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International Legal Cooperation to Combat Communicable Diseases: Hope for Global Governance?

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International Legal Cooperation to Combat Communicable Diseases: Hope for Global Governance?

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Abstract

Contrary to the belief that the development of science and technology would eradicate the serious communicable diseases, the global society today would define emerging and re-emerging infectious diseases as one of the most serious threats to human security. Thus, this paper explores the legal and soft-law measures to collectively combat such diseases including SARS and H5N1 Avian Influenza. First, the possibility of newly adopted International Health Regulations (IHR) at the World Health Organization (WHO) in May 2005 is examined. As legally binding legal rules, and now covering even health damages through terrorism, the potential of the IHR as the primary tool for effectively preventing and containing infectious diseases is to be highly evaluated. As supplementary measures, soft-law type international cooperation has to be also taken into consideration. Importance of the universal jurisdiction would be confirmed in addressing bioterrorism along with the effective uses of export control as well as transportation security frameworks. In the sphere of public health protection, it is concluded that the difference in effectiveness between legally binding rules and non-binding rules has been blurring, which would be a base upon which modern sources of international law and governance could be studied.

Key words: WHO, IHR, public health law, bioterrorism

1. Introduction- Communicable Disease as a Global Threat

Unprecedented increase of movement of people, animals and goods in a globalized world has brought a somewhat unexpected threat to the life of mankind. A few decades ago, it was widely believed that the power of science and technology would eradicate the serious communicable diseases in the near future. It was beyond imagination that the global society would define emerging and re-emerging communicable diseases as one of the most serious threats to human security in the first decade of the 21st century.

It was in May 2003 when the World Health Organization (WHO) characterized SARS "as the first severe infectious disease in the twenty-first century, poses a serious threat to global health security, the livelihood of populations, the functioning of health system, and the stability and growth of economics"[1] . H5N1 Avian Influenza in poultry, first found in 1878, also shocked the world months after the eradication of SARS had been proclaimed in 2003, when its aspect of zoonosis was recognized[2] . H5N1 Avian Influenza, running rampant again in 2005, already killed more than 60 people as of October 28, 2005[3] . While no death of Avian Influenza has been caused from human-to-human infection up until now, once new type of virus is born to bring such infection, which may well bring the death of 5 million to 150 million people around the world according to Senior UN System Coordinator for Avian and Human Influenza (appointed on 29 September 2005 by the Secretary General).

International community quickly responded such threat: US initiative of International Partnership on Avian and Pandemic Influenza (IPAPI) launched on 14 September was followed by, *inter alia*, ASEAN plus 3 Agriculture Ministers' Conference (30 Sept.), international conference for that matter held in Washington, D.C. with the participation of about 80 countries and the WHO (7-8 Oct.), Ottawa conference with 30 countries and 9 international organizations (24-25 Oct.) which issued a 18-point Communiqué[4] , and various level of EU-related meetings. After H5N1 Avian Influenza was found in Russia, Kazakhstan, China, and Mongolia in summer of 2005, by the end of October, competent authorities of Turkey, Greece, Rumania, Croatia, UK, and Sweden also confirmed its outbreak in their territories[5] , which accelerated EU actions such as import ban of concerned meats and birds as well as the monitoring of migratory birds. APEC (November in Korea) and East Asia Summit (December

1) 56th WHA, agenda item 14.16, WHA 56.29 (28 May 2003), p.1; Concerning the novel character of SARS, see, *e.g.*, Fidler (2004) pp.3-9.

2) http://www.idsc.nih.go.jp/disease/avian_influenza/QA040401.html (date accessed: 30 April 2005).

3) Between December 2003 and October 2004, 32 persons died of Avian Influenza among 44 infected, 20 in Viet Nam and 12, in Thailand. Between December 1, 2004 and October 28, 2005, 32 died among 75 infected. Among 32 deceased, 24 in Viet Nam, 4 in Cambodia, 3 in Indonesia, and 1 in Thailand.

4) Ottawa: 2005: Global Pandemic Influenza Readiness (25 Oct. 2005), http://www.hc-sc.gc.ca/ahc-asc/media/nr-cp/2005/2005_fin_e.html (date accessed: 26 Oct.2005).

5) *Nikkei Shimbun* (evening)(18 Oct. 2005) p.1; *Asahi Shimbun* (18 Oct. 2005), p.7; *ibid.*, (24 Oct. 2005), p.2.

in Malaysia) will provide another useful fora to address the issue.

It seems evident that internationally quick and cooperative responses to the Avian Influenza pandemic threat is enabled by the lessons of SARS on domestic, regional and international level. SARS set a new standard for international cooperation for combating communicable diseases, but what was the unique nature of SARS that drastically changed the perception and degree of collective engagements of states and other institutions towards serious communicable diseases? Clearly acuteness of a disease, different from, *e.g.*, HIV/AIDS, and high rate of lethality are to be regarded as the important factors to select SARS as a special disease, but, after all, the number of death caused by SARS, less than 800 in 2003, is no comparison with other major communicable diseases. For instance, in the Western Pacific areas where SARS played havoc, tuberculosis alone kills more than 1000 people everyday[6] . Thus, let alone the mortality rate and the unprecedented speed of spreading, it seems the significance of the economic loss caused by SARS, due to the suspension of air transportation of persons and goods, which made the disease unique among various serious communicable diseases. Growth rate of GDP was declined for the second quarter of 2003 by 2.3 percent in Singapore, 1.9 percent in Taiwan, 4 percent in Hong Kong, and 0.5 percent in China[7] .

In addition to the natural communicable diseases, bioterrorism should be internationally prevented and contained, because increasing number of innocent civilians are victimized by "international terrorism"[8] . Anthrax attack in October 2001 in USA[9] followed by a failed attempt of anthrax release in Tokyo in 1993 and a chemical salin attack in a Tokyo subway in 1995, both conducted by a Japanese religious cult "AUM", widely awakened the fear of bio-chemical terrorism[10] .

Under the circumstances, this paper explores the international legal and soft-law measures to better address severe global communicable diseases including ones caused by terrorism. First, the possibility of International Hearth Regulations (IHR) is studied to better address the prevention and control of infectious diseases. Significance of the unique nature of the IHR as a legally-binding rule made at an international governmental organization would be particularly taken note of in order to think the scope of obligations and applicability of the IHR. Then, soft- law type of measures are considered as a tool as useful as legally-binding

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6) Omi & Inoue (2003) p.43.

7) Emma Xiaopin Fan, "SARS: Economic Impacts and Implications" RED Policy Brief Series (ADB), No.15 (2003), cited in Omi & Inoue (2003) p.43.

8) Terrorism trends indicate continuous increase the scale of damages to life and health of persons in one incident as well as the continuous increase in number of "international terrorism" for the last 2 decades. Miyasaka (2002), pp.48-51.

9) Anthrax terrorism killed 5 persons among 22 infected. CDC (2001) pp.973-976.

10) While the legal definition of "terrorism" has not been established even today, general understanding on what the "international terrorism" exists. When either the place of the crime, nationality of suspects or the objects of attack in one terrorists attack is not restricted within the border of one country, it can be referred to as "international terrorism".

measures in a world where the non-governmental entities, ranging from non-recognized states to so-called international NGOs to private corporations, play a critical role in implementing international norms. Third, consideration is extended to the legal and quasi-legal measures to combat bioterrorism, and finally, conclusion would be stated.

2. IHR as a Valuable Tool

(1) Quasi-Legislative Power of WHA: Superiority to the Treaty

Control of international communicable diseases has been primarily dealt with by World Health Organization (WHO). The World Health Assembly (WHA), a policy-making organ of WHO, has the authority for treaty-making with respect to all the mandate of the organization (Article 19)[11] as well as quasi-legislative power in 5 specified fields (Article 21 (a)-(e)) including "sanitary and quarantine requirements and other procedures designed to prevent the international spread of disease" (Article 21(a)). Thus, it seems natural that one may expect the existence of reasonable number of treaties to deal with the epidemic prevention and containment. In fact, there has been no such treaty, and the only one treaty adopted until now under Article 19 of the WHO Constitution is International Framework Convention on Tobacco Control (2003) to deal with tobacco-related diseases. Why Article 19 has not been more frequently made the use of? The answer might be simple; treaty-making process could be essentially cumbersome enough. Although consensus is not required at the WHA different from some kind of international fora[12] , Article 19 conditions a two-thirds vote of the WHA for adopting a treaty, which is to be followed by time-consuming ratification process. Amendment would also entail uncertain process. Fatal flaws could be found out in such a time-consuming procedure to combat spread of critical epidemic, since operational rules have to be adaptable to rapid developments of scientific techniques and knowledge. Therefore, legally binding regulations made at the WHA seems a better choice, if not an ideal tool[13] .

International Sanitary Regulations made under Article 21 (a) of WHO Constitution in 1951 was renamed in 1969 as IHR, and revised three times since then. Purpose and objective of the IHR are to strike a fine balance between the prevention of spread of transnational infectious diseases and the maximum protection of trade and travel on the land, at sea and in the air (Article 2 of the IHR). As the globalization rapidly proceeds, especially in the post-

11) "Treaty" (in a broad sense) can be adopted in many names including treaty (in a narrow sense), convention, agreement, protocol, charter and statute. Name does not make any difference in validity and priority order of application as far as "treaty" (in a broad sense) is concerned.

12) Consensus is required at *e.g.*, UN- related Conference on Disarmament and UN Committee on the Peaceful Uses of Outer Place (COPUOS) for adopting any legal instrument.

Cold War era, satisfying both purposes with an appropriate balance has been increasingly difficult. Responses by individual states towards SARS clearly proved the difficulty.

(2) Balanced Applicability of the IHR: "Contracting Out"

It has to be taken into consideration that quasi-legislative authority of the WHA is not identical to the true legislative power held by the legislature in a sovereign state. Clear indication for that would be the fact that national implementation of the IHR is restricted by the techniques of "contracting out" provided for in Article 22 of the WHO Constitution. A member state could derogate the obligation of some of IHR rules when it notifies the Director-General with "rejection or reservation" of the adopted regulations within a certain period (Current IHR Articles 87 and 88; Revised IHR (2005) Articles 59, 61 and 62) (Since the IHR made in 1981 will have been in effect until May 2007, it is called "current IHR"). "Rejection" stipulated both in the WHO Constitution and in the IHR has the same legal implication with "reservation" provided for in Article 2 (d) of the Vienna Convention on the Law of Treaties (1969). It is also reconfirmed both in Article 62.3 of the IHR (2005) and Article 88.2 of the IHR (1981) as the same expression of "[a] rejection in part of these Regulations shall be considered as a reservation".

Scope of "contracting out" of certain rules of the IHR is not unrestricted, however, contrasting with the considerably liberal reservation system provided for in the Vienna Convention on the Law of Treaties (Articles 19-23). If one-third of the States object to the "rejection or reservation" made by a certain member within 6 months of the notification of the IHR adoption, and a majority of the WHA makes an objection due to the incompatibility with the object and purpose of the IHR, then such "rejection" shall not be admitted (Article 62.6-9 of the IHR (2005))(compatibility test). Compatibility test collectively employed in case of "rejection or reservation" of the IHR shows a notable development of international law in that the discretionary power of a sovereign state to decide the compatibility is limited (Article

13) IHR *woul*d stand out by its strong legal status, since most internal regulations are not legally binding. Observance of non-binding rules and regulations by member states would be usually assured by the inherent necessity to maintain the integrity as an organization. One example would be Radio Regulations (RR) of the International Telecommunications Union (ITU), which is a specialized agency of the UN as is WHO. RR are substantially binding among member states while there is no provision in the ITU Constitution (latest amendment in 2002) that RR shall be entered into force among members. Compliance with RR is secured by the fact that failure to do so would directly jeopardize national interests of effective use of frequencies and orbital slots. Rules would be abided by when it would serve its own national interests in a direct and clear way. IHR being legally binding to members can illustrate two things: first, it implies the strong will of WHO to control sovereign acts to collectively stop the spread of a rampant epidemic. Then, as the other side of the coin, it may be said that without strong legal pressure, member states would not necessarily keep minimum interference rule with international traffic and trade to protect its own country. Or it is also possible that a member would not report suitably to WHO on the occurrence of an epidemic in its territory, being afraid of the eventual economic damages. Until recently, it seems that direct interests for each state and inherent necessity were not appropriately shared with 192 member states of WHO.

20)[14] .

In sum, in terms of the given authority of the WHA in making quasi-laws and in deciding the scope that each member state can derogate the obligation of the IHR, it seems safely concluded that such WHO regulations could represent a rather desirable legal instrument in the transitional phase of global society, where the comprehensive character of sovereignty is being shrunken on one hand, yet the traditional Westphailan systems on the other hand die hard.

(3) 2005 Amendment of IHR

After the 1969 adoption of the IHR, minor revision was twice conducted in 1973 and 1981. Since 1983 (1981 revision was entered into force in 1983), only 3 communicable diseases - cholera, plague and yellow fever – remained notifiable diseases under the IHR[15] , while different emerging and re-emerging communicable diseases had created substantial threats to the global health. At the 48th WHA in 1995, accordingly, a sweeping revision of the current IHR was decided[16] . Somewhat slow process of the IHR revision gave WHO a hard experience of having difficulty in requiring the prompt notification and response to the WHO with nations where SARS had become rampant, for WHO lacked a legal foundation to do so.

The revised IHR (WHA 58.3 A58/55 Agenda item 13.1), adopted on 23 May 2005 at the WHA, have strengthened the states obligations in many ways, while the purpose of it remains essentially unchanged. The purpose and scope of the IHR (2005) is to prevent, protect against, control and provide a public health response to the international spread of disease without unnecessary interference with international traffic and trade (Article 2). To accomplish such goal, the provisions which can restrict traffic and trade are provided for in a way that could not be employed in an excessive way (ex. Article 15. 3 and Article 17 (a)-(g) of the IHR (2005)).

Under the new IHR, states' obligation to notification is considerably strengthened both in terms of the time frame and scope of the subject matters. Members shall notify WHO within 24 hours of any "event" ("a manifestation of disease or an occurrence that creates a potential for disease", [Article 1.1]) which may constitute "public health emergency of international concern" (Article 1.1)[17] (Article 6), which constitutes the biggest difference

14) Among multilateral treaties, *e.g.*, International Convention on the Elimination of All Forms of Racial Discrimination (Art. 20, Para. 2) stipulates that a rejection of two-thirds of member states toward a reservation would make it impossible for reservation, since it is regarded as the demonstration of the incompatibility with object and purpose of the Convention.

15) Last revision was conducted in 1981, when smallpox was removed from the reportable communicable diseases.

16) On the drafting process, see, e.g., Aginam (2005) pp.78-81.

17) "[P]ublic health emergency of international concern" is defined as "an extraordinary event which is determined, as provided in these Regulations: (i) to constitute a public health risk to other States through the international spread of disease and (ii) to potentially require a coordinated international response;"

from current IHR of obligatory notification system of only 3 infectious diseases (cholera, plague and yellow fever).

In order to minimize a subjective judgement by a member, new regulations try to make it clear as much as possible about the "event" to notify. In this respect, Annex II of the IHR (decision instrument) provides a useful tool to decide if an "event" constitutes "public health emergency of international concern" or not. In Annex II, non-binding and indicative guideline, questions are provided in each of the following criteria: (1) seriousness of the public health impact of the event; (2) unusual or unexpected nature of the event; (3) potential for the event to spread internationally; and/or (4) the risk that restrictions to travel or trade may result because of the event. State parties that answer any 2 of the 4 criteria shall notify WHO under Article 6 of the IHR (2005). For the purpose of closely and effectively working with the "WHO IHR Contact Points" including notification, "National IHR Focal Point" shall be designated by each member state (Article 4.1-4).

Strengthened *ex officio* power is given to Director-General to decide if there exists "public health emergency of international concern" in accordance with the procedures set out in Articles 12 and 49 of the IHR irrespective of the assessment of a member state in whose territory the event arises. In addition, another strengthened capacity of WHO is that it "may take into account reports from sources given other than notifications or consultation" (Article 9) from or with a state in whose territory the event is allegedly occurring. Use of reports not from a state concerned has become finally de jure rights by the IHR (2005) from de facto operations conducted for some time, beginning no later than 2001 WHA meeting[18] . Practices by international organizations which make use of the evidence provided by other members, not the affected ones or non-members have been recently also found in other UN systems including IAEA, and can be positively evaluated as an appropriately strengthened international control in the 21st century[19] .

Since "disease-specific approach" is abandoned in favor of "public health risks" now, there needs also a clearer standard to avoid unnecessarily strict restriction against world traffic. Once notification is made from a member state, WHO has to make a real-time response according to the specific facts and details of each emergency by making recommendations for implementation by the state of notification and other members. Authority of WHO to issue temporary recommendations (Article 15) and standing recommendations (Article 16) depending on the situation is reasonably controlled in terms of duration and contents (Article

18) WHA, Global Health Security: Epidemic Alert and Response, WHA54.14 (21 May 2001).

19) One precedent would be a 1992 resolution at the board of governors of International Atomic Energy Agency (IAEA), which declared that third-party information could be used to decide if the violation was committed in regard to NPT safeguard agreement (INFCIRC/153 type safeguards). Prior to the resolution, a clandestine development of nuclear weapons had to be detected only through documents submitted by a country to be inspected.

17 and 18).

As the most important tasks of the revised IHR, member states have to endeavor to enhance capacity to detect, assess, notify and report events in accordance with Annex I of the IHR (core capacity requirements for designated airports, ports and ground crossings) no later than 5 years from entry into force of the IHR, *i.e.*, June of 2012 (Articles 5.1 and 59.1). Without the appropriate infrastructure to detect, prevent and contain a severe infectious disease, no enumerated legal instruments would only prove useless. Traditionally, international laws including international health laws did not usually require member states to achieve a certain goal through standardized ways and measures. States have the discretion to choose the measures adjustable to their domestic systems as long as the required results are achieved. New developments of international agreements, on the contrary, tend to indicate how states shall achieve a certain goal. Shift of the nature of states' obligation has occurred from "obligation of result" to "obligation of measures". State parties are tasked with a lot to meet the criteria of the IHR (2005), which could be only attained by streamlining its own domestic systems and international cooperation, especially to build capacity of the detection, assessment, information sharing and notification.

Further, it is underlined that the implementation of the new IHR shall be with full respect for the dignity, human rights and fundamental freedoms of persons (Article 3.1). For the supreme value of human rights, traditional concept of sovereignty has to be relegated. It does not only seem to imply the restriction of sovereign rights, but also suggest the possibility that other entities raging from unrecognized states to non-governmental organizations should be treated as if they were members of the WHO for purposes of global health security.

3. Non-Biding Measures: Possibility of "Global Governance"

It is peculiar that in international law, non-binding rules and arrangements sometimes function more effective than legally binding formal law. Non-binding rules- often called substantial sources of international law, or soft law- have already played an important role in the field of world health and a future prospect would be even more promising, taking account of the fact that global problems today could only be tackled by cooperative actions among states, international governmental organizations, big corporations-especially multinational enterprises, belligerency in a sovereign state and with various type of NGOs. Importance of statehood as a qualification is gradually decreasing as far as the constructing the world governance is concerned such as protecting global environment, countermeasuring international terrorism, and accomplishing global health security.

For global health security, most important soft law measures have been taken by WHO. Article 23 of WHO Constitution provides that the WHA has authority to make recommendations to member states with respect to any matter within the competence of WHO. In accordance with it, the WHA issued resolutions to address the SARS, the effectiveness of which is highly regarded irrespective of their legally non-binding character[20] . However, it also has to be mentioned that they could be useless to states which categorically denied the enforceability of recommendations.

Other than WHO recommendations, a series of activities based on the declarations of international and regional organizations as well as multilateral conferences are also of importance. Global responses against H5N1 Avian Influenza would be regarded as a good example for the possibility of global governance based on the soft-law type commitments[21] . Let aside such engagements, the following are some examples that are important in the Asian region. As a UN-related network, Joint UN Programme on HIV/AIDS should be pointed out. Global Fund to Fight HIV/AIDS, Tuberculosis, and Malaria, first proposed at the July 2000 G8 Summit in Okinawa, was established in May 2001. The Global Fund, an independent legal entity founded under Swiss law, represents a model of public-private partnership for management.

Global Outbreak Alert and Response Network (GOARN), a network of the networks of communicable diseases institutions worldwide was set up through WHO (initially in 1998 and) formally in April 2000. It merits mentioning that GOARN is incorporated in the "source" that would supply reports to WHO to help its work (Article 9 of the IHR (2005)). GOARN, after detecting and confirming the outbreak of a severe communicable disease, provides necessary expertise and medical technology to combat it. When necessary, international teams of GOARN would be dispatched to the state needed through a WHO system[22] .

Hot line, a better surveillance system and other measures for local health security was constructed at ASEAN plus 3 Health Ministers Special Meeting against SARS in Malaysia, in April 2003. APEC Health Ministers Meeting, in June 2003 in Thailand, agreed to share diseases information and to collectively take actions to apply the same principles on health check for immigration[23] . Global Health Security Action Group (GHSAG) Ministerial Meeting, established under the auspices of WHO by the health ministers of G7 nations, Mexico and European Union (EU), took action against smallpox and transnational institutional cooperation[24] .

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20) See, *e.g.*, Fidler (2003) pp. 1-2.
21) See, Section 1(Introduction-Communicable Disease as a Global Threat) of this paper.
22) On the GOARN, *see*, http://www.who.int/csr/outbreaknetwork/en/ (date accessed: 18 April 2005).
23) Ministry of Health, Labor and Welfare (2005) pp.274-275.
24) *Ibid*.

In implementing the revised IHR, flexible international cooperation could be duly developed to promote the world health security. In the area where prompt action is needed, flexible governmental and private partnership could bring best results, as one phenomenon of the seeds of Global Governance.

4. Bioterrorism and International Law

Until recently, international legal measures against bioterrorism were categorized into three: first category includes international conventions to prohibit the use and manufacture of biological weapons; second, UN anti-terrorism legal agreement, and third involves export and transportation control regimes based on soft law. After "9.11", however, there seems a tendency all three are constricted into one direction with the help of, *e.g.*, UN Security Council Resolution 1540: prevention of bioterrorism through stricter national legislation and enhancing international legal cooperation. Such trends may also indicate the hope for global governance in that the demarcation of law and "non-law" is blurring as well as the increasing importance of the participation of various actors, irrespective of their international legal personality, is evident.

(1) International Conventions and Universal Jurisdiction

As international conventions included in the first category, Protocol for the Prohibition of the Use in War of Asphyxiating, Poisonous or Other Gases, and of Bacteriological Methods of Warfare (1925) (133 states parties) and Convention on the Prohibition of the Development, Production and Stockpiling of Bacteriological (Biological) and Toxin Weapons and on Their Destruction (hereinafter referred to as "BTWC") (1972) (153 states parties) have more importance. Since BTCW does not contain verification measures different from Chemical Weapons Ban Convention (1993) (160 states parties), efforts were made since 1991 to adopt a verification protocol to the BTWC. The composite text was, however, rejected by the US in July 2001, (note that before "9.11"), because of its ineffectiveness to ensure compliance and the necessity to protect domestic pharmaceutical business and sensitive biodefense information from the US standpoint[25] . The USA, never been supportive to the verification protocol, reinforced its objection after anthrax terrorism in October 2001, believing that biological weapons would be very likely to be used by terrorists instead of sovereign states. Thus, mandates of sixth review conference of the BTWC (to be held in 2006) were restructured to strict national implementation of the treaty instead of some kind of verification measures:

25) Zanders, Hart, Kuhalau & Simon (2002) pp.672-673.

each state party is required to assure that no such weapons are manufactured, introduced, or in any way used in its territory and its nationals would not develop, manufacture, acquire or use biological and toxin weapons irrespective of place[26] . Such mandates are similar to UN Security Council Resolution 1540 adopted on 28 April 2004, which is legally binding although mere a resolution, because it was adopted under Chapter VII of the UN Charter (Articles 25). Resolution 1540 directs a member state to equip itself with strict national export and border control laws to prohibit any non-State actors to acquire and use in any way weapons of mass destruction (WMD). It seems that BTWC may have succeeded in adjusting to the global change of security ramification[27] .

In a second category, UN-made International Convention for the Suppression of Terrorist Bombings (1998) (132 states parties) can be mentioned since "explosive or other lethal device" include biological agents or toxins or similar substances (Article 1, Paragraph 3b). This Convention provides that any person commits an offence if that person unlawfully and intentionally delivers, places, discharges or detonates an explosive or other lethal device in a public place (Article.2) and that a state party shall enable such offences punishable by appropriate penalties (Article 4). Most characteristics of this Convention is the obligation of a state party to establish a universal jurisdiction in its penal law in order to put the alleged offender under its criminal procedures irrespective of the place the offence was conducted (Article 6)[28] . If the alleged offender is found and arrested in 132 states parties, he or she cannot escape from the criminal procedures, either in that country or in the state to be extradited, which could be the country of the place of offence or even the state of his (her) nationality. In short, such universal jurisdiction might be said as a world criminal court being located in any like-minded country for a specific subject in terrorism.

(2) Soft Law Type International Legal Cooperation

Center of the third category is export control regime, soft law measures. Australia Group (AG), originally set up in 1985 for preventing the spread of chemical weapons, extended its mandates in 1992 for that of biological weapons. With respect to biological

26) Ward (2004) pp.183-199. The following is the mandates given to annual meetings which were and are to be held to prepare for review conferences: (i) National mechanisms to establish and maintain security and oversight of pathogenic microorganisms and toxins (2003); (ii) Enhancing international capabilities for responding to, investigating and mitigating the effects of cases of alleged use of biological or toxin weapons or suspicious outbreaks of disease (2004); (iii) Strengthening and broadening national and international institutional efforts and existing mechanisms for the surveillance, detection, diagnosis and combating of infectious diseases affecting humans, animals and plants (2004); and (iv) The content, promulgation, and adoption of codes of conduct for scientists (2005). Hart, Kuhlau & Simon (2003) pp.648-649.

27) Guthrie, Hart, Kuhlau & Simon (2004) pp.661-667. Less positive evaluation on the 2003 meeting is seen in Tucker (2004) p.34.

28) UN made 13 such anti-terrorism conventions with universal jurisdiction between 1963 (high jacking) and 2005 (nuclear terrorism).

weapons nonproliferation, AG provides indicative guidelines with which member states (39 states and European Commission) should comply. Currently AG guidelines list certain biological agent, plant and animal pathogens (111 in total) and 7 biological manufacturing facilities and equipments as items to be controlled by domestic export control laws not to be contributed to manufacture biological weapons[29] . Membership of AG is rather limited to like-minded developed countries to maintain the guideline effectively in operation without a legally-binding instrument. While it cannot be denied that there exists merits in such treatment that would also result in alienating developing countries by restricting the availability of sensitive materials and technologies to developed countries. Task urgently required is that legal and financial assistance should be provided to the developing countries to establish and operate appropriate export control legislation. If more states are equipped with catch-all export control laws, then AG could be substantially enlarged. It is interesting to note that the requirements to UN members by the UNSC Resolution 1540 abovementioned, would lead nations exactly in that direction. Should international cooperation for that purpose be successful, that could be a real representative of international interactions for foreseeing global governance.

As transportation security regime, Container Security Initiative (CSI), made by administrative agreements between Bureau of Customs and Border Protection (BCBP) of US Department of Homeland Security (DHS) and counterparts of 20 nations (37 ports) (as of May 2005), has been developed to identify and target containers that pose a risk for terrorism, using intelligence, automated information and pre-screening. CSI agreements allow, based on reciprocity, foreign inspectors in national ports to screen high-risk containers[30] . Also US-led Proliferation Security Initiative (PSI), launched in May 2003, is an international law enforcement cooperation mechanism against WMD proliferation. Often declared by US high-ranking officials that "activity, not organization"[31] , PSI is a typical soft law type multilateral legal enforcement measures assisted by bilateral mutual ship-boarding agreements (hard law for the rights to visit and confiscate on the high seas) and UN SC Resolution 1540. As of May 2005, 15 core members participate in PSI with another 60 supportive[32] .

5. Conclusion

It seems that the time has come for unique nature of the IHR to be made the most of

29) http://www.australiagroup.net (date accessed: 5 May 2005).

30) http://www.bxa.doc.gov/Compliance and Enforcement/ (date accessed: 21 Feb.2005). CSI began in March 2003. As of April 2005, 12 Asian ports, 20 European ports, 2 South American ports and 1 African port are in operation.

31) See, e.g., Denny (2003) p.3.

32) Porth (2005) p.1.

for achieving global health security. Taking note of the fact that the revised IHR contains the device on which various types of actors in today's international society could play an important role, further cooperation for capacity building of member states has to be conducted. Capacity building is consisted of enhancing science and technological ability for detection, assessment and communications, establishing adequate domestic legislation for preventing and mitigating severe communicable diseases, and constructing a actual operational system. In other words, capacity building involves the comprehensive actions for members, which cannot be easily attained for many countries without the appropriate international cooperation. Such international cooperation should be carried out not only in the form of providing funds and assisting setting up of a legal regime, but also transferring of state-of-the art technology.

To globally combat bioterrorism, streamlining national laws are also urgently required both to satisfy treaty obligations and soft law obligations of export, border control and transportation security regimes. Key issue is national legislation the contents of which have to be reasonably standardized. SC Resolution 1540 made at the UN can act as a catalyst to consolidate antiterrorism efforts having been made in various manners. It is interesting to reconsider that implementation of Resolution 1540 would also be a useful tool to meet the IHR requirements for capacity building, especially in the management of airports, ports and ground crossings of member states.

Today's global reality does not allow to restricting actors of actively involving with health security to entities having international legal personality. Emerging and re-emerging infectious diseases including ones from bioterrorism must be collectively tackled by various types of actors, raging from nonrecognized states, to competent international organizations, and to private partners such as NGOs and enterprises. It is needless to say that the WHO would work as the center for the state-to-state and public-private partnerships as a neutralized coordinator. In the coming era that the full respect for human rights and fundamental freedom of individual persons are to be more important, or in the era of so-called Global Governance, the role of WHO would be of vital importance.

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