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Heidi L. Lamberston

Comments

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Heidi L. Lambertson*

I. Introduction

In his famous essay *On Liberty*, philosopher John Stuart Mill questions: "How much of human life should be assigned to individuality, and how much to society?"[1] Mill's attempt to balance individual liberty[2] and social order is not a novel concept,[3] especially in

* J.D. Candidate, The Dickinson School of Law of the Pennsylvania State University, 2007; B.A. English/Pre-law, *summa cum laude*, Indiana University of Pennsylvania, The Robert E. Cooks Honors College, 2004.

1. *See* JOHN STUART MILL, ON LIBERTY Part IV, ¶ 1 (1869).

2. This term is used generically to mean the choice, or the ability to exercise freedoms bestowed upon the individual by the laws of his or her respective country.

3. *See* Jacobson v. Mass., 197 U.S. 11 (1905) (deciding that in the interest of public health, a man could be forcefully subjected to a smallpox vaccination against his will):

> There are manifold restraints to which every person is necessarily subject to the common good. On any other basis organized society could not exist with safety to its members. Society based on a rule that each one is a law unto himself would soon be confronted with disorder and anarchy. Real liberty for

the realm of public health law.[4] In recent decades, however, globalization has magnified the challenge for international health governance to effectively safeguard individual liberty. The movement of people and goods across national borders has produced a heightened threat of the importation of infectious diseases,[5] which has likewise increased the potential for human rights violations in implementing public health measures to contain these diseases.

Moreover, public health regulation significantly affects human rights in several ways, including: surveillance (privacy); vaccination and treatment (bodily integrity); travel restrictions (movement); and isolation and quarantine (liberty).[6] The list of human rights public health governance implicates is not exhaustive.[7] This is precisely why the challenge is for public health measures to be tailored in such a way as to anticipate, account for, and ultimately minimize prospective intrusions on individual liberty.

The 2005 revision of the World Health Organization's (WHO)

> all could not exist under the operation of a principle which recognizes the right of each individual person to use his own, whether in respect to his person or property, regardless of the injury that may be done to others.

Id. at 26.

4. Legal systems and international human rights permit governments to infringe on individual liberty in the interest of protecting public health. *See* U.N. Econ. & Soc. Council, *Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights*, U.N. Doc. E/CN.4/1985/4/Annex, (1985), *available at* http://www1.umn.edu/humanrts/instree/siracusaprinciples.html (last visited Jan. 10, 2006) [hereinafter *Siracusa Principles*].

> No state party shall, even in time of emergency threatening the life of the nation, derogate from the Covenant's guarantees of the right to life; freedom from torture, cruel, inhuman or degrading treatment or punishment, and from medical or scientific experimentation without free consent; freedom from slavery or involuntary servitude; the right not to be imprisoned for contractual debt; the right not to be convicted or sentenced to a heavier penalty by virtue of retroactive criminal legislation; the right to recognition as a person before the law; and freedom of thought, conscience and religion. These rights are not derogable under any conditions even for the asserted purpose of preserving the life of the nation.

Id. at Part II.D, ¶ 58.

5. *See* MAX HARDIMAN ET AL., GLOBAL CRISES, GLOBAL SOLUTIONS: MANAGING PUBLIC HEALTH EMERGENCIES OF INTERNATIONAL CONCERN THROUGH THE REVISED INTERNATIONAL HEALTH REGULATIONS 1 (2002), *available at* http://www.who.int/csr/resources/publications/ihr/WHO_CDS_CSR_GAR_2002_4_EN/en/ (last visited Jan. 10, 2007) (contending that few public health risks solely implicate national concerns).

6. *See* Lawrence O. Gostin, *World Health Law: Toward a New Conception of Global Health Governance for the 21st Century*, 5 YALE J. HEALTH POL'Y L. & ETHICS 413, 423 (2005) [hereinafter *New Conception*].

7. "Infectious disease control implicates the rights to life, liberty and security of person, privacy, health, an adequate standard of living, food, housing, education, development. . . ." DAVID P. FIDLER, INTERNATIONAL LAW AND INFECTIOUS DISEASE 169 (1999).

International Health Regulations[8] (IHR) is the only global regulation for the control of infectious diseases.[9] It endeavors to modernize public health governance by providing a framework to assess and control an international public health event.[10] Because the international traveler is an important figure in the scheme of effective disease control, the protection of individual liberty remains a persistent concern for many countries.[11] This Comment compares the human rights safeguards for travelers under the IHR 1969[12] with the safeguards proposed under the IHR 2005 to determine their practical limitations and to make recommendations for improvement.

The next four parts of this Comment provide a basis for understanding the background and substance of the IHR 1969. Part II examines the history of international disease control leading up to the adoption of the IHR 1969. Part III focuses on the revisions of the IHR 1969, specifically highlighting the inadequacies of the current Regulations and comparing the major changes implemented in the IHR 2005. Part IV discusses the legal capacity of the proposed Regulations. Part V compares and evaluates human rights safeguards under both sets of Regulations concerning health measures, treatment of personal data and baggage, and charges. The conclusion evaluates the IHR 2005's human rights safeguards and recommends improvement for these protections.

II. Historical Background of the IHR

The origin of the IHR dates back to the cholera epidemics in Europe from 1830 to 1847.[13] The first International Sanitary Conference, held in

8. The International Health Regulations refer collectively to two international instruments of the World Health Organization: the current International Health Regulations (1969) and the revised International Health Regulations (2005). The IHR 2005 will replace the IHR 1969 when they become effective in June 2007. For a discussion of the adoption of IHR 2005, see *infra* Parts III.B and IV.A.

9. HARDIMAN ET AL., *supra* note 5, at 3.

10. An "event" is the "manifestation of disease or an occurrence that creates a potential for disease." World Health Assembly, *Revision of the International Health Regulations*, WHA Res. 58.3, at Part I, art. 1, 58th Ass., 8th plen. mtg. (May 23, 2005), *available at* http://www.who.int/gb/ebwha/pdf_files/WHA58/WHA58_3-en.pdf (last visited Jan. 10, 2007) [hereinafter IHR 2005].

11. Not all WHO Member States prioritize the protection of human rights. For a complete list of the 193 WHO Member States, see World Health Organization, *Countries*, *available at* http://www.who.int/countries/en/index.html (last visited Jan. 10, 2007) [hereinafter *WHO Member States*].

12. World Health Organization, International Health Regulations (1969), 3d ed. 1983, *available at* http://www.who.int/csr/ihr/current/en/index.html (last visited Jan. 10, 2007) [hereinafter IHR 1969].

13. *See* World Health Organization, *Frequently Asked Questions about the International Health Regulations*, http://www.who.int/csr/ihr/howtheywork/faq/en/

Paris in 1851, addressed the international effects of infectious diseases.[14] Very few of the proposed conventions were adopted.[15] In 1903, the adopted conventions were replaced by a new International Sanitary Convention.[16]

It was not until the turn of the Twentieth Century that the United States became involved in the international effort to control the spread of infectious diseases. In 1902, United States delegates met in Washington, D.C., and established the International Sanitary Bureau (ISB).[17] The European States followed in 1907 by developing their own health institution, L'Office International d'Hygiéne Publique (OIHP).[18] In 1923, the Health Organization of the League of Nations (HOLN) was formed and vowed to "take steps in matters of international concern for the prevention and control of disease."[19]

The ISB, OIHP, and HOLN were separate entities that functioned independently and enforced regulations within their limited area of control.[20] Consequently, these institutions did virtually nothing toward coordinating global public health efforts.[21] The founding of the United Nations (U.N.) in 1945 brought harmony to disjointed international health governance by identifying the protection of global public health as one of its objectives.[22] To fulfill that mandate, the U.N. established the WHO.[23]

The WHO Constitution became enforceable against Member States in 1948.[24] In 1951, the World Health Assembly (WHA), the WHO's

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index.html (last visited Jan. 10, 2007) [hereinafter *WHO FAQ*].

14. *Id.*

15. *But see* HARDIMAN ET AL., *supra* note 5, at 1 (recognizing that the International Sanitary Convention dealing with cholera was adopted in Venice in 1892, and another convention dealing with plague was adopted in 1897).

16. *Id.* at 2.

17. This organization eventually became the Pan-American Sanitary Bureau (PASB), which was a precursor to the Pan- American Health Organization (PAHO). *Id.*

18. The name of this institution translates into "International Bureau of Public Health." *Id.*

19. League of Nations Covenant art. XXIII, ¶ f.

20. HARDIMAN ET AL., *supra* note 5, at 2.

21. *See id.*

22. *See* U.N. Charter art. 55, ¶ b (stating that because "conditions of stability and well-being are necessary for peaceful and friendly relations" the U.N. shall promote "higher standards of living" and "solutions of international economic, social, health and related problems"), *available at* http://www.un.org/aboutun/charter/ (last visited Jan. 10, 2007).

23. The objective of the WHO is "the attainment by all peoples of the highest possible level of health." CONST. OF THE WORLD HEALTH ORGANIZATION, art. 1, *available at* http://www.who.int/about/en/ (follow "WHO Constitution" hyperlink) (last visited Jan. 10, 2007) [hereinafter WHO CONST.].

24. All countries that are members of the U.N. may become Member States by accepting the WHO Constitution. Other countries can be admitted by a majority vote of

governing body, adopted[25] the International Sanitary Regulations (ISR).[26] The ISR were renamed the International Health Regulations in 1969.[27] Although they were slightly modified in 1973 and again in 1981,[28] the IHR remain substantially the same as when they were first adopted half a century ago.

III. Revision of the IHR

A. The Reasons for Revision

Being that they are the first major changes to the Regulations in over thirty years, the revisions to the IHR 1969 aim to be more responsive to the problems spawned by disease transmission in an increasingly globalized society. In fact, the WHA's 2005 adoption of the proposed Regulations came only months before several recent disease outbreaks.[29] Avian influenza raged through Vietnam and Thailand during 2004 and 2005,[30] and in September 2005, the polio virus was discovered among Amish children living in Minnesota.[31]

1. Limited Coverage

Initially, the IHR applied to only six public health concerns: cholera, plague, relapsing fever,[32] smallpox, typhus, and yellow fever.[33]

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the World Health Assembly. *See id.* at arts. 4, 6.

25. The WHA has the authority to adopt conventions, promulgate regulations, and make recommendations. *Id.* at arts. 19, 21, 23.

26. The ISR are described as "the end product of the intensive infectious disease diplomacy by countries in the mid-nineteenth and early twentieth centuries." HARDIMAN ET AL., *supra* note 5, at 2.

27. *Id.*

28. The latter modification excluded smallpox, which had been globally eradicated. *See Global Smallpox Eradication*, WHA Res. 33.4, World Health Assembly, 33rd Ass. (May 8, 1980).

29. The diseases discussed in this paragraph are only the most recent public health scares. For a more thorough discussion of earlier disease outbreaks that prompted the revision of the IHR 1969, see *infra* Part III.A.1.

30. *See* World Health Organization, *Cumulative Number of Confirmed Human Cases of Avian Influenza A/(H5N1) Reported to WHO*, Jan. 9, 2007, http://www.who.int/csr/disease/avian_influenza/country/cases_table_2007_01_09/en/index. html (last visited Jan. 10, 2007) [hereinafter *Avian Influenza Deaths*].

31. This was the first outbreak of polio in the United States since 1979. The virus was discovered on September 29, 2005, in an eight-month-old girl, and was subsequently confirmed in four other Amish children. *See* Gardiner Harris, *5 Cases of Polio in Amish Group Raise New Fears*, N.Y. TIMES, Nov. 18, 2005, at A1.

32. Relapsing fever is one of several diseases that are caused by a tick bite. *See* WebMD, *Tick Bites: Topic Overview*, http://www.webmd.com/hw/skin_wounds/hw87788.asp (last visited Jan. 10, 2007).

33. *WHO FAQ, supra* note 13.

After the IHR 1969 were modified, their scope was limited to cholera, plague and yellow fever.[34] Therefore, the IHR 1969 do not account for new public health threats[35] that arose since the ISR's adoption in 1951. As evidence of the problematic nature of the IHR 1969's limited disease coverage, it is estimated that approximately thirty new infectious agents have been identified in the last three decades.[36]

The need for updated coverage was prompted by the international outbreak of new infectious diseases. Ebola hemorrhagic fever devastated Yambuku, Zaire, and other parts of Africa starting in 1976.[37] The United States also had a short-lived scare in 1989 after the Ebola virus appeared in a monkey quarantine facility in Reston, Virginia.[38] The outbreak of SARS in China drew worldwide attention in 2003.[39] Avian influenza, although less devastating than Ebola or SARS,[40] is the most recent threat to emerge. Bioterrorism also remains a concern in the wake of the September 11th attacks.[41]

In contrast to the disease coverage of IHR 1969, the IHR 2005 contain provisions for dealing with existing, new, and reemerging diseases, including diseases caused by non-infectious agents.[42] This is an important revision because it broadens the scope of international disease control beyond those disease outbreaks that are immediately foreseeable or predictable.

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34. *Id.*

35. Reasons for these emergent threats include: changes in the way food is processed, encroachment on unexplored areas of the world, and the increase in cross-border travel. *See* Rob Stein, *SARS Prompts WHO to Seek More Power to Fight Disease; Proposals Include Visits to Nations Threatened by an Epidemic*, WASH. POST, May 18, 2003, at A10.

36. *See* WHO Takes Key Steps to Combat Emerging Diseases, PR NEWSWIRE U.S., Sept. 21, 2005 [hereinafter Steps to Combat Emerging Diseases].

37. The mortality rate of the Zaire strain of Ebola was approximately 90%. See LAURIE GARRET, THE COMING PLAGUE: NEWLY EMERGING DISEASES IN A WORLD OUT OF BALANCE 100-52 (1995) for a comprehensive discussion on the devastating spread of Ebola in Zaire.

38. *See* Richard Preston, The Hot Zone: A Terrifying True Story (1995).

39. For a list of all countries that have reported probable cases of SARS, see World Health Organization, *Summary of Probable SARS Cases with Onset of Illness from 1 November 2002 to 31 July 2003*, http://www.who.int/csr/sars/country/table2004_04_21/en/index.html (last visited Jan. 10, 2006) [hereinafter *SARS Deaths*].

40. *Compare id.* (the number of SARS-related deaths stands at 774) *with* World Health Organization, *Ebola Hemorrhagic Fever Fact Sheet*, http://www.who.int/mediacentre/factsheets/fs103/en/index.html (the number of deaths from Ebola is over 1200) (last visited Jan. 10, 2007), *and Avian Influenza Deaths*, *supra* note 30 (the number of reported deaths from the A/(H5N1) strain of avian influenza currently stands at 157).

41. *See, e.g.*, Ian Urbina, *City Weighs Plan to Deliver Medicine to Public After Attack*, N.Y. TIMES, Feb. 7, 2005, at B1.

42. *See WHO FAQ*, *supra* note 13.

2. Notification Dependence

The current IHR are completely dependent on Member States to notify the WHO of a disease outbreak.[43] Notification is limited to the three covered diseases: cholera, plague and yellow fever.[44] Not surprisingly, the WHO's reliance on Member States' notification caused complications; diseases would spread before the agency could institute or recommend containment measures. For instance, the Chinese government did not confirm a SARS epidemic existed until several months after it began,[45] when SARS had already caused widespread devastation.[46]

By contrast, the proposed IHR endow the WHO with greater control over disease management by expanding Member States' notification requirements. Under the new IHR, the WHO provides detailed criteria that Member States must use in order to determine whether an event constitutes a public health emergency of international concern.[47] Such an event requires mandatory reporting and must be brought to the WHO's attention "by the most efficient means of communication available."[48] The WHO also requires mandatory reporting for an enumerated list of "unusual and unexpected" diseases,[49] and recommends careful scrutiny in evaluating the need for notification of other diseases "which have demonstrated the ability to cause serious public health impact and to spread rapidly internationally."[50]

3. Weak Collaborative Mechanisms

The IHR 1969 lack mechanisms to facilitate communication between Member States and the WHO when a public health threat is

43. *See* IHR 1969, *supra* note 12, at Part II.

44. "Each health administration shall notify [the WHO] . . . within twenty-four hours of its being informed that the first case of a disease subject to the Regulations . . . has occurred in its territory." *Id.* at Part II, art. 3.

45. *See* Stein, *supra* note 35.

46. Of the 774 total probable deaths from SARS, 685 deaths are attributable to China. *See SARS Deaths*, *supra* note 39.

47. The determination of a public health emergency of international concern is made based on the following four criteria: seriousness of the public health impact, unusual or unexpected nature of the event, potential for the event to spread internationally and/or the risk that restrictions to travel or trade may result because of the event. *See* IHR 2005, *supra* note 10, at annex 2.

48. *Id.* at Part II, art. 6, ¶ 1.

49. The following diseases are "unusual and unexpected" and *shall* [emphasis added] be reported to the WHO: smallpox, poliomyelitis due to wild-type poliovirus, human influenza caused by a new subtype, and SARS. *Id.* at annex 2.

50. The following diseases *may* [emphasis added] require notification of the WHO: cholera, pneumonic plague, yellow fever, viral hemorrhagic fevers, West Nile fever, and "other diseases that are of special national or regional concern." *See id.*

identified. This weakness resulted in inadequate notification[51] because certain Member States were ill-equipped to effectively maintain contact with the WHO during a public health crisis.[52] The proposed IHR require Member States to establish a National IHR Focal Point[53] and to designate authorities who are responsible for implementing health measures under the Regulations. The WHO will then appoint IHR Contact Points to communicate with the National Focal Points on IHR matters.[54] Additionally, the IHR 2005 lay out the core capacities[55] a Member State must have at the local and national level to "detect, assess, notify and report events"[56] to the WHO.

The IHR 2005 require the WHO to assist Member States in implementing the Regulations.[57] The WHO may grant Member States an extension to fulfill the core capacities requirement.[58] This collaborative implementation framework ensures the participation of both the Member States and the WHO in developing the most effective communication scheme[59] to deal with emerging diseases and emergency health threats. The guidelines for reporting and communicating with the WHO also provide Member States with a clear indication of their responsibilities.

4. Lack of Risk-Specific Measures

Under the IHR 1969, the WHO lacks the authority to prescribe measures tailored to a specific disease outbreak.[60] By contrast, the proposed IHR grant the WHO the power to issue both temporary and

51. See Stein, *supra* note 35, on the Chinese government's sluggishness in reporting the SARS epidemic.

52. Member States range from industrialized nations such as the United States, Canada, Japan and China, to more impoverished countries like Somalia, Afghanistan, and Bangladesh. These latter countries likely lack the funding and resources necessary to develop disease communication centers. *See WHO Member States*, *supra* note 11.

53. A National IHR Focal Point is the "national centre, designated by each State Party, which shall be accessible at all times for communications with WHO IHR Contact Points." IHR 2005, *supra* note 10, at Part I, art. 1.

54. *Id.* at Part I, art. 4, ¶ 3.

55. Member States are required to have certain basic, or "core" capacities for disease surveillance and response, and for treatment and assessment at points of entry. Only the former types of core capacities are being referenced here. See *id.* at annex 1.A for an enumerated list of the core capacities a Member State must have for surveillance and response. See *infra* Part V.A.2 for a discussion of the core capacities required at points of entry.

56. IHR 2005, *supra* note 10, at Part II, art. 5, ¶ 1.

57. *Id.* at Part II, art. 5, ¶ 3.

58. *Id.* at Part II, art. 5, ¶ 2.

59. Contact details are required to be "continuously updated and annually confirmed." *Id.* at Part I, art. 4, ¶ 4.

60. *See* HARDIMAN ET AL., *supra* note 5, at 3.

standing recommendations.[61] Although these recommendations are non-binding,[62] the WHO has the option to prescribe or modify the measures required to minimize the spread of diseases.[63] Because the diseases covered under the proposed IHR are not circumscribed,[64] the WHO can also customize its response to the concerns posed by a specific public health event. Nevertheless, the effectiveness of these recommendations depends heavily on refining communication[65] between the WHO and Member States.

5. Nominal Compliance Incentives

Under the former IHR, there is a mandatory reporting requirement for outbreaks of cholera, plague, and yellow fever.[66] However, Member States sometimes failed to report disease cases for fear that news of the outbreak would impact international travel and trade.[67] Thus, there was little incentive for Member States to notify the WHO because economic losses were practically certain once the WHO released information about the public health event. Therefore, Member States were encouraged to participate in the revision process because it permitted them to develop rules and guidelines that they would be likely to follow.

In addition, the proposed IHR attempt to reduce interference with trade[68] by allowing Member States to make provisional confidential notifications to the WHO.[69] The WHO will not report a public health event until it determines that the event is a public health emergency of international concern, or until it confirms the contamination or spread of the disease.[70] The WHO may also report the event if it believes control measures are unlikely to succeed, are needed immediately, or if the

61. Temporary and standing recommendations are non-binding advice that the WHO may issue to Member States. Temporary recommendations apply to a public health emergency of international concern, but standing recommendations are more "routine or periodic" in application. IHR 2005, *supra* note 10, at Part I art. 1.

62. *Id.*

63. Recommendations may be tailored to the following areas: persons, baggage, cargo, containers, conveyances, goods and postal parcels. *Id.* at Part III, art. 18.

64. See *supra* Part III.A.1 on the IHR 2005's disease coverage, which includes existing, new and reemerging diseases.

65. See *supra* Part III.A.3 on the implementation of National Focal Points and IHR Contact Points under the IHR 2005.

66. *See* IHR 1969, *supra* note 12, at Part II, art. 3, ¶ 1.

67. For example, during a 1994 outbreak of plague in India, the country lost an estimated $1.7 billion in revenue. *See* HARDIMAN ET AL., *supra* note 5, at 3.

68. One of the enumerated purposes of the proposed IHR is to "avoid unnecessary interference with international traffic and trade." IHR 2005, *supra* note 10, at Part I, art. 2.

69. *See id.* at Part II, art. 11.

70. *Id.* at Part II, art. 11, ¶¶ 2(a), (b).

Member State lacks the capacity to contain the threat.[71] Although some financial harm may inevitably occur, assessment-based reporting has an obvious advantage over the former mandatory reporting system. The WHO can now control the dissemination of information to other Member States and to the public, thereby ensuring that economic losses remain at a minimum.

Another incentive for compliance is intertwined with the WHO's ability to promulgate disease-specific recommendations.[72] In issuing, modifying, or terminating recommendations, the WHO is required to consider "the views of the State Parties directly concerned"[73] in order to temper international trade interference. This collaborative assessment approach continues to promote the possibility of trade between Member States even in the wake of a disease outbreak.

B. The Revision Process

The WHA resolved to revise the IHR in 1995.[74] The call for revision was catalyzed by outbreaks of cholera in Peru, plague in India, and Ebola in Zaire.[75] In preparing to draft the new Regulations, the WHA asked Member States for support in identifying and responding to international public health emergencies,[76] including emergencies involving biological or chemical agents.[77] The WHA continued to foster a collaborative relationship with Member States by passing a resolution establishing intergovernmental working groups (IGWG).[78] The IGWG allowed Member States to review draft revisions of the IHR and to propose changes.

While the drafting of the IHR was ongoing, the immediate need for

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71. *Id.* at Part II, art. 11, ¶¶ 2(c), (d).

72. See *supra* Part III.A.4 on the WHO's ability to issue temporary and standing recommendations tailored to the necessities of a specific disease outbreak.

73. IHR 2005, *supra* note 10, at Part II, art. 17(a).

74. *See* World Health Assembly, *Revision and Updating of the World Health Regulations*, WHA Res. 48.7, 48th Ass., 12th plen. mtg. (May 12, 1995).

75. *Id.*

76. *See* World Health Assembly, *Global Health Security: Epidemic Alert and Response*, WHA Res. 54.14, 54th Ass., 9th plen. mtg. (May 21, 2001), *available at* http://ftp.who.int/gb/pdf_files/WHA54/ea54r14.pdf (last visited Jan. 10, 2007).

77. *See* World Health Assembly, *Global Public Health Response to Natural Occurrence, Accidental Release, or Deliberate Use of Biological and Chemical Agents or Radionuclear Material That Affect Health*, WHA Res. 55.16, 55th Ass., 9th plen. mtg. (May 18, 2002), *available at* http://www.who.int/gb/ebwha/pdf_files/WHA55/ewha5516.pdf (last visited Jan 10, 2006).

78. *See* World Health Assembly, *Revision of the International Health Regulations*, WHA Res. 56.28, World Health Assembly, 56th Ass., 10th plen. mtg. (May 28, 2003), *available at* http://www.who.int/gb/ebwha/pdf_files/WHA56/ea56r28.pdf (last visited Jan. 10, 2007).

uniform public health governance became clear due to two serious international disease outbreaks: SARS and avian influenza. The WHA intervened and issued resolutions asking Member States to commit to controlling the SARS epidemic[79] by increasing their pandemic influenza preparedness and response.[80] Finally, after revisions by the IGWG in both 2004 and 2005,[81] the WHA adopted the IHR on May 23, 2005.[82]

IV. Legal Capacity, Sanctions and Interpretation

A. Legal Effect

The IHR would merely be a useless list of public health protocols if it were not grounded in international law. Thus, within eighteen months of the WHA's adoption of the IHR 2005 (by June 2007), a Member State must accept the Regulations as legally binding or provide its reasons for non-acceptance.[83] Non-Member states may also agree to be bound by the Regulations.[84] There are, however, limitations to a Member State's non-acceptance. A Member State's reservation must not be incompatible with the "object and purpose" of the IHR 2005.[85] The WHA has the sole discretion to determine whether a Member State has met this test and can reject the Regulations.[86]

Still, the June 2007 adoption deadline for Member States did not seem soon enough given the "ongoing outbreaks . . . of highly pathogenic avian influenza" and the possibility of a pandemic.[87] Thus, in May 2006, the WHA called for immediate compliance, on a voluntary basis, with the IHR 2005 provisions considered relevant to preventing an avian and human influenza pandemic.[88] Specifically, Member States

79. *See* World Health Assembly, *Severe Acute Respiratory Syndrome (SARS)*, WHA Res. 56.29, 56th Ass., 10th plen. mtg. (May 28, 2003), *available at* http://www.who.int/gb/ebwha/ pdf_files/WHA56/ea56r29.pdf (last visited Jan. 10, 2007).

80. *See* World Health Assembly, *Strengthening Pandemic-Influenza Preparedness and Response*, WHA Res. 58.5, 58th Ass., 8th plen. mtg. (May 23, 2005), *available at* http://www.who.int/gb/ebwha/pdf_files/WHA58/WHA58_5-en.pdf (last visited Jan. 10, 2007).

81. *See WHO FAQ*, *supra* note 13.

82. For the resolution adopting the IHR 2005, see IHR 2005, *supra* note 10.

83. WHO CONST., *supra* note 23, at art. 20.

84. IHR 2005, *supra* note 10, at Part X, art. 64, ¶ 1.

85. *Id.* at Part X, art. 62, ¶ 1.

86. *See id.* at Part X, art. 62, ¶ 9.

87. *See* World Health Assembly, *Application of the International Health Regulations (2005)*, WHA Res. 59.2, 59th Ass., 8th plen. mtg. (May 26, 2006), *available at* http://www.who.int/gb/ebwha/pdf_files/WHA59/WHA59_2-en.pdf (last visited Jan. 10, 2006). Of the 157 currently confirmed deaths from the A/(H5N1) strain of avian influenza, 45 occurred in Indonesia in 2006. *See Avian Influenza Deaths*, *supra* note 30.

88. *See id.* The relevant provisions include the following:

were asked to immediately establish National IHR Focal Points, and the Director General was asked to designate IHR Contact Points.[89] Member States were also requested to cooperate with one another to boost their vaccination production capacity.[90]

B. Penalties and Dispute Resolution

Because the revision of the IHR was a collaborative effort that involved both the WHO and Member States, compliance is ostensibly in the best interest of all parties. Although there are no sanctions, *per se*, for failure to adhere to the IHR 2005, the WHO is permitted to monitor compliance with the Regulations.[91]

The IHR 2005 offer several dispute mechanisms to settle interpretation disagreements between two or more Member States, including: arbitration, mediation, negotiation, and conciliation.[92] Additionally, Member States may agree to refer the matter to the Director-General.[93] In the event of a dispute between the WHO and one or more Member States, the matter is submitted to the WHA.[94] If the dispute remains unresolved, it is then submitted to the International Court of Justice.[95]

C. Interpretation

The IHR and other relevant international agreements "should be

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(1) Annex 2, in so far as it requires prompt notification to WHO of human influenza caused by a new virus subtype;
(2) Article 4 pertaining to the designation or establishment of a National IHR Focal Point within countries and the designation of WHO IHR Contact Points, and the definition of their functions and responsibilities;
(3) Articles in Part II, pertaining to surveillance, information-sharing, consultation, verification and public health response;
(4) Articles 23 and 30-32 in Part V pertaining to general provisions for public health measures for travellers on arrival or departure and special provisions for travellers;
(5) Articles 45 and 46 in Part VIII pertaining to the treatment of personal data and the transport and handling of biological substances, reagents and materials for diagnostic purposes.

Id. at ¶ 2.

89. *Id.* at ¶¶ 4(1), 5(1).
90. *Id.* at ¶ 4(5).
91. IHR 2005, *supra* note 10, at Part X, art. 54, ¶¶ 2, 3.
92. *Id.* at Part X, art. 56, ¶ 1.
93. *Id.* at Part X, art. 56, ¶ 2. Dr. Margaret Chan, who was appointed by the WHA on November 9, 2006, is currently the Director-General of the WHO. *See* World Health Organization, *Director-General's Office*, http://www.who.int/dg/en/ (last visited Jan. 10, 2006).
94. IHR 2005, *supra* note 10, at Part X, art. 56, ¶ 5.
95. WHO CONST., *supra* note 23, at art. 75.

interpreted so as to be compatible" with one another.[96] Member States retain the sovereign right under international law and the Charter of the U.N. to implement public health legislation, but that legislation must be consistent with the purpose of the IHR.[97] Where appropriate, the WHO is required to cooperate with intergovernmental organizations and international bodies and may coordinate with such entities for the protection of public health.[98] Under the proposed IHR, the WHO will therefore continue to foster working relationships with many international organizations.[99] In implementing the IHR, the WHO will also work with specific regional organizations, such as the European Union and the European Commission.[100]

V. Traveler Safeguards: Substantive Changes between the IHR 1969 and the IHR 2005

A. Health Measures

Global public health governance affects many aspects of human rights,[101] and in this context also presents opportunities for gross abuse.[102] Health measures can be extremely intrusive,[103] invasive,[104] or

96. IHR 2005, *supra* note 10, at Part X, art. 57, ¶ 1. For a roadmap of possible interactions between the IHR 2005 and other international instruments, see World Health Organization, *Review and Approval of Proposed Amendments to the International Health Regulations: Reservations to the International Health Regulations: Report by the Secretariat* (Jan. 27, 2005), *available at* http://www.who.int/gb/ghs/pdf/IHR_IGWG2_ID2-en.pdf (last visited Jan. 10, 2007).

97. IHR 2005, *supra* note 10, at Part I, art. 3, ¶ 4.

98. *Id.* at Part II, art. 14, ¶ 1.

99. The WHO has standing agreements with the following organizations, the: International Labour Organisation, Food and Agriculture Organization of the United Nations, United Nations Educational, Scientific and Cultural Organization, International Atomic Energy Agency, International Fund for Agricultural Development, United Nations Industrial Development Organization, Universal Postal Union, International Air Transport Association, International Civil Aviation Organization, International Maritime Organization, Office International d'Epizooties (World Organisation for Animal Health) and World Trade Organization. *See generally* WHO CONST., *supra* note 23.

100. *WHO FAQ*, *supra* note 13.

101. *See New Conception*, *supra* note 6, at 423.

102. Singapore's measures in containing the SARS epidemic were described by one journalist as "draconian." The country placed Internet cameras in the homes of quarantined patients, made some patients wear electronic monitoring bracelets, and installed thermal-imaging scanners to take passengers' temperatures in airports. *See* Richard C. Paddock, *A Hotbed of SARS Warfare: Mass Temperature Testing is Just One of the Tools that the Autocratic City-State of Singapore is Wielding in Winning its Assault on the Disease*, L.A. TIMES, May 8, 2003, at 1.

103. The IHR 2005 define 'intrusive' as "possibly provoking discomfort through close or intimate contact or questioning." IHR 2005, *supra* note 10, at Part I, art. 1.

104. Invasive "means the puncture or incision of the skin or insertion of an instrument

humiliating[105] to an individual. These measures also risk being applied in a discriminatory fashion,[106] or in an excessive manner. Thus, clear boundaries need to be drawn between treatment measures that are permissible during a public health event, and those that violate international law.[107]

1. Purpose and Basic Principles

The IHR 1969 concisely state their mission as "maximum protection, minimal restriction," which refers to trade boundaries, not human rights.[108] The proposed IHR boast that their purpose is to "respond to the international spread of disease" by methods "restricted to public health risks, and which avoid unnecessary interference with international travel and trade."[109] There is no mention of minimizing interference with individual liberty in either of the Regulations' mission statements. Instead, the concern rests entirely on limiting the economic consequences of disease control. Such an oversight indicates that the priority of the revised IHR lies in sustaining commerce, not in protecting human rights.

Oversimplified statements of human rights protections continue to appear throughout the IHR 2005. Following the statement of purpose, the IHR 2005 vaguely refers to implementing the Regulations "with full respect for the dignity, human rights, and fundamental freedoms of persons."[110] In Part VIII, the IHR 2005 state that health measures "shall be initiated and completed without delay" in a "non-discriminatory manner."[111] Article 32 expounds somewhat on the meaning of "non-discriminatory,"[112] but provides no suggestion of what type of behavior

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or foreign material into the body or the examination of the body cavity." Temperature-taking by any method other than rectally, and collection of urine, feces, or saliva samples are specifically listed as measures that are non-invasive. *Id.*

105. The old IHR provided that a traveler who has come from an area infected with cholera, or who presents symptoms of cholera, does not have to submit to rectal swabbing, but "may be required to submit to a stool examination." IHR 1969, *supra* note 12, at Part V, art. 64.

106. Gender, sociocultural, ethnic and religious concerns of travelers shall be considered in implementing health measures. IHR 2005, *supra* note 10, at Part V, art. 32(b).

107. The IHR 1969 were adopted before the development of international human rights law, so the current IHR do not protect human rights under international law. However, the IHR 2005 are subject to interpretation under international law. *See id.* at Part X, art. 57, ¶ 1.

108. IHR 1969, *supra* note 12, at foreword.

109. IHR 2005, *supra* note 10, at Part I, art. 2.

110. *Id.* at Part I, art. 3, ¶ 1.

111. *Id.* at Part VIII art. 42. The IHR 1969 make a similar statement. *See* IHR 1969, *supra* note 12, at Part IV, art. 24.

112. *See* IHR 2005, *supra* note 10, at Part V, art. 32(b).

is explicitly prohibited. In sum, the human rights principles and objectives stated in the IHR 2005 remain too generalized to provide travelers with satisfactory assurances of protection against governmental intrusion.[113]

In addition to their failure to enumerate human rights principles, it has also been suggested that the IHR 2005's mission statement does not conform to the realities of effective disease control.[114] Globalization has generated economic prosperity, but it also has encouraged the expeditious spread of disease.[115] In fact, the objective of the WHO Constitution[116] does not even mention commerce or trade, and therefore starkly contradicts the IHR's mission statement.[117]

2. Core Capacities Requirements: Points of Entry[118]

In contrast to the elusive human rights principles that are weakly set forth in the proposed IHR, the basic requirements[119] for controlling disease at points of entry are more specifically enumerated.[120] Many of these mandates implicitly acknowledge human rights concerns by requiring sufficient treatment availability and conditions.[121] The IHR 2005 contain a full-page description of the minimum treatment requirements Member States' points of entry must have not only in general, but also in responding to a public health emergency of international concern.[122] This is a vast improvement over the old IHR treatment requirements. Medical equipment, staff and facilities under the IHR 1969 were simply mandated to be "adequate."[123]

The IHR 2005 provide that at all times, points of entry shall provide access to "appropriate medical service," which includes adequate diagnostic facilities, equipment, and staff.[124] If the facility cannot

113. *See* Lawrence O. Gostin, *International Infectious Disease Law: Revision of the World Health Organization's International Health Regulations*, 291 J. AM. MED. ASS'N 2623, 2626 (2004) [hereinafter *Infectious Disease Law*].

114. Gostin contends that it is impossible to have "unimpeded travel and trade" while ensuring "full public health protection." *Id.* at 2624.

115. *See, e.g., Steps to Combat Emerging Diseases*, *supra* note 36.

116. *See* WHO CONST., *supra* note 23, at art. 1.

117. *See Infectious Disease Law*, *supra* note 113, at 2624.

118. Points of entry are places like airports and ports. They are defined as passages "for international entry or exit of travelers . . . as well as agencies and areas providing services to them on entry or exit." IHR 2005, *supra* note 10, at Part I, art. 1.

119. The term "basic requirements" is used here to refer to the statement that Member States must maintain these requirements "at all times." *Id.* at annex 1.B.

120. *See id.*

121. *See id.*

122. *See id.*

123. IHR 1969, *supra* note 12, at Part III, arts. 15, 18 ¶ 2.

124. IHR 2005, *supra* note 10, at annex 1.B, ¶ 1(a).

sufficiently handle a sick traveler's condition, it must transport the patient to an alternative, fully equipped medical facility.[125] Travelers are also guaranteed a "safe environment"[126] at points of entry.

The core capacities required at points of entry for a public health emergency of international concern are more stringent than the basic requirements. First, Member States must establish and maintain a "public health emergency contingency plan," which names agencies, coordinators and contact points for managing the emergency.[127] Medical and veterinary facilities must make arrangements to render services to sick travelers and animals.[128] Points of entry must leave appropriate space for conducting interviews[129] and quarantining[130] travelers. Similar to the basic requirements, trained personnel and appropriate medical equipment must be on-hand.[131]

The core capacities requirements dispel the ambiguities of the former IHR by defining exactly what resources are needed for disease containment and treatment at points of entry. Although this may seem to leave little flexibility in how Member States can implement the requirements, the history of the IHR 1969 demonstrates that explicit guidelines are better than leaving open-ended decision-making to Member States.[132] As an added safeguard, Member States are required to monitor and inspect the basic requirements to ensure compliance and to determine if additional provisions are necessary to maintain a safe environment.[133]

3. Temporary and Standing Recommendations

Under the former IHR, the WHO was not empowered to make disease-specific recommendations;[134] however, the proposed IHR allows the WHO to issue temporary and standing recommendations.[135] These recommendations may be disseminated periodically or during a public

125. *Id.* at annex 1.B, ¶ 1(b).

126. Points of entry must furnish "potable water supplies, eating establishments, flight catering facilities, public washrooms, and appropriate and solid liquid waste disposal services." *Id.* at annex 1.B, ¶ 1(d).

127. *Id.* at annex 1.B, ¶ 2(a).

128. *See id.* at annex 1.B, ¶ 2(b).

129. *See id.* at annex 1.B, ¶ 2(c).

130. The WHO prefers that quarantine be provided at a facility away from the point of entry. *See id.* at annex 1.B, ¶ 2(d).

131. *See id.* at annex 1.B, ¶ 2(g).

132. For example, see *supra* Parts III.A.2,3 on the collaboration and notification problems under the IHR 1969.

133. *See* IHR 2005, *supra* note 10, at annex 1.B, ¶ 1(d).

134. *See supra* Part III.A.4 on the lack of risk-specific measures in the IHR 1969.

135. See *supra* note 61 on the difference between temporary and standing recommendations.

health emergency of international concern.[136] Like the core capacities, the WHO's disease control recommendations also implicate human rights. Article 17 declares that these recommendations must not be "more intrusive to persons than reasonably available alternatives that would achieve the appropriate level of health protection."[137] Article 18 enumerates the type of recommendations that may be issued,[138] and thus gives some clarification to Article 17's vague reference to what constitutes "other reasonable available alternatives."

The IHR 2005's balancing test between the proposed recommendation and other reasonably available alternatives is an improvement over the old IHR, which only applied health measures so as "not to cause undue discomfort to any person, or injury to his health."[139] Still, the list of temporary and standing recommendations is not exclusive.[140] This gives the WHO significant breadth to issue recommendations adapted to a particular situation. However, the possibility that this flexibility will invite abuse is tempered by providing specific criteria that the Director-General is required to consider before issuing recommendations.[141] Relevant international law, advice of committees and of Member States, and scientific evidence and information are all factors that the Director-General must assess.[142]

It is also important to note that both temporary and standing recommendations serve as the WHO's non-binding advice[143] to Member States. Member States' failure to follow these recommendations does

136. *See* IHR 2005, *supra* note 10, at Part III, arts. 15, 16.

137. *Id.* at Part III, art. 17, ¶ 1(d).

138. Recommendations that the WHO may issue to State Parties with respect to persons may include any of the following advice:

-No specific health measures are advised;
-Review travel history in affected areas;
-Review proof of medical examination and any laboratory analysis;
-Require medical examinations;
-Require vaccinations or other prophylaxis;
-Place suspect persons under public health observation;
-Implement quarantine or other health measures for suspect persons;
-Implement isolation and treatment when necessary of affected persons;
-Implement tracing of contracts of suspect or affected persons;
-Refuse entry of suspect and affected persons;
-Refuse entry of unaffected persons to affected areas; and
-Implement exit screening and/or restrictions on persons from affected areas.

Id. at art. 18, ¶ 1.

139. IHR 1969, *supra* note 12, at Part IV, art. 25, ¶ 1(a).

140. The language "recommendations . . . may include" suggests that the WHO can issue temporary or standing recommendations that are not listed in Article 18. *See* IHR 2005, *supra* note 10, at Part III, art. 18.

141. *See id.* at Part III, art. 17.

142. *Id.*

143. *See id.* at Part I, art. 1.

not permit the WHO to bring an enforcement action.[144] Therefore, the IHR 2005 allow Member States to issue their own health measures as long as they achieve "the same or greater level of health protection than WHO recommendations," or as long as they are not otherwise prohibited by the Regulations.[145] Member States are required to craft their health measures using criteria similar to those considered by the Director-General.[146] The consideration requirements of both the Director-General and the Member States control abuse by ensuring health measures are well-researched before being implemented.

In sum, the recommendation issuance procedures established by the IHR 2005 greatly minimize the opportunities for human rights abuses because of the checks and balances between the WHO and Member States. The WHO researches the recommendations, but Member States can still reject them without legal penalty, and Member States are always free to implement their own measures within the IHR 2005's guidelines. The system, though, is only as dependable as the entities involved, and if the recommendations are not well-regulated or well-monitored, traveler safeguards still risk being ignored.

4. Vaccinations and Examinations

Traditional democratic notions of bodily integrity[147] demand the enforcement of stringent guidelines before an international traveler can be poked and prodded against his will. Under the IHR 2005, a traveler cannot be vaccinated or examined without his informed consent or the informed consent of his guardian.[148] However, if a traveler fails to consent to a health measure, he may be denied entry; if there is evidence of a health risk, he may be compelled to be vaccinated or examined.[149] Similar to the temporary and standing recommendations, the examination must be the least intrusive means to achieve the public health objective.[150] Vaccinations that involve a risk of disease transmission must be administered "in accordance with established national or international safety guidelines."[151]

144. See *supra* Part IV.B on penalties and dispute resolution under the IHR 2005.

145. IHR 2005, *supra* note 10, at Part VIII, art. 43, ¶ 1.

146. Member States' determinations of what health measures to implement shall be based upon scientific principles, available scientific evidence of a risk to human health, and any available guidance or advice from the WHO. *Id.* at Part VIII, art. 43, ¶ 2.

147. The American legal system prosecutes an intentional harmful or offensive touching as a battery. *See, e.g.,* Snyder v. Turk, 627 N.E.2d 1053, 1057 (Ohio Ct. App. 1993).

148. *See* IHR 2005, *supra* note 10, at Part V, art. 23, ¶ 3.

149. *See id.* at Part V, art. 31, ¶ 2.

150. *Id.* at Part V, art. 31, ¶ 2(a).

151. *Id.* at Part V, art. 23, ¶ 4.

By contrast, the IHR 1969 do not require informed consent before health authorities may vaccinate or examine a traveler. Under the IHR 1969, when health authorities deem it necessary, they are permitted to examine any person arriving on an international voyage,[152] and any person departing on an international voyage.[153] Any traveler who exhibits symptoms of cholera within the incubation period may be required to submit to a stool examination.[154] "Vaccination against yellow fever may be required of any traveler leaving an infected area on an international voyage,"[155] but inoculation against plague is not a condition of admission.[156] Some of these requirements are obsolete, but they illustrate the vast leeway afforded to health authorities under the IHR 1969 compared to the informed consent restrictions of the IHR 2005.

5. Isolation and Quarantine[157]

Isolation and quarantine are two of the oldest public health tools used to contain infectious diseases.[158] The terms "isolation" and "quarantine" are often used interchangeably, but they refer to two different health measures. Isolation is the separation of a known infected person.[159] Quarantine is the restriction of activities or the separation of a healthy person who has been exposed to an infectious disease.[160] In both instances, the goal is to limit the spread or the possible spread of infection or contamination.[161]

The IHR 2005 briefly address the treatment of travelers who are subject to isolation or quarantine.[162] Travelers must be provided with adequate food, water, clothing, protection for baggage, and medical treatment.[163] One cause for concern is that Member States are only required to provide a means of communication for quarantined or

152. *See* IHR 1969, *supra* note 12, at Part IV, art. 36, ¶ 1.
153. *See id.* at Part IV, art. 30, ¶ 3.
154. *Id.* at Part V, art. 64, ¶ 2.
155. *Id.* at Part V, art. 66, ¶ 1.
156. *Id.* at Part V, art. 51.
157. Although here the terms are referred to only as impacting human beings, isolation and quarantine may also be applied to infected or suspect goods. For a discussion of the treatment of personal items under the IHR 2005, see *infra* Part V.C.
158. Lawrence O. Gostin, *Ethical and Legal Challenges Posed by Severe Acute Respiratory Syndrome: Implications for the Control of Severe Infectious Disease Threats*, 290 J. AM. MED. ASS'N 3229, 3230 (2003) [hereinafter *SARS Implications*].
159. *See* IHR 2005, *supra* note 10, at Part I, art. 1.
160. *See id.*
161. *See id.*
162. *See id.* at Part V, art. 32(c).
163. *Id.*

isolated travelers who do not speak the native language "if possible."[164] This is inconsistent with the mandate requiring Member States to account for "gender, sociocultural, ethnic or religious concerns of travelers"[165] because these concerns cannot be voiced when there is a communication barrier. Conversely, the IHR 1969 do not specify the particulars of isolation and quarantine beyond the fact that Member States have the power to implement these health measures when necessary.[166]

It is ironic that the IHR 2005 devote only a paragraph to addressing isolation and quarantine safeguards despite the fact that these measures involve physical confinement, which is a significant encroachment on individual liberty.[167] Recognizing Member States' need for more detailed guidance, one scholar proposes integrating substantive and procedural safeguards to guarantee that containment measures are implemented with due regard for human rights.[168] Such an incorporation would take the arbitrariness out of containment measures and ensure that only those who are truly infected or at risk would be subject to isolation or quarantine.

B. Personal Data

When personal data is involved, there are two main issues that implicate the conflict between individual liberty and public health governance. One issue involves privacy concerns over the collection and dissemination of health information.[169] The other issue entails the type of health information that international travelers should be required to provide before being admitted into a country.

The IHR 2005 devote an entire article to the treatment of personal data.[170] Health information collected or received by a Member State from another Member State or from the WHO "which refers to an identified or identifiable person shall be kept confidential and processed

164. *Id.*

165. *Id.* at Part V, art. 32(b).

166. *See* IHR 1969, *supra* note 12, at Part IV, art. 23.

167. During the SARS outbreak, Singapore hired a security agency to enforce quarantine. The agency used electronic bracelets and Internet cameras to supervise quarantined patients. *See* Paddock, *supra* note 102.

168. Lawrence O. Gostin comments that the revised IHR "are silent regarding the legal standards and fair processes necessary for isolation, quarantine, and other compulsory measures." *Infectious Disease Law*, *supra* note 113, at 2626.

169. Disclosure of sensitive health information can ruin a person's career or even his life. A prominent example is the disclosure of the late Arthur Ashe's HIV-positive status. *See Technology is Changing Health Data Security Landscape*, HEALTH DATA MGMT., Sept. 18, 1997.

170. *See* IHR 2005, *supra* note 10, at Part VIII, art. 45.

anonymously as required by law."[171] However, Member States may disclose personal data "where essential for the purposes of assessing and managing a public health risk,"[172] but the disclosure is subject to certain qualifications.[173] The WHO is also required to furnish a traveler with his personal data if he requests it.[174] In contrast, the IHR 1969 make no mention of any confidentiality or privacy guidelines regarding the treatment of personal information.

The IHR 1969 and the IHR 2005 both provide that an international traveler shall not be required to produce any health documents beyond those required by the Regulations.[175] The IHR 2005 qualify that no traveler possessing a valid certificate of vaccination shall be denied entry unless there is "verifiable" evidence that the vaccine was ineffective.[176] In addition, the IHR 2005 provide an updated Model International Certificate of Vaccination or Prophylaxis with criteria listed for establishing the validity of the certificate.[177] However, inoculation against yellow fever is the only vaccination that may be required as a condition of entry,[178] and it is only required if the traveler leaves an area where the risk of yellow fever transmission is present.[179] Member States must designate yellow fever vaccination centers for travelers,[180] and they have the option to quarantine those travelers who are without a valid

171. *Id.* at Part VIII, art. 45, ¶ 1.

172. *Id.* at Part VIII, art. 45, ¶ 2.

173. The Member State and/or the WHO must ensure that the personal data are:

(a) Processed fairly and lawfully, and not further processed in a way incompatible with that purpose;

(b) Adequate, relevant and not excessive in relation to that purpose;

(c) Accurate, and where necessary, kept up to date; every reasonable step must be taken to ensure that data which are inaccurate or incomplete are erased or rectified; and

(d) Not kept longer than necessary.

Id.

174. This information must be provided "without undue delay or expense." *Id.* at Part VIII, art. 45, ¶ 3.

175. IHR 1969, *supra* note 12, at Part VI, art. 81; *Id.* at Part VI, art. 35.

176. IHR 2005, *supra* note 10, at Part VI, art. 36, ¶ 2.

177. There are minor changes between the Model International Certificate of Vaccination or Prophylaxis in the IHR 1969 and the IHR 2005, but they are not noteworthy. Both Regulations state that the vaccine must have been approved by the WHO, the certificate must be signed by an authorized medical practitioner or health worker, and the certificate must bear the official stamp of the administering center. IHR 1969, *supra* note 12, at app. 2; *id.* at annex 6.

178. Although there may be recommendations that travelers receive other vaccinations, or the requirements could be subject to change during a public health event, yellow fever is the only disease for which vaccination may be required as a condition of entry. *See* IHR 2005, *supra* note 10, at annex 7, ¶ 1.

179. *See id.* at annex 7, ¶ 2(b).

180. *See id.* at annex 7, ¶ 2(f).

vaccination certificate and who pose a risk of transmission.[181]

Overall, the IHR 2005's guidelines for maintaining personal data are a vast improvement over those of the IHR 1969. Information technology poses a high threat of disclosure that was not present when the Regulations were first adopted, which is why it is imperative that the IHR 2005 recognize this change and implement safeguards to deal with emerging technological threats like computer hacking. Also, while the IHR 2005 do not expand on the type of documentation needed for entering a country, they do give a better overview on how Member States can and should regulate vaccination requirements. This dispels the possibility of international travelers encountering capricious vaccination requirements.

C. *Personal Items*

The IHR 2005 permit Member States to inspect "baggage cargo, containers, conveyances, goods, postal parcels and human remains" for public health purposes on arrival or departure.[182] In addition to issuing temporary and standing recommendations for travelers, the WHO is empowered to issue these recommendations for baggage and other cargo.[183] Recommendations may include a review of measures taken on departure to eliminate contamination, implementation of isolation and quarantine, and, at the most extreme, seizure and destruction of infected or suspect items.[184] To minimize the damage associated with these health measures, Member States must provide or arrange for the "protection of baggage and other possessions."[185]

The main difference between the IHR 1969 and the IHR 2005 regarding baggage procedures relates to the temporary and standing recommendations, which do not appear in the former IHR. Other than this, the IHR 1969 provide that "every precaution shall be taken to avoid any damage" to cargo, goods, baggage, containers and other articles.[186] They also vaguely state that baggage is subject to any of the health measures in the Regulations when it comes from an infected area or when contamination is suspected.[187]

Even though baggage is personal and may be particularly important

181. *See id.* at annex 7, ¶ 2(h).
182. *Id.* at Part V, art. 23, ¶ 1(b).
183. *See id.* at Part III, art. 18, ¶ 2.
184. This list of recommendations with regard to baggage, cargo, containers, conveyances, goods or postal parcels is not exhaustive. For a more detailed list of potential recommendations, see *id.* at Part III, art. 18, ¶ 2.
185. *Id.* at Part V, art. 32(c).
186. IHR 1969, *supra* note 12, at Part IV, art. 25, ¶ 2.
187. *See id.* at Part IV, art. 46, ¶ 1.

to travelers, its preservation should never take priority over public health. The IHR 2005 recognize this practical limitation by preserving the IHR 1969's health measures with respect to baggage, which include fostering mechanisms that allow for the protection of baggage when feasible. This compromise acknowledges the importance of personal possessions while continuing to further the IHR's purpose of ensuring maximum public health protection.

D. Charges

Health measures concerning persons, data, and baggage can be expensive, so a question arises as to who should be required to absorb these costs. Medical examinations, vaccinations on arrival, isolation and quarantine, vaccination certificates, and any health measure applied to baggage are provided to the traveler free of charge under the IHR 2005.[188] Member States may charge for any services other than the above mentioned, including those "primarily for the benefit of the traveler,"[189] but the charge is not permitted to exceed the actual cost of the service rendered.[190] A traveler is never denied the ability to depart pending payment,[191] and charges are levied "without distinction as to nationality, domicile, or residence of the traveler."[192]

Only vaccinations and medical examinations are provided to travelers free of charge under the IHR 1969.[193] However, the IHR 2005 retain the identical language as the IHR 1969 regarding non-discriminatory application of charges.[194] Similarly, charges under the IHR 1969 are not permitted to exceed the actual cost of the service rendered.[195] Unlike the IHR 2005, however, there are no provisions in the IHR 1969 regarding a traveler's failure or inability to pay.

Even with the expanded free services under the IHR 2005, it has been suggested that travelers, especially those subject to isolation or quarantine, deserve compensation for any income lost during the duration of these health measures.[196] The rationale behind a remuneration scheme is that the community should bear the financial burden when individual liberty is compromised in favor of public

188. *See* IHR 2005, *supra* note 10, at Part VII, art. 40, ¶ 1.
189. *Id.* at Part VII, art. 40, ¶ 2.
190. *See id.* at Part VII, arts. 40, ¶ 3(b); 41, ¶ 1(b).
191. *See id.* at Part VII art. 40, ¶ 6.
192. *Id.* at Part VII arts. 40, ¶ 3(c); 41, ¶ 1(c).
193. *See* IHR 1969, *supra* note 12, at Part VII, art. 82, ¶ 1.
194. *See id.* at Part VII, art. 82, ¶ 2(c).
195. *See id.* at Part VII, art. 82, ¶ 2(b).
196. "Fairness may require compensation, particularly for the poor who lose vital income during isolation or quarantine." *SARS Implications*, *supra* note 158, at 3234.

health.[197] In spite of this logic, determining compensation is probably too speculative to be appropriately quantified, and too susceptible to abuse without explicit compensation limits. Even then, the better rationale may be to put funding toward disease containment rather than traveler compensation, with the hope of decreasing casualties and improving the effectiveness of isolation and quarantine measures.

VI. Conclusion

International travel is an important facet of a globalized society, and the IHR 2005 are just one of the mechanisms that seek to protect those who must venture beyond national boundaries. As public health scholar Lawrence O. Gostin notes, "[w]ithout a certain level of health, safety and security . . . people cannot . . . meaningfully exercise their autonomy or participate in social or political life."[198] The goal, then, is to harmonize individual liberty with the needs of public health law, and not to usurp individual liberty under the auspices of protecting the social order. In other words, it is crucial not to forget the "public" in public health law.

One recurring suggestion for improving the balance between human rights and public health necessity is for the IHR 2005 to incorporate the Siracusa Principles.[199] These principles are "well accepted by the international community."[200] They acknowledge that "[d]erogation from rights recognized under international law in order to respond to a threat to the life of the nation is not exercised in a legal vacuum. It is authorized by law and as such it is subject to several legal principles of general application."[201] As such, U.N. Member States[202] and even non-Member States are prohibited from violating certain fundamental human rights, even in times of public emergency.[203]

If the IHR 2005 incorporated the Siracusa Principles, these principles would give greater meaning to Article 3's goal of implementing the Regulations "with full respect for the . . . human rights of persons."[204] Fundamental human rights would be explicitly enumerated, with little or no room for controversy over whether a health measure violates these rights. Incorporation of the Siracusa Principles

197. *See id.*

198. Lawrence O. Gostin, *World Health Law: The Model State Emergency Health Powers Act: Public Health and Civil Liberties in a Time of Terrorism*, 13 HEALTH MATRIX 3, 32 (2003).

199. *See generally Siracusa Principles*, *supra* note 4.

200. *Infectious Disease Law*, *supra* note 113, at 2626.

201. *Siracusa Principles*, *supra* note 4, at Part II.D, ¶ 61.

202. For a list of the 192 U.N. Member States, see United Nations, *List of Member States*, http://www.un.org/Overview/unmember.html (last visited Jan. 10, 2006).

203. *See Siracusa Principles*, *supra* note 4, at Part II.D, ¶ 58.

204. IHR 2005, *supra* note 10, at Part I, art. 3, ¶ 1.

would also shift the IHR's heavy focus on minimalizing trade interference by putting more emphasis on the human element of public health law.

Moreover, several public health experts perceive safeguarding human rights as critical to implementing effective global public health governance.[205] Essentially, the theory is that "the best way to promote and protect public health is to promote and protect human rights."[206] This concept is not outlandish because garnering public trust and cooperation and promoting education are consistently endorsed as methods of improving public health governance.[207] However, unilateral efforts by public health authorities to promote human rights are only part of the solution. Individuals also need to take responsibility for educating themselves on international health law and their basic human rights under these laws.[208]

205. *See, e.g.*, FIDLER, *supra* note 7, at 170.

206. *Id.*

207. *See, e.g.*, Barry S. Levy, M.D., *Twenty-First Century Challenges for Law and Public Health*, 32 IND. L. REV. 1140. Levy opines that effective public health governance necessitates listening to people in the community, educating the community, and advocating for healthy conditions and "the basic human rights on which they are based." *Id.* at 1158-59.

208. A good general starting point for keeping up-to-date on public health events is the website of the World Health Organization. *See* World Health Organization Home Page, http://www.who.int/en/ (last visited Jan. 10, 2007).