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Military Forces, Global Health, and the International Health Regulations (2005)

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Author Note
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Abstract
Security, economic, development, and humanitarian threats created by infectious diseases have heightened the importance of military forces to national and global public health responses. This article explores the increasing need for military involvement in public and global health surveillance and response to infectious disease threats, and focuses on how military forces can more effectively support implementation of the World Health Organization’s International Health Regulations (2005) (IHR (2005)). The article explains the major changes made in negotiations that produced the IHR (2005) and the importance of these changes to military-to-military activities and civilian-military cooperation. It identifies five areas in which military forces can advance implementation of the IHR (2005) —compliance, coherence, coordination, cooperation, and capacity — and includes examples from various countries illustrating how militaries can contribute to progress on IHR (2005) implementation. It recommends additional actions from military forces, including a proposal for a Global Military Working Group on the Implementation of the IHR (2005) led by the International Committee on Military Medicine.

Keywords: bioterrorism, capacity building, civilian-military cooperation, Department of Defense, emerging infectious diseases, global health, global health security, implementation, International Health Regulations (2005), military forces, military-to-military cooperation, public health, surveillance, World Health Organization
Introduction

The history of humanity’s struggle with infectious diseases records the impact of military forces on the emergence, spread, and control of such diseases. This military involvement has included spreading pathogens through war, mitigating the damage infections have inflicted on fighting forces, and contributing to the protection of general population health. The complexity of the military’s role in public health nationally and globally has increased in the past 10 to 15 years because of changes in the threats posed by infectious diseases. With such diseases increasingly manifesting as security, economic, development, and humanitarian concerns, military forces have faced new demands on their capabilities to support public health within and beyond the territories they protect.

One important development in this new relationship between the military and global health is the International Health Regulations (2005) (IHR (2005)), adopted by the World Health Organization (WHO) (WHO, 2008). Developed to advance global health security (WHO, 2008), the IHR (2005) radically changed the international law applicable to the international spread of disease (Fidler, 2005). Although most attention generated by the IHR (2005) has focused on civilian public health, the IHR (2005) are important to militaries. Understanding the challenges and opportunities defense establishments face from the IHR (2005) is important to support the regulations and manage the increasing health demands on militaries. This article examines the IHR (2005)’s implications for military forces and explores strategies for militaries to advance the IHR (2005) as an instrument of global health security.

Military Forces and Global Health: New Context, New Rules

New Context: The Military and Global Health

Military forces have long been concerned about population health in two contexts. First, militaries require healthy personnel to undertake their missions. Historically, armies endured severe morbidity and mortality from infectious diseases during armed conflict. This attrition led to improvements in military hygiene, sanitation, and treatment of wounds. Starting in the twentieth century, the task of protecting troops also addressed the potential use of biological weapons in warfare. The laws of war also placed increasing demands on military forces concerning the health of enemy combatants, prisoners of war, and civilians in war zones or under military occupation. These rules included, among others, the prohibition on weapons that cause superfluous injury or unnecessary suffering (Henckaerts & Doswald-Beck, 2005), and the duty of an occupying military to maintain health services in occupied territory (Geneva Convention (IV), 1949, Article 56).

These contexts are limited to the primary security functions of military forces. However, efforts to mitigate health threats to troops and reduce adverse health consequences of military operations have produced some “spill over” benefits for general population health. Knowledge gained and research undertaken by military personnel have informed interventions for protecting civilians, such as contributions the U.S. military made to malaria control and treatment (Ockenhouse, Magill, Smith, & Milhous, 2005).

The relationship between military forces and public and global health changed in the 1990s, producing an expanded role for military organizations, especially with respect
to supporting the civilian sector. This context emerged in the wake of two crises. The first involved the vulnerability of countries to the emergence and re-emergence of naturally occurring infectious diseases. For military forces, emerging infectious diseases (EIDs) presented new threats to the old concern about the health of military personnel, as evidenced by concerns about the impact HIV and AIDS could have on armed forces in Africa (Feldbaum, Lee, & Patel, 2006).

However, political responses that characterized EIDs as threats to national security, foreign policy, and development interests affected the military’s involvement in national and global public health. In the United States, President Bill Clinton expanded the Department of Defense’s mission “to include supporting global surveillance, training, research, and response to emerging infectious disease threats” (White House, 1996). This new task made the Department of Defense important to the larger U.S. effort to “[e]stablish a global infectious disease surveillance and response system” that would protect U.S. citizens from naturally occurring infectious diseases (White House, 1996). Later, national strategies to address infectious disease threats, such as pandemic influenza, assigned roles to the military (U.S. Homeland Security Council, 2006; U.S. Department of Defense, 2006). The message behind these developments was that it was necessary to utilize defense assets in integrated “whole of government” efforts to strengthen surveillance and response, given the nature and danger of the threat.

The second crisis involved bioweapons and bioterrorism. Revelations in the early 1990s about the former Soviet Union’s and Iraq’s bioweapons programs stimulated efforts to address bioweapons proliferation by states. This concern connected with long-standing military needs to protect troops from bioweapons in armed conflict. However, fears about bioterrorism added a new element. Military capabilities in disease surveillance and biodefense research and development were brought to bear on bioterrorism through surveillance of suspicious events and development of detection systems and countermeasures. These efforts supported actions being taken in the civilian sector to prevent, protect against, and respond to bioterrorist attacks.

What unified developments across these crises was the need for civilian and military capabilities to work together against EIDs and bioterrorism for the protection of the health of military personnel and the general public. This objective required conceptual and policy shifts. Civilian public health, long starved of resources in many countries, had to accept the need to draw on military capabilities in addressing EIDs. National security communities had to understand that responding to a bioterrorist attack required robust civilian health systems. The lines demarcating military and civilian realms began to blur, creating the need to integrate civilian and military efforts against pathogenic threats.

Similar conclusions emerged from other health activities undertaken by military forces. The use of military capabilities for medical treatment and public health in responding to humanitarian disasters (WHO, 2005, ¶¶ 46-49), winning “hearts and minds” in counterinsurgency operations (Feldbaum & Michaud, 2010), and delivering health assistance to developing countries through hospital ships (O’Brien, 2009) raised the profile of military forces in global health. These activities generated controversy because they highlighted inadequate civilian capacities and created concerns about the militarization of development and humanitarian assistance. Nevertheless, these activities deepened the importance of
military capabilities and their integration into civilian efforts to strengthen public health nationally and globally.

**New Rules: Towards the IHR (2005)**

At the same time the relationship between the military and global health was transforming, WHO embarked on revising the International Health Regulations (1969) (IHR (1969)) (WHO, 1983). This process had to address the threats from EIDs and bioterrorism that were altering the military-global health interface. Thus, crafting new rules for international disease at a time when the military's role in this realm was expanding constituted an important development for armed forces.

The IHR (1969) and predecessor treaties did not affect military forces significantly. The regime that developed from the nineteenth century through the IHR (1969) focused on infectious diseases, the spread of which countries associated with international trade and travel. The rules applied to only a few diseases, with only cholera, plague, and yellow fever remaining constant from the first international sanitary conference in 1851 through the IHR (1969). The rules were geared more toward protecting trade than strengthening public health. The regime's basic bargain involved two obligations: countries suffering outbreaks of specified diseases agreed to report such outbreaks, and other countries agreed to apply only scientifically justified responses to the trade and travel coming from the outbreak country. Governments did not view this regime as important to foreign policy, national security, or development interests. The rules left the matter of bioweapons to the security community to handle through arms control.

The regime's narrow scope had limited impact on civilian and military health efforts. Civilian officials and military forces had more diseases to worry about than cholera, plague, and yellow fever. During the 1960s and 1970s, experts questioned the traditional regime's approach in light of changes in transportation technologies and the need to address diseases not covered by the rules (Dorolle, 1969; Velimirovic, 1976). Violations by countries (e.g., failure to report outbreaks and application of unjustified trade restrictions) undermined the regime's credibility (Fidler, 1999).

EIDs and bioterrorism again exposed the inadequacy of the traditional rules and highlighted the need for a strategy that required a broader scope of application, imposed more demanding obligations, and produced more surveillance and response capacities. With the military's role in global health increasing, new rules with wider application, tougher duties, and requirements for more capacity promised to implicate defense organizations more than the traditional regime. From the military's perspective, the IHR (2005)'s adoption reflected the transformed global health context in which the military operated, and underscored the new responsibilities of military forces in this context.

**International Health Regulations (2005): Key Changes**

The IHR (2005) contain rules never before seen in efforts to control the international spread of disease. The differences between the IHR (2005) and the IHR (1969) are too many to analyze here, so this paper focuses on key revisions, which make
the IHR (2005) “one of the most radical and far-reaching changes to international law on public health since the beginning of international health cooperation in the mid-nineteenth century” (Fidler, 2005, p. 326). The IHR (2005) contain other provisions that have undergone less radical, but still important, changes. Understanding these transformations and changes is a necessary prelude to examining their implications for militaries.

Expanded Scope of the IHR (2005)

The IHR (2005) expand the scope of the rules in terms of their purpose, application, obligations, participation, and WHO’s authority. The IHR (2005)’s purpose resembles that of the IHR (1969) in aiming to control the international spread of disease while avoiding unnecessary interference with trade and travel (Article 2). However, the new regulations focus more on protecting population health than trade interests. The change is clear in the new scope of disease coverage, which abandons the disease-specific approach and adopts a strategy to identify existing and unknown disease threats. The IHR (2005) require States Parties to notify WHO of all disease events that might constitute a public health emergency of international concern (PHEIC) (Article 6 and Annex 2) — an expansion of the obligations of States Parties in notifying disease outbreaks.

The IHR (2005) also expand the scope of application by including accidental and intentional releases of biological, chemical, and radiological agents (Articles 1, 6, and 7). This change reflects the understanding that health harms are not limited to EIDs but can include biological, chemical, and radiological terrorism and accidental releases of health-harming substances. Including these dangers is consistent with an “all hazards” approach, which also expands the scope of the obligations.

The IHR (2005) also expand WHO’s scope of participation and authority. As examined further below, the IHR (2005) allow WHO to use information from non-governmental sources (Articles 9 and 10) — powers neither the IHR (1969) nor any prior version of these rules permitted. This rule makes non-governmental actors participants in global surveillance and empowers WHO to assess information received from outside governmental channels. In another unprecedented move, the IHR (2005) increase WHO’s authority by empowering the WHO Director-General to declare a PHEIC and issue temporary recommendations on actions States Parties should take in response to a declared PHEIC (Articles 12 and 15).

Core Capacities for Surveillance and Response

The IHR (2005) require States Parties to develop and maintain core capacities for surveillance and response (Articles 5, 13, and Annex 1). The old rules only imposed requirements for public health capabilities at designated points of entry and exit (e.g., adequate sanitation at sea ports). The new rules include such requirements (Annex 1), but transcend them in imposing obligations on developing core surveillance and response capacities throughout their territories. These obligations seek to ensure that countries have baseline capabilities to identify and respond to disease events and comply with the IHR (2005). States Parties have to develop these core capacities by 2012, with options for extensions until 2016 (Articles 5 and 13).
Use of Non-Governmental Sources of Information

The IHR (2005) empower WHO to collect, analyze, and verify information received from non-governmental sources (Articles 9 and 10). This authority reflects the conclusion that any regime on the international spread of disease limited to government-provided information would fail, as the IHR (1969) had. New information technologies created opportunities for national and international health agencies to obtain information from more sources about disease events. Permitting WHO to use such information and requiring States Parties to respond to WHO verification requests transform the notification dynamic by (1) reducing incentives governments have to cover up disease events for fear of economic or political repercussions; and (2) increasing incentives for countries to cooperate with WHO to address identified problems. WHO statistics demonstrate that non-governmental actors constitute a significant source of information (Institute of Medicine, 2009).

WHO Director-General’s Power to Declare a PHEIC and Issue Temporary Recommendations

The IHR (2005) authorize the WHO Director-General to declare that a disease event constitutes a PHEIC (Article 12), and to issue temporary recommendations on how States Parties should respond (Article 15). Nothing like these authorities existed in previous regimes. The WHO Director-General first exercised these powers in declaring pandemic influenza A (H1N1) a PHEIC in April 2009, and issuing temporary recommendations on responding to the threat. The authority to declare a PHEIC and issue temporary recommendations represents the potential for the WHO Director-General to exercise political and economic power vis-à-vis governments. Combined with the ability to collect, use, and verify information from non-governmental sources, the declaration and temporary recommendation powers create constraints on sovereignty in the name of global health.

Respect for Human Rights

The IHR (2005) state that their implementation “shall be with full respect for the dignity, human rights and fundamental freedoms of persons” (Article 3.1). The IHR (2005) contain other provisions (Articles 23.2-23.5, 31.1, 31.2, 32, 42, 43.2, and 45.1-45.3) relevant to protecting the human rights of persons subject to health measures within the scope of the regulations (Plotkin, 2007). The inclusion of human rights principles underscores how the IHR (2005) have departed from the past primary concern about balancing trade and public health. It also reflects increased attention on human rights created by policy responses to EIDs and bioterrorism. Actions taken by some governments during the H1N1 pandemic, such as isolation and quarantine of travelers, came under human rights scrutiny through the IHR (2005)’s application.

National IHR Focal Points

The IHR (2005) seek to improve communications by requiring each government to establish a National IHR Focal Point with the responsibility of implementing the regulations (Article 4). This approach aims to streamline and make more effective communication channels within and among national governments and WHO, which also must establish IHR Contact Points. Experience to date, including with H1N1, indicates that the National IHR Focal Points have improved information flows and contributed to the success achieved so far (Katz, 2009).
Other Changes

The IHR (2005) contain other important, if less radical, changes that deserve mention. With abandonment of the disease-specific approach, the new regulations could not contain maximum measures limiting States Parties’ responses to disease events. Instead, the IHR (2005) require that measures applied to trade and travelers have public health and scientific justifications. For measures that seek greater protection than WHO recommends, the State Party has to consider scientific principles, evidence, and advice from WHO (Article 43.2). For more protective measures that significantly interfere with trade and travel, the State Party must provide WHO with the public health rationale and scientific information supporting the measures (Article 43.3). During the H1N1 pandemic, some countries applied measures, such as import bans on pork, which had no public health or scientific justification. WHO also modified technical aspects of the regulations, such as replacing the old de-ratting certificate for ships with the ship sanitation control certificate (Annex 3) and the old international certificate of vaccination or revaccination against yellow fever with the model international certificate of vaccination or prophylaxis (Annex 6).

International Health Regulations (2005) and Military Forces

In keeping with the expanded role of military forces in global health, the IHR (2005)’s implications for defense establishments are significant (Johns et al., 2010). Given diversity among militaries, no single blueprint for handling the IHR (2005) is possible. However, each military should review the IHR (2005) against its missions and resources. Such reviews could keep in mind five useful categories: compliance, coherence, coordination, cooperation, and capacity. Table 1 provides examples of military strategies under each category and of national efforts to implement such strategies.

Compliance

The IHR (2005) contain binding international legal obligations. The IHR (2005) do not exempt military forces, dilute rules for such forces, or provide national security exceptions. The only IHR (2005) provision that specifically mentions “Armed Forces” permits, under certain conditions, active members of such forces to have a document different from but equivalent to the International Certificate of Vaccination and Prophylaxis (Annex 6). The IHR (2005)’s principle of achieving “universal application for protection of all people of the world” underscores this point (Article 3). The extent of military compliance needed will depend on how governments use militaries for functions affected by the IHR (2005). For example, some militaries might control points of entry and exit, and, depending on the functions of the military’s border control responsibilities, the IHR (2005) could apply to military personnel actions. Other militaries might have no role in border control but be involved in disease monitoring among troops at home and overseas that the IHR (2005) affect through provisions on surveillance and notification of disease events.

Controversy in this context arose concerning an understanding the United States issued upon accepting the new regulations. The IHR (2005) require States Parties, as far as practicable, to inform WHO of public health risks identified outside their territories that might cause international disease spread (Article 9.2). The United States accepted this obligation with the understanding that it is impractical to notify these risks when a notification “would undermine the ability of the U.S. Armed Forces to operate effectively in pursuit of
U.S. national security interests” (Appendix 1). The concern is that notifying such risks in a country hosting U.S. military forces could harm the forces’ ability to fulfill their mission by creating problems with the host government, especially if that government has failed to notify WHO of the risk, as required under the IHR (2005). Iran criticized the U.S. understanding, arguing that it dilutes U.S. obligations by placing its interests above the IHR (2005)’s universal application and exempting U.S. armed forces from the regulations (Appendix 1).

The merits of the U.S. and Iranian positions could be debated, but, as a practical matter, the key to mitigating the potential tension created by Article 9.2 is effective cooperation about the IHR (2005) between the government providing military forces and the government hosting them (Johns et al., 2010). Such cooperation can increase the incentives a host government has to communicate with WHO about public health risks in its territory that might cause international disease spread, reducing the need for Article 9.2 to cause friction. This article returns to the importance of cooperation on the IHR (2005) below.

Coherence

For a State Party to comply with the IHR (2005), all governmental elements must be consistent in their implementation of the regulations. The military plays an important part in achieving coherence among national agencies with responsibilities for activities affected by the IHR (2005) (WHO, 2007). For most countries, control over military forces is not decentralized, removing coherence challenges created by federal systems that locate civilian public health powers at the state or provincial level. Achieving coherence requires vetting relevant legislation, regulations, instructions, and operating practices in civilian and military sectors and making changes to ensure both sectors apply the same or equivalent rules and strategies. Coherence issues could arise in a number of IHR (2005) contexts, including use of defined terms, application of the decision instrument that guides notification of disease events, recognition of technical requirements (e.g., the new ship sanitation certificate), and respect for human rights principles.

Coordination

Coherence is necessary but not sufficient to advance “whole of government” implementation of the IHR (2005). Also important is coordination among governmental agencies tasked with responsibilities relevant to the IHR (2005) (WHO, 2010b). Branches of the military must work together and communicate in managing the surveillance, response, and other obligations in the IHR (2005), as must military and civilian agencies. Effective intra-military and civilian-military coordination have been problematic in other contexts, including intelligence sharing, counterinsurgency, counterterrorism, development efforts, and disaster relief. Thus, the coordination challenge facing the military in implementation of the IHR (2005) should not be underestimated.

The obligation to establish an IHR National Focal Point has helped facilitate better communication and coordination, but intra-military and civilian-military coordination and communication involve complex political, chain-of-command, information sharing, and technical issues that should be addressed proactively and not primarily as part of post-crisis “lessons learned.” Including “stress tests” for intra-military and civilian-military coordination capabilities in simulations and “table top” exercises involving EID or bioterrorism threats could facilitate identifying and managing coordination problems.
Cooperation

Military forces also have a role in IHR (2005) implementation by including the IHR (2005) in military-to-military and civilian-military cooperation. Many countries participate in military-to-military programs that involve technical assistance, training, and joint military exercises. Such programs can incorporate more health-related issues, including the military’s role in IHR (2005) implementation. For example, the Global Health and Security Working Group of the Center for Strategic and International Affairs has proposed that the U.S. government “create a specific health theme for DOD’s military-to-military activities,” (Center for Strategic and International Studies, 2010) and cooperation on the IHR (2005) could form part of such a health focus. Similarly, potential exists to address the IHR (2005) in ventures between military forces and civilian agencies in other countries (International Military Forum on Emerging Infectious Diseases, 2010). Such military-to-military and civilian-military cooperation would help countries fulfill their obligation under the IHR (2005) to collaborate on implementation of the regulations (Article 44.1).

Capacity

Militaries in developed and developing countries have a role to play in the capacity building needed to implement the IHR (2005) (International Military Forum on Emerging Infectious Diseases, 2010). As noted earlier, the IHR (2005) require States Parties to develop and maintain core capacities for surveillance and response, and, as a nearly universally accepted instrument, all countries have responsibilities for capacity building. One of the biggest concerns about the IHR (2005)’s future remains the inadequacy of these capacities in many countries and the insufficient efforts being mounted to address this problem (Wilson, Brownstein, & Fidler, 2010). Military forces alone will not solve this challenge, but they can contribute by:

a. Strengthening the military’s own capacities in disease surveillance and response;

b. Supporting civilian efforts at home and abroad to build detection and intervention capacities;

c. Supplementing civilian capacity in contexts where such capacity is inadequate or ineffective because of insecure conditions;

d. Helping foreign militaries build their IHR (2005)-relevant capacities; and

e. Assisting development agencies build capabilities in developing and least-developed countries.

Although important, military involvement with capacity building faces challenges. Not all militaries have the resources and personnel to scale up capacity-building activities, and resources for such activities are increasingly difficult to access because of fiscal problems in many nations. Increasing military contributions should not come at the expense of building civilian capacity and increasing civilian-led capacity-building endeavors. Further, military efforts need to avoid building capacity that is mainly relevant to the health and security interests of the country providing assistance, meaning that the capacity must reflect not only the IHR (2005)’s demands but also the recipient country’s public health challenges. Military participation in capacity building with foreign civilian counterparts also has to
be sensitive to concerns in the civilian and non-governmental communities about greater military involvement in public health (Table 1).

Table 1. Summary Table of IHR (2005) Implementation Objectives and Potential Military Strategies

<table>
<thead>
<tr>
<th>Strategy for Military Forces</th>
<th>National Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>IHR (2005) Implementation Objective: Compliance</td>
<td>Comprehensively review military missions and existing law, regulations, instructions, and operating procedures against requirements of the IHR (2005)</td>
</tr>
<tr>
<td>IHR (2005) Implementation Objective: Coherence</td>
<td>Ensure military understanding, interpretation, and application of IHR (2005) is identical or equivalent within all military branches and with those civilian agencies</td>
</tr>
<tr>
<td>• Thai military efforts to work with and support the Thai Ministry of Public Health on IHR (2005) implementation and compliance (International Military Forum on Emerging Infectious Diseases, 2010)</td>
<td>• Disease reporting within branches of military forces and between the military and civilian health agencies in Peru through development of military-based electronic disease surveillance system based on IHR (2005) requirements (Chretien et al., 2007)</td>
</tr>
<tr>
<td>• Integration of the decision instrument in Annex 2 of the IHR (2005) into U.S. Department of Defense management of public health emergencies (U.S. Department of Defense, 2010)</td>
<td>• Expanding an inter-ministerial group on preparing Brazil's responses to emerging infectious diseases to include the Brazilian military (International Military Forum on Emerging Infectious Diseases, 2010)</td>
</tr>
<tr>
<td>• Inclusion of the military in South Africa's Provincial Outbreak and Response Teams to coordinate disease surveillance and responses consistent with the IHR (2005) (International Military Forum on Emerging Infectious Diseases, 2010)</td>
<td>• Military reporting of disease information in remote areas on the Thai/Myanmar and Thai/Cambodian borders to the Thai Ministry of Public Health (International Military Forum on Emerging Infectious Diseases, 2010)</td>
</tr>
<tr>
<td>Strategy for Military Forces</td>
<td>National Examples</td>
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</tr>
<tr>
<td>IHR (2005) Implementation Objective: Compliance</td>
<td></td>
</tr>
</tbody>
</table>
| Include IHR (2005) implementation issues in health aspects of overseas military-to-military activities and in military assistance to foreign civilian agencies | • Czech Republic bilateral (e.g., with Poland) and multilateral (e.g., with NATO) military-to-military cooperation on disease surveillance (International Military Forum on Emerging Infectious Diseases, 2010)  
• Peruvian military-to-military cooperation with Ecuador and military-to-civilian cooperation with Panama concerning electronic disease surveillance (International Military Forum on Emerging Infectious Diseases, 2010)  
• Enhancement of civilian-military cooperation on pandemic influenza at U.S. Africa Command meeting for Asian and African countries (Skinner, 2009) |
| IHR (2005) Implementation Objective: Capacity |  |
| Support surveillance and response capacity building in foreign countries in both the military and civilian sectors | • Thai military efforts to support malaria control capacities in Myanmar and Cambodia (International Military Forum on Emerging Infectious Diseases, 2010)  
• Capacity-building assistance on malaria control provided by the Institute of Tropical Medicine of the French Army Health Corps to the Vietnamese Army Health Corps (Chretien et al., 2007) |


Given the complexity of issues that arise for military forces under the IHR (2005), a working group of representatives of different military forces around the world that identifies difficulties militaries have with IHR (2005) compliance, disseminates best practices for implementation, generates opportunities for military-to-military cooperation, and collaborates with WHO could be valuable. The International Committee on Military Medicine, which is in official relations with WHO, could sponsor such a working group. Formation of this working group could be an outcome of the International Military Forum on Emerging Infectious Diseases on the military's role under the IHR (2005) held in St. Petersburg in September 2010.

**Conclusion**

Elevating the IHR (2005) within the transformed responsibilities militaries have in global health requires understanding these regulations and the need for military forces to leverage their capabilities for IHR (2005) implementation. Moving in this direction does not mean the militarization of the IHR (2005) but acceptance that EIDs and bioterrorism warrant effective “whole of government” responses. In the global health realm, the main military mission is to support and supplement civilian-led actions. To the extent that militaries have not identified how they can shoulder their burden of implementing the IHR (2005), this mission will not be accomplished.
References


