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The IHR revisions: socialization, compliance and changing norms of global health security

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Abstract

This paper takes a constructivist approach to examining one of the new norms embodied in the recently revised International Health Regulations. More precisely, the paper focuses on the provisions that seek to restrain states from applying disproportionate international travel and trade restrictions in response to a disease outbreak occurring in another country. This new norm, which aims to limit unjustified 'additional health measures', has significant implications for state sovereignty. Using the example of the 2009 H1N1 'swine flu' pandemic, the paper examines whether state behaviour and the discourse surrounding that outbreak supports a constructivist contention that a new norm has been created and that most states can be expected to comply with that norm most of the time. We conclude by discussing what the discourse over H1N1 suggests about the extent to which the new norm concerning additional health measures has been internalized by states.

Key words: global health security; International Health Regulations; norm compliance; norm life cycle; pandemic influenza

Introduction

By its very nature, international law frequently conflicts with, and impinges upon, state sovereignty. Indeed it is intentionally designed to do so, its purpose being to regulate the behaviour of states in the international system by codifying certain rules, principles and expectations, and enshrining them in treaties, guidelines and legal agreements. Over time the scope of international law has expanded dramatically. For many years the sole referent of international law was the state; however since the Second World War, the proliferation of non-state actors has also witnessed international law being increasingly expanded to cover their activities as well. Previously domestic policy areas have also come to be subject of international law, with the consequence that, as Neff has noted, "There scarcely seemed any walk of life that was not being energetically 'internationalized' after 1945 – from monetary policy to civil aviation, from human rights to environmental protection, from atomic energy to economic development, from deep-sea bed mining to the exploration of outer space, from democracy and governance to transnational crime-fighting".[1] As globalising processes have progressively encouraged greater interconnectedness, the demand for codified international rules appears to be growing rather than diminishing.

Applying international law to health is not, however, a new development. Perhaps surprisingly, some of the earliest attempts to establish frameworks to guide interstate cooperation were prompted by concerns over communicable disease outbreaks hampering international trade. In the 14th century, the city-state of Venice was the first to institute a system of quarantine designed to prevent the importation of disease. Although controversial at the time, other city-states soon followed the Venetian example, instituting their own systems that applied a range of different measures and standards. In 1851, in response to the worldwide spread of cholera and the severe impact it was having on the populations and international trade of European powers, the first International Sanitary Convention was held in an attempt to establish some consistent rules around quarantine practices. The meeting, which was attended by mostly European governments, failed to achieve its objective. Despite another 14 meetings and conventions being held over the next 100 years, it was not until the creation of the World Health Organization (WHO) in 1948, and the passage of the International Sanitary Regulations in 1951, that a universal agreement was eventually reached.

[1] Stephen C. Neff. 'A Short History of International Law', in *International Law*, ed. Malcolm E. Evans (Oxford: Oxford University Press, 2003), chapter 1: 31-58, 54.

When endorsed in 1951 the International Sanitary Regulations, which were renamed the 'International Health Regulations' (IHR) in 1969, applied to six 'quarantinable' diseases.[2] Under the terms of the agreement, WHO member states were expected to report outbreaks of these six diseases and, where necessary, take certain actions to prevent their importation from other affected territories. Over time, the number of diseases subject to the IHR was progressively reduced so that, by 1981, the IHR applied to only three – cholera, plague and yellow fever. Even so, from their entry into force the IHR suffered from a lack of compliance primarily because governments, concerned over their reputation and/or the trade restrictions that other countries would impose, often declined to report outbreaks. At the same time, states often responded to outbreaks in other countries by implementing disproportionately severe travel and trade restrictions, further undermining the likelihood of states seeing it as in their interests to report outbreaks. In 1995, the decision was taken to revise and update the IHR, principally to broaden the scope of diseases subject to the Regulations and address the pervading lack of compliance. The 58th World Health Assembly (WHA) subsequently endorsed a new version of the Regulations in May 2005, and the new legislative framework officially entered into force on 15 July 2007.

This paper examines one particular aspect of the revised IHR (2005): the 'additional health measures' that states are permitted to implement in the event of a Public Health Emergency of International Concern (PHEIC). These provisions seek to redress one of the key shortcomings of the former 1951 and 1969 agreements, and go to the heart of the IHR's overall aim of offering protection against the international spread of disease "in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade".[3] These provisions are also one of the more significant changes to the normative framework supporting global health security objectives introduced in recent years. This paper, which proceeds in three parts, assesses the extent to which this new international norm has been internalized by the WHO's member states. It first provides a brief outline of the changes relating to trade and travel-related additional health measures under the new IHR and identifies the content of the new norm. In the second section the paper sketches out a social constructivist understanding of international norms and

[2] World Health Organization. *International Sanitary Regulations. World Health Organization Regulations No. 2. Technical Report Series No. 41*. Geneva: World Health Organization, 1951; and World Health Organization. *International Health Regulations (1969). Third Annotated Edition*. Geneva: World Health Organization, 1983.

[3] Article 2 - World Health Organization. *International Health Regulations (2005). Second Edition*. Geneva: World Health Organization, 2008, 10.

how they affect state behaviour, in particular looking at the 'internalization' process through which norm-compliant behaviour becomes routinized within states' domestic practices, albeit with the possibility of non-compliance remaining. Social constructivists argue that most states abide by international norms most of the time, and tell us that certain things can be expected on those occasions when states do not comply, particularly that the noncompliant party will usually attempt to justify its actions and that other states can be expected to criticise its behaviour. Accordingly, these elements can give us important insights regarding the extent to which states have been socialized into a new norm. In the third section the paper examines the discourse around the actions of certain countries during the 2009 H1N1 pandemic and the extent to which justifications for, and criticisms of, their behaviour are suggestive of a widely shared international norm. We conclude by discussing what the discourse over H1N1 suggests about the extent to which the new norm concerning additional health measures has been internalized by states.

The IHR 2005 and "additional health measures"

The history of the revision of the IHR – a process which began in 1995 and was concluded in 2005 – has been discussed in considerable detail elsewhere.[4] It is not our intention, therefore, to revisit that history here. Instead, we focus on the development of one particular norm that has been enshrined within the revised Regulations, namely the expectation that, when confronted with a public health risk or PHEIC, states will adhere to the advice of the WHO and will not, in seeking to prevent the importation of disease into their territory, take any action that may cause unnecessary or unjustified harm to international travel and trade.

Said another way, under the terms of the revised IHR member states have agreed to place limits on their sovereignty, restricting the range of actions they may take in responding to public health risks and PHEICs. Although they remain free to take any action designed to protect human health, as outlined in various articles throughout the revised framework – notably Articles 15 through 19, and Article 43 – governments have agreed to abide by the WHO's recommendations in responding to disease outbreaks, and importantly, to not exceed

[4] David P. Fidler. 'From International Sanitary Conventions to Global Health Security: The New International Health Regulations'. *Chinese Journal of International Law* 4, no. 2 (2005): 325-392; and Adam Kamradt-Scott. 'The WHO Secretariat, Norm Entrepreneurship, and Global Disease Outbreak Control'. *Journal of International Organizations Studies* 1, no. 1 (2010): 72-89.

that advice except where a clear public health rationale and justification for doing so exists. Where governments do decide to diverge from WHO advice and implement so-called 'additional health measures' that are more restrictive, invasive, or intrusive than the WHO recommends, under Article 43 of the revised IHR they are now required to provide justification for their actions and present scientific evidence in support of their case. This new norm thereby represents a significant break with the former IHR framework, considerably expanding not only the authority of the WHO but also (in theory) placing significant constraints on the sovereignty of member states.

Two contextual explanations are important in the case of additional health measures. The first is that they are crucial to meeting the IHR's overall objective of providing the maximum security against the international spread of infectious disease whilst causing the minimum possible interference with international trade and traffic. Striking this balance had been central to every precursor of the IHR (2005), from the International Sanitary Conventions of the 19th Century through to the 1969 version of the IHR, and was seen as no less important in the new regulations. Indeed, given the centrality of a globalized economy and international free trade to contemporary international relations, its importance for the success of the new Regulations was arguably even greater. In recognition of this, the WHO went to great lengths to address the compatibility of the IHR with other trade agreements, such as those under the World Trade Organization. The second important aspect to highlight is that the excessively stringent measures put in place by some states in response to disease outbreaks under the previous (1969) version of the IHR were one of the problems that the revision process sought to overcome. Economically damaging overreactions to disease outbreaks were frequently cited as one of the reasons why governments refused to report disease outbreaks. Cash and Narasimhan, for example, showed how the economic losses resulting from trade restrictions imposed as a result of cholera and plague outbreaks in Peru and India respectively served as real disincentives for states to report disease outbreaks.[5]

Previous versions of the IHR did limit the scope of legitimate health measures, but the rules changed significantly in the latest IHR. The 1969 version of the IHR contained a number of specific provisions to this effect, including prohibitions on refusing entry to vessels not infected (Article 28) and on a state applying health measures to a vessel that does

[5] Richard A. Cash and Vasant Narasimhan. 'Impediments to global surveillance of infectious diseases: consequences of open reporting in a global economy'. *Bulletin of the World Health Organisation* 78, no. 11 (2000): 1358-1367

not call at one of its ports (Article 32). As van Tigerstrom has noted, many of these provisions were narrowly defined and focussed on the limited number of diseases that were notifiable under the IHR 1969.[6] The 2005 version of the IHR include a number of similar provisions that limit the measures that states may implement, some of which derive from the 1969 version. Article 25, for example, limits the measures that can be applied to ships and aircraft in transit; Article 26 does the same for lorries, trains and coaches in transit; Article 27 addresses the measures states can take in relation to an infected conveyance; and Articles 28 and 29 deal with ships, aircraft, lorries, trains and coaches at ports of entry.

In more general terms, however, what has occurred in the IHR (2005) is a shift away from "an approach which prohibited all measures save those specifically authorized by the regulations, and moved towards a set of restrictions based on certain principles (e.g. the need for scientific evidence, and the use of the least restrictive measures reasonably available) and procedures (e.g. notifying the WHO of additional measures, and reviewing every three months)".[7] It is these new general principles and procedures that, for us, constitute a new international norm which have the effect of constraining state sovereignty in significant ways.

Under Articles 15 and 16 of the IHR (2005) the WHO Director-General is given the power to issue recommendations to member states on appropriate health measures in the event of a PHEIC. Article 18(2) outlines the types of recommendations that can be made in respect of trade restrictions thus:

> Recommendations issued by WHO to States Parties with respect to baggage, cargo, containers, conveyances, goods and postal parcels may include the following advice:
>
> - no specific health measures are advised;
> - review manifest and routing;
> - implement inspections;
> - review proof of measures taken on departure or in transit to eliminate infection or contamination;
> - implement treatment of the baggage, cargo, containers, conveyances, goods, postal parcels or human remains to remove infection or contamination, including vectors and reservoirs;
> - the use of specific health measures to ensure the safe handling and transport of human remains;
> - implement isolation or quarantine;

[6] Barbara van Tigerstrom. 'The Revised International Health Regulations and Restraint on National Health Measures. *Health Law Journal* 13 (2006): 35-76.
[7] ibid, 53-54.

- seizure and destruction of infected or contaminated or suspect baggage, cargo, containers, conveyances, goods or postal parcels under controlled conditions if no available treatment or process will otherwise be successful; and
- refuse departure or entry.[8]

States are generally expected to follow whatever recommendations the Director-General announces. Article 43 does allow states to impose measures beyond what the Director-General advises (and even to impose measures specifically prohibited under other Articles), but only if those actions:

> ...are otherwise consistent with these Regulations. Such measures shall not be more restrictive of international traffic and not more invasive or intrusive to persons than reasonably available alternatives that would achieve the appropriate level of health protection.[9]

In deciding whether or not to introduce additional health measures states are required to take into account:

a) scientific principles;
b) scientific evidence that there is a risk to human health, or where such evidence is lacking, the available information including from the WHO, other relevant intergovernmental organizations, and international bodies; and
c) any available guidance or advice from the WHO.[10]

Upon receipt of this information, the WHO is authorized to share this data with other governments and assess the appropriateness of the measures taken. Where the organization deems that there is insufficient cause to justify the state's actions, the WHO is again authorized to comment on this publicly, and to request the government in question to reconsider the measures. Although the IHR does not allow for the WHO to impose penalties on those states that do not comply, by publicly requesting that the state reconsider its actions – in effect granting the WHO the ability to 'name and shame' – the organization's authority

[8] World Health Organization, 2008, 17-18.
[9] ibid, 29.
[10] Article 43, paragraph 2 – ibid.

as an independent arbiter has been substantially reinforced. What we have in terms of trade restrictions and disease control under the IHR (2005), therefore, is a general principle that any restrictions should be the minimum necessary to provide for health security; an expectation that the Director-General will offer guidance on appropriate restrictions in the event of a PHEIC; yet the provision for states to go beyond these recommendations *only* if they can justify doing so on the basis of scientific evidence. Accordingly, states have clearly consented to a new constraint on their sovereignty in order to benefit from collective efforts to achieve global health security. The question is to what extent can they be expected to comply with that commitment?

Compliance and non-compliance: Insights from social constructivist theory

Social constructivists argue that the behaviour of states within international society is regulated by international norms, whether those norms are 'soft' behavioural expectations or 'hard' international law.[11] States can and do violate these norms, but the degree of compliance – even on the part of the most powerful states in the international system – tends to be higher than rational choice theorists predict. Indeed, constructivists claim, it is this tendency to comply with international norms that makes the continued functioning of an international society of states possible.[12] Where a state does violate the rules of international society it will usually feel compelled to provide the other members of that society with some justification for its actions. This justification may take any one of a variety of forms: claiming that the rule does not apply to the particular circumstances in question; arguing that the action is in line with the conflicting requirements of a different norm; claiming that the circumstances are so exceptional as to make non-compliance an acceptable course of action; or, most fundamentally, arguing that the norm is not a valid rule of international society. In general, constructivists would argue, states tend not to undertake actions that cannot be legitimated by reference to the prevailing law, rules and norms of international society, and they tend to behave for the most part in ways that are prescribed by international norms.

That said, it is important not to overestimate the extent to which state behaviour is determined by international norms. Just as is the case with domestic law, states are able to

[11] Martha Finnemore. 'Are Legal Norms Distinctive?'. *International Law and Politics* 32 (2000): 699-705.

[12] Alexander Wendt. 'Anarchy is what states make of it: the social construction of power politics'. *International Organization* 46, no. 2 (1992): 391-425.

violate widely-held international norms, frequently with little or no prospect of any 'punishment' being imposed. The constructivist response to this is that norms are counterfactually valid - their existence is not necessarily refuted by instances of noncompliance. Kratochwil and Ruggie draw a useful comparison with domestic laws on drink driving, asking

> Does driving while under the influence of alcohol refute the law (norm) against drunk driving? Does it when half the population is implicated? To be sure, the law (norm) is *violated* thereby. But whether or not violations also invalidate or refute a law (norm) will depend upon a host of other factors, not the least of which is how the community assesses the violation and responds to it.[13]

Where a justification for non-compliance is not offered, or where the one offered is seen as inadequate, we commonly see other members of international society criticising the behaviour of the noncompliant state. The presence or absence of condemnation in cases of noncompliance, therefore, becomes a useful test of the strength of a norm – an issue we return to in our discussion of the influenza case study, below.

The reason we adopt this ideationally-oriented constructivist approach is that the changes we have seen in the global disease control regime in recent years can best be understood as the product of significant changes in shared understandings about disease, security and sovereignty. While material changes to the global environment (for example increased cross-border travel and trade) were partly responsible for motivating the IHR revisions, we can only appreciate why states have agreed to such onerous demands and limitations on their sovereignty by taking into account some important ideational changes that have taken place. Although the IHR revisions have often been portrayed as a rational response to a heightened threat (the product of massively increased international travel and trade and the emergence of new and exotic diseases, as well as drug resistant strains of old ones) we argue that the process needs to be seen in the light of some important ideational changes. In particular, the 'securitization' of disease, which has broadened understandings of what constitutes a 'global security threat', has fundamentally changed the previously predominant view that how states manage health crises is primarily a domestic concern. The revised IHR were a product of this changed understanding, and have in turn acted as an engine of socialization, requiring states

[13] Friedrich Kratchowil and John G. Ruggie. 'International organization: a state of the art on the art of the state'. *International Organization* 40, no. 4 (1986): 753-775, 767. Original emphasis.

to adopt certain structures, practices and behaviours in the name of advancing collective 'global health security'. Why states agreed to impose common standards on things such as surveillance infrastructure requirements and verification timeframes, despite the vast health inequalities amongst states and the huge differences in their domestic health systems, and why they agreed to the limitations on their freedom to impose health measures, can only be appreciated when understanding the power of the social construct behind the global health security idea.[14]

Whether international norms *matter* (in other words whether they affect state behaviour) has been a long-running debate in International Relations theory. Some of the more sophisticated realist theorists do accept that a norm-driven 'logic of appropriateness' influences state behaviour in some circumstances;[15] although they would not expect states to comply where they didn't see that compliance as being in their interests. Alternatively, theorists in the neoliberal institutionalist mould would see norms such as the IHR provisions on additional health measures as examples of rational cooperative action, arguing that states have a preference for cooperation and highlighting the absolute gains that can be made rather than realism's focus on relative gains.[16] In other words, institutionalists would see cooperation and coordination through the IHR is the product of a rational response to interdependency.[17]

Yet crucial to the constructivist case is the idea that states are not engaged in a constant process of calculating how to maximise their interests, but rather that compliance is "A matter of applying socially generated convictions and understandings about how national interests are likely to be achieved in any particular policy domain".[18] Where the constructivist approach adopted here is fundamentally different from rational choice theories is over the ways in which those interests (and indeed the identities of actors) are understood as being formed, and in particular the extent to which they are 'at stake' in social interactions.

[14] These issues are addressed in greater depth than is possible here in Sara Davies, Adam Kamradt-Scott and Simon Rushton, *Disease Diplomacy: Politics, Pandemics and Global Health Security* (forthcoming: Johns Hopkins University Press).
[15] Stephen D. Krasner. 1999. *Sovereignty: Organized Hypocrisy*. (Princeton, NJ: Princeton University Press, 1999).
[16] Robert Keohane. *After hegemony: Cooperation and discord in the world political economy*. (Princeton, NJ: Princeton University Press, 1984).
[17] For a comparison of realist, neoliberal and 'cognitivist' approaches to international regimes see Andreas Hasenclever, Peter Mayer and Volker Rittberger. *Theories of International Regimes*. (Cambridge: Cambridge University Press, 1997), Chapter 1, 1-7.
[18] Peter M. Haas. 'Choosing to Comply: Theorizing from International Relations and Comparative Politics', in *Commitment and Compliance: The Role of Non-binding Norms in the International Legal Systeym*, ed. Dinah Shelton. (Oxford: Oxford University Press, 2000), Chapter 2, 43-64, 62.

Rational choice theories tend to view actors' identities and interests as exogenously given, and where they do change this is likely to be a consequence of material changes. The constructivist approach, on the other hand, views identities and interests as 'constituted' through social interactions. According to this view, the identities and interests of states are inevitably affected by their participation in the international system, and therefore by prevailing international norms. States internalize norms, and for the most part tend to understand their interests, and therefore behave, in accordance with those norms in an almost 'subconscious' fashion. Thus, approaches that treat interests as exogenously given and identities as essentially stable fail to account for some of the more interesting ways in which the global response to cross-border disease threats has changed.

These different theoretical approaches translate into very different expectations about compliance. Such is the challenge to state sovereignty posed by the new provisions on additional health measures that realists would expect relatively low levels of compliance. Realists, of course, would only consider compliance to be likely if a state deemed that to be in its interests in any case, or if the rule was backed by some kind of enforcement capability (for example if the rules are enforced by a global hegemon). In the case of the IHR (2005), as we mentioned above, no such enforcement mechanism exists. Neoliberal institutionalist scholars, by contrast, have made the case that realists tend to underestimate the degree of compliance that we see in practice. They have explained this via an emphasis on the incentives that states have in long-term stable cooperation, even in some cases at the expense of some short-term costs, and on the ways in which institutions can be designed in ways to reduce the likelihood of non-compliance.

Yet these explanations both rest on the assumption that states' understandings of their interests remain essentially static and that they act as rational utility-maximisers. We argue, however, that the process leading up to the IHR revisions, and subsequent events, have changed underlying assumptions about the roles and interests of international actors. When states agreed to the revised IHR framework they subscribed to new expectations of each other, new material requirements, and new social norms. States are role players in the global health security regime and, as we will see below, tend to play (and expect others to properly play) their roles. If constructivists are right we would expect to see certain things happen in cases of noncompliance with a norm which is widely seen as a legitimate behavioural expectation. In simplified form, social constructivists would expect that:

- Most states will comply most of the time;
- Compliance would not be a conscious calculation but rather that states form their understanding of their interests in the light of the norm;
- Compliance may well become routinized, for example in bureaucratic procedures and processes;
- Instances of non-compliance (which are possible) will be accompanied by attempts by the non-compliant state to justify its behaviour;
- Noncompliance will be criticized by other states, even if they do not usually go so far as to take enforcement action; and
- Such criticisms will be couched in terms of the norm: that the non-compliant state has failed to live up to the behavioural expectations of its peers.

In the next section we investigate compliance with the IHR's additional health measures rules in the case of the 2009 H1N1 influenza pandemic in order to examine the extent to which these constructivist expectations have been met. Of particular interest is whether or not there is evidence in that discourse to support a constructivist reading of the new regulations, and if so what the history of the H1N1 pandemic can tell us about the current state of compliance and internalization.

The 2009 H1N1 Influenza Pandemic and IHR compliance

Particularly since 2005, the international community has invested considerable human, financial and technical resources in preparing for another influenza pandemic. For many, the 2003 SARS outbreak was considered a "wake-up call", demonstrating just how rapidly communicable diseases could spread around the world and the economic damage that such events could inflict, even when large numbers of human fatalities did not occur.[19] The subsequent emergence and progressive global dissemination of the H5N1 influenza virus (commonly referred to as "Bird Flu") from late 2003 onwards reinforced the message that another pandemic remained a distinct probability. In the view of many public health officials, it was simply not a matter of 'if' but 'when'. In November 2005, just six months after the IHR (2005) had been endorsed by the 58th WHA, the international community met again at the WHO headquarters in Geneva, Switzerland, to develop a strategy for strengthening global pandemic preparedness. According to the joint United Nations System Influenza Coordinator (UNSIC) and World Bank's 2010 report, between 2005 and 2009 some US$4.3 billion was

[19] Sheela V. Basrur, Barbara Yaffe and Bonnie Henry. 'SARS: A Local Public Health Perspective'. *CJPH*. 95, no. 1 (2004): 22-24, 22.

allocated to strengthening public health response efforts, enhancing disease surveillance capabilities, and boosting global production capacity for developing influenza vaccines and antiviral medications.[20]

In April 2009, this investment appeared to be both timely and appropriate following the revelation that a novel strain of H1N1 influenza had successfully achieved human-to-human transmission in La Gloria, Mexico, the previous month. Due, however, to Mexico's limited laboratory capacity it took some weeks before the US Centers for Disease Control and Prevention and Canadian health authorities confirmed on 23 April that a novel strain had indeed emerged, by which time the virus had already spread internationally.[21] The WHO published its first global alert regarding the outbreak the next day, on 24 April 2009.[22]

Following the global alert, the WHO urged the international community to launch an aggressive and widespread public health campaign to combat the H1N1 threat. Due to the fact that the outbreak was caused by a novel strain of influenza, Director-General Margaret Chan invoked the IHR (2005) for the first time and convened the inaugural meeting of the IHR Emergency Committee on 25 April 2009, drawing together scientific experts to provide technical advice and recommendations on what measures should be taken. On the basis of this Committee's advice, the alert status was raised from Phase 3 (limited transmission) to Phase 4 (community-level outbreaks) on 27 April 2009,[23] and was eventually raised to Phase 6 (Pandemic) on 11 June 2009.[24] The WHO Secretariat also began to issue daily (and in some instances twice-daily) updates on the global situation, as well as publishing various recommendations and technical advice on such matters as surveillance and monitoring, the safety and efficacy of vaccines, and measures aimed at reducing exposure to the virus.[25]

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[20] United Nations System Influenza Coordinator and World Bank. *Animal and Pandemic Influenza: A Framework for Sustaining Momentum. Fifth Global Progress Report, July 2010*. (Bangkok: UNSIC and World Bank, 2010), 31.
[21] Jon Cohen. 'Out of Mexico? Scientists Ponder Swine Flu's Origins'. *Science* 324, no. 5928 (2009): 700-702.
[22] World Health Organization. 'Influenza-like illness in the United States and Mexico. Global Alert and Response (GAR), 24 April 2009'. World Health Organization, http://www.who.int/csr/don/2009_04_24/en/index.html (accessed 14 July 2011).
[23] World Health Organization. 'Swine influenza - Statement by WHO Director-General, Dr Margaret Chan. Media Centre, 27 April 2009'. World Health Organization, http://www.who.int/mediacentre/news/statements/2009/h1n1_20090427/en/ (accessed 14 July 2011).
[24] World Health Organization. 'DG Statement following the meeting of the Emergency Committee. Global Alert and Response (GAR), 11 June 2009'. World Health Organization, http://www.who.int/csr/disease/swineflu/4th_meeting_ihr/en/ (accessed 14 July 2011).
[25] World Health Organization. 'Pandemic influenza prevention and mitigation in low resource communities'. World Health Organization, http://www.who.int/csr/resources/publications/swineflu/PI_summary_low_resource_02_05_2009.pdf (accessed 15 July 2011).

In an attempt to circumvent the risk that the outbreak would become known as the 'Mexican Flu' (and the inevitable economic damage that would result to Mexico if such an association developed) the WHO initially labelled the outbreak 'Swine Flu' on account of the fact that the H1N1 virus was also found to infect pigs. Within days, however, it became apparent that some countries were employing additional health measures that seemed to contravene the object and purpose of the IHR (2005). These included:

- In late April, the Egyptian authorities ordered the mass culling of all pigs throughout the country (estimated between 250,000 to 400,000 livestock) even though there had been no recorded cases of human H1N1 in the country, nor any reported outbreaks of H1N1 in pigs worldwide;
- In China and Singapore, government authorities began to automatically quarantine tourists based on their nationality (notably Mexican, American and Canadian citizens) or if they had recently travelled to Mexico irrespective of their potential exposure to the virus;
- Several countries including Argentina, Cuba, Ecuador, and Peru issued immediate temporary suspension orders on all flights to Mexico, and North America more generally; and
- Over 20 countries imposed import bans on live pigs, pork, and pork products citing concerns over the risk of H1N1 infection.[26]

All of these actions went far beyond the measures suggested by the WHO, which had issued a statement as early as 26 April 2009 that trade and travel restrictions were not recommended.[27] On 27 April 2009, the Secretariat expanded on its advice, explicitly stating "There is also no risk of infection from this virus from consumption of well-cooked pork and pork products".[28] On 30 April 2009, the Food and Agriculture Organization (FAO), World Organization for Animal Health (OIE), and the WHO then issued a joint statement (which was re-issued again on 7 May 2009) stipulating that pork and pork products were safe.[29] Nonetheless, a small number of countries persisted with travel restrictions and/or live pig and

[26] Rebecca Katz and Julie Fischer. 'The Revised International Health Regulations: A Framework for Global Pandemic Response'. *Global Health Governance*. 3, no. 2 (2010): 1-18; and James G. Hodge, Jr. 'Global Legal Triage in Response to the 2009 H1N1 Outbreak'. *Minnesota Journal of Law, Science & Technology*. 11, no. 2 (2010): 599-628.
[27] World Health Organization. 'Swine flu illness in the United States and Mexico - update 2. Global Alert and Response (GAR)'. World Health Organization, 26 April 2009, http://www.who.int/csr/don/2009_04_26/en/index.html (accessed 15 July 2011).
[28] World Health Organization. 'Swine influenza – Update 3. Global Alert and Response (GAR)'. World Health Organization, 27 April 2009, http://www.who.int/csr/don/2009_04_27/en/index.html (accessed 13 July 2011).
[29] World Health Organization. 'Joint FAO/WHO/OIE Statement on influenza A(H1N1) and the safety of pork. WHO Media Centre – Statements'. World Health Organization, 7 May 2009, http://www.who.int/mediacentre/news/statements/2009/h1n1_20090430/en/index.html (accessed 14 July 2011).

pork import bans to the extent that a series of complaints were formally lodged with the WTO in late June 2009.[30] These restrictions, which flew in the face of the WHO advice, were prima facie breaches of the additional health measures norm. The responses to those cases of non-compliance, and the justification put forward in support of them, are examined in the remainder of this section.

Those countries most affected by the pork import bans and travel restrictions (notably, Mexico, the USA and Canada) were understandably quick to condemn them. Canada's trade minister, for example, openly rebuked the governments responsible. Invoking the principles outlined in the IHR (2005) that additional health measures needed to substantiated by sound scientific evidence, the minister observed that governments should "make decisions that are scientifically based…We would expect those countries, which have gone ahead with the ban or were thinking about it, would stop and have a look at scientific guidelines and would recognise that the meat itself is not a problem".[31] Likewise, China's actions in, firstly, quarantining Mexican citizens without just cause, and then later imposing pork bans, received a strong admonition from the Mexican authorities and prompted the WHO to formally request the public health rationale for China's actions under the IHR (2005).[32]

Such arguments from the 'victims' of travel and trade restrictions are perhaps to be expected but, adding weight to the suggestion that the norm on additional health measures was widely seen as valid, even those countries that were not large pork exporters or that did not have citizens forcibly quarantined, joined with affected countries in condemning the trade and travel restrictions, criticizing those governments who imposed them while praising those countries who based their decisions on science.[33] Although the WHO Secretariat refrained from 'naming and shaming' those countries that contravened the IHR (2005), other United Nations agencies were not so restrained. A representative of the FAO roundly condemned the

[30] World Trade Organization. 'Members discuss trade responses to H1N1 flu. World Trade Organization Sanitary and Phytosanitary Measures'. World Trade Organization, 25 June 2009, http://www.wto.org/english/news_e/news09_e/sps_25jun09_e.htm (accessed 14 July 2011).
[31] Laura MacInnis. 'Mexico says pork import bans unjustified, illegal'. Reuters, 5 May 2009, http://uk.reuters.com/article/2009/05/05/idUKL5956461 (accessed 14 July 2011).
[32] David P. Fidler. 'H1N1 After Action Review: Learning from the Unexpected, the Success and the Fear'. *Future Microbiology* 4, no. 7 (2009): 767-769.
[33] World Trade Organization, 2009.

actions of the Egyptian authorities, labelling the slaughter of the indigenous pig population as "a real mistake".[34]

Indeed, even though only a small proportion of countries knowingly contravened the IHR (reflecting the idea that most countries comply most of the time), it is also clear that many of those states that did exhibit noncompliance were cognisant that their actions required at least some form of justification, indicating that they recognised the validity of the norm regarding additional health measures to some extent. As early as 4 May 2009, for example, the Chinese authorities released a statement that they were not intentionally discriminating against Mexican citizens.[35] The following month the Chinese health minister formally apologised to his Mexican counterpart, expressing regret for not discussing his country's containment strategy earlier and praising the Mexican government for its transparency throughout the pandemic.[36] Later, when confronted in the WTO, China again sought to justify its actions on the basis of "its large vulnerable population, the burden on its public health system, the importance of pigs and pork, and the fact that the H1N1 virus shares some genetic make-up with influenza that affects pigs".[37] Other countries such as Iraq, which had slaughtered three wild boars in a Baghdad zoo, admitted that its actions were not based on science but rather were intended "to break a barrier of fear" amongst zoo visitors.[38] Similarly the Philippines, which had banned pork imports from the US, Mexico and Canada on 25 April 2009 as a "precautionary measure",[39] lifted the ban less than a week later for the US and Mexico and maintained the ban on Canada only because there was reportedly a suspected case of swine-to-human H1N1.[40]

Admittedly, a smaller subset of governments remained staunchly unapologetic, even antagonistic, to the suggestion that their actions were irresponsible. Arguably the most

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[34] Phil Stewart. 'UN agency slams Egypt order to cull all pigs'. Reuters, 29 April 2009, http://www.reuters.com/article/2009/04/29/idUSLT11250 (accessed 14 July 2011).
[35] BBC. 'China denies flu discrimination'. BBC World Service, 4 May 2009, http://news.bbc.co.uk/1/hi/world/asia-pacific/8032157.stm (accessed 14 July 2011).
[36] Associated French Press. 'China apologises to Mexico for tough H1N1 flu stand'. Channelnewsasia.com, 4 July 2009, http://www.channelnewsasia.com/stories/afp_asiapacific/view/440320/1/.html (accessed 14 July 2011).
[37] World Trade Organization, 2009.
[38] Jomana Karadesh. 'Wild boars killed in Iraq over swine flu fears'. CNN.com/world, 3 May 2009, http://edition.cnn.com/2009/WORLD/meast/05/03/iraq.boars/ (accessed 14 July 2011).
[39] Mohit Joshi. 'Philippines bans pork imports from Mexico, US'. TopNews.in, 25 April 2009, http://www.topnews.in/philippines-bans-pork-imports-mexico-us-2156861 (accessed 14 September 2011).
[40] Maila Ager. 'Import ban on pork lifted, except Canada'. Inquirer.net, 4 May 2009, http://newsinfo.inquirer.net/breakingnews/nation/view/20090504-203022/Import-ban-on-pork-lifted-except-Canada (accessed 14 July 2011).

extreme illustration of this was demonstrated by Russia's chief veterinary officer, Nikolai Vlasov, when he stated he not only agreed with Russia's ban on pork imports, but that ""Health officials should stick to their own business and not promote the world pork trade".[41]Elsewhere, a small number of countries such as Indonesia, Egypt, the Ukraine, North Korea, and Ghana simply failed to provide any justification or explanation for their actions whatsoever. Taking note of the fact that many of the countries that had imposed the pork import bans are comprised of predominantly Muslim populations, speculation understandably emerged that the bans were religiously motivated.[42] Certainly, the silence demonstrated by these countries would seem to indicate that the process of socialization around the additional health measures norm is not yet fully complete, as – at least according to a constructivist reading – it would be reasonable to expect that most if not all countries that contravened the norm would seek to explain their actions to some degree. The lack of attempt by these states to justify the additional health measures thereby suggests only two possible explanations: a) they simply viewed the international community's condemnation with little regard, suggesting they placed little or no value in the IHR (2005) norms; or b) they recognized there was no reasonable justification for their actions, and so silence was used as a strategy to avoid international attention and thereby minimize any condemnation and/or repercussions. Given that the IHR (2005) framework was passed with unanimous approval in May 2005,[43] and that the WHO's global health security function has been further endorsed and reinforced in May 2011,[44] we maintain that the latter of these two explanations is the more likely in most cases, although some – North Korea being the most obvious example – are states which habitually show little concern for international condemnation of their actions.

It is again important to note, however, that the majority of countries fully complied with the IHR norm regarding additional health measures. For the most part WHO recommendations were strictly adhered to, and governments were quick to indicate where

[41] Aleksandras Budrys. 'Russia says extends pork import ban to Canada, Spain'. Reuters, 4 May 2009, http://www.reuters.com/article/2009/05/04/us-flu-russia-idUSTRE5431PB20090504 (accessed 14 July 2011).
[42] Nadim Audi. 'Culling Pigs in Flu Fight, Egypt Angers Herders and Dismays U.N.'. New York Times Online, 30 April 2009, http://www.nytimes.com/2009/05/01/health/01egypt.html (accessed 14 July 2011).
[43] Kumanan Wilson, Christopher McDougall, David P. Fidler and Harvey Lazar. 'Strategies for implementing the new International Health Regulations in federal countries'. *Bulletin of the World Health Organization*. 86, no. 3 (2008): 215-220.
[44] World Health Organization. 'WHO reform. World Health Assembly Resolution WHA64.2'. World Health Organization, 20 May 2011, http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_R2-en.pdf (accessed 15 July 2011).

their actions were based on sound scientific evidence and where uncertainty remained.[45] Adding weight to the case that the majority of countries had internalized the norm, governments were also observed to provide very little justification to their respective domestic populations for why they were not implementing more severe trade and travel restrictions to prevent the further importation of the H1N1 virus. Instead, the overwhelming focus was on how countries could help reduce illness via vaccination or the use of antiviral medications, combined with measures that individuals could take to mitigate their personal risk of contracting influenza.

Conclusion

The 2009 H1N1 pandemic represented the first invocation and test of the revised IHR, and the first opportunity to judge the extent to which states had internalized the new norms surrounding additional health measures. What can we draw from this case? Were the expectations of constructivist scholars borne out? And if not, why not?

Overall there seems to be evidence to suggest that the majority of the international community have internalized the revised IHR (2005) additional health measures norm. As we have observed above, the vast majority of countries did comply, refraining from imposing restrictions in excess of the WHO Director-General's recommendations even though domestically it may have been politically expedient to implement tougher restrictions. Thus, even though there was significant noncompliance (in that approximately 10 per cent of countries applied measures that contravened the additional health measures norm) most states did in fact comply.

Moreover, there is sufficient evidence to suggest that the majority of states complied with the IHR norm regarding additional health measures not from a sense of obligation per se, but rather because they had internalized the principle it represents. Said another way, even though the decision to comply with the IHR may have represented a rational choice for some countries, based either on a sense of legal obligation or short-term policy objectives, it can also be reasonably argued that governments complied with the IHR because they had actually come to believe that the norms enshrined within the framework reflect a preferred system for

[45] Andrea S. Fogarty, Kate Holland, Michelle Imison, R Warwick Blood, Simon Chapman and Simon Holding. 'Communicating uncertainty - how Australian television reported H1N1 risk in 2009: a content analysis'. *BMC Public Health* 11: 181. doi: 10.1186/1471-2458-11-181.

interstate cooperation – an ideal system for international communicable disease control where political interests are minimized – and constrained their behaviour (and sovereignty) accordingly. Seen in this light, compliance with the IHR in the context of the 2009 H1N1 influenza pandemic reflects a more profound, deep-seated change in states' interests; and we could reasonably expect to see compliance in the future become routinized, reflected for instance, in bureaucratic procedures and processes, and codified in national law.

Of those countries that failed to comply, at least half sought to justify their actions for doing so and, along with those countries that remained silent, all were openly criticized and publicly rebuked over their breach in protocol. It seems, then, that most of the expectations of constructivist scholars were indeed borne out in the case examined here, and that states have willingly traded elements of state sovereignty to ensure greater health security. Nevertheless, it has to be admitted that there was a relatively high level of noncompliance in the first real test of the IHR (2005). Realist scholars would no doubt seize on this as evidence that their predictions are correct and that what occurred throughout the H1N1 pandemic was proof that states happily ignore international law when it does not coincide with their interests, at least if there is little prospect of noncompliance leading to enforcement action. We contend, however, a better explanation is that the norm socialization and internalization process is currently incomplete – not surprising when considering the norms embodied within the IHR (2005) are new. It is clearly problematic to draw too many bold conclusions on the basis of a single case. Given that new communicable diseases and other public health risks are continuing to emerge at an alarming rate, however, there is little doubt that compliance with the 'additional health measures' norm will soon be tested again.