little interest in the kind of capacity building implementation of the IHR 2005 require.

17.1 For my thoughts on the challenges related to biosecurity, including analysis on how States, IGOs, and non-state actors can improve global biosecurity, see David P. Fidler and Lawrence O. Gostin, *Biosecurity in the Global Age: Biological Weapons, Public Health, and the Rule of Law* (Stanford University Press, 2008).

17.2 In brief, existing intergovernmental and treaty approaches to biological weapons are in serious trouble and are rapidly trying to adjust to the new threats biological weapons and biological terrorism pose. The main treaty on biological weapons, the Biological Weapons Convention (BWC), has been overtaken by events, and its relevance for future strategies against biological weapons and biological terrorism is in serious doubt. Part of the doubt stems from the BWC's lack of provisions that address the national and international needs to integrate arms control, law enforcement, and public health capabilities into a coordinated biosecurity strategy. Constructing this new kind of biosecurity strategy will require, as we elaborate in *Biosecurity in the Global Age*, the construction of a "global biosecurity concert" that is not entirely dependent on the BWC or any one IGO.

18.1 The IHR 2005 are designed to prepare WHO member States to be able to identify and address threats from new or previously unrecognized communicable diseases, which is another reason why the IHR 2005 are so important to global health governance today. Attempting to deal with existing disease problems, such as the four diseases of most immediate interest to the Committee, and simultaneously remain prepared for unknown but anticipated threats constitutes a tall order for governments and IGOs, which causes strain in national and international public health systems that remain under-funded and under-staffed.

20.1 The Committee needs to examine more than IGOs because of the way in which global health governance is evolving. To provide perhaps the most dramatic example, many people now believe that the Gates Foundation is becoming the *de facto* center of gravity for global health policy and funding, eclipsing the traditional lead role of the WHO and even the historically influential U.S. CDC. This example constitutes just one feature of a rapidly changing context for addressing global health problems, a context that is increasingly posing more and more difficult challenges for IGOs.

20.2 Traditionally, States created IGOs to help manage their relations in a condition of anarchy, a condition in which States recognized no superior, common authority that regulated their sovereignty. States and cooperative mechanisms they created, such as IGOs, dominated this condition of anarchy. Global health now faces a new kind of anarchy, what I have called "open-source anarchy," in which State, intergovernmental, and non-governmental actors access and influence global politics on health in ways never before seen. The governance task now extends beyond getting IGOs to function more effectively because non-state actors play significant, and increasingly influential roles, in global health, and especially with communicable disease issues.