South Africa as a result of the increased and efficient production. These benefits are not yet partly because globalization and conflicts. Turmoil in one n a global pandemics.

The Politics of Surveillance and Response to Disease Outbreaks
The New Frontier for States and Non-state Actors

Edited by
SARA E. DAVIES
Queensland University of Technology, Australia

JEREMY R. YOUDE
University of Minnesota Duluth, USA

ASHGATE
Chapter 1
Surveillance, Response, and Responsibilities in the 2005 International Health Regulations
Sara E. Davies and Jeremy R. Youde

Introduction

When the World Health Organization's (WHO) first Director of International Health Regulations (IHR) coordination, Dr Guénaël Rodier, gave an interview on the significance of the revised IHR (unanimously passed by the 2005 World Health Assembly) he was keen to stress their coercive power. Asked what were the incentives for states to comply with the revised IHR, he replied:

In today's information society, you cannot ignore or hide a problem for very long. You can perhaps ignore or hide an event for a day or two, but after a week it's virtually impossible. WHO and its partners have a powerful system of gathering intelligence that will pick anything up immediately. One of the incentives for countries to report such events is that these will already have been reported via the electronic highway. We will be in a much better position to help if we have been involved early on by the affected country. The fear of being named and shamed by the media and other countries concerned by the situation is in itself an incentive. (Rodier 2007: 428–30)

Essentially, Rodier argued that the revised IHR embrace both normative and tactical changes—but its real power is intelligence gathering. The revised IHR rest on states adopting a new norm under which states feel an obligation to their citizens and other countries to engage in active disease surveillance. States have a certain responsibility to themselves and each other, and will adhere to certain behavioral precepts to uphold this new understanding. The combination of the growth and reliance on information communication technology (ICT) and recognition of the importance of respecting human rights in disease surveillance fundamentally changes how public health and international organizations gather and act on information on outbreak events. The media, blogs, and SMS messages work in tandem with recognition of human rights to monitor disease outbreaks, and have become as important, if not more so, as traditional communication from states.

As early as 2000, public health surveillance was evolving from a government-controlled tool to one that individuals could harness and control. Rather than
wait for states to inform WHO and other states of outbreaks, individuals and non-government organizations have been encouraged to harness this technology to instantly relay local media reports of outbreaks around the world (Grein et al. 2000, Brownstein et al. 2008). Between 1997 and 2001, approximately two-thirds of reports about infectious disease outbreaks initially came through these new sources rather than official country reports (Heymann et al. 2001: 332). The revised IHR encourage states to report outbreaks and respect human rights for fear of being named and shamed if they fail to do so—the technological capacity of individuals to contribute to global outbreak surveillance is changing. In turn, what states are expected to survey and report.

We propose that the revised IHR, in particular its inclusion of the WHO's right to receive non-state surveillance reports and the inaugural reference to international human rights principles in outbreak response, has a significance that may go beyond outbreak response. States have increasingly associated their capacity to respond to outbreaks with their responsibility as sovereign states in an international society. The failure to respond in a timely manner to an infectious disease outbreak is increasingly shameful for a “responsible” state, which as we further detail below, has the potential to either enrich or curtail the rights of individuals during and after an outbreak event.

Most analyses of the revised IHR and the new obligations they introduced have primarily concentrated on the relationship between the state and WHO, or the strength of the structures—between the state and WHO—to comply with the IHR. Neglected in these analyses, though, is an examination of whether the revised IHR's emphasis on surveillance has empowered a new actor—the individual. In this chapter, we ask how the inclusion of ICT and human rights principles into the revised IHR has empowered the individual. We interpret the “empowerment” claim as being one that could apply in a number of ways—from the individual providing disease outbreak alerts, to states introducing quarantine laws that reflect the need for disease containment but is responsive to the individual's rights of citizens and non-citizens. Most of all, in this chapter, we are interested in the concept of sovereignty as responsibility that was promoted within the revised IHR. The revised IHR allowed non-state reports and made explicit reference to human rights instruments, we propose, because governments were persuaded that responsible states allow individuals to seek responsive and effective outbreak response from their states. Further, if a state fails to uphold this obligation within the revised IHR, then individuals have the right to take the means to “name and shame” them. There still exist significant limitations on the ability of individuals to fully realize their potential with regards to ICT and human rights recognition, as we will discuss in this chapter. Despite such shortcomings, we propose—and the contributions that follow in this book further reveal in the areas of surveillance, outbreak containment, timely reporting and risk communication—that significant advances have been made under this revision. The question is whether there exists the potential to further this nascent attempt at realizing sovereignty as responsibility in the area of outbreak surveillance, response, and containment.
In this chapter we focus on two key elements that were introduced in the revised IHR that directly engage the role of the individual as much as the state and the WHO: recognition of human rights principles in outbreak response, and the allowance for non-state actors to directly communicate with WHO and share outbreak surveillance intelligence. We explore the political impact of these two developments in four sections. First, we define how the concept of global biosurveillance developed under the revised IHR and how this definition delineates the decision making process in IHR (2005) that spells out the situations in which states, non-state actors, or individuals should report disease outbreaks to WHO. Second, we examine how IHR (2005) empowers individuals through recognizing and respecting human rights. Third, we look at the ability of the individual to report and access information about disease outbreaks through information communication technology (ICT) systems. Finally, we present the present the existing shortcomings and ambiguities in the IHR (2005)'s relationship between the individual, the sovereign, and the international community.

Health Surveillance and the IHR (2005)

Public health surveillance—the capacity to do it promptly, accurately, and on an ongoing basis—has developed a very specific significance within global health politics (Weir and Mykhalovskiy 2010). In 2005, the World Health Assembly passed Resolution 58.3, which defined surveillance as:

*The systematic ongoing collection, collation, and analysis of data for public health purposes and the timely dissemination of public health information for assessment and public health response as necessary.* (WHO 2005)

Particularly important here is the emphasis on collecting information to guide action. The data gathered through public health surveillance are important only in that they facilitate appropriate responses. This change was particularly important given how the revised IHR shifted its surveillance and reporting mandates.

Chapter 2 provides more detail on the changes embodied within IHR (2005) and the reasons behind its significant reforms, but it is useful to highlight some of the rationale at this point. At the most fundamental level, the IHR had to be reformed because they were no longer relevant to the health challenges the international community faced. IHR (1969) relied on passive surveillance mechanisms that focused only on very specific diseases and offered no opportunity for non-state actors to play any role. What little surveillance did occur only targeted points of entry and exit, thus leaving most of any given country (and its citizens) undefended and irrelevant to the IHR's reporting mechanisms.

By the last decade of the twentieth century, it was clear that new and re-emergent infectious diseases simply could not be addressed by the IHR. States...
saw a need for a more active form of biopolitical surveillance in order to find new disease outbreaks and stop them as soon as possible. The growth in the number of reputable and reliable nongovernmental organizations, combined with the recognition that states may have motivations not to report disease outbreaks, encouraged consideration of the role non-state actors could play in addressing health security as we entered the twenty-first century.

IHR (2005) fundamentally transformed health surveillance in four key ways. First, it introduced the concept of the “all-risks” approach to surveillance. Instead of specifying specific diseases or conditions that would trigger surveillance mechanisms, the “all-risk” approach focused on “public health emergencies of international concern” (PHEIC). Such events threatened the international community, had the opportunity to spread, and required international cooperation to adequately address. Gone was the list of notifiable diseases from IHR (1969). In its place was a decision-making matrix to allow state and non-state actors to assess whether they needed to report an outbreak to WHO (see Figure 1.1).

Second, IHR (2005) also set up permanent surveillance and reporting structures. A state had to constantly remain vigilant for outbreaks, and it always had to have a direct line to WHO in case of a reportable outbreak. Third, IHR (2005) gave WHO permission to accept and act on reports from non-state sources. This ended the bottleneck that, in the past, had allowed states to hide potentially embarrassing information about outbreaks and stymied WHO’s ability to act. Finally, the new International Health Regulations placed human rights at the core of responding to public health emergencies of international concern. Governments had to always remain cognizant of the human rights implications of any actions they took to stop a disease’s spread. If a state introduced limitations on human rights to combat an outbreak, such action had to be justified, minimal in its application, and limited in its duration. This put IHR (2005)’s mandates in line with 1985’s Siracusa Principles, which explicitly lays out the narrow conditions under which governments can temporarily abrogate human rights (United Nations 1985).

These four changes to IHR (1969) are so far-reaching and removed from the scope its predecessor that calling the changes “revisions” understates the enormity of the changes. The 2005 instrument—through the expanded scope and surveillance obligations, and the inclusion of an expanded reporting system and human rights principles—embodies multiple technical and legislative changes by the state to meet their core capacity requirements to the instrument. We contend that the revised IHR incorporates a deeper understanding of what a responsible sovereign should do in the event of an outbreak. This understanding is particularly notable, as we will present next, through the portioning of power to the individual under the IHR in the areas of human rights recognition and outbreak reporting. Both inclusions are potential avenues for individual agency that, theoretically, allows a person to challenge the behavior of a state in the event of an outbreak according to the IHR specified chain of events. Of course, these inclusions are far from perfect, but their presence is a notable advance to the concept of sovereignty as responsibility in the area of outbreak surveillance and response.
Public health event detected by surveillance system

Human cases of smallpox, polio (wild-type), SARS, and influenza (new subtypes)

Events of potential national or international public health concern

Human cases of diseases that have a proven ability to cause national or international public health concern

Serious public health impact?

Unusual or unexpected event?

Significant risk of international spread?

Significant risk of trade/travel restrictions?

Yes to at least 2 of the 4?

Report event to WHO

Figure 1.1 Decisionmaking instrument for IHR (2005), adapted from Annex 2

Human Rights in IHR (2005)

Between the IHR's original incarnation and its 2005 revised version, public health officials came to recognize the importance of human rights in implementing effective disease control strategies. Six articles within IHR (2005) address human rights. Article 3 states that IHR (2005) should be implemented "with full respect for the dignity, human rights, and fundamental freedom of persons." Article 23 states that travelers should not be subject to medical examinations without...
their consent and that any such examinations should be as minimally invasive as possible. Article 31 reaffirms Article 3, specifically highlighting the importance of respecting travelers' dignity, human rights, and fundamental freedoms. Article 42 states that the IHR (2005) should be implemented in a transparent, non-discriminatory manner. Article 43 guarantees to states the right to implement their own disease control measures outside the formal IHR (2005) process, provided that they are generally consistent with IHR (2005) and not more intrusive than necessary. Finally, Article 45 states that personal data is kept anonymous and confidential, and it be retained only as long as necessary for its specific purpose.

IHR (2005)'s emphasis on human rights adds a useful counterweight to the increased surveillance measures that are promoted as a core capacity requirement for states to meet their IHR obligations. More surveillance for more diseases and from more sources may engender suspicion and anger, but IHR (2005) provide the suspicious with an out. They know they have certain rights that must be respected, and the state knows that it must respect those rights. The Regulations provide the aggrieved with a framework for demanding their rights. All parties understand what the state owes its citizens and travelers within its borders. IHR (2005) offer "explicit protections of the interests of individuals" (Plotkin 2007: 841)—something completely absent from previous versions.

IHR (2005) recognize the importance of human rights by expanding public health surveillance beyond the state. National government officials may lack the awareness of disease outbreaks, or they may have incentives for concealing that information. Non-governmental organizations, local health clinics, local media sources, and individuals seeing changes in their communities may be better positioned to witness and understand that a problem is emerging. It can take time for information to trickle up to national health officials in the old passive surveillance systems. The more proactive, diffuse surveillance encapsulated in IHR (2005) streamlines the process of getting necessary information to WHO in a timely manner. The explicit inclusion of non-state actors in an international treaty represents a significant step forward. Non-state actors and individuals, through social media, can help ensure that states live up to their international legal obligations.

IHR (2005) and Internet-based Surveillance

The World Health Assembly (WHA) formalized the role of internet-based surveillance when it passed Resolution 54.14 in 2001, thus greatly expanding individual access to reporting systems. This resolution gave WHO the authority to incorporate internet surveillance and reporting programs (ISRPs) into its efforts to verify outbreaks and offer assistance with infection control, diagnostics, and fieldwork teams to afflicted states through its Global Outbreak Alert and Response Network (GOARN) (Heymann et al. 2001). While WHA Resolution 54.14 does not specifically mention GOARN or any particular ISRP, their work was documented
in the report of the WHO Secretariat (A54/9)—and Report A54/9 and WHA54.17 were both presented during the same WHA session (WHO 2001).

The underlying premise of GOARN and its associated Global Public Health Intelligence Network (GPHIN) is that “reports of infectious disease events around the world are regularly received by WHO through formal laboratory and epidemiological channels and from sources such as nongovernmental organizations, the media or electronic discussion groups.” GPHIN provides the conduit to “seek, collect and verify information on reported epidemics, working closely with its collaborating centers, governments and governmental agencies, as well as relevant nongovernmental organizations and other partners in the global outbreak alert and response network” (WHO 2001: paragraph 7–8).

Despite falling under the innocuous label “Other Reports,” Article 9 of the revised IHR introduced far-reaching changes in disease reporting procedures. Under this article, states authorized the WHO to take into account “sources other than [official] notifications or consultations” and required it to “assess these reports according to established epidemiological principles and then communicate information on the event to the State Party in whose territory the event is allegedly occurring” (WHO 2005: Article 9.1). Furthermore, the article mandates that states respond to WHO communications within 24 hours while allowing the source of the report to remain confidential. This may not be of paramount importance for ISRPs (depending on the ISRP source, media or informant), but it is for the nongovernmental organizations, religious organizations, or individuals who can also inform WHO of outbreak events.

During the 1990s, the evolution of internet technology inspired the creation of “global” surveillance networks. Some of these internet surveillance networks, such as BioCaster (see Chapter 6), rely primarily upon ontology software for text mining and language translation for report compilation. Others, such as GPHIN (see Chapter 5), rely on analyst software and human analysts. Under GPHIN, analysts with language proficiency in Arabic, Farsi, English, Spanish, Russian, Chinese, Portuguese and French sift through thousands of reports produced daily to determine which ones need to be placed on the subscriber-only alert page. GPHIN was one of the first real-time surveillance networks created, developed in cooperation with WHO Headquarters with Public Health Agency of Canada in 1996. Its reports are primarily issued to fee-paying subscribers and are therefore not publicly accessible. HealthMap is a free access internet surveillance network that analyzes media reports on a scale similar to GPHIN and also collates reports from other surveillance internet providers such as MedISys (EU joint research center project), ProMED Mail, WHO and Google Search Term Trends—including blogs and “social media” sites—to produce real-time alerts of disease outbreak with color codes indicating source reliability (which entails “last minute” human moderation prior to posting) (Castillo-Salgado 2010).

With the wide range of internet surveillance networks, questions arise about the accuracy and value of the reports they produce (Hartley et al. 2010). Many argue that these networks are vital to the global disease reporting alert and response
structure. GPHIN has been essential to the WHO’s capacity to identify disease events and provide direct assistance to states, sometimes prior to those states and their neighbors, being aware of the extent of the outbreak (Heymann et al. 2008). As Pat Drury, head of Alert and Response Operations at WHO Headquarters, argued to the United Kingdom’s (UK) Intergovernmental Organizations Select Committee in 2008, such “sources of information” help WHO’s special operations center identify which media and incident reports need to be assessed for risk to the local and international community, which leads to recommendations for the country and WHO to take appropriate action (Heymann et al. 2008: 211). For example, WHO was able to use local reports of higher than usual pneumonia outbreaks in Southern China over 2002–2003 to seek clarification of the event, which turned out to be SARS. Similarly, online discussions on the ProMED Mail site among witnesses in China enhanced the risk assessment process at WHO Headquarters, informing their decision to request permission from the Chinese government to dispatch an investigation team in February 2003 to enter China to verify the extent of the outbreak (Heymann and Rodier 2004: 173–5; Madoff and Woodall 2005).

The fact that it was less likely that states would be able to prevent the leakage of information about disease outbreaks, given the proliferation of internet surveillance networks, and that states were able to find the “signal” amongst the “noise” (Brownstein et al. 2008: 1019), was one of the key reasons why they agreed to IHR (2005) revisions that provided for WHO (2005) under Article 9 to “take into account reports from sources other than notifications or consultations, and shall assess these reports according to established epidemiological principles and then communicate information on the event to the State Party in whose territory the event is allegedly occurring.”

Ambiguities and Underdevelopment in the IHR (2005)’s Global Health Nexus

The recognition of human rights and the empowerment of non-state sources to contribute to epidemic infectious disease outbreaks are both hallmarks of IHR (2005). By including both of these elements, IHR (2005) sought to make sovereigns accountable for their health outbreak response at both the global and individual level by empowering individuals (O’Malley et al. 2009). Surveillance has become a political act in that it signifies a states responsibility to report IHR listed diseases, irrespective of capacity.

Despite these lofty goals, success has been more mixed in practice and the politics is complicated. The rhetoric supporting these dramatic changes to better incorporate the individual into these global practices did not necessarily translate into the appropriate activities. This is not to suggest that IHR (2005) is fatally flawed or that the underlying principle—sovereigns as responsible actors in outbreak response—is merely utopian wishful thinking. Instead, these difficulties reflect that existent oversights and ambiguities undermine the IHR’s ability to live
HO's capacity to identify disease outcomes prior to those states and to outbreak (Heymann et al. 2008). Operations at WHO Headquarters, governmental Organizations Select Operations at WHO Headquarters, or national organizations would be able to prevent the event, which turned on the ProMED Mail site among the seven to the State Party in whose jurisdiction the event occurred. WHO (2005) sought to make surveillance, response, and responsibilities up to its promises. Bringing attention to them and shaming states that fail to live up to their obligations, though, will allow for changes and improvements.

Falling Short on Human Rights

The revised International Health Regulations' explicit embrace of human rights represents a significant step forward in infectious disease surveillance. By acknowledging the importance of respecting human rights, IHR (2005) can allay some of the fears that may exist around disease surveillance systems. The inclusion of human rights-related clauses also reflects the changing norms and standards within the global community.

Despite this progress, though, the force of human rights protections in IHR (2005) is underdeveloped and lacking in substantial backing. Chapter 2 details these shortcomings in greater detail, but it is important to acknowledge here that IHR (2005) conceptualizes human rights in a highly ambiguous manner. It is unclear whose human rights should be respected, as many of the explicit references to human rights exist in reference to travelers as opposed to residents or citizens. Furthermore, IHR (2005) does not reference any existent human rights treaties, depriving the regulations of firm precedents for understanding and implementing human rights protections. There is also no mechanism for investigating human rights abuses within WHO. While IHR (2005) call on states to respect human rights, they designate no office or agency to take action if one or more of those states fail to uphold their human rights obligations.

Being more explicit about human rights protections within IHR (2005) would encourage states to better integrate human rights thinking into their application of the Regulations. There is scope for WHO to clarify how states may fulfill their responsibilities towards the IHR in a way that does not abrogate or ignore the potential for individuals to contribute to, and benefit from, the IHR in an emancipatory way. But WHO has a delicate balance to tread here. Beyond the self-monitoring tool, there remains a gap between promoting human rights in the IHR and how the Organization may engage in some measure of monitoring or investigation of reports of human rights violations. The IHR (2005) Review Committee advocated WHO consult with state authorities when media reports suggested that human rights violations occurred (WHO 2011: 82). This arrangement would presumably be less formal than an actual investigation of human rights violations—something WHO lacks the resources or experience to conduct on its own—but even an informal approach could still signal to states that their actions do receive notice.

Chapter 2 goes on to reveal, it is on this latter point where unofficial sources can perhaps play their most useful role in encouraging compliance with and respect for human rights within health surveillance procedures.
Limitations in Internet-based Surveillance

Internet-based health surveillance systems should give individuals greater access to disease outbreak reporting systems, especially when governments may have an interest in censoring or selectively releasing information about disease outbreaks to the public’s detriment. While this holds great promise, the experiences thus far suggest that these Internet-based surveillance systems continue to give governments and official news sources a dominant voice. Individuals have less access than originally hoped for, and the systems themselves struggle to distinguish between official government and individual reports.

When we are attempting to track the efficiency, effectiveness and coverage of surveillance technologies—whether at the national or global level—we need to understand more about the political systems in which these technologies are operating. A quick scan of a MedSys or HealthMap output for 30 days will generate a lot of news media sources, but the vast majority of their content has been informed by public health officials releasing outbreak news. Governments may also spread rumors in order to advance their own interests (Brownstein et al. 2008: 1022), and Blench demonstrated that the quantity of official report sources—which are verified—is virtually equal to that of news media report sources (Blench 2010: slide 19). As Nigel Collier notes in Chapter Six, the epidemic intelligence upon which Internet-based surveillance systems rely still struggle to figure out how to deal with the possibility of bias in their data. If these systems are using potentially biased information from official sources, this may inadvertently compromise or weaken their efficacy. Despite its important implications, the basic fact that at least half of all the reports come from the government itself has not yet penetrated discussion about the utility of surveillance for keeping governments transparent and how to test the quality of surveillance reports from governments during an outbreak (Heymann et al. 2008; Rodier 2007; Klobentz 2010: 122–3).

Understanding that governments are a significant source for ISRPs is important for two reasons. First, failure to acknowledge this fact feeds into the potentially unwarranted notion that states are not cooperating with the release of health information. Second, this neglect of the government’s role as a source of information inflates the “intelligence” capacity of ISRPs without acknowledging their success relies upon governments making this information available. Therefore, what is new and needs to be emphasized is the search tool that ISRPs provide and the promotional impact of this information for people in situations where information cannot break through the state barrier. We cannot know precisely to what extent ISRPs are ahead of states until there is a clearer distinction in the ISRP reporting of outbreaks between sources that have some level of associated government input and those that are wholly “independent,” which in turn “shames” states to engage in higher quality surveillance and response.

Noting the source limitations of servers also allows us to realistically understand the contribution that individuals and ISRPs can make to shedding


light on those places where the communication and political freedom to report is constrained. HealthMap has argued that while 85% of its reports come from news media sources, there is a “clear bias towards increased reporting from countries with higher numbers of media outlets, more developed public health resources, and greater availability of electronic communication infrastructure” (Brownstein et al. 2008: 1021). The French Institute for Public Health Surveillance has noted similar concerns about the coverage gaps that their server has in particular geographic locations, and GPHIN has also referred to such coverage gaps (Rotreau et al. 2007: 1591, Blench 2008: 299–303). Surveillance “blackholes” also arise in locations that place limits on the freedom of the internet, press, and independent actors. Previous experiences detailed by Madoff and Woodall (2005) reveal that it is highly unlikely individuals in autocratic countries would be able or willing to make extensive use of such internet technology. Nor can we assume that the provision of anonymity will make it any easier for the NGOs on the ground in countries where they are strictly bound to memorandum of understandings with their host government (i.e. North Korea) and where access to the internet is limited, monitored or regulated. There is not much that ISRPs or WHO can do about these problems, but heightened awareness of the human rights implications of “early reporting” and ISRP monitoring of such deficiencies, may facilitate more individual risks to supply those early warnings and constrain the retaliatory response of the state against that individual. In sum, there needs to be further consideration of how civil liberties and political freedoms are deeply connected to the efficiency of ISRPs and health system performance in general.

There can be no doubt that the allowance of non-state communications to WHO of a suspected outbreak heralds an important moment for situating power and agency beyond the nation state. We need to understand, though, how instances of individual agency work before we start proclaiming its transformative potential. First, there remain profound limitations for communicating outbreaks in despotic, autocratic regimes without the political or civil freedoms to freely communicate. The fact that there has been such little discussion of this, and especially the practical implications of the confidentiality clause under IHR (2005), is cause for concern (Youde 2009).

Second, we need to acknowledge the role of the state in assisting Article 9, and how it influences the work of ISRPs specifically. The study by Emily Chan and her colleagues, for example, noted that within the vast majority of reports on sites such as ProMed, HealthMap and MedISys, many of their online updates include government representatives reporting outbreak events or confirming the existence of ongoing tests to determine source or type of outbreak (Chan et al. 2010). Rarely is it acknowledged that the ISRP may have found an outbreak that the state already knew existed, furthermore that the ISRP found it because the state reported the event. In sum, the view is that the public airing of the “signal”—rather than who issued the signal—creates the impetus for action, but this view is flawed if the signal came from the state in the first instance.
Conclusion

As the chapters that follow in this volume will reveal, the revised IHR has presented a significantly new expectation on the responsibility of the state and the wider international community concerning disease outbreak surveillance. Instead of being solely a top-down process driven entirely by state interests, IHR (2005) now functions as the nexus that mediates the states responsibility to the individual and the global community. The treaty aims to link the individuals affected by its biosurveillance requirements with the policymakers who set up these systems. In this way, it aims to empower individuals by explicitly recognizing the important role of human rights in devising a global health regime and by harnessing the power of information communication technologies to allow individuals to share and access information about the infectious disease outbreaks that could potentially affect them.

While the revised IHR shows some promise, the treaty remains underspecified and ambiguous in certain crucial areas. As such, the promises of human rights and the ability of individuals to make meaningful contributions to reporting infectious disease outbreaks have not yet met expectations. This does not mean that we are failing to see sovereignty as responsibility in action—the acceptance of the IHR revisions confirms this point—but it does mean that we cannot rest on our laurels. Just as global health is an ever-changing field, so too our analysis of technological innovation, the action that improved surveillance facilitates (and demands), along with the expectations of effective sovereign policy commitment to this responsibility must all change and adapt. Most crucially, it must be recognized that surveillance may not be a political act but it engages with political actors, political situations and has political repercussions.

References

will reveal, the revised IHR has the responsibility of the state and ng disease outbreak surveillance. driven entirely by state interests, nediates the states responsibility to treaty aims to link the individuals empowers individuals by explicitly ights in devising a global health nation communication technologies mation about the infectious disease e, the treaty remains underspecified h, the promises of human rights and contributions to reporting infectious ns. This does not mean that we are action—the acceptance of the IHR in that we cannot rest on our laurels. too our analysis of technological surveillance facilitates (and demands), sovereign policy commitment to this crucially, it must be recognized that engages with political actors, political
The Politics of Surveillance and Response to Disease Outbreaks
