
The Mexican Experience of the NAPAPI Revision Process*

María Esther Coronado Martínez**

Abstract

In 2007, Mexico, the USA and Canada signed the North America Plan for Avian and Pandemic Influenza (NAPAPI). During the 2009 H1N1 pandemic, the plan was implemented for the first time. After the emergency, the three countries decided to review their response, and update the plan. This study analyses the trinational negotiations towards the amended NAPAPI of 2012. More specifically, it focuses on the intergovernmental synergies and intersectoral dynamics in Mexico's domestic policy-making process relevant to the negotiations. The general research questions guiding this analysis were: how do domestic intergovernmental processes and intersectoral dynamics in Mexico affect the crafting of foreign policy? And how does international cooperation affect the domestic public health agenda? The study seeks to answer these questions by examining the H1N1 pandemic, the challenges facing Mexico in the course of the pandemic, and its experience of NAPAPI. It also examines the domestic policy process in Mexico for revising this trinational plan.

Keywords: Pandemic Influenza, Cooperation, NAPAPI, Policy-making, Intersectoral Collaboration

* Received on 29 October 2015 and approved for publication on 20 January 2016.

** Carleton University, Ottawa, Canada; mariacoronadomartine@email.carleton.ca.



Introduction

Despite recent advances in research and development, infectious diseases are still an open chapter in global health (Michaud 2010). Every year the World Health Organization (WTO) identifies hundreds of emerging infectious diseases (EIDs), including new influenza viruses. EIDs are regarded as threats to the health of nations due to their capacity to not only affect humans but also to burden health systems, infrastructure, and economies (Ear 2012; Michaud 2010; Caballero-Anthony 2008; Fidler 1997). Given that globalisation has enabled the rapid spread of EIDs worldwide, international cooperation is the best instrument for preventing and containing a pandemic (Fidler 1997; Zacher and Keefe 2007; Labonte 2008), motivating states to set up international and regional institutions and concluding international agreements for managing these events (Fidler 1997; 2001; Zacher and Keefe 2007).

Due to the complexity of infectious diseases and of international cooperation to manage pandemics, multisectoral participation is essential. This affects the ways in which national states participate in formulating and implementing international policies. Given this, international cooperation to manage and control pandemics typically results in a two-level game process, as reaching international agreements depend on domestic dynamics (Putnam 1998). Various scholars have tried to disaggregate this complex process (Katzenstein 1978; Putman 1998). However, more research is needed about the role of multisectoral foreign policy in international negotiations, and how international cooperation affects sectoral policy-making at the national level.

The field of global health offers a range of cases, due to the importance of intersectoral action to achieve health goals (WHO 1997; Tess and Mussa 2013; O'Neill et al 1997). One of these is Mexico during the negotiations towards the revised North America

Plan for Avian and Pandemic Influenza (NAPAPI), after the H1N1 outbreak in 2009. Intersectoral action was indispensable for dealing with the outbreak as well as concluding an amended agreement on future responses in the region.

This article studies this case, examines how international cooperation impacts on a public health domestic agenda, and how domestic intergovernmental processes and intersectoral dynamics influence the crafting of foreign policy. The discussion will focus on the synergies and dynamics surrounding the integration of the trilateral negotiations with Mexico's domestic policy-making process during NAPAPI's revision following the 2009 emergency.

The role of domestic policy in international cooperation on infectious diseases

Various scholars have addressed the relevance of cooperative agreements and institutions at the regional and international level. According to them, these agreements provide information, reduce transaction costs, make commitments more credible, and facilitate coordination and the operation of reciprocity (Keohane 1985; Young 1989; Keohane and Martin 1998; Dai 2007). They also modify states' behaviour and self-interest (Krasner 1983; Keohane 1985; Young 1989). Furthermore, due to the interdependencies between these spheres, states need to coordinate policies that may result in greater cooperation (Keohane 1984; Dai 2007).

Neo-realist theorists argue that international agreements are a response to the vital interests of states (Mearsheimer 1995). The idea that infectious diseases are a threat to national security and can damage countries' economies and military capabilities leads to the proposition that countries agree to cooperate due to a convergence of

the relevant international issue with their national interests, and therefore that the cooperation in question will only remain effective as long as the states involved regard it as advantageous (Fidler 1997:38). Diseases are now seen as a potential threat to the stability of states, with both political and security implications (Price Smith 2009; Ingram 2005). This has resulted in growing international mobilisation and coordination to counter the public health threats posed by emerging infectious diseases (Fidler 1997; WHO 2007; Michaud 2010).

These assumptions help to explain why countries have entered into agreements such as NAPAPI which are aimed at preventing and containing health threats posed by communicable diseases. However, they do not clarify how countries reach these agreements, given their complexity and their impact on domestic politics.

In this regard, global health governance grapples with three major features of the current international health system affecting international cooperation (Fidler 2010; Frenk and Moore 2013), namely the complexity of health problems; political interests; and the generally inadequate mechanisms for collective action (Fidler 2010). The large number of actors involved in global health issues at the domestic and international level adds to these factors as they compete for influence and resources, often creating a fragmented process incapable of producing a convergence of interests in the process (Fidler 2012; Frenk and Moore 2013). At the same time, divergent political interests often result in divergent strategies for addressing health problems (Zacher and Keefe 2007; Fidler 2010). Given the multiplicity of health issues requiring responses, policy-makers face a dilemma of prioritisation, resulting in uneven health governance in both quantitative and qualitative terms (Fidler 2012:12).

Other analysts have addressed the complexity of reaching cooperative agreements, examining key domestic factors rather than

systemic ones. They regard states as complex organisations rather than simple unitary actors, and domestic politics as a variable that alters the prospects of effective international cooperation (the decision to subscribe to an agreement, as well as its contents). Therefore, in this approach, the complexity of reaching international agreements rests on the differences among states, their institutional designs, and the interplay between the relevant international dimension and domestic policies (Putnam 1998). As such, governments embody multiple actors and multiple interests that can be in conflict (Putnam 1988). Therefore, policy choices are the result of ‘policy games’ at the domestic level, and decisions are the aggregate result of sub-actors’ preferences (Putnam 1998; Underdal 1998). The general propositions associated with this approach are as follows:

- 1) Each decision-maker evaluates the costs and benefits of various options in order to maximise the net benefits, but this may not necessarily be most consistent with the national interest (Underdal 1998: 16).
- 2) The perspectives and interests of decision-makers are determined by their positions and roles in domestic politics (Allison 1971).
- 3) Society constrains policy-makers and governments in general (Putnam 1998; Underdal 1998).
- 4) The policy process is a game (Putnam 1998). Implementation games tend to differ from those involved in reaching an agreement; they have different patterns of participation and influence (Allison 1971).
- 5) Policy options tend to become more specific during the process of implementation and compliance (Underdal 1998).
- 6) The more specific the policy measure required for compliance, the more determinate and differentiated its impact on society tends to be (Underdal 1998).

Thus, reaching an international agreement depends not only on aggregate national costs and benefits, but also on their domestic distribution.

Two-level game theory can therefore be used to understand the formation of agreements such as NAPAPI that required the participation of multiple domestic sectors during both the negotiation and implementation processes. The propositions noted above allow an understanding that domestic actors have dissimilar interests, and that their cost—benefit assessments may differ. Therefore, NAPAPI can be seen as the result of interaction among relevant actors at the domestic level, and their ability to influence the international process.

The international context

In embarking on this analysis, it is important to describe the international context. Health security in North America emerged after 9/11, with numerous mechanisms prioritising planning for influenza pandemics (Avery 2010: 8).

One of these was the Global Health Security Initiative (GHSI), an informal network established under the leadership of the USA after 9/11. GHSI is a high-level decision-making group comprising the ministers of health of the the G-7 nations, Mexico, and the European Commission. It provides member countries with a platform for discussing policies aimed at preparing for and responding to health security threats (GHSI 2011: 1-8). In 2002, at about the time when the GHSI was founded, Severe Acute Respiratory Syndrome (SARS) emerged in China (WHO 2006: VII). In the same year, the WHO confirmed the international spread of the influenza A virus subtype H5N1, commonly known as avian influenza, or ‘bird flu’ (Enemark 2009: 192).

The Mexican Experience of the NAPAPI Revision Process

The SARS and H5N1 threats challenged disease surveillance, notification, and reporting systems for communicable diseases at the national and international level.¹ In 2003, the only instrument for monitoring the outbreak of these types of diseases was the International Health Regulations (IHR) of 1969, which only required countries to provide notifications of three communicable diseases: cholera, yellow fever, and the plague. In May 2003, the World Health Assembly adopted resolution WHA56.28 (WHO 2005), which recognised the need to reform existing practices for preventing and responding to international outbreaks. Revised IHR were released in 2005, and entered into force in June 2007, requiring countries to provide notifications of single cases of specific diseases, including smallpox, human influenza caused by a new subtype, and SARS (WHO 2008), and commit themselves to improving their public health capabilities in respect of alerts as well as responses. In addition, the World Health Organization (WHO) made an urgent call for increased international cooperation to take up the challenges posed by these threats (WHO 2007).

On 14 September 2005, during the IHR negotiation process, the then US president, George W Bush, also announced the establishment of an International Partnership on Avian and Pandemic Influenza (IPAPI) in the UN General Assembly. IPAPI was aimed at impelling major donor countries to invest in and assist countries already dealing with the H5N1 virus (Enemark 2009).

The SPP and NAPAPI

Against this background, plus the process of regional integration which began with the North America Free Trade Agreement (NAFTA) in 1994, Canada, the US and Mexico entered into an agreement aimed at greater cooperation on a range of security and economic issues. Entitled the Security and Prosperity Partnership of

North America (SPP), it was launched at a trilateral summit in Waco, Texas, in March 2005.

The SPP involved 11 working groups on a range of economic and infrastructure issues, including health, clustered under a prosperity agenda and a security agenda (SPP 2005:1). The health working group (HWG) initially formed part of the prosperity agenda (SPP 2005: 27), but was later integrated with the emergency management working group under the security agenda. At the trilateral SPP summit in Cancun in March 2006, emergency management and pandemic influenza were recognised as two of five regional priorities, thus starting the NAPAPI process (Avery 2010).

NAPAPI 2007 was the HWG's major deliverable. This was a complex initiative, as Mexico's capacity to respond to pandemics was more limited than those of Canada and the US. Moreover, the intersectoral nature of NAPAPI negotiations required each country to form a team comprising representatives of different agencies. The lead domestic agencies were Public Safety Agency in Canada, the State Department in the United States, and the Secretariat of Health in Mexico (Avery 2010:9).

NAPAPI was unveiled on 21 August 2007 at an SPP summit in Montebello, Canada. The plan provided a general framework for a coordinated response to an influenza outbreak. It contained directives for preparedness; communication; the prevention, control and eradication of highly pathogenic strains of avian influenza; the protection of essential infrastructure; and the protection and continuity of essential systems (SPP 2007:3). It also contained a working structure for coordination and communication among the three countries both before and during emergencies.

Given its multisectoral design, the plan required the integration of areas other than health. Moreover, implementing the plan required ongoing bilateral and trilateral work. As a result, each of the three

**The Mexican Experience of the NAPAPI
Revision Process**

countries established coordinating bodies (SPP 2007:39) of senior officials, with rotating chairmanships.

In the case of Canada, members were drawn from Public Safety, the Department of Foreign and International Trade, the Public Health Agency of Canada, and the Canadian Food Inspection Agency. In the US, members were drawn from the Departments of State, Health and Human Services, Homeland Security, and Agriculture. In Mexico, members were drawn from the Secretariats of Health, Agriculture and Foreign Affairs (SPP 2007:40). NAPAPI also envisaged the establishment of working groups for specific items, with the HWG the most important.

**Mexico's system of
preparedness and response**

Given that Mexico is less developed than the US and Canada, and has a complex health system, its approach to health security and its role under NAPAPI have differed from those of the other two countries.

The Mexican health system

Article 40 of the Constitution of the United Mexican States² (Camara de Diputados 2012) affirms that Mexico is a representative, democratic, federal republic with independent states. There are three levels of government (federal, state and municipal), with three separated spheres (executive, legislative and judiciary). According to article 4 of the constitution, all people have the right to health. The Health Act of 1984 (Camara de Diputados 1984) establishes the following sanitary authorities (in hierarchical order): the president, the General Health Council, the Secretariat of Health, and state governments. Article 5 provides for a national health system involving public and private service providers, integrated with both

federal and local government (OECD 2005). The whole system is coordinated by the Secretariat of Health.

Although the government decentralised the health system in the 1990s, all international health issues fall in the executive and federal domain, under the International Health Act of 1985 (Camara de Diputados 1986). As such, the Secretariat of Health coordinates and is responsible for activities related to preparedness for and responses to pandemic influenza.

A national organisation for responding to pandemic influenza

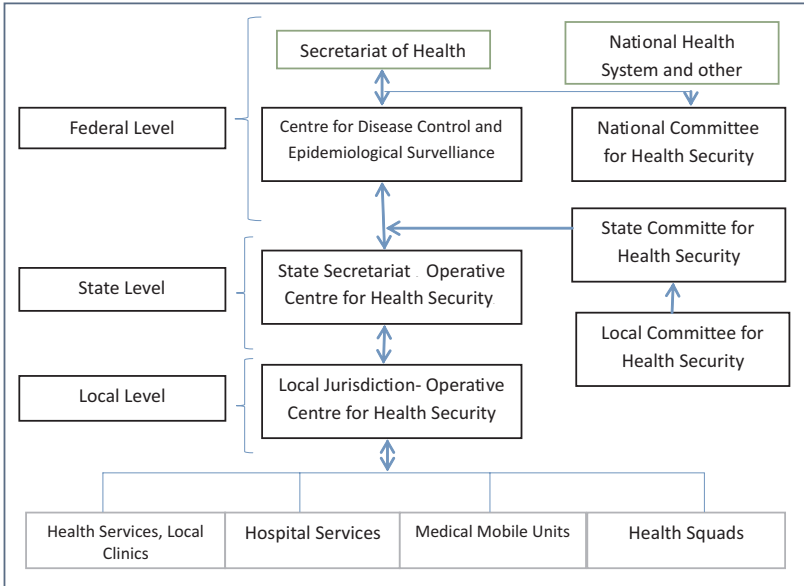
From 2001 onwards, the international context prompted all three NAPAPI countries to devise national plans for dealing with pandemic influenza (Kuri-Morales et al. 2006). In 2003, the then Mexican secretary of health created a National Committee for Health Security (Secretaria de Salud 2003), which still exists today. Its mandate is to analyse, formulate, coordinate, follow up and assess policy, strategies and activities regarding health security, with the aim of establishing tools for the timely attention to epidemiological emergencies and health crises. Its members are the Secretary of Health, the Undersecretary of Health Prevention and Promotion, the head of the National Centre for Epidemiological Surveillance and Disease Control, a representative of the Federal Commission for Sanitary Regulation, and representatives of other departments in the Secretariat of Health. Other federal agencies may only participate by invitation (Secretaria de Salud 2003). The Mexican system for dealing with pandemic influenza is depicted in Figure 1.

In 2004, the National Committee for Health Security created a working group for pandemic influenza, tasked with drafting a national plan for preparedness and response (Kuri-Morales et al. 2006). Led by the Secretariat of Health, the group comprised

The Mexican Experience of the NAPAPI Revision Process

Figure 1

The Mexican system for dealing with influenza pandemics



Source: Compiled by author from Mexican legislation (Secretaria de Salud 2003).

representatives of four other federal agencies as well as four other representatives of the health system (see Figure 2). In 2005, the National Committee was tasked with elaborating the National Preparedness and Response Plan for Pandemic Influenza. Released on 20 October 2005, the plan stressed ongoing preparation for a future outbreak, while acknowledging the participation of Mexico as a member of the GHSI, and the inclusion of avian influenza as one of the main topics of the recently signed SPP (Secretaria de Salud 2006).

The first version of the National Plan did not include guidelines for coordination at either the national or the international level. In March 2008, given that multisectoral coordination was a core issue, the Secretariat of Health issued a working document entitled 'Operative Multi-Sectoral Strategy' (Consejo de Salubridad General 2009)

Box 1: Participants in the Working Group for Pandemic Influenza

The agencies involved in the working group and the drafting of the national plan for preparedness and response were the Secretariat of Health; General Coordination for Civil Protection (Secretariat of Governance); the Secretariat of Agriculture, Livestock, Rural Development, Fisheries and Food; the Secretariat for National Defence; the Secretariat of the Navy; the Mexican Institute for Social Security ; the Institute of Security and Social Services for Civil Servants; the oil company *Petróleos Mexicanos*; and the National System for Family Development.

Source: Compiled by the author, based on Kuri-Morales et al (2006) and Secretaria de Salud (2003)

which outlined a general plan for the coordination and participation of other actors in case of an influenza outbreak (see Table 1 in the appendix). In April 2009, the government released detailed guidelines for a coordinated response to pandemic influenza (Secretaria de Salud 2010).³

NAPAPI and the H1N1 outbreak of 2009

The H1N1 outbreak in 2009 brought a new understanding of what needs to be done to prepare for and respond to an influenza pandemic. Although the NAPAPI was a useful tool, it demonstrated many limitations.

Countries had created NAPAPI as a response to a latent H5N1 threat. However, early in 2009, Mexico detected an unusual prolongation of the influenza season, and isolated cases of what became known as H1N1 (initially named swine flu) in small villages, which had also occurred during the US influenza season (Cohen 2009).

As a result, the Mexican president empowered the Secretary of Health to coordinate and implement measures for containing the virus, in collaboration with other federal agencies and state governments (Secretaria de Gobernacion 2009; Cordova-Villalobos 2010). The entire federal government became involved in a

multisectoral, coordinated response. Following the trilateral agreement, NAPAPI was activated (Otero 2009).

NAPAPI simplified communications among the three countries, strengthening personal and institutional linkages among those working in the health community. It also gave Mexico access to technical assistance with improving health facilities, technology, and methods for detecting and monitoring infectious diseases.

The announcement of the new virus had international consequences. Given their recognition of the International Health Regulations (IHR-2005), both Mexico and the US notified the WHO of the outbreak. In line with IHR article 12 (2), the director-general of the WHO established an emergency committee to assess the situation (WHO 2008). After the committee's first session, the WHO classified the illness as a '*public health emergency of international concern*', and defined the phase of the epidemic response (Chan 2009a).

Despite its commitment to trinational collaboration embodied in NAPAPI, the US was one of the first countries to implement travel alerts to Mexico. At that time, there was no scientific evidence of a pandemic, especially since the outbreaks were small and in relatively isolated areas. Belgium, Argentina, the UK, Peru, and Uruguay soon followed suit. One of the most extreme responses came from China, which quarantined a group of Mexican holiday travellers and cancelled an Aeromexico flight from Tijuana to Shanghai (Niño de Haro 2009).

After critical moments in Mexico during April and May 2009, the virus spread worldwide, and on 11 June the WHO declared a pandemic (this status is reached when a virus spreads across several distinct geographical regions). By September 2009, the six regional WHO offices (of America, South Asia, Africa, East Mediterranean,

Western Pacific, and Europe) had reported 254 206 cases and 2 837 deaths (Jimenez-Corona et al. 2010: 194).

Another crisis arise when companies manufacturing the H1N1 vaccine were unable to scale up production rapidly enough to meet demand. For Mexico, this was a particularly sensitive issue since it had donated the H1N1 virus to the WHO for developing the vaccine as early as May. Between September and October 2009, Mexico had to negotiate with pharmaceutical companies to obtain the vaccine, as they had sold the initial production run to other countries, including Canada and the US (Secretaria de Salud 2010: 21).

The aftermath: assessing the trinational response under NAPAPI

Mexico experienced many undesirable consequences during the outbreak. According to the Inter-American Development Bank, the pandemic reduced Mexico's GDP by 0.5% (Cordova-Villalobos 2010: XXVI). The most important contributing factors to this were the measures applied by other countries, which disrupted international trade as well as tourism, both key sectors of the Mexican economy. Among other things, during the emergency, the flow of international air travellers to Mexico decreased by 20%—25% (Cordova-Villalobos 2010: XXVI). As a result, Mexico staged an international meeting called 'Lessons Learned: Influenza Outbreak H1N1', held in Cancun on 1-3 July 2009. This was also the first step towards reviewing NAPAPI, as the three countries involved discussed the need to reassess their trilateral response to outbreaks (Secretaria de Salud 2009).

The Cancun meeting was followed by an SPP summit in Guadalajara on 9-10 August 2009, where leaders agreed to review the trinational plan for dealing with H1N1. This was followed by a meeting of

The Mexican Experience of the NAPAPI Revision Process

senior government officials in Mexico City in October 2009, tasked with formally evaluating the outbreak, reviewing the lessons learnt, and developing improved strategies for dealing with future outbreaks. The US was represented by the Undersecretary of Homeland Security, the Head of the Health Unit in the Department of Defence, and the Undersecretary of Health and Human Services. The Canadian delegation was led by the Director-General of Public Safety and the Undersecretary of Health, and the Mexican delegation by the Undersecretary of Health Promotion and Prevention and the Undersecretary of Population, Migration and Culture in the Ministry of the Interior (Mejia 2009).

Mexico presented a study that identified problems encountered in the course of the pandemic, as well as possible improvements (Government of Mexico 2009). The H1N1 outbreak had challenged the regional response, pointing up a clear need to adjust NAPAPI. The meeting then focused on indentifying shortcomings in NAPAPI, and formulating proposals for changes or improvements.

The process started in June 2010 with a concept paper drafted and presented by the US. It acknowledged that NAPAPI 2007 had to be updated, based on the trilateral response to the H1N1 outbreak of 2009 and the lessons learnt from it, thus enabling it to improve its response to the ongoing threat of H5N1 (HSWG 2010). The three countries identified the following problems:

- 1) NAPAPI had been based on the assumption that a pandemic would be transmitted from Asia, once H5N1 had reached a sustained and efficient level of transmission from animals to humans. Therefore, the plan was intended to contain a threat from outside (HSGW 2012: 3).
- 2) Scientific analyses had focused on avian viruses. However, H1N1 was a new influenza strain transmitted from non-avian species (Ponce de Leon et al 2010). A revised approach would

require taking into account the human health interface with different species (HSGW 2012:23).

- 3) Capabilities for the timely identification of the virus were inadequate. There were also delays in sharing appropriate information about the new strain (HSGW 2012).
- 4) NAPAPI 2007 (Appendix 1) had prescribed some actions, or ‘major tasks’, that countries did not complete in time. Since the plan was not legally binding (SPP 2007), there was no specific funding for these activities, and human and financial resources were limited to ordinary agency budgets under headings such as ‘emergency management’ or ‘pandemic preparedness and response’.
- 5) Although communications were a positive feature of the response, there was room for improving communications both within and among countries (Cohen 2009).
- 6) NAPAPI 2007 had envisaged collaboration in numerous areas, implying a range of cross-sectoral and coordinated activities, and had advocated the establishment of specific instruments and tools for implementing various aspects of the response envisaged by the plan. This required the strengthening of intersectoral cooperation, especially in respect of essential infrastructure. However, some agencies were reluctant to become involved in an area (health) which they regarded as an exclusive competence⁴ (Secretaria de Salud 2010).
- 7) Lastly, there had been a shortage of antiviral drugs and vaccines (HSGW 2012).

Mexico had experienced adverse consequences due to its limited national capacity for diagnostic, testing and monitoring, which hampered its efforts to identify and contain H1N1 (Cohen 2009). The Mexican government had also failed to persuade the international community – and specifically the US – not to take unilateral action against it. Finally, perhaps the worst problem was the shortage of

The Mexican Experience of the NAPAPI Revision Process

vaccines, caused by the fact that the pharmaceutical companies has sold their stocks to the US and Canada (and some European countries) even though Mexico had provided the H1N1 strain for worldwide vaccine production. Therefore, Mexico saw the process as an important window of opportunity for analysing the implementation of NAPAPI and to promote its revision, based on its experiences during the pandemic.

Amending NAPAPI: a two-level-game policy process

On 15 June 2010, the SPP Health Working Group began the NAPAPI revision. By then, the working group had been renamed: according to a concept paper drafted and presented by the US, the revision was led by the ‘North American Health Security Working Group (NAHS WG), integrated by representatives of the Ministries of Health from the three countries’ (HSWG 2010). Given the new association with security, the paper proposed that health agencies be mandated to work ‘in coordination and collaboration with stakeholders from other sectors involved in pandemic influenza preparedness and response including human health, animal health, agriculture, transportation, borders, communications, surveillance, emergency response, foreign affairs and others’ (HSWG 2010).

The revision addressed 48 specific issues and areas. The trilateral process required each country’s lead health agency to organise domestic consultations, assemble the necessary information, and present it to the HSWG. Following this, the group ‘would coordinate the drafting of recommendations and present them to the Coordinated Body’ (HSWG 2010). The initial timeline for these activities was from July 2010 to March 2011, but they were concluded in the summer of 2011.

In July 2010, the three governments designated their respective focal points. In the US, this was the Office of the Assistant Secretary for Preparedness and Response in the Department of Health and Human Services; in Canada, the Public Health Agency; and in Mexico, the Office of the Assistant Director General of Epidemiology in the Secretariat of Health. These three agencies were responsible for coordinating the national processes in their respective countries, and communicating with other NAHS members.

The NAHS WG met twice to review progress made during meetings of the Global Health Security Action Group (GHSAG), a sub-group of the GHSI, in Washington DC in November 2010 and March 2011. Ministers of health, undersecretaries, and members of the working group met to discuss the project during a GHSI ministerial meeting in Mexico City in December 2010 (Secretaria de Salud 2010).

Also, a cross-sectoral trilateral workshop was held in November 2010, aimed at strengthening the network of officials, and creating initial linkages in areas where participants had not worked together before. The workshop also presented the participants with an opportunity to establish cross-sectoral communications, given that the only direct interlocutors at the trilateral level were the focal points. This was especially the case in respect of agencies dealing with animal health. Indeed, the workshop concluded with a document entitled ‘Guidelines for Providing Assistance under the NAPAPI (for Avian Influenza)’, signed in 2010 by veterinary officers of all three countries. This document eventually became Annex III of NAPAPI 2012 (NALS 2012).

The three countries focused on providing solutions to problems inhibiting cooperation and collaboration, which they identified as the most important aspects of the plan. In this regard, the Mexican focal point for the NAHS WG described the trinational process as ‘an experience of collaboration between three different countries with

The Mexican Experience of the NAPAPI Revision Process

different needs and capacities, which are aware of a common problem and are willing to work together and support each other'.⁵ At this stage, most of the consultations were at the technical level. By 2011, however, most of the people involved in NAPAPI had worked together for longer than six years, confirming that the trilateral venture had gone beyond initial political interests and the science-based approach that had dominated many aspects of the original plan.

The Mexican perspective

Following the foregoing account, the Mexican perspective on the pandemic and the implementation of NAPAPI can be summarised as follows:

- 1) The international context had created a chain reaction in pandemic influenza planning, and Mexico had to act in this context.
- 2) Pandemic influenza was initially seen as a technical issue, to be dealt with by health systems only.
- 3) However, after the H1N1 outbreak there was a clear need for greater intersectoral collaboration (HSWG 2010, Secretaria de Salud 2010). The 2009 influenza outbreak clearly required a response from all sectors and levels of government.
- 4) Given this, Mexico changed its approach to NAPAPI 2012, notably by proposing the establishment of expanded multisectoral teams for dealing with future outbreaks (see Table 1 in the appendix).

Mexican intersectoral coordination and dynamics

NAPAPI is not only relevant to the health sector, but also forms part of Mexican foreign policy, and specifically addresses the complex relationship between Mexico and the US. As an 'executive order', it

did not require the involvement of the legislative or the judiciary. Article 2 of the Celebration of Treaties Act (Camara de Diputados 1992) states that federal agencies may collaborate on international instruments with foreign government institutions, as long as this is related to their specific areas of competence or jurisdiction. Article 7 requires the agency concerned to consult the Secretariat of Foreign Affairs. The Act also empowers the Secretariat of Health to contribute to foreign policy. Moreover, during the H1N1 outbreak, the Mexican president enforced, for the first time, Article 73. XVI of the national constitution, which states that the Secretariat of Health should dictate all public health measures during epidemics. Therefore, during the outbreak, the entire Mexican government was required to respond to the roles and responsibilities assigned by the Secretariat of Health (Secretaria de Gobernacion 2009).

The process: multisectoral response, key actors, and interests

In line with two-level game theory, the bureaucratic process set up in Mexico to revise NAPAPI emerged from the government's legal framework and institutional design. (Putnam 1998). Moreover, the involvement of a wide range of domestic actors with diverse interests and agendas made the revision process both unusual and challenging, in that it required the participation of policy-makers, officials, technical experts and others in different spheres and at different levels of government. Each of these actors evaluated the costs and benefits of various options based on their positions, roles and interests (Underdal 1998; Allison 1971). Moreover, as the trilateral agreement was based on goodwill, political will was essential for its development. These factors created a particular 'game' during the negotiations around the revised agreement.

The Mexican Secretariat of Health led the domestic revision process, and became the focal point for the trilateral negotiations. On 24

The Mexican Experience of the NAPAPI Revision Process

August 2010, the Secretariat of Health asked eight federal agencies to designate a representative to participate in the national consultation. The agencies were also required to review the 2007 version of NAPAPI, and comment on it. The inter-agency working group included more than 12 federal agencies (see Tables 2a and 2b, listing the main actors and their interests in Mexico's domestic negotiations). Many of these actors did not make substantive contributions, because they regarded this a mainly health issue.

Besides the Secretariat of Health, the agencies with a major interest in NAPAPI were those who were working on issues related to or affected by the plan, and had already interacted with their American and Canadian counterparts. Since agencies did not have resources specifically allocated to NAPAPI, all these activities had to be linked to existing national programmes or other trilateral or bilateral mechanisms. This makes it possible to trace the interests of the most important role players, as well as their perceptions of their particular costs and benefits, and how these affected the revised version of NAPAPI. The following account is based on an interview with a former director of the Institutional Liaison Office in the Directorate General of Epidemiology, a key official in the area of influenza preparedness in the Mexican Secretariat of Health, as well as internal documents:⁶

- The main concern of the Secretariat of Health was to improve and strengthen mechanisms for emergency management within and across the three countries. Domestically, this meant closer collaboration with the Civil Protection System, which is managed by the Secretariat of Governance. The main challenge in this respect was that responses to health emergencies are coordinated by the Secretariat of Health, while Civil Protection coordinates the responses to all others. The Health Secretariat also wanted to improve the dissemination of messages of common interest, and well as exchanges of relevant information. There was a need for

more information about the domestic situation on the one hand, and for an effective trilateral response, based on scientific evidence, on the other. Both aspects would require careful coordination, to ensure that the same messages were communicated, and avoid confusion or misinformation.

- As regards border and transport issues, the Secretariat of Communications and Transportation presented a proposal for revising the treatment of land and air travellers, involving the collaboration of transport, health and customs authorities. Some of these issues had already been addressed by the International Civil Aviation Organization (ICAO). The proposal also included an intent to incorporate Common Concepts for Operation adopted by the three NAPAPI countries in October 2006, spelling out operational protocols for civil aviation in the case of pandemics. Due to their controversial nature, the Secretariat for Foreign Affairs also involved itself in these issues.
- The Secretariat of Agriculture, Livestock, Rural Development, Fisheries and Food addressed the need for technical assistance with improving national capacities to deal with animal health, an important challenge during the H1N1 outbreak.
- There was also a continuing interest by the Secretariat of Health in improving Mexico's capacities for surveillance, response, clinical and lab diagnostic testing, and the timely exchange of information.

By 25 October 2010 all the relevant agencies were required to submit proposals for incorporation into a coherent national proposal for the trilateral cross-sectoral workshop to be held in Washington DC in November 2010. After this trilateral gathering, domestic consultations were limited to informal exchanges. This meant that the Health Secretariat had to draft an integrated national proposal for submission at the trilateral level. This proposal was circulated among relevant agencies from all three countries. All of them were able to make comments and additions before creating a final version of the

**The Mexican Experience of the NAPAPI
Revision Process**

new NAPAPI draft. This proposal, along with the one from Canada and the USA, was circulated for comments. By the second half of 2011, the new version of NAPAPI had been completed and was ready.

Other Mexican actors and interests

Some Mexican agencies had consulted the private sector as well as civil society organisations during the revision process in case they had to participate in the process of implementation. The most important challenge in formulating proposals for revising NAPAPI was to integrate all these potential actors into an effective response to a future pandemic. The revised NAPAPI now requires government agencies in all three countries to work with domestic non-state actors on formulating specific response plans based on official national guidelines (NALS 2012).

The epistemic community

An important achievement in the course of the NAPAPI process was the founding of a trilateral epistemic community for pandemic influenza, comprising policy-makers, government officials, scientists and technicians as the core component of a framework of cooperation and collaboration. This group of people worked together before, during and after the influenza outbreak of 2009, and understand the complexity and scope of the problem.

The political context

Although NAPAPI was based on science and evidence-based decision-making, the political context of its implementation was also a key element. As Underland (1996) has argued, effective implementation requires clear options, determined in the course of an effective policy process. Because NAPAPI is not binding, and

therefore depends on voluntary collaboration, these options had to be clearly defined.

In Mexico, the influenza outbreak was in the political and media spotlight for much of 2009. The international steps taken against Mexico were widely regarded as excessive, and the costs they imposed on the country as unnecessarily high. This reaction was not confined to Mexico alone; the WHO was globally criticised for declaring a pandemic. The problem with these sorts of negative reactions in politically unstable countries like Mexico is that they can have unexpected and far-reaching consequences. NAPAPI 2012 was politically endorsed in all three countries (USDHHS 2012a). However, the plan, and influenza planning in general, are no longer priority issues in Mexican politics or public opinion.

NAPAPI 2012

The NAPAPI review process began in 2010, and the Technical Working Group met twice in Washington DC. The document went through a final technical review in the week of 16-20 May 2011. Legal aspects of the agreement were managed by the Mexican Secretariat of Foreign Affairs, under the Celebration of Treaties Act.

The purpose of the trinational collaboration was to have a coherent document suitable for endorsement by the Office of the Presidency in Mexico, the United States White House, and the Privy Council Office of Canada. On 3 April 2012, during the North American Leaders Summit (NALS) held in Washington DC, the US president, Barak Obama, the Canadian prime minister, Stephen Harper, and the Mexican president, Felipe Calderon, issued a joint statement announcing the conclusion of NAPAPI 2012 as a ‘collaborative and multisectoral framework to strengthen our response to future animal and pandemic influenza events in North America, and [the countries] commit to its implementation’ (The White House 2012). It requires

The Mexican Experience of the NAPAPI Revision Process

the three countries to develop concrete programmes for strengthening their preparedness for and responses to future outbreaks.

According to the US Department of Health and Human Services, the updated plan ‘provides, for the first time, a framework for the health, agriculture, security, and foreign affairs sectors of all three countries to collaborate on pandemic preparedness and response. Collaboration among these partners is vital for a faster response to pandemic threats’ (USDHHS 2012b).

The plan requires the three countries to coordinate their border policies in order to avoid unnecessary restrictions on travel and trade during an outbreak. According to the Assistant Secretary for Preparedness and Response in the US Department of Health and Human Services, ‘H1N1 provided a stern reminder that diseases don’t respect national borders and can spread rapidly in our interconnected world, so protecting health requires cooperation and collaboration among countries. NAPAPI represents a trilateral commitment to enhancing health security across the continent’ (USDHHS 2012b). The main features of NAPAPI 2012 are outlined in Box 2.

Box 2: The North America Plan for Animal and Pandemic Influenza (NAPAPI) 2012

The revised plan refers to animal instead of avian influenza, reflecting a new understanding that a pandemic virus can be transmitted from avian and non-avian animal species.

It focuses on the human/animal interface, and adopts a broader approach to addressing its different dimensions.

It underscores the need to develop policy frameworks and protocols for regional action, and emphasises that antiviral drugs and vaccines need to be available in sufficient quantities.

It acknowledges that an influenza pandemic can start outside or inside the region.

It emphasises cross-sectoral collaboration as a means of strengthening emergency response capabilities.

It mentions the need to build a plan that will allow business to continue functioning during a pandemic

It advocates a coordinated approach to the protection of vital infrastructure as well as the participation of state and non-state actors, including the private sector.

It establishes a North American Senior Coordinating Body (SCB) with policy, planning and response capabilities.

It consolidates the Health Security Working Group (HSWG) as a technical and policy advisory group of experts.

It tasks the HSWG with developing comprehensive, coordinated, evidence-based guidelines for action, called NAPAPI Implementation Actions .

In sum, while NAPAPI 2012 is broader and more elaborate than its predecessor, it remains a framework document that requires the newly established North America Health Security Working Group (HSWG) to develop and complete more specific ‘NAPAPI Implementation Actions’. It is also non-binding, and relies on the goodwill of its participants. Instead, the three countries involved in NAPAPI – as well as others – should consider developing legally binding instruments for joint action in this vital area instead of retaining general frameworks that can be repudiated in the name of national security. The ‘goodwill approach’ is the most important factor hampering international cooperation in respect of pandemics worldwide.

Conclusion

This study has described the development of NAPAPI 2012 after the influenza outbreak of 2009, and its consequences for Mexico. The country faced a health emergency that required an effective intersectoral response. At the same time, it sought to comply with relevant international agreements, notably NAPAPI 2007. Its commitments to these international instruments had various consequences at the national and international level. For instance, the government had to organise itself to provide an effective response, and collaborate with the international community to establish

The Mexican Experience of the NAPAPI Revision Process

prevention and control measures. This required mobilising federal and local agencies in different sectors in order to protect citizens against a catastrophe. This was a massive undertaking which also caused some conflicts, mainly because most agencies had not dealt with such a situation before. However, while its efforts were criticised, the government did manage to deal with the outbreak and its consequences.

At the same time, the country's international obligations rendered it vulnerable to international action, and it was subjected to adverse measures adopted unilaterally by a close neighbour and NAPAPI partner. However, this ultimately gave Mexico an opportunity to renegotiate a key instrument of international collaboration in the field of health, and solidify its collaboration with its NAPAPI partners.

Mexico was able to play a more active role in the renegotiation of the trilateral plan, with the participation of various domestic role players. However, in line with two-level game theory, national actors' interest and participation in the negotiations were driven by their positions and roles in domestic politics. Therefore, many were reluctant to play a more active role, as they had concluded that this would not benefit them directly, and would impose certain costs. Nevertheless, the new plan has created greater synergies among the agencies that will be required to deal with a future pandemic. The revised plan enjoys strong political support. However, it is still non-binding, which makes it susceptible to individual choices and unilateral action by signatories.

References

Allison, Graham T. 1971. *Essence of Decision: Explaining the Cuban Missile Crisis*. Boston: Little, Brown.

Arias, Carlos and Susana López. 2010. 'Biología del virus de influenza A'. In Jose-Angel Cordova Villalobos, Jose Luis Valdespino Gómez and Samuel Ponce de León Rosales (eds), *La epidemia de influenza A/H1N1 en México*. Mexico City: Editorial Médica Panamericana. Chap. 1.

Avery, Davis Howard. 2007. 'The North American Plan for Avian and Pandemic Influenza: a case study of regional health security in the 21st century'. *Global Health Governance*, III (3): 1-26.

Caballero-Anthony, Mely. 2008. 'Non-traditional security and infectious diseases in ASEAN: going beyond the rhetoric of securitization to deeper institutionalization'. *The Pacific Review*, 21 (4): 507-525.

Cámara de Diputados. 1984. *Ley General de Salud*. Ciudad de México: Cámara de Diputados del H. Congreso de la Unión de México.

_____. 1986. *Reglamento de la Ley General de Salud en Materia de Sanidad Internacional*. Ciudad de México: Cámara de Diputados del H. Congreso de la Unión de México.

_____. 1992. *Ley sobre la Celebración de Tratados*. Ciudad de México: Cámara de Diputados del H. Congreso de la Unión de México.

_____. 2012. *Constitución Política de los Estados Unidos Mexicanos*. Ciudad de México: Cámara de Diputados del H. Congreso de la Unión de México.

Chan, Margaret. 2009a. 'Swine influenza'. Statement by WHO Director-General, Dr Margaret Chan. World Health Organization [online]. 27 April. Available at http://www.who.int/mediacentre/news/statements/2009/h1n1_20090427/en/ [accessed on 29 March 2012].

_____. 2009b. 'World now at the start of 2009 influenza pandemic'. Statement to the press by WHO Director-General Dr Margaret Chan. World Health Organization [online]. 11 June. Available at http://www.who.int/mediacentre/news/statements/2009/h1n1_pandemic_phase6_20090611/en/ [accessed on 3 June 2012].

Cohen, Jon. 2009. 'Exclusive: interview with head of Mexico's top swine flu lab'. *Science Now* [online]. 1 May. Available at <http://news.sciencemag.org/2009/05/exclusive-interview-head-mexicos-top-swine-flu-lab> [accessed on 29 March 2012].

Cordova-Villalobos, Jose Angel. 2010. 'Introducción: La epidemia de influenza A(H1N1) en México'. In Jose-Angel Cordova Villalobos, Jose Luis

**The Mexican Experience of the NAPAPI
Revision Process**

Valdespino Gómez and Samuel Ponce de León Rosales (eds), *La Epidemia de Influenza A/H1N1 en México*. Mexico City: Editorial Médica Panamericana: XXIX-XXXIII.

Dai, Xinyuan. 2007. *International Institutions and National Politics*. Cambridge, UK: Cambridge University Press.

Enemark, Christian. 2009. 'Is pandemic flu a security threat?' *Survival*, 51 (1): 191-214.

Fidler, David P and Lawrence O Gostin. 2008. *Biosecurity in the Global Age: Biological Weapons, Public Health and the Rule of Law*. Stanford, California: Stanford Law and Politics.

Fidler, David P. 2010. *The Challenges of Global Health Governance* (First Edition). New York: Council of Foreign Relations.

_____. 1997. 'The globalization of public health: emerging diseases and international relations'. *Global Legal Studies Journal*, 5 (11): 11-51.

_____. 2007. 'A pathology of public health securitism: approaching pandemics as security threats'. In Andrew F Cooper et al (eds), *Governing Global Health*. Burlington: Ashgate: 41-60.

Frenk, Julio and Suerie Moon. 2013. 'Governance challenges in global health'. *New England Journal of Medicine*, 368 (10): 936-942.

Global Health Influenza Programme. 2010. *Pandemic Influenza Preparedness and Response: A WHO Guidance Document*. Lyon: World Health Organization.

Global Health Security Initiative (GHSI). 2011. *Ten Years of Collaborative Action*. Ottawa: GHSI.

Health Security Working Group (HSWG). 2010. 'Proposal for the Review of the 2007 NAPAPI'. Concept paper. 5 August. Secretariat of Health of Mexico.

Ingram, Alan. 2005. 'The new geopolitics of disease: between global health and global security'. *Geopolitics*, 10: 522-545.

Jiménez-Corona, María Eugenia et al. 2010. 'Epidemiología de la influenza A(H1N1)'. In Jose-Angel Cordova Villalobos, Jose Luis Valdespino Gómez and Samuel Ponce de León Rosales (eds), *La epidemia de influenza A/H1N1 en México*. Mexico City: Editorial Médica Panamericana. Chap. 11.

Katzenstein, Peter J. 1978. *Between Power and Plenty: Foreign Economic Policies of Advanced Industrial States*. Madison: University of Wisconsin Press.

Keohane, Robert O and Lisa L Martin. 1995. 'The promise of institutionalist theory'. *International Security*, 20 (1): 39-51.

Keohane, Robert. 1985. *After Hegemony: Cooperation and Discord in the World Political Economy*. Princeton, NJ: Princeton University Press.

Krasner, Stephen D. 1983. 'Structural causes and regime consequences: regimes as intervening variables'. In Stephen D Krasner (ed), *International Regimes*. Ithaca, NY: Cornell University Press.

Kuri-Morales, Pablo et al. 2006. 'Pandemia de influenza: la respuesta de México'. *Salud Pública de México*, 48 (1): 72-79.

Labonté, Ronald. 2008. 'Global health in public policy: finding the right frame?' *Critical Public Health*, 18 (4), 467-482.

Marshall, Sarah Jane. 2005. 'Governments in a dilemma over bird flu'. *Bulletin of the World Health Organization*, 85 (5): 325-326

Mearsheimer, John. 1994. 'The false promise of international institutions.' *International Security*, 19 (3): 5-49.

Mejía, Gerardo. 2009. 'Países de Norteamérica evalúan pandemia de influenza A'. *El Universal* [online]. 5 October. Available at <<http://archivo.eluniversal.com.mx/notas/631169.html>> [accessed on 29 March 2012].

Michaud, Joshua. 2010. 'Governing implications of emerging infectious disease surveillance and response as global public goods'. *Global Health Governance*, III (2): 1-13.

Niño de Haro, Humberto. 2009. 'Aeromexico cancela vuelos a Shanghai y Roma'. *El Universal* [online]. 22 May. Available at <<http://archivo.eluniversal.com.mx/notas/599718.html>> [accessed on 29 March 2012]

North American Leaders Summit (NALS). 2012. *North American Plan for Animal and Avian and Pandemic Influenza (NAPAPI)*. 2 April. Available at <http://www.publicsafety.gc.ca/cnt/rsrscs/pblctns/nml-pndmc-nflnz/index-eng.aspx> [accessed on 29 March 2012].

The Mexican Experience of the NAPAPI Revision Process

O'Neill, Michel et al. 1997. 'Coalition theory as a framework for understanding and implementing intersectoral health-related interventions.' *Health Promotion International*, 12 (1): 79-87.

OECD. 2005. *Reviews of Health Systems: The Mexican Health System*. Paris: Organization for Economic Cooperation.

Otero, Silvia. 2009. 'Influenza México active Plan de Contingencia para América del Norte', *El Universal* [online]. 24 April. Available at <<http://archivo.eluniversal.com.mx/notas/593486.html>> [accessed on 30 March 2012]

Ponce de León Rosales, Samuel et al. 2010. 'Un nuevo virus: influenza A(H1N1)'. In Jose-Angel Cordova Villalobos, Jose Luis Valdespino Gómez and Samuel Ponce de León Rosales (eds), *La epidemia de influenza A/H1N1 en México*. Mexico City: Editorial Médica Panamericana. Chap. 2.

Price-Smith, Andrew T. 2002. *The Health of Nations*. Cambridge: MIT Press.

Putnam, Robert D. 1988. 'Diplomacy and domestic politics: the logic of two-level games'. *International Organization*, 42 (3): 427-460.

Secretaría de Gobernación. 2009. *Decreto por el que se ordenan diversas acciones en materia de salubridad general, para prevenir, controlar y combatir la existencia y transmisión del virus de la influenza estacional epidémica*. Ciudad de México: Diario Oficial de la Federación.

Secretaría de Salud. 2003. *Acuerdo por el que se crea el Comité Nacional para la Seguridad en Salud*. Ciudad de México: Secretaría de Salud de México.

—. 2009. 'Comunicado de Prensa No. 213, Secretaria de Salud Concluye reunión de alto nivel sobre lecciones aprendidas de la influenza A (H1N1)'. *Comunicación Social* [online]. 3 July. Available at <www.salud.gob.mx> [accessed on 16 April 2012].

—. 2010. 'Situación Actual de la Pandemia'. *Boletín de Prensa Secretaría de Salud* [online]. 19 July. Available at <http://portal.salud.gob.mx/sites/salud/descargas/pdf/influenza/situacion_actual_epidemia_190710.pdf> [accessed on 12 June 2012].

—. 2010. 'Versión Estenográfica Conferencia de Prensa Reunión Ministerial GHSI México'. *Comunicación Social* [online]. 3 December. Available at <www.salud.gob.mx> [accessed on 5 April 2012].

_____. 2012. 'Plan Nacional de Preparación y Respuesta'. Secretaría de Salud. Available at www.salud.gob.mx [accessed on 2nd April 2012]

Security and Prosperity Partnership of North America (SPP). 2005. *Report to Leaders, June 2005*. Washington DC.

_____. 2007. *North American Plan for Avian and Pandemic Influenza*. August. Available at http://www.iatp.org/files/258_2_99891.pdf.

Tess, Beatriz Helena and Fernando Mussa A. 2012. 'Intersectoral health-related policies: the use of a legal and theoretical framework to propose a typology to a case study in a Brazilian municipality.' *Ciencia & Saúde Colectiva*, 19 (11): 4449-4456.

The White House. 2012. 'Joint Statement by the North America Leaders'. Office of the Press Secretary [online]. 2 April. Available at <<http://www.whitehouse.gov/the-press-office/2012/04/02/joint-statement-north-american-leaders>> [accessed on 2 April 2012]

Underdal, Arild. 1998. 'Explaining compliance and defection: three models'. *European Journal of International Relations*, 4 (1): 5-30.

US Department of Health and Human Services (USDHHS). 2012a. *HHS Pandemic Influenza Plan*. November. Available at <<http://www.flu.gov/planning-preparedness/federal/hhspandemicinfluenzaplan.pdf>> [accessed on 2 April 2012]

_____. 2012b. 'North America countries join forces to prepare for pandemics.' Press Office [online]. 2 April. Available at <<http://www.phe.gov/Preparedness/news/Pages/napapi-120402.aspx>> [accessed on 2nd April 2012]

World Health Organisation (WHO). 2006. *SARS: How a Global Epidemic Was Stopped*. Western Pacific Region. Geneva.

_____. 2008. *International Health Regulations 2005*, Second Edition. Geneva.

_____. 2005. 'Review and approval of proposed amendments to the International Health Regulations'. Report by the Secretariat. Intergovernmental Working Group on the Revision of the International Health Regulations. 27 January. Available at http://apps.who.int/gb/ghs/pdf/IHR_IGWG2_ID2-en.pdf.

_____. 2007. *The World Health Report 2007 – A Safer Future: Global Public Health Security in the 21st century*. Geneva. Available at <http://www.who.int/whr/2007/en/>

Young, Oran R. 1989. *International Cooperation*. Ithaca New York: Cornell University Press.

**The Mexican Experience of the NAPAPI
Revision Process**

Zacher, Mark W and Tania J Keefe. 2007. *The Politics of Global Health Governance: United by Contagion*. New York: Palgrave Macmillan.

Appendix

Table 1

Multisectoral operative strategy for pandemic influenza preparedness and response in Mexico

Scope	Actors
Human Health	Secretariat of Health Mexican Institute for Social Security Institute of Security and Social Services for Civil Servants Mexican Oil Company (Petróleos Mexicanos) National System for the Family Development Secretariat of National Defense Secretariat of Navy Mexican Red Cross Associations and Schools of Medicine
Economy	Secretariat of Economy Secretariat of Government Accountability Secretariat of the Treasury Bank of Mexico Association of National Banks National Academy of Pharmaceutics Sciences Pharmaceutics Industry National Chamber Information Industry National Chamber Employers' Confederation of Mexico Mexican Council of Businessmen
Essential Services	Secretariat of Energy Secretariat of Transportation and Communications Secretariat of Social Development National Water Commission Mexican Postal Service
Security	General Coordination for Civil Protection of the Secretariat of Governance Secretariat of National Defense Secretariat of Navy Secretariat of Public Safety/ Federal Police Office of the General Attorney

María Esther Coronado Martínez

Animal Health	Secretariat of Agriculture, Livestock, Rural Development, Fisheries and Food Secretariat of Environment and Natural Resources Federal Attorney for Environmental Protection
Education	Secretariat of Education National Council of Sciences and Technology National Autonomous University of Mexico National Polytechnic Institute National Association of Universities and Higher Education Institutions National Association of Parents Union of National Educators
Borders, Foreign Affairs and Tourism	Secretariat of Foreign Affairs Secretariat of Governance/ National Institute of Immigration Secretariat of Tourism Secretariat of the Treasury/ General Costumes Services

Source: Compiled by the author, based on NAPAPI 2012.

Table 2

Actors and their interests in Mexico's domestic negotiations

	ACTORS	INTERESTS
<i>Emergency Coordination and Communications</i>	General Health Council Secretariat of Health National Committee for Health Security General Coordination for Civil Protection (Secretariat of Governance) Secretariat of Agriculture, Livestock, Rural Development, Fisheries and Food Secretariat of Foreign Affairs	Improving communications, notably standard messages and communications involving risk assessments. At the domestic level, this implied improved coordination between the health system and the civil protection system, which are required to respond jointly to health emergencies.
<i>Animal Influenza</i>	Secretariat of Agriculture, Livestock, Rural Development, Fisheries and Food Secretariat of Foreign Affairs/ Chief Veterinary Officer, Animal Health Directorate Secretariat of Natural Resources and Environment	Greater collaboration in the sphere of health, notably improved communications about the notification of influenza among animals.

**The Mexican Experience of the NAPAPI
Revision Process**

<i>Surveillance and Epidemiology</i>	Secretariat of Health/ Office of the Assistant Director General of Epidemiology	General improvements at the national level, and strengthened collaboration at the trinational level.
<i>Laboratory Practices</i>	Secretariat of Health/ Institute of Epidemiologic Reference and Diagnostic	More effective mechanisms for collaboration, the sharing of information, and technical assistance with improving diagnostic methods and lab capabilities.
<i>Vaccines and Antivirals</i>	Secretariat of Health/ Undersecretary for Health Promotion and Prevention Office of the Assistant Director General of Epidemiology Institute of Epidemiologic Reference and Diagnostic	Improving research and development, technical assistance with production capabilities, and a more scientific approach to vaccination.
<i>Sharing of Personnel</i>	Secretariat of Foreign Affairs Secretariat of Health	The three countries were working on mechanisms for exchanging personnel. The Mexican Secretariat of Health had an interest in retaining and promoting this programme because of the opportunities it represented.
<i>Public Health Measures</i>	General Health Council Secretariat of Health National Health System	Greater collaboration, and the integrated application of health measures, considering that a virus can appear inside or outside the region.
<i>Border Monitoring and Control Measures</i>	Secretariat of Communications and Transportation Secretariat of Navy Secretariat of Foreign Affairs Costumes Services SAGARPA Federal Commission for Health Risk Protection	Establishing clearer principles for collaboration and coordination, in order to avoid adverse unilateral responses. These principles would include a trilateral agreement for establishing screening measures at all ports of entry, based on scientific evidence.
<i>Critical Infrastructure</i>	Secretariat of Energy Secretariat of Communications and Transportations Secretariat of Public Safety Secretariat of Health Secretariat of Defense Center for Investigation and National Security Secretariat of Economy	Creating a general framework for protecting essential infrastructure without compromising the national interest.

Source: Compiled by the author, based on NAPAPI 2012.

Notes

- 1.** One of the major problems arose from China's delay in recognising the outbreak, which limited the WHO's ability to respond rapidly, and stifled the participation of the Global Outbreak Alert and Response Network (GOARN). GOARN was established in 2000 to provide technical collaboration in respect of the identification and confirmation of and response to outbreaks, but was only able to assist China after February 2003 when the virus had already spread through several large regions.
- 2.** Translated by the author from the original Spanish.
- 3.** During the emergency, the government prepared a document entitled 'Guías generales para la organización y coordinación durante una pandemia de influenza', but this was circulated only as an internal communication.
- 4.** Interview, Former Director of the Institutional Liaison Office, Directorate General of Epidemiology, Mexico's Secretariat of Health, and Mexico's focal point for the negotiation of NAPAPI 2012, Ottawa, Ontario, April 1, 2012.
- 5.** Ibid.
- 6.** Former director of the Institutional Liaison Office in the Directorate General of Epidemiology, Mexican Secretariat of Health, and Mexico's focal point for the negotiation of NAPAPI 2012, Ottawa, Ontario, 1 April 2012. The internal documents were obtained through the Mexican System for Access to Information.

About the Author

María Esther Coronado Martínez is a doctoral student in international affairs at the Norman Paterson School of International Affairs (NPSIA) of Carleton University in Ottawa, Canada. Her research interests include global health, health security, and international cooperation on health issues. She holds a master's degree in public policy and administration from the Centro de Investigación y Docencia Económicas (CIDE) in Mexico City, and a bachelor's degree in international affairs from the Universidad de las Américas AC in Mexico City. After receiving her master's

**The Mexican Experience of the NAPAPI
Revision Process**

degree, she worked for six years on multilateral issues in the Secretariat of Health of the Mexican Directorate General for International Affairs. She currently lives in Gatineau in Quebec, Canada.