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Reinforcing Global Health Normative Frameworks and Legal Obligations: Can Adaptive Governance Help?

William Onzivu

Introduction

Global health law: A challenge of governance

The world population faces unprecedented transnational public health threats due to increased travel, environmental changes, modern communications and other technological change.¹ The double burden of infectious and non-infectious diseases,² including influenza A (H1N1), HIV/AIDS, malaria, tuberculosis, maternal and child diseases and tobacco demonstrate the globalized nature of contemporary public health threats.³ Globalization in the face of poor domestic health systems⁴ has accentuated the spread of disease and harmful products, undermining public health.⁵ Public health legislation in most of the developing world is obsolete and in urgent need of reform.⁶ Unfortunately, the governance of international health cooperation is not optimized to promote global health. First, global health institutions including the World Health Organization (WHO), face challenges in tackling the underlying determinants of health, such as poverty, which in turn damages global health.⁷ Secondly, the inhabitants of international health space now include a multiplicity of States, international

- 1 Tony McMichael and Robert Beaglehole, 'The Global Context of Public Health', in Robert Beaglehole (ed.), *Global Public Health, a New Era* (Oxford: Oxford University Press, 2003).
- 2 World Health Organization, *World Health Report 1999: Making a Difference*, (WHO, 1999).
- 3 World Health Organization, Influenza A(H1N1): Frequently Asked Questions: www.who.int/csr/disease/swineflu/frequently_asked_questions/en/.
- 4 World Health Organization, *World Health Report 2008: Primary Health Care – Now More than Ever* (WHO, 2009).
- 5 William Onzivu, 'Globalism, Regionalism or Both: Health Policy and Regional Economic Integration in Developing Countries, an Evolution of a Legal Regime?', *Minnesota Journal of International Law*, 2006, 15(1): 117.
- 6 Commonwealth Secretariat review of public health legislation across the 54 Member States of the Commonwealth Secretariat, report on file with the author, 22 July 2011.
- 7 Allyn Taylor, 'Global Governance, in International Health Law and WHO: Looking towards the Future', *Bulletin of the World Health Organization*, 2002, 80(12): 975–80.

organizations and other non-state actors.⁸ The roles of these actors in shaping global health governance continue to evolve.⁹ The multiplicity of actors has also led to challenges of accountability, institutional fragmentation and normative congestion in global health. Thirdly, existing health governance models have not optimized global health despite the pluralistic discourses in biomedicine, economics, human rights, security and neo-liberalism.¹⁰ Therefore, the search for alternative models is critical. In this chapter, I argue that adaptive governance has the potential to reinforce global health governance.

Global health legal and normative frameworks: Definition

The WHO Constitution defines health as a ‘state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’. Global health law includes several multilateral treaties, rules, regulations and dispute settlement mechanisms that all contribute to promoting health, addressing global health threats such as infectious diseases, tobacco control and food safety.¹¹ It also includes resolutions adopted by WHO organs such as its World Health Assembly,¹² and WHO Regional Committees.¹³ The emerging field of global health law has expanded the scope of health beyond the domestic to the comparative, regional and global.¹⁴ Gostin defines global health law as the body of substantive, procedural and institutional laws that aim at creating conditions for the highest attainable physical and mental health.¹⁵

- 8 Kent Buse and Gill Walt, ‘An Unruly Melange? Coordinating External Resources to the Health Sector: A Review’, *Social Science & Medicine*, 1997, 45: 449–63; Kelly Lee, Suzanne Fustukian and Kent Buse, ‘An Introduction to Global Health Policy’, in Kelly Lee, Kent Buse and Suzanne Fustukian (eds), *Health Policy in a Globalising World* (Cambridge: Cambridge University Press, 2002), 3–17; Kelly Lee and Hillary Goodman, ‘Global Policy Networks: The Propagation of Healthcare Financing Reform since the 1980s’, in Kelly Lee, Kent Buse and Suzanne Fustukian (eds), *Health Policy in a Globalising World* (Cambridge: Cambridge University Press, 2002).
- 9 Obijior Aginam, ‘Health or Trade? A Critique of Contemporary Approaches to Global Health Diplomacy’, *Asian Journal of WTO and International Health Law and Policy*, 2010, 5(2): 355–80.
- 10 Kelly Lee, ‘Understanding of Global Health Governance: The Contested Landscape’, in Adrian Kay and Owain Williams (eds), *Global Health Governance: Crisis, Institutions and Political Economy* (London: Palgrave, 2009); *Ibid.*
- 11 David Fidler, ‘International Law and Global Public Health’, *Kansas Law Review*, 1999, 48: 1–26.
- 12 WHO Resolution. WHA61.19: www.who.int/whr/2008/whr08_En.pdf.
- 13 WHO Regional Office for Africa, *The Work of WHO in the African Region 2008: Annual Report of the Regional Director* (Reg'l Comm. Res. AFR/RC59/2, 2009), 26.
- 14 Michel Belanger, *Global Health Law, an Introduction* (Cambridge: Cambridge Scientific Publishers & Editions des Archives Contemporaines, 2011), 22–32.
- 15 Lawrence Gostin, ‘Meeting Basic Survival Needs of the World’s Least Healthy People toward a Framework Convention on Global Health’, *Georgetown Law Journal*, 2008, 96: 331–92; Lawrence Gostin and Allyn Lisa Taylor, ‘Global Health Law: A Definition and Grand Challenges’, *Public Health Ethics*, 2008, 1: 53–63; see also Gostin’s chapter in this book.

Adaptive governance: The scope

Adaptive governance institutions are those ‘capable of generating long-term, sustainable policy solutions’ to complex and dynamic natural resource problems through collaboration among diverse resource users and governmental agencies.¹⁶ This form of governance is adaptable, flexible and responsive and extends from natural systems to human organizations. It reacts to surprises from ecological and human institutions and systems.¹⁷ Adaptive governance recognizes that, because science is constantly evolving, our understanding of natural systems or the effect of human interactions on them is rarely complete.¹⁸ Scientific answers are social constructs and instead of long-term scientific predictions of outcomes and adopting one-time static policies, adaptive management monitors outcomes and maintains flexibility to alter policies, should predictions prove inaccurate or scientific understanding advance. The concept would ensure that institutions, laws and policies are appropriately flexible to address the dynamic global health challenges as the science, learning and other evidence evolve.

Adaptive governance has its origins in complexity theory. Rooted in physical and biological sciences its scope is now broad.¹⁹ At the core of complexity theory is not a cluster of unrelated systems but a complex adaptive system.²⁰ The relationships between the inter-related parts of this system, the combination of their autonomy and interaction, the capacity of the system for self-adaptation, self-reorganization and the potential for new properties emerge.²¹ Over time, several fields of study have developed within the social sciences unified by three common themes: the complexity and uncertainty associated with various aspects of social life; the need for some intensified form of ‘social learning’ as a response to this uncertainty; and the role of institutions and governance systems in facilitating such learning processes. The increasing complexity and volatility of modern markets has led many to focus on the role of innovation

16 John T. Scholz and Bruce Stiftel (eds), *Adaptive Governance and Water Conflict: New Institutions for Collaborative Planning* (Washington, DC: Resources for the Future Press, 2005), 5.

17 Ibid., 2.

18 J. B. Ruhl, ‘Thinking of Environmental Law as a Complex Adaptive System: How to Clean up the Environment by Making a Mess of Environmental law’, *Houston Law Review*, 1997, 34: 933; Carl Folke, Thomas Hahn, Per Olsson and Jon Norberg, ‘Adaptive Governance of Socio-ecological Systems’, *Annual Review of Environment and Resources*, 2005, 30: 441; James Oglethorpe, *Adaptive Management: From Theory to Practice* (Gland, Switzerland: IUCN, 2002).

19 Paul Cilliers, *Complexity and Post Modernism* (London: Routledge, 1998), 112–40.

20 James N. Rosenau, *Distant Proximities: Dynamics beyond Globalization* (Princeton, NJ: Princeton University Press, 2003), 212–13.

21 James N. Rosenau, ‘NGOs and Fragmented Authority in Globalizing Space’, in Yale Ferguson and Barry R. J. Jones (eds), *Political Space: Frontiers of Change and Governance in a Globalizing World* (New York: State of New York Press, 2002).

and adaptability in economic life. This has necessitated research into learning processes within organizations, as well as the problem of creating reflexive institutional frameworks to facilitate constant learning and innovation across national, regional and global institutions. Secondly, in international relations, scholarship on the behaviour of states in complex interdependence has focused on developing flexible and adaptive international institutions, to respond to rapidly changing global conditions and knowledge of their causes. Others focus on the role of international institutions in counteracting potentially paralysing uncertainty, helping states to develop cognitive models to survive in a complex world, and to identify the interests in it.

Thirdly, work in public law, on learning-centred alternatives to traditional command-and-control regulatory frameworks, has spurred experimentalist and new governance approaches.²² The integration of the social sciences enriches adaptive governance transcending natural, ecological, human and social processes and institutions. Adaptive governance in social spheres and institutions, including health, requires refinements augmented by social theories. This chapter focuses on five key features of adaptive governance: continuous learning, policy making as experimentation, avoiding irreversible harm, monitoring and feedback and pluralism and process.

Continuous learning

Adaptive governance focuses on facilitating continuous learning as a sine qua non of any response to uncertainty and systemic unpredictability of a social system. A one-time view of the world, scientific or normative, is inadequate to reflect dynamic and evolving realities and to respond to continually changing information and understanding. In global health, policy-making is often based on scientific or other form of evidence. This reflects the importance of continuous learning as a key element of adaptive governance.

Learning in adaptive governance is both simple and complex. Simple learning refers to the acquisition of information, the development of new skills and the building of new competencies.²³ In simple learning, actors participate in the regulatory process, receive new and updated information, learn how to resolve defined problems more effectively and adapt their problem-solving skills to changing conditions. This would require adjustment to health policies to achieve set goals. However, complex learning is not simply a response to inadequate information but to the fundamental limitations of human cognition. It goes beyond learning better solutions to defined problems to redefining

22 Peter Hill, 'Understanding Global Health Governance as a Complex Adaptive System', *Global Public Health*, 2011, 6(6): 593–605.

23 Meric S. Gertler and David A. Wolfe, *Innovation and Social Learning: Institutional Adaptation in an Era of Technological Change* (Macmillan/Palgrave: Basingstoke, 2002).

the particular problem and knowledge about it.²⁴ Complex learning entails expanding awareness of the inherently limited nature of human knowledge and recognizes people's intrinsic ignorance and capacity for mistake. This learning may require reconstitution of actors' preferences, identities and beliefs and the reconstruction of policy-makers' cognitive map which they use to make sense of their world and redefine it.²⁵

Policy-making as experimentation

Policy interventions are often viewed as separate from knowledge accumulation and risk-analysis. In adaptive governance, policy-making is a central component of the learning process. Policy interventions are learning by doing and quasi-experiments. Unforeseen consequences are treated as valuable opportunities for learning. This experimental approach implies that policy makers must act despite uncertainties. Adaptive governance is designed to trigger action in conditions of incomplete knowledge without postponing action until 'enough' is known. It acknowledges that time and resources are too short to defer action to tackle urgent problems.²⁶ Policy interventions in adaptive governance are focused towards generating critical information to enhance certainty, knowledge and experience base. Adaptive governance requires deliberate experimentation to generate the information.²⁷ However, active policy changes must be reversible without risk-taking in decision making.²⁸ Such deliberate experimental interventions require resilience, supervisory and accountability mechanisms and the assurance that adaptive management interventions do not risk unacceptable and irreversible outcomes.²⁹

- 24 Joanne Scott and David M. Trubek, 'Mind the Gap: Law and New Approaches to Governance in the European Union', *European Law Journal*, 2002, 8(1): 1–18; Charles F. Sabel, 'Learning by Monitoring: The Institutions of Economic Development', in Neil J. Smelser and Richard Swedberg (eds), *The Handbook of Economic Sociology* (Princeton, NJ: Princeton University Press, 2005).
- 25 David Schlosberg, 'Reconceiving Environmental Justice: Global Movements and Political Theories', *Environmental Politics*, 2004, 13(2): 517–40; Alexander Wendt, *Social Theory of International Politics* (Cambridge: Cambridge University Press, 1999), 1–6.
- 26 Ronald D. Brunner, Lindy Coe-juell, Christina Cromley, Christine Edwards, Toddi A. Steelman and Donna Tucker, *Adaptive Governance: Integrating Science, Policy and Decision Making* (New York: Columbia University Press, 2005), 2; Kai N. Lee, 'Appraising Adaptive Management', *Conservation Ecology*, 1999, 3(2): 3.
- 27 Catherine Allan and George B. Stankey (eds), *Adaptive Environmental Management, a Practitioners Guide* (London: Springer, 2009); Carl Walters, 'Challenges in Adaptive Management of Riparian and Coastal Ecosystems', *Conservation Ecology*, 1997, 1(2).
- 28 Brunner, Coe-juell, Cromley, Edwards, Steelman and Tucker, *Adaptive Governance*, 2.
- 29 Derek Armitage, Fikret Berkes and Nancy Doubleday, *Collaboration, Learning and Multi-Level Governance: Adaptive Co-Management* (UBC Press, 2007), 19, 83; Lance Gunderson, 'Resilience, Flexibility and Adaptive Management – Antidotes for Spurious Certitude?', *Conservation Ecology*, 1999, 3(1), 7.

Avoiding irreversible harm

Recognition of the uncertain, dynamic and evolving character of environmental, social and economic systems leads to a strong emphasis on maintaining the resilience of a system.³⁰ As it is impossible to predict exactly what a complex system will do, or to engineer a static desired policy condition, one pivotal goal of policy becomes the maintenance of system resilience, and its ability to adapt and evolve. This helps avoid irreversible negative environmental or social conditions, but can restrain subsequent policy options, experimentation and learning. Adaptive governance favours impermanent, reversible policy interventions and adoption of strict oversight mechanisms to encourage or ensure reversibility. Policy responses to uncertainties are selected on their robustness. In this way, irreversible and damaging global health policy is minimized or avoided and options for improved health decision making is unfettered.

Monitoring and feedback

Policy-making in adaptive governance is an iterative process of review and revision. Scientific knowledge is not definitive or final, but subject to review as new information and priorities emerge.³¹ The smooth functioning of this iterative process depends critically on the progressive development of mechanisms for regular monitoring of specificity of processes and outcomes of policy interventions. Outcomes of monitoring processes routinely feed back into the policy process, to reassess policy goals, assumptions and objectives themselves.³² Such self-conscious monitoring and feedback mechanisms facilitate learning, fine-tune policy instruments, highlight knowledge gaps, reveal the shortcomings of problem-definition and knowledge and create a culture of openness and experimentation in the conduct of policy.³³

Pluralism and process

Cooney and Lang emphasize that adaptive governance approaches necessitate pluralist approaches to knowledge as its production and application is a socio-political process.³⁴ They argue that governance structures are not focused towards identifying a single, correct body of knowledge to guide policy, but to

30 Ibid.

31 Carl Bruch, 'Adaptive Water Management: Strengthening Laws and Institutions to Cope with Uncertainty', in Asit K. Biswas, Cecilia Tortajada and Rafael Izquierdo-Avino (eds), *Water Management in 2020 and Beyond* (Heidelberg: Springer, 2009).

32 Rosie Cooney and Andrew T. F. Lang, 'Taking Uncertainty Seriously: Adaptive Governance and International Trade', *The European Journal of International Law*, 2007, 18: 523–51.

33 Ibid.

34 Ibid.

mobilize alternative knowledge, map out uncertainties and enable a disciplined process for decision-making in areas of uncertainty.³⁵ The aim of policy-making is not solely to accumulate knowledge, but also to discover and highlight the inadequacies of prevailing knowledge frameworks. Policy-making is less about the attainment of a single optimal solution and more about providing a forum for creating consensual knowledge and agreed processes to guide policy.³⁶ This implies that policy-making processes and underlying knowledge assumptions and judgements should be transparent, explicit and open to scrutiny. Adaptive governance emphasizes open forums for discursive and communicative interaction – information exchange and problem-centred negotiation – in policy formulation. A second implication is the need for broader participation in the production and deployment of knowledge. Adaptive governance prioritizes broader participation in the production and deployment of knowledge due to the diverse values and knowledge of different stakeholders. Approaches integrating multiple perspectives often produce better outcomes and ‘efficient’ public policy becomes redefined as policy which responds as far as possible to the values, interests and concerns of all stakeholders.³⁷

Adaptive governance and WHO law

The WHO constitution

The Constitution of the WHO was adopted in 1946 as the UN Charter that empowered the WHO to spearhead global health protection and promotion within the United Nations system.³⁸ The Constitution endows WHO with the powers to adopt Conventions, regulations and recommendations that deal with any matters within its competence.³⁹ The Constitution also empowers WHO’s World Health Assembly (WHA) to adopt regulations on sanitation and quarantine, nomenclatures of diseases, causes of death, public health practices and standards for international diagnostic procedures. The Constitution has enabled WHO to spearhead the development and implementation of the WHO Framework Convention on Tobacco Control, the International Health Regulations (2005) and the Nomenclature Regulations. WHO has adopted significant Resolutions in areas such as human rights, health workforce,

35 Ibid.

36 Mario Giampietro, ‘Complexity and Scales: The Challenge for Integrated Assessment’, *Scaling in Integrated Assessment*, 2003, 3(2/3): 247.

37 Oglethorpe, *Adaptive Management*.

38 United Nations, United Nations Charter, Article 57.

39 World Health Organization, *Basic Documents, Constitution of the World Health Organization*, Articles 1–2, 45th edn (WHO, 2005).

neglected diseases, public–private partnerships, climate change and intellectual property, innovation and public health.

The WHO Constitution demonstrates the complexities and need for flexibility in WHO law in the following aspects. First, the WHO constitutional definition of health as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, is evolutionary in its implementation.⁴⁰ The definition also reflects health as psychosocial and physical, acknowledging that humans adapt in social environments.⁴¹ At WHO's creation in 1946, it was envisaged that the Constitution would provide a framework for international law to play an expanding role in global health. The WHA has broad standard setting functions and addresses public health issues that are often evolutionary, complex, uncertain and requiring new knowledge to inform policy. Secondly, the WHO Constitution is a functional and purposive instrument. It is general and flexible reflecting changing political environments and processes that have enabled WHO to assume roles unforeseen when it was established and its Constitution adopted. Thirdly, the WHO Constitution envisages its operation through multi-sectoral and collaborative actions.⁴² Reflective of this approach, WHO constitutional space is inhabited by stakeholders beyond the organization and its member States and includes other UN system organizations and civil society. It is in this context that, for example, WHO houses over 20 public–private partnerships in global health that include the Global Alliance on Vaccine and Immunization (GAVI) and the Medicines for Malaria Venture (MMV). The Constitution also empowers WHO to promote scientific, technical and legal learning and participation of diverse actors. The challenge for WHO is expanding the diversity of inhabitants in its constitutional and policy space in the public interest.

The WHO Framework Convention on Tobacco Control

With over 170 parties to date, the WHO Framework Convention on Tobacco Control (FCTC) has been hailed as one of the major public health treaties.⁴³ FCTC requires its parties to implement public health protection measures by regulating tobacco advertising, promotion, sponsorship, packaging and labelling.⁴⁴ It also regulates the tobacco industry,⁴⁵ illicit trade in tobacco products, tobacco price and tax measures, sales of tobacco, treatment of tobacco dependence, smoke-free environments, research and exchange of information,

40 WHO, *Basic Documents*, Preamble.

41 Jennifer Prah Ruger, 'Global Health Justice', *Public Health Ethics*, 2009, 2(3) (2009): 261–75, 267.

42 Gian Luca Burci, 'Institutional Adaptation without Reform: WHO and the Challenges of Globalization', *International Organization Law Review*, 2005, 2: 437–43.

43 WHO, Framework Convention on Tobacco Control, 42 I.L.M. 518 (2003).

44 *Ibid.*, Articles 9–10.

45 *Ibid.*, Article 5(3).

scientific, technical and legal cooperation.⁴⁶ The Conference of Parties has adopted guidelines on tobacco labelling and packaging, advertisement and promotion, exposure to tobacco smoke and on monitoring the tobacco industry. The development and implementation of the Convention is a catalyst for an adaptive framework of governance for several reasons. First, the Convention requires multi-sectoral tobacco control measures at the global, regional and national levels. Its state negotiators were a mix of health, foreign affairs, trade and finance officials that also exhibited sectoral tensions.⁴⁷ Secondly, the Convention adopts a demand control approach to tobacco regulation through tax and price measures that must be reviewed and changed periodically, to meet evolving tobacco control needs.⁴⁸ Thirdly, the treaty provides for its implementation without exclusive reliance on protocol,⁴⁹ and recognizes Parties' obligations in other international instruments while prioritizing their right to protect public health.⁵⁰ Fourthly, the Convention provides for the scientific and technical cooperation among Parties and other actors on tobacco control,⁵¹ and prohibits reservations to it.⁵² It also provides for education, training and exchange of information. The progressive development of the Convention entails capacity-building workshops where learning and exchange of information continues to be implemented around the world.⁵³ Despite FCTC's adaptive features, the Convention has faced complex implementation challenges such as monitoring the tobacco industry, the dearth of domestic comprehensive tobacco control legislation and multi-sectoral coordinating mechanisms adopted by Parties. Embedding a robust adaptive governance strategy in the FCTC would significantly bolster its effective implementation.

The International Health Regulations

The revised International Health Regulations (IHR) 2005 entered into force after a 10-year negotiation.⁵⁴ The IHR's purpose is 'to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks and which avoid unnecessary interference with international traffic and trade'.⁵⁵ The most radical change in IHR (2005) is its application to

46 Ibid., Article 8, 11–22.

47 Ibid., Preamble, Article 5(1).

48 Ibid., Articles, 4–16.

49 Ibid., Articles 3–5.

50 Ibid., Articles 2, 13, 16 and Preamble.

51 Ibid., Part VII of the Convention.

52 Ibid., Article 30.

53 Dr Gro-Harlem Brundtland once referred to the treaty's development as a global public health university.

54 World Health Organization, *The International Health Regulations*, (2005).

55 Ibid., Article 2.

all 'public health emergencies of international concern', including not only infectious disease outbreaks, but also chemical and radio-nuclear events and perhaps other threats to health as well.⁵⁶ Disease is defined quite broadly as 'an illness or medical condition, irrespective of origin or source that presents or could present significant harm to humans'.⁵⁷

It requires States to strengthen core surveillance and response capacities at the primary, intermediate and national level, as well as at designated international ports, airports and ground crossings. Core capacities to be developed include contact points, assessing risks, determining public health events of international concern (PHEIC) and recommending measures for use by States during a PHEIC (both after consultation with external experts); provision of technical assistance to States in response to PHEIC; monitoring and evaluation of IHR(2005) implementation. Mechanisms for public health and additional measures under the IHR include various requirements, including basing such measures on scientific principles, evidence and information.⁵⁸ There is provision for adopting standing recommendations by WHO,⁵⁹ and requirement of consultation with affected States Parties.⁶⁰ While the IHR demonstrates some adaptive elements such as continuous monitoring, learning, use of scientific evidence, pluralism⁶¹ and multisectoralism, its implementation continues to face challenges in achieving effective public health outcomes. Ineffective monitoring of reporting outbreaks has been a challenge in the history of the IHR. For example, China failed to report SARS promptly. The standing recommendations adopted under the Regulations do not have the binding force of WHO's standing and temporary recommendations. Sharing of virus samples, despite a successful conclusion through the 2011 WHA Resolution, continues to be a contentious issue. Countries have been slow in undertaking required assessments and legal and policy frameworks for domestic implementation of the IHR remain underdeveloped especially in many developing countries.

A 2011 IHR review report highlighted a number of shortcomings of the IHR legal regime. The reported stated that:

Despite the positive features of the IHR, many States Parties lack core capacities to detect, assess and report potential health threats and are not on a path to complete their obligations for plans and infrastructure by the 2012 deadline specified in the IHR. Continuing on the current trajectory will not enable countries to develop these capacities and fully implement the IHR. Of the 194 States Parties, 128, or 66 per cent, responded to a recent WHO questionnaire on

56 Ibid., Articles 12 and 13.

57 Ibid., Article 1.

58 Ibid., Article 43.1–2.

59 Ibid., Article 16.

60 Ibid., Article 43.6.

61 The Global Outbreak Alert Response Network (GOARN) provides scientific expertise with operational capacities comprising 100 agencies and research institutes.

their progress. Only 58 per cent of the respondents reported having developed national plans to meet core capacity requirements, and as few as 10 per cent of reporting countries indicated that they had fully established the capacities envisaged by the IHR. Further, as documented by external studies and a WHO questionnaire, in some countries National Focal Points (NFPs) lack the authority to communicate information related to public-health emergencies to WHO in a timely manner. The most important structural shortcoming of the IHR is the lack of enforceable sanctions. For example, if a country fails to explain why it has adopted more restrictive traffic and trade measures than those recommended by WHO, no legal consequences follow[.]⁶²

The review further stated that there is no systematic monitoring by WHO of instances where human rights are not respected in implementing the IHR.⁶³ Furthermore, WHO does not have a mandate to investigate whether particular measures constitute violations of this provision in the IHR. During the pandemic, there were media reports of travellers being quarantined and detained as a consequence. It appears to be a weakness that WHO does not monitor whether human rights are being respected in implementing the IHR.⁶⁴ Therefore, the IHR requires optimum governance framework as its actors focus on its domestic implementation and adaptive governance offers a compelling framework of action.

Implications for global health law

Benefits of adaptive governance

Facilitates policy experimentation

Adaptive governance enhances cross-sectoral learning beyond narrow medical approaches to broader legal and normative approaches in global health. It could promote regular use of law as a tool for fulfilling WHO's mandate under Article 19 of its Constitution.⁶⁵ New areas for legal and normative instruments could become a routine and institutionalized feature of WHO law, with participation of all stakeholders including end-users of global health identified and mandated. Adaptive governance would ensure that some WHA resolutions can potentially become candidates for legally binding treaties. While the WHA resolutions

62 Implementation of the International Health Regulations (2005): Report of the Review Committee on the Functioning of the International Health Regulations (2005) in Relation to Pandemic (H1N1) 2009: Report by the Director-General: Annex (World Health Organization, Sixty-Fourth World Health Assembly, A64/10, 5 May 2011), paragraphs 23–4.

63 Ibid., para 91.

64 Ibid., paras 92–3.

65 Article 19 of the WHO Constitution authorizes the Organization to promote and adopt Conventions, regulations and recommendations that address any matter within its competence.

have flexibilities in global health policy development and implementation, they are not binding in nature. Policy experimentation would also promote a purposive interpretation of WHO constitutional law. Hence renewed options to promote the monitoring and implementation of WHO law could be developed. One key mechanism would be the need to strengthen the good offices of WHO Director-General and regional Directors-General. Traditionally, good offices consist in a third-party government, international organization or an individual attempting to bring conflicting parties to a negotiating table without interfering in the negotiations themselves.⁶⁶ In international organizations, good offices are exercised at various levels often by the Head of the Secretariat or some of its officers.⁶⁷

WHO's mandate increasingly emphasizes the importance of prevention and promotion that focus on communities, groups and populations.⁶⁸ WHO has adapted its institutional mechanisms to cope with changes resulting from globalization of public health,⁶⁹ but these require a versatile framework. Adaptive governance offers it.

Promotes global health co-regulation

Global health agencies including WHO are international institutions endowed with powers and obligations as international administrative agencies. Adaptive governance would promote co-regulation of global health from below to include end-users of global health such as communities in developing countries. This would broaden WHO's stakeholders beyond the state and other actors.⁷⁰ Multisectorality ensures that global health legal regime becomes an administrative practice and shared exercise where multi-stakeholder processes are sites where regulatory problems are defined, innovative solutions devised and institutional relationships enhanced to ensure quality and legitimacy of regulatory actions.⁷¹ This broadening of stakeholders enhances WHO supervision of global health normative frameworks. WHO has routine reporting systems through the WHA and additional stakeholders could help scrutinize such reports to promote normative implementation. Adaptive

66 The Hague Conventions of 1899 and 1907 on the Pacific Settlement of Disputes provides for good offices as a mechanism for settling any disputes between the powers.

67 Bertrand G. Ramcharan, *Humanitarian Good Offices in International Law: The Good Offices of the United Nations Secretary-General in the Field of Human Rights* (The Hague: Martinus Nijhoff, 1983).

68 William Onzivu, '(Re)invigorating the World Health Organization's Governance of Health Rights: Repositioning an Evolving Legal Regime, Its Challenges and Prospects', *African Journal of Legal Studies*, 2011, 4(3): 225–56.

69 Burci, *Institutional Adaptation without Reform*, 437–43.

70 Bradley C. Karkkainen, 'Collaborative Ecosystem Governance: Scale, Complexity, and Dynamism', *Virginia Environmental Law Journal*, 2002, 21: 189–243.

71 Jody Freeman, 'Collaborative Governance in the Administrative State', *UCLA Law Review*, 1997, 45(1): 1–98.

governance can reinforce WHO's public health management functions to promote global health law.⁷²

Promotes implementation of WHO law and policy

The implementation of Doha Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) and Public Health⁷³ and the need for utilization of TRIPS flexibilities to provide access to essential medicines especially for developing countries has led to WHO normative action in this area. This has included the adoption of a WHA Resolution.⁷⁴ The Resolution requested United Nations and other intergovernmental organizations to critically examine TRIPS including its human rights implications. It echoed a UN Resolution which recognized this conflict and sought to establish 'the primacy of human rights obligations over economic agreements'.⁷⁵

In May 2003, the WHA adopted a resolution recommending the creation of a Committee on Intellectual Property Rights, Innovation and Public Health (CIPRH), to evaluate the impact of IP protections on the development of new drugs.⁷⁶ The resolution urged members 'to reaffirm that public health interests are paramount in both pharmaceutical and health policies and to adapt national legislation to use TRIPS flexibilities'.⁷⁷ The subsequent plan of action contains concrete action points to promote innovation, research and access to medicine. However, its follow-up remains problematic, with a number of richer countries negotiating adverse bilateral agreements that undermine public health protection.⁷⁸

This scenario reflects the challenges of implementing WHO soft law. Adaptive governance would ensure a strong functional basis to reinforce their implementation and follow-up.

Monitoring and feedback mechanisms would be re-examined to promote participation of all stakeholders. Adaptive governance would promote evaluation that facilitates enforcement of and compliance with international health legal and normative instruments. Evaluation refers to a careful

72 Benjamin Mason Meir and Ashley M. Fox, 'International Obligations through Collective Rights: Moving from Foreign Health Assistance to Global Health Governance', *Health and Human Rights*, 2010, 12(1): 61.

73 WT/MIN(01)/DEC/2 14, 14 November 2001, 41 *ILM* 755 (2002).

74 World Health Organization, Intellectual Property Rights, Innovation and Public Health, 2003 WHA 56.27, 28 May 2003.

75 Office of the High Commissioner for Human Rights Sub-Comm. on the Promotion and Protection of Human Rights, Res. 2000/7, U.N. Doc. E/CN.4/Sub/2/2000/L.20 (17 August 2000).

76 World Health Organization, Intellectual Property Rights, Innovation and Public Health, 2003 WHA 56.27, 28 May 2003.

77 *Ibid.*, para 1(1).

78 Equinet, SEATINI, TARSC Policy Brief 21, Policy Series 17: Protecting Health in the Proposed Economic Partnership Agreement between East and Southern African Countries and the European Union, 2007, Harare.

retrospective assessment of the merit, worth and value of administration, output and outcome of government interventions, which is intended to play a role in future, practical action situations.⁷⁹ The IHR review committee is an evaluative mechanism for adaptive governance in action and a similar mechanism for the WHO FCTC would promote its monitoring and implementation.

Limits of adaptive governance

Undermines WHO law as binding global health law

The WHO Constitution, the FCTC and the IHR 2005 are binding instruments but adaptive governance would require that they are flexible, regularly modified and reviewed. While the progressive development of global health law is concomitant with reviews, laws must be predictable to facilitate their effectiveness. Rapid changes to WHO laws could undermine their legitimacy. Adaptive governance has been viewed as a political project undertaken by Western Nations to foster an international legal order that perpetuates a neo-colonialist status quo, a so-called gentler civiliser of (developing) nations:⁸⁰ It is thus viewed as a potential ploy by the developed world to capture the global health political and normative agenda to the detriment of developing nations.

Regulatory capture

Critics argue that the United Nations, in its quest for resources, faces regulatory capture by powerful vested interests. Global health normative instruments that promote commercial companies' participation have been criticized as a slippery slope towards the commercialization of the UN system and legitimization of illegitimate private self-regulation.⁸¹ For example, some public-private partnerships have been seen to undermine the promotion of equity in health. Critics argue that commercial sector participation at WHO potentially misdirects global health priorities.⁸² Profit-seeking corporations' participation in global health could impact on WHO's leadership and adversely affect the promotion of equitable global health.⁸³

79 Evert Vedung, *Public Policy and Program Evaluation* (New Brunswick, NJ: Transaction Publishers, 1997).

80 Mónica García-Salmones, 'Taking Uncertainty Seriously: Adaptive Governance and International Trade: A Reply to Rosie Cooney and Andrew Lang', *European Journal of International Law*, 2009, 20(1): 167–86.

81 Kent Buse and Amalia Waxman, 'Public-Private Health Partnerships: A Strategy for WHO', *Bulletin of the World Health Organization*, 2001, 8: 79.

82 Gavin Yamey, 'Faltering Steps towards Partnerships', *British Medical Journal*, 2002, 325: 1236–40.

83 Augustine D. Asante and Anthony B. Zwi, 'Public-Private Partnerships and Global Health Equity: Prospects and Challenges', *Indian Journal of Medical Ethics*, 2007, IV(4): 179.

Squeezing out the public character of global health law

Global health governance is subject to the scrutiny of public international law. Yet adaptive governance requires a pluralistic amalgam of public and private actors shaping a (public) legal regime. Corporate private actors in global health inhabit public, not private, space and deal with health, which is a core global public good.⁸⁴ The UNDP (United Nations Development Programme) defines a global public good as a public good with benefits that are strongly universal in terms of countries, people and generations.⁸⁵ The over 20 Global Public–Private Partnerships housed within WHO contain constituents from both public and private sectors with heterogeneous legal features and inherent conflicting and competing interests. Their governance reflects nodal governance, a social adaptation accomplished in significant part through the creation and operation of ‘nodes’.⁸⁶ While power is transmitted across networks, the actual point where knowledge and capacity are mobilized for transmission is the node.⁸⁷ Adaptive governance contradicts the public character of global health law because it embodies competing private and public nodes with often divergent vested interests in the global health enterprise.⁸⁸

Conclusion

In the face of increasing disease threats, global health law continues to explore appropriate governance frameworks. Adaptive governance provides a concrete model and enables participation, pluralism, continuous learning and experimentation, use of science as well as evaluation and monitoring. These elements can strengthen the effectiveness of WHO law. The WHO Constitution, the FCTC and IHR provide precedents for effective progressive development and implementation of global health law. However, adaptive governance is not a panacea to the malaise that faces the functional effectiveness of WHO law and policy. It has the potential to breed unpredictability in the legal regime due to its over-emphasis on regular amendments to legal and normative instruments.

84 David Woodward and Richard Smith, ‘Global Public Goods and Health: Concepts and Issues’, in Richard Smith, Robert Beaglehole, David Woodward and Nick Drager (eds), *Global Public Goods for Health: Health Economic and Public Health Perspectives* (Oxford: Oxford University Press, 2003), 10–12.

85 United Nations Development Programme, *Providing Global Public Goods: Managing Globalization, 25 Questions and Answers* (New York: UNDP, 2002).

86 Scott Burris, Peter Drahos and Clifford Shearing, ‘Nodal Governance’, *Australian Journal of Legal Philosophy*, 2005, 30: 30.

87 Scott Burris, ‘Symposium: SARS, Public Health, and Global Governance: Governance, Micro Governance and Health’, *Temple Law Review*, 2004, 77: 335.

88 Burris, Drahos and Shearing, ‘Nodal Governance’.

Its emphasis on multisectorality ignores potential capture by vested interests of the public interest in global health law and policy. Despite its shortcomings, adaptive governance provides a useful framework for reinforcing the effectiveness of global health and the overall improvement of WHO law and policy. However, to reinforce global health legal and normative frameworks, adaptive governance tools must redistribute global health benefits; promote participation of all actors as legitimate inhabitants of global health in a public regulatory space. Finally, institutionalized evaluation of laws and policies, underpinned by public health ethics, must be embedded at the core of global health governance.