

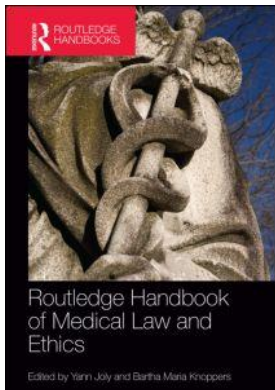
This article was downloaded by: 10.3.97.143

On: 03 Dec 2023

Access details: *subscription number*

Publisher: *Routledge*

Informa Ltd Registered in England and Wales Registered Number: 1072954 Registered office: 5 Howick Place, London SW1P 1WG, UK



Routledge Handbook of Medical Law and Ethics

Yann Joly, Bartha Maria Knoppers

The role of international organizations in promoting legal norms

Publication details

<https://www.routledgehandbooks.com/doi/10.4324/9780203796184.ch21>

Obijiofor Aginam

Published online on: 29 Aug 2014

How to cite :- Obijiofor Aginam. 29 Aug 2014, *The role of international organizations in promoting legal norms from:* Routledge Handbook of Medical Law and Ethics Routledge

Accessed on: 03 Dec 2023

<https://www.routledgehandbooks.com/doi/10.4324/9780203796184.ch21>

PLEASE SCROLL DOWN FOR DOCUMENT

Full terms and conditions of use: <https://www.routledgehandbooks.com/legal-notices/terms>

This Document PDF may be used for research, teaching and private study purposes. Any substantial or systematic reproductions, re-distribution, re-selling, loan or sub-licensing, systematic supply or distribution in any form to anyone is expressly forbidden.

The publisher does not give any warranty express or implied or make any representation that the contents will be complete or accurate or up to date. The publisher shall not be liable for an loss, actions, claims, proceedings, demand or costs or damages whatsoever or howsoever caused arising directly or indirectly in connection with or arising out of the use of this material.

The role of international organizations in promoting legal norms

Obijiofor Aginam¹

We meet as we fight to defeat SARS, the first new epidemic of the twenty-first century ... Globalization of disease and threats to health mean globalization of the fight against them ... The events of the last few weeks also prompt us to look closely at the *instruments of national and international law*. Are they keeping up with our rapidly changing world?

(Brundtland 2003a)

21.1 Introduction: the relevance of legal norms

Brundtland's observation in the wake of the SARS epidemic in 2003 underscores the relevance of 'the instruments of national and international' legal norms in global health governance. It is now widely accepted in academic literature, national health policies, and policy frameworks of relevant international organizations that 'globalization of public health'² is afoot. In an interdependent world, public health raises globalized challenges that require innovative legal and ethical norms to guide the actions of nation-states and non-state actors. Public health, especially at the global level, is now 'comprised of numerous and varied actors with competing values, interests, and motivations' (Zacher and Keefe 2008: 135; Cooper *et al.* 2007: 3–14). To effectively address these competing values, interests, and motivations, nation-states have cooperated to establish inter-governmental organizations with clear mandates. This chapter explores the mandate of the World Health Organization (WHO) to promote legal and ethical norms relevant to international medical and public health issues.

1 PhD, Senior Research Fellow and Head of Governance for Global Health, United Nations University – International Institute for Global Health (UNU-IIGH), Kuala Lumpur, Malaysia; Adjunct Research Professor of Law, Carleton University, Ottawa, Canada.

2 The 'globalization of public health' refers to the cumulative impact of the cognitive, spatial, and temporal dimensions of global interdependence on public health across various regions and societies of the world. In the infectious disease context, the globalization of the world's political economy creates opportunities for disease pathogens to travel transcontinental distances with the speed of a jet. On globalization of public health, see Lee and Dodgson (2000), Lee *et al.* (2002), Yach and Bettcher (1998a, 1998b), Brundtland (2001, 2003b), Woodward *et al.* (2001), Fidler (1997a, 2004).

21.2 The mandate and legal and normative authority of the World Health Organization

The WHO was established at the International Health Conference when 61 representatives of participating nation-states officially ratified its constitution in New York on 7 April 1948 (WHO 2001: 1; Burci and Vignes 2004). With 194 current member states, the WHO is a specialized agency of the United Nations (UN) with a mandate to ‘act as the directing and coordinating authority on international health work’ (International Health Conference (IHC) 1948, articles 2(a)–2(v)). As an inter-governmental organization, the WHO’s normative and legal parameters are firmly rooted in a state-centric international system.³ The WHO *Constitution* permitted the organization to use innovative instruments to create ethical and legal norms – treaties, legally binding regulations, and non-legally binding declarations (soft law) to pursue its public health mandate. Despite well-founded criticisms that the WHO did not fully utilize these legal mechanisms during its six-decade history, two landmark events in 2005 marked significant improvements: the adoption of the *International Health Regulations* (IHR) and the operationalization of the WHO *Framework Convention on Tobacco Control* (FCTC) in 2005.

The legal and normative authority of the WHO falls into three categories: (1) treaty-making powers analogous to conventional treaty negotiation, adoption, and ratification by states in international law; (2) the authority to adopt legally binding regulations analogous to legislative or quasi-legislative process in domestic law; and (3) the authority to adopt non-binding recommendations analogous to ‘soft law’ in international law.

The WHO’s conventional treaty-making authority – similar to that of most multilateral institutions in the international system – is covered by article 19 of its *Constitution* which provides that:

[T]he Health Assembly shall have the authority to adopt conventions or agreements with respect to any matter within the competence of the Organization. A two-thirds vote of the Health Assembly shall be required for the adoption of such conventions or agreements, which shall come into force for each Member when accepted by it in accordance with its constitutional processes.

(IHC 1948)

Although article 19 is a conventional treaty-making authority that most international organizations derive expressly from their constitutions, charters, or other constituent instruments, in the case of the WHO, some scholars argue that, when combined with its ambitious objective ‘[for] all peoples [to attain] ... the highest possible level of health,’ and its equally ambitious definition of health as ‘a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity’ (IHC 1948, preamble), article 19 provides the Organization with virtually limitless treaty-making power. Moreover, it surpasses any treaty powers possessed by the WHO’s precursors, including the Pan American Sanitary Bureau, the International Office of Public Health, and the Health Organization of the League of Nations.⁴

³ Only states can be members of the WHO, as provided for by article 3 of the WHO *Constitution*: ‘membership in the Organization shall be open to all States’ (IHC 1948).

⁴ David P. Fidler was the leading exponent of this argument in the late 1990s (Fidler 1998). Fidler argued that the WHO is facing an international legal tsunami that will require a sea change in its attitude towards international law; that the WHO’s lack of interest in international law does not reflect the historical experience of states and international health organizations prior to World War II; and that while the WHO has been accused of focusing too little on international law, international relations prior to World War II were plagued by too much international health law.

Article 21 of the WHO *Constitution* authorizes the World Health Assembly (the WHO's highest policymaking organ) to adopt legally binding regulations concerning:

- (a) Sanitary and quarantine requirements and other procedures designed to prevent the international spread of disease;
- (b) Nomenclatures with respect to diseases, cause of death and public health practices;
- (c) Standards with respect to diagnostic procedures for international use;
- (d) Standards with respect to the safety, purity and potency of biological, pharmaceutical and similar products moving in international commerce;
- (e) Advertising and labeling of biological, pharmaceutical and similar products moving in international commerce.

(ICH 1948)

Regulations adopted by the World Health Assembly under article 21 are legally binding for all WHO member states, except for those that invoke the 'contracting out' procedure provided for at article 22 of the *Constitution*. Such regulations come into force for all WHO member states after the Health Assembly gives due notice of their adoption, except in cases where members notify the WHO Director-General of a rejection or reservation(s) within the period specified in the notice. Articles 21 and 22 of the WHO *Constitution* have been described as creating a quasi-legislative procedure that constitutes a radical departure from the conventional international treaty-making practice in the late 1940s when it was first established (Sharpe 1947).⁵

Article 23 of the WHO *Constitution* gives the World Health Assembly the authority to adopt non-legally binding resolutions (soft law) with respect to any matter within the competence of the organization. Although soft-law instruments, like recommendations and declarations, are not automatically legally binding, international law scholars agree that such instruments nonetheless catalyzed the evolution of rules in international law (Gruchall-Hesierski 1984, cited in Szasz 2001: 26–7; Chinkin 1989). Soft-law instruments 'operate in a grey zone between law and politics' (Malanczuk 1997: 54), and are considered a special characteristic of international law, especially on emerging economic and environmental issues (Malanczuk 1997: 54). In sum, the legal and normative authorities of the WHO fall within the three categories of conventional treaty-making authority (articles 19–20); regulatory authority (articles 21–22); and non-binding soft-law authority (article 23).

Medical and public health experts, including physicians and epidemiologists, have historically dominated the WHO. In its first five decades (1948–98), the WHO did not significantly elaborate legal norms in the pursuit of its mandate. In the 1990s, the WHO's under-utilization of its enormous legal and normative authority became the subject of intense debate among (international) legal scholars. Tomasevski (1995: 859),⁶ Taylor (1992: 302), and Fidler (1998) criticized the increased 'medicalization' of the WHO as a result of the organization's reluctance to use international legal mechanisms. According to Fidler:

⁵ For a study of international legislative processes of international organizations 'by which an increasingly substantial amount of international law is steadily being created,' see Szasz (2001) and Kwakwa (2002).

⁶ Tomasevski strongly critiqued the WHO's overt bias in favor of non-binding and non-legal norms built upon ethical rather than legal principles. She also observed that an important reason for the WHO's bias for non-binding rules is the traditional reluctance of the medical profession to submit itself to the rule of law. Beginning in the eighteenth century, medical associations developed codes of professional behavior. Self-regulation presumes the exclusion of lay persons, thus reinforcing the traditional paternalism of the medical profession, dating back to the Hippocratic Oath, the assumption that whatever a physician decides is, by definition, correct.

[The] WHO was isolated from general developments concerning international law in the post-1945 period. This isolation was not accidental but reflected a particular outlook on the formulation and implementation of international health policy. WHO operated as if it were not subject to the normal dynamics of the anarchical society; rather, it acted as if it were at the center of a transnational Hippocratic society made up of *physicians, medical scientists, and public health experts*. The nature of this transnational Hippocratic society led WHO to approach international public health without a legal strategy.

(1999a: 15)

Similarly, Taylor observed:

[The] WHO's traditional reluctance to utilize law and legal institutions to facilitate its health strategies is largely attributable to the internal dynamics and politics of the organization itself. In particular, this unwillingness stems, in large part, from the organizational culture established by the conservative medical professional community that dominates the institution.

(1992: 303)⁷

The WHO's 'medical' approach was understandably influenced by science through proving the germ theory correct. Once physicians and epidemiologists understood how humans were infected by disease, they automatically turned to diagnosis and healing rather than to international legal norms for solutions. International legal scholars who are critical of WHO's non-legal approaches to global health work recognize this viewpoint. As Fidler observed:

The common argument used to explain WHO's antipathy towards international law is that WHO is dominated almost exclusively by people trained in public health and medicine, which produces an ethos that looks at global health problems as medical-technical issues to be resolved by the application of the healing arts. The medical-technical approach does not need international law because the approach mandates application of the medical and technical resource or answer directly at the national or local level.

(1998: 1099)

Science arguably catalyzed the development of international health law in the 1890s by providing the breakthrough needed to facilitate agreement by nation-states on common rules and values codified in the *International Sanitary Conventions*.⁸ However, the contemporary antibiotic revolution in the wake of affirming the germ theory impeded the WHO's sustained deployment of international legal strategies. The propensity for doctors and public health officials to combat infectious agents directly largely diverted efforts from seeking legal recourse through treaties and regulatory regimes that can also serve as effective tools in solving medical and health problems.

Situating this discourse in the post-1945 world order, the international system has undergone a significant and dynamic transformation. The expanded definition of health in the WHO *Constitution* as 'a state of complete physical, mental and social well-being and not merely the

⁷ For a discussion of this theme in other seminal writings, see Fidler (1997b: 788, 1999b), Aginam (2005), Lakin (1997), and L'Hirondel and Yach (1998).

⁸ For a discussion of the science and politics of the international sanitary conferences in the nineteenth century, see Howard-Jones (1975), Goodman (1977), Fidler (2001), and Aginam (2005).

absence of disease or infirmity' meant drawing linkages between public health, and poverty, underdevelopment, human rights, food (in)security, food safety, climatic and related environmental changes, natural disasters, wars and the use of weapons of mass destruction, international trade agreements, and other multi-faceted dimensions of the globalization phenomenon. On almost all of these issues, legal and ethical norms are relevant and important tools in the mandate and work of international organizations. In retrospect, the post-1945 decades since the establishment of the United Nations witnessed the evolution of international legal norms on human rights (including the right to health), global environmental issues (multilateral environmental agreements), international humanitarian laws, food and agriculture, and trade-related health concerns, among many others (Fidler 1999b; Aginam 2005). The WHO, largely due to the 'medicalization' of its public health mandate, did not play any active role in the negotiation and adoption of these legal norms.

21.3 WHO, norms, and norm entrepreneurship: locating the linkages

In political theory, 'norms' are generally understood as a 'standard for appropriate behavior for actors with a given identity' (Finnemore 1996, cited in Finnemore and Sikkink 1998: 891; Katzenstein 1996: 5; Klotz 1995). Norm entrepreneurs are individuals, NGOs, states, or international organizations, which actively promote a norm and seek its acceptance by all the relevant actors, especially nation-states. Although the categories of norms differ across disciplines, 'the most common distinction is between regulative norms, which order and constrain behavior, and constitutive norms, which create new actors, interests, or categories of action' (Ruggie 1998, cited in Finnemore and Sikkink 1998: 891). Finnemore and Sikkink identified the three stages of the norm's adoption: emergence, acceptance ('norm cascade'), and internalization (1998: 895). Norm entrepreneurs play a critically important role in augmenting norm emergence through persuasion in their 'attempt to convince a critical mass of states (norm leaders) to embrace new norms' (Finnemore and Sikkink 1998: 895).

There are two pre-conditions for a norm to successfully emerge: *norm entrepreneurs* (agents with strong notions about appropriate or desirable behavior in their community), and *organizational platforms* (where international norm promoters advocate for the adoption of their norms). While individuals – such as Swiss national Henry Dunant – are often credited with norm entrepreneurship, modern-day norm entrepreneurs would most likely work within international organizations to facilitate norm emergence. As Finnemore and Sikkink affirmed:

[O]ne prominent feature of modern organizations and an important source of influence for international organizations in particular is their use of expertise and information to change the behavior of other actors. Expertise, in turn, usually resides in professionals, and a number of empirical studies document the ways that *professional training of bureaucrats in these organizations helps or blocks the promotion of new norms* within standing organizations.

(1998: 899)

In over sixty years, only two legally binding normative instruments have served as analytical benchmarks for exploring the WHO's role as either a norm entrepreneur or organizational platform: the *International Health Regulations* and the *Framework Convention on Tobacco Control*.

21.3.1 *International Health Regulations (IHR 2005)*

The IHR (then known as ‘International Sanitary Regulations’) was adopted by the WHO in 1951 pursuant to article 21 of its constitution. The WHO renamed the regulations the *International Health Regulations* in 1969 and has slightly modified them twice in 1973 and 1981. The IHR represent one of the earliest legally binding regulatory tools for global management of certain infectious diseases. As of 1997, the IHR became legally binding for virtually all WHO member states. The IHR function as regulatory surveillance mechanisms for the sharing of epidemiological information on the trans-boundary spread of cholera, plague, and yellow fever. The fundamental principle of the IHR was to ensure ‘maximum security against the international spread of diseases with minimum interference with world traffic’ (WHO 1983: 5). To achieve this purpose, the IHR obliged the WHO member states to notify the Organization of any outbreaks of cholera, plague, and yellow fever in their territories. Any notification sent by a member state to the WHO was transmitted to all other member states in order to mount an appropriate response to such outbreaks.

The IHR call for maximum public health measures applicable during outbreaks and outline rules for international traffic and travel. They require, among others, health and vaccination certificates against these three diseases for travelers from infected areas, as well as mandated detailed containment measures at airports and seaports. Measures listed in the IHR are the maximum measures allowed in outbreak situations and aim to protect the country against the risk of overreaction and unnecessary embargoes between contiguous neighbors, trading partners, and other countries. These embargoes are often economically damaging and have severe consequences for tourism, traffic, and trade.

By the 1990s, it became evident the IHR were largely unsuccessful in regulating global health. Chief among the reasons for their ineffectiveness was the fear of outbreak, specifically if the potential remained for other member states to take excessive measures if an outbreak did occur and was reported to the WHO. Such was the case during the cholera epidemic in South America – first reported in Peru in 1991 – which is estimated to have cost over \$700 million in trade and other losses. Similarly the 1994 plague outbreak in India led to \$1.7 billion losses in trade, tourism, and travel as a result of excessive embargoes and restrictions imposed by other countries (Taylor 1997: 1348; Garrett 1996: 73–4).⁹

The economic costs of disease outbreaks that are not subject to reporting obligations under the IHR were high in certain countries. The SARS outbreak, which first emerged in Southern China and spread rapidly to other countries, was reported to have ‘rocked Asian markets, ruined the tourist trade of an entire region, nearly bankrupted airlines, and spread panic through some of the world’s largest countries’ (Lemonick and Park 2003: 13). In Canada, the economic cost of the SARS outbreak was estimated at \$30 million daily. It was estimated that China and South Korea each suffered \$2 billion in SARS-related tourism and other economic losses. Visitor arrivals dropped drastically in Singapore, while Hong Kong carrier Cathay Pacific cut its weekly flights by 45 per cent (Lemonick and Park 2003: 13). Apart from the negative effects of costly embargoes, other reasons often cited for the ineffectiveness of the IHR include its relative inexperience in the creation and enforcement of norms and legal regimes, inability to adapt to changing circumstances in international traffic, trade, and public health, and limited protection against only three diseases.

⁹ Taylor states that in the case of plague outbreak in India, such excessive measures included closing airports to aircrafts that were arriving from India, barriers to importation of foodstuffs, and in many cases the return of Indian guest workers even though many of them had not lived in India for several years. Garrett also states that India lost almost two billion dollars as a result of excessive measures following the plague outbreak.

Recognizing its inefficacy, the 48th World Health Assembly passed a resolution calling on the Director-General of the WHO to revise the IHR in May 1995. Pursuant to this resolution, the WHO held an informal consultation of experts in December 1995 (WHO 1995). The expert group proposed a range of amendments to the IHR, and in February 1998, the WHO circulated a provisional draft of new regulations to member states. The proposed amendments focused on expanding disease surveillance to include immediate reporting of syndromes, as well as epidemiological information for their emergence, prevalence, and control. A number of other reliable sources were central to providing the WHO with disease surveillance information, including the WHO Collaborating Centers, non-governmental organizations, mass media, other international organizations, and non-member states. Whereas previously the WHO depended on member states to report outbreaks, the sheer volume of information provided by these other sources was unprecedented. Few, if any, disease outbreaks can be hidden thanks to extensive global media networks, and innovations in communications technology spawned independent global outbreak monitoring sources. Examples of these include: the Global Public Health Information Network (GPHIN), an electronic surveillance system developed by Health Canada; Pro-MED, a private initiative of the Federation of American Scientists' Program for Monitoring Emergent Infectious Diseases which creates a global system of early detection and response to disease outbreaks; and PACNET, an Internet-based information provider on disease outbreaks in the Pacific region. The implication of these innovations, therefore, is that disease outbreaks can no longer be hidden under the veil of state sovereignty.

The new (revised) *International Health Regulations* (2005) have been described as innovative (Fidler 2005; Baker and Fidler 2006; Lo 2010) and officially entered into force on 15 June 2007 as a normative tool for global disease outbreak control. The emergence of the revised IHR was largely catalyzed by the outbreak and global spread of Severe Acute Respiratory Syndrome (SARS), a new deadly and terrifying infectious disease.

21.3.2 *Framework Convention on Tobacco Control*

The WHO *Framework Convention on Tobacco Control* (FCTC) directly implicates the WHO as a norm entrepreneur in global health governance. In May 1999, the World Health Assembly adopted (by consensus) Resolution WHA52.18 urging the Director-General of the WHO to enter into multilateral negotiations for the FCTC. The FCTC negotiation process was the WHO's first use of its treaty-making authority under article 19 of its *Constitution*.

As a governance/regulatory tool, FCTC was based on the evidence that tobacco use is one of the leading causes of preventable deaths and a leading contributor to the global burden of disease (Murray and Lopez 1996, 1997). There are over 1 billion smokers in the world, and it was then estimated that about four million people die yearly from tobacco-related diseases. Although tobacco use is a leading cause of premature death in industrialized countries, the epidemic of tobacco addiction, disease and death is rapidly shifting to developing countries (Murray and Lopez 1996, 1997).¹⁰ Powerful and influential tobacco multinational companies targeted growing markets in Latin America in the 1960s, the newly industrialized economies of Asia (Japan, the Republic of Korea, Taiwan and Thailand) in the 1980s, and women and young persons in Africa in the 1990s (Connolly 1992). Tobacco use is medically associated with a range of diseases and

¹⁰ Taylor (1996) also states that the absence of effective domestic regulation of tobacco in developing countries has created a lucrative opportunity for transnational tobacco companies to target such countries. In many of the poorer states, aggressive tobacco promotion by the tobacco industry and Western states simply overwhelms underfunded national tobacco control efforts.

fatal health conditions including lung and bladder cancers, heart diseases, bronchitis and emphysema, and increased antenatal and prenatal mortality.

In May 1999, the World Health Assembly established an initial working group and an Intergovernmental Negotiating Body (open to WHO's 191 member states) to discuss proposed drafts of the WHO *Framework Convention on Tobacco Control* and related protocols. The Tobacco Free Initiative of the WHO prepared background documents for the working group, enumerating possible elements to be covered by the *Framework Convention* and other elements of subsequent protocols. Draft elements of the *Framework Convention* included a preamble, principles and objectives, obligations, institutions, implementation mechanisms, lawmaking processes and final clauses (signatories, reservations, ratification and withdrawal). Potential elements for subsequent related protocols would include cigarette prices and harmonization of taxes, measures against smuggling, duty-free tobacco products, tobacco advertising and sponsorship, reporting of toxic constituents of tobacco products, packaging and labeling, and tobacco and agricultural policy.

The FCTC negotiating process comprised different phases: Working Groups (1999–2000); Public Hearings (2000); and Intergovernmental Negotiating Body Sessions (2000–3). The Intergovernmental Negotiating Body (INB) finalized its work on the first public health treaty under the auspices of the WHO in February 2003. The WHO FCTC was adopted by the 56th World Health Assembly in May 2003, and was open for signature until 29 June 2004. The FCTC was signed by 168 states during this period, which also expressed their willingness to subsequently become a Party to the Convention. In accordance with article 36 of the WHO FCTC, the FCTC entered into force on 27 February 2005, 90 days after the 40th state acceded to, ratified, accepted, or approved it (WHO 2014). With over 170 states parties, the FCTC was widely accepted by WHO member states within a relatively short period. Regular sessions of the Conference of the Parties (COP) for the WHO FCTC are held every two years, when it authorizes the COP to adopt protocols to the Convention (WHO 2003, article 33). After four years of negotiations, the first Protocol to the FCTC – the *Protocol to Eliminate Illicit Trade in Tobacco Products* – was adopted by the Parties to the FCTC at the 5th session of the COP on 12 November 2012.

As the WHO member states continue to accept the FCTC and its protocol(s), embedding the terms of the Convention in the legislative, legal, institutional, and policy frameworks of these states, serious trade and investment questions will likely be raised in the years ahead, particularly for developing countries where tobacco conglomerates exert influence and continue to exploit poverty and underdevelopment. The WHO should devise effective policy strategies to counter this.

21.4 Postscript: the WHO, norm dynamics, and emerging legal and ethical issues

As an international organization, the WHO's role and relevance as the 'directing and coordinating authority on international health work' has been challenged in complex ways by the dynamics of the globalization of public health. While the organization remains essentially an intergovernmental institution with membership exclusively composed of nation-states, the trends, realities, and dynamics of the phenomenon of globalization prove the emerging and re-emerging medical and public health issues defy the territorial boundaries of individual nation-states. As such, the WHO must devise innovative normative (legal and ethical) strategies and tools to tackle these issues. The effects of economic globalization have permeated public health, mobilizing communicable and non-communicable diseases and related medical and public health threats. The globalization of public health has led to the concept of 'global health governance'

that looks beyond state-centrism to identify the emerging and other relevant non-state actors and stakeholders in the global health arena. The relevance of legal and ethical norms in the relationship between WHO as an international organization and these emerging actors, whether proliferating public-private partnerships or other networks, is both intriguing and complex. However, most scholars agree that innovations are needed. As Cooper *et al.* observed:

These innovations will need to come in the realm of ideas, as the prevailing principles and norms that guide global health governance are redefined and reinvented for a comprehensively and instantaneously interconnected, complex world. They will be needed in the realm of institutions, where new rules, decision-making procedures, resources, and participants are required if the expectations and behavior of the world's countries and citizens are to converge on the reality, rather than just the ideal, of health for all. In both cases, the still dominant Westphalian model – now almost half a millennium old – of sovereign territorial states engaging in limited international cooperation for particular purposes is fast approaching the end of its useful life.

(2007: 4)

Looking beyond the Westphalian (state-centric) model, the successor system will be carefully crafted to accommodate all the emergent relevant actors and stakeholders. According to Cooper *et al.*:

Designing, developing and delivering the successor system will require the talents of many from national and sub-national governments, international institutions, healthcare professionals, philanthropists, the private sector, local communities, nongovernmental organizations (NGOs), faith groups, committed groups and victims from around the world.

(2007: 4)

In both the contemporary (dominant) state-centric model and the imagined successor system with multiple actors and stakeholders, the WHO, as an inter-governmental organization, will continue to play a key role in the elaboration of legal and ethical norms.

21.5 Conclusion

The WHO, a specialized agency of the United Nations, is mandated to 'act as the directing and coordinating authority on international health work' (ICH 1948, articles 2(a)–2(v)). As an inter-governmental organization, the WHO's normative and legal parameters are firmly rooted in a state-centric international system. The WHO's Constitution permits the organization to use innovative instruments to create ethical and legal norms – treaties, legally binding regulations, and soft law – to pursue its public health mandate. In the contemporary dynamic and evolving international system, the effectiveness of the WHO as a norm entrepreneur largely depends on how the Organization manages the two interlinked challenges of (1) innovatively deploying its legal and constitutional authorities to initiate new norms in a dynamic international/global system; and (2) crafting a symbiotic and cooperative relationship with the new (non-state) actors in the global health arena. These challenges are critically important for the WHO's continued relevance and legitimacy as a norm entrepreneur for emerging and re-emerging medical and public health issues. To effectively address them, the WHO must collaborate with other relevant international organizations, within and outside the United Nations system, whose mandates touch

on public health, including the Food and Agriculture Organization of the United Nations, the World Trade Organization, and the World Organization for Animal Health.

References

- Aginam, O. (2005) *Global Health Governance: International Law and Public Health in a Divided World*. Toronto: University of Toronto Press.
- Baker, M. G. and Fidler, D. P. (2006) 'Global public health surveillance under the new International Health Regulations,' *Emerging Infectious Diseases*, 12 (7): 1058–65.
- Brundtland, G. H. (2001) *Globalization as a Force for Better Health* (lecture), London School of Economics, 16 March.
- Brundtland, G. H. (2003a) 'Address to the Fifty-sixth World Health Assembly,' transcript, *World Health Organization*, 18 May, viewed 11 December 2013 at: <http://www.who.int/dg/speeches/2003/wha56speech/en/>.
- Brundtland, G. H. (2003b) 'Global health and international security,' *Global Governance*, 9 (4): 417.
- Burci, G. L. and Vignes, C. H. (2004) *World Health Organization*. London: Kluwer Law International.
- Chinkin, C. M. (1989) 'The challenge of soft law: development and change in international law,' *International and Comparative Law Quarterly*, 38 (4): 850–66.
- Connolly, G. N. (1992) 'Worldwide expansion of transnational tobacco industry,' *Journal of the National Cancer Institute Monographs*, 12: 29–35.
- Cooper, A. F., Kirton, J. J., and Schrecker, T. (2007) 'Governing global health in the twenty-first century,' in A. F. Cooper, J. J. Kirton, and T. Schrecker (eds), *Governing Global Health: Challenge, Response, Innovation*. Aldershot: Ashgate.
- Fidler, D. P. (1997a) 'The globalization of public health: emerging infectious diseases and international relations,' *Indiana Journal of Global Legal Studies*, 5 (1): 1.
- Fidler, D. P. (1997b) 'Return of the fourth horseman: emerging infectious diseases and international law,' *Minnesota Law Review*, 8: 771–868.
- Fidler, D. P. (1998) 'The future of the World Health Organization: what role for international law,' *Vanderbilt Journal of International Law*, 31: 1079–87.
- Fidler, D. P. (1999a) 'International law and global public health,' *University of Kansas Law Review*, 48 (1): 1–58.
- Fidler, D. P. (1999b) *International Law and Infectious Diseases*. Oxford: Clarendon Press.
- Fidler, D. P. (2001) 'The globalization of public health: the first 100 years of international health diplomacy,' *Bulletin of the World Health Organization*, 79 (9): 842–9.
- Fidler, D. P. (2004) *SARS, Governance and Globalization of Disease*. New York: Palgrave Macmillan.
- Fidler, D. P. (2005) 'From international sanitary conventions to global health security: the new International Health Regulations,' *Chinese Journal of International Law*, 4 (2): 325–92.
- Finnemore, M. and Sikkink, K. (1998) 'International norm dynamic and political change,' *International Organization*, 54 (4): 887–917.
- Garrett, L. (1996) 'The return of infectious diseases,' *Foreign Affairs*, viewed 10 September 2013 at: <http://www.foreignaffairs.com/articles/51623/laurie-garrett/the-return-of-infectious-disease>.
- Goodman, N. M. (1977) *International Health Organizations and Their Work*. London: Churchill Livingstone.
- Howard-Jones, N. (1975) *The Scientific Background of the International Sanitary Conferences 1851–1938*. Geneva: World Health Organization.
- Katzenstein, P. J. (1996) 'Introduction: alternative perspectives on national security,' in P. J. Katzenstein (ed.), *The Culture of National Security: Norms and Identity in World Politics*. New York: Columbia University Press.
- Klotz, A. (1995) *Norms in International Relations: The Struggle Against Apartheid*. Ithaca, NY: Cornell University Press.
- Kwakwa, E. (2002) 'Some comments on rule-making at the World Intellectual Property Organization,' *Duke Journal of International Law*, 12 (1): 179.
- L'Hirondel, A. and Yach, D. (1998) 'Develop and strengthen public health law,' *World Health Statistics Quarterly*, 51 (1): 79–87.
- Lakin, A. (1997) 'The legal powers of the World Health Organization,' *Medical Law International*, 3 (1): 23–49.
- Lee, K. and Dodgson, R. (2000) 'Globalization and cholera: implications for global governance,' *Global Governance*, 6 (2): 213–16.

- Lee, K., Buse, K., and Fustukian, S. (eds) (2002) *Health Policy in a Globalising World*. Cambridge: Cambridge University Press.
- Lemonick, M. D. and Park, A. (2003) 'The truth about SARS,' *Time Magazine*, 5 May.
- Lo, C. (2010) *A Commentary on the International Health Regulations (2005): A New Charter for Global Health Matters*. Taipei: Angle.
- Malanczuk, P. (1997) *Akehurst's Modern Introduction to International Law*, 7th edn. London: Routledge.
- Murray, C. L. and Lopez, A. D. (1997) 'Alternative projections of mortality and disability by cause 1990–2020: global burden of disease study,' *Lancet*, 349 (9064): 1498–504.
- Murray, C. L. and Lopez, A. D. (eds) (1996) *The Global Burden of Disease: A Comprehensive Assessment of Mortality and Disability From Diseases, Risk Factors in 1990 and Projected to 2020*. Cambridge, MA: Harvard School of Public Health.
- Sharpe, W. R. (1947) 'The new World Health Organization,' *American Journal of International Law*, 41 (509).
- Szasz, P. C. (2001) *Selected Essays on Understanding International Institutions and the Legislative Process*. New York: Transnational Publishing.
- Taylor, A. L. (1992) 'Making the World Health Organization work: a legal framework for universal access to the conditions of health,' *American Journal of Law and Medicine*, 18 (4): 301–46.
- Taylor, A. L. (1996) 'An international regulatory strategy for global tobacco control,' *Yale Journal of International Law*, 21 (2): 257–304.
- Taylor, A. L. (1997) 'Controlling the global spread of infectious diseases: toward a reinforced role for the International Health Regulations,' *Houston Law Review*, 33: 1347.
- Tomasevski, K. (1995) 'Health,' in O. Schachter and C. C. Joyner (eds), *United Nations Legal Order*, Vol. II. Cambridge: Cambridge University Press.
- Woodward, D., Drager, N., Beaglehole, R., and Lipson, D. (2001) 'Globalization and health: a framework for analysis and action,' *Bulletin of the World Health Organization*, 79 (9): 875.
- World Health Assembly (1999) *Resolution WHA52.18: Towards a WHO Framework Convention on Tobacco Control*, World Health Organization. Geneva: WHA.
- World Health Organization (WHO) (1995) 'The International Response to Epidemics and Application of the International Health Regulations: Report of a WHO Informal Consultation,' viewed 10 December 2013 at: http://whqlibdoc.who.int/hq/1996/WHO EMC_IHR_96.1.pdf.
- World Health Organization (WHO) (2001) *Basic Documents*, 43rd edn, World Health Organization.
- World Health Organization (WHO) (2014) 'Parties to the WHO Framework Convention on Tobacco Control,' viewed 10 January 2014 at: http://www.who.int/fctc/signatories_parties/en/index.html.
- Yach, D. and Bettcher, D. (1998a) 'The globalization of public health, I: threats and opportunities,' *American Journal of Public Health*, 88 (5): 735–8.
- Yach, D. and Bettcher, D. (1998b) 'The globalization of public health, II: the convergence of self-interest and altruism,' *American Journal of Public Health*, 88 (5): 738–41.
- Zacher, M. W. and Keefe, T. J. (2008) *The Politics of Global Health Governance: United By Contagion*. New York: Palgrave Macmillan.

International normative instruments

- International Health Conference (IHC) (1948) *Constitution of the World Health Organization*, viewed 16 September 2013 at: <http://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf?ua=1>.
- World Health Organization (WHO) (1983) *International Health Regulations (1969)*, Third Annotated Edition. Geneva: World Health Organization.
- World Health Organization (WHO) (2003) *WHO Framework Convention on Tobacco Control*, viewed 4 December 2013 at: <http://whqlibdoc.who.int/publications/2003/9241591013.pdf?ua=1>.