SALVAGING THE GLOBAL NEIGHBOURHOOD: MULTILATERALISM AND PUBLIC HEALTH CHALLENGES IN A DIVIDED WORLD

by

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ABSTRACT

This thesis explores the relevance of international law in the multilateral protection and promotion of public health in a world sharply divided by poverty and underdevelopment. In this endeavour, the thesis predominantly uses the concept of "mutual vulnerability" to discuss the globalisation of diseases and health hazards in the emergent global neighbourhood. Because pathogens do not respect geo-political boundaries, this thesis argues that the world has become one single germ pool where there is no health sanctuary.

The concept of mutual vulnerability postulates that the irrelevance or obsolescence of national boundaries to microbial threats has created the capability to immerse all of humanity in a single microbial sea. It follows, therefore, that neither protectionism nor isolationism offers any effective defences against advancing microbial forces. As a result, the thesis argues that contemporary multilateral health initiatives should be driven primarily by enlightened self-interest as opposed to parochial protectionist policy.

This study is primarily situated within the discipline of international law. Nonetheless, it draws on the social sciences in its analysis of traditional medicine in Africa. It also makes overtures to medical historians in its discussion of the attitudes of societies to diseases and to the evolution of public health diplomacy, to international relations in its analysis of international regime theories, and to a number of other disciplines interested in the phenomenon of globalisation. This interdisciplinary framework for analysis offers a holistic approach to public health policy-making and
ill scholarship to counter the segmented approaches of the present era. Thus, this thesis is concerned with four related projects.

First, it explores the relevance of legal interventions in the promotion and protection of public health. If health is a public good, legal interventions are indispensable intermediate strategies to deliver the final dividends of good health to the vulnerable and the poor in all societies.

Second, it explores multicultural approaches to health promotion and protection and argues for a humane health order based on multicultural inclusiveness and multi-stakeholder participation in health-policy making. Using African traditional malaria therapies as a case study, the thesis urges an animation of transnational civil society networks to evolve a humane health order, one that fulfils the desired vision of harmony and fairness.

Third, it makes an argument for increased collaboration among lawyers, epidemiologists and scholars of other disciplines related to public health. Using the tenets of health promotion and primary health care, the thesis urges an inter-disciplinary dialogue to facilitate the needed "epidemiological transition" across societies, especially in the developing world.

Fourth, the thesis makes modest proposals towards the reduction of unequal disease burdens within and among nation-states.

The thesis articulates these proposals generically under the rubric of *communitarian globalism*, a paradigm that strives to meet the lofty ideals of the "law of
humanity". In sum, it projects a humane world where all of humanity is inexorably tied in a global compact, where the health of one person rises and falls with the health of every other person, and where every country sees the health problems of other countries as its own.

Arduous as these tasks may be, they are achievable only if damaged trust of past decades is rebuilt. Because the Westphalian sovereign states lack the full capacity to exhaustively pursue all the dynamics of communitarian globalism, multilateral governance structures must necessarily extend to both state and non-state actors. In this quest, the thesis concludes, international law - with its bold claims to universal protection of human rights and the enhancement of human dignity - is indispensable as a mechanism for reconstructing the public health trust in the relations of nations and of peoples.
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DEDICATION

This work is concurrently dedicated to:

*Osodieme*, that rare gem of a woman who summoned the courage to give birth to me on a highway without any form of medical assistance in the heat of the Nigerian civil war, and my father, *Ezeonyekachi* who at that difficult moment of my birth abandoned his career as a teacher and became my mother's emergency gynecologist, midwife and nurse, all in one.

*Chichi*, my beloved wife, who became part of my life in the middle of this work and inspired me to get to the finishing line.

*Nwando Aguolu*, that little voice of love and reason whom I have missed dearly all these years of my sojourn in a foreign land in the course of this work.

Millions of innocent children all over the Third World whose daily lives - for no fault of theirs - are continuously threatened by deadly, but preventable infectious and non-communicable pathogens, diseases, and health hazards.
A: INTRODUCTION AND GENERAL OVERVIEW

In the late 1960s, my mother gave birth to me in the heat of the Nigerian civil war. My parents lived in a small rural village in Eastern Region of Nigeria - the then breakaway Republic of Biafra - that came under heavy shelling by Nigerian federal troops. Biafra was completely cut off by an economic blockade. From the perspective of persons living in rural villages, the impression was widespread that the Nigerian federal authorities were pursuing a war of genocide. Like most wars, bombs hit both military and non-military targets, fell on innocent civilians, and completely destroyed social infrastructures. Massive hunger and starvation set in, resulting in uncontrollable malnutrition, deplorable medicare, and excessively high infant mortality. It was in this difficult and hopeless situation - life in a war-torn neighbourhood - that my mother's painful childbearing labour started when she was about to have me. Because of an acute shortage of gasoline in war-ravaged Biafra there was no car to take my mother to the nearest medical clinic then managed by Irish Catholic Missionaries, about a twenty-minute drive from the village where she lived with my father. In this medically hopeless situation, providence had it that I was born on a highway absolutely without any kind of medical assistance. My father, who was then a teacher, became my mother's emergency midwife, nurse and gynaecologist, all in one.

The above scenario, albeit a war situation, is a microcosm of the contemporary health divide between the industrialised and developing worlds. The reality is that even in times of peace and normalcy, more than half of the world's population faces very difficult and turbulent health challenges fairly similar to the above scenario. In many developing countries, access to clean water, food, housing, nutritious diets and sanitation is a luxury
rather than a necessity. Medical clinics are kilometres away and inaccessible, and the cost of medicines is prohibitive and beyond the reach of the majority that are poor. There is one physician to thousands of people. Babies are not vaccinated against leading killer diseases, and public health budgets are a tiny fraction of spending in other comparable public sectors like defence and foreign affairs. Strategies for primary health care, health protection and health promotion lack the needed policy interventions that will ultimately deliver health benefits to the populace as a public good.

At the dawn of the twenty-first century, humanity is both on a hinge and fringe of history. Natural disasters and environmental calamities, food insecurity, wars and civil conflicts, globalisation, forced and intentional migrations, travel, trade and tourism, poverty, and underdevelopment combine to propel the emergence and spread of diseases and pathogenic microbes across national boundaries. History is replete with epidemics and pandemics that decimated a sizeable percentage of humanity - the Plague of Athens in 430 BC, the Black Death (Bubonic Plague) in 14\textsuperscript{th} century Europe; small pox, measles, scarlet fever, chicken pox and influenza in the Americas in the 16\textsuperscript{th} and 17\textsuperscript{th} centuries, and global swine flu in 1918-1919. Together with recent outbreaks of certain infectious diseases - \textit{ebola haemorrhagic fever}, lassa-fever, hanta-virus, West Nile virus, the re-emergence of multi-drug resistant tuberculosis, the global pandemic of HIV/AIDS, and other diseases that transcend national boundaries - humanity is now re-positioned for a severe battle with the microbial world. Epidemics and pandemics serve as wake-up calls for nation states, multilateral institutions and civil society to rise to the enormous challenges and vicious threats posed to humanity by disease. Because the interaction between humanity and diseases is almost as ancient as human history, and because
infectious diseases have killed more people than wars, the challenge of protection of humanity's health against microbial threats should catalyse a co-ordinated multilateral policy response to facilitate the needed "epidemiological transition"\(^1\) across societies.

The concept of health, its definition and parameters differ across societies, cultures and disciplines. It has been observed that,

human health is a derivative of multiple circumstances, not all of them fully understood or subject to accurate measurement. Because health is a relative term, both its measurement and its indicators assume varying interpretations within and among societies, cultures, and geographic regions. Any endeavour to examine the health environment on a global scale- as distinct from a compound of statistics gathered from individual states- must therefore be sensitive to attitudinal variations. Not all societies place the same value on health; not all individuals accept the validity of even the most basic of health determinants.\(^2\)

As a result, health has become analogous to the proverbial "road traversed by many pathways". Almost everyone has a view of what health means, what it does not mean, how to protect or promote it, its parameters and determinants, its linkages with other socio-economic factors and the paradigms - legal, legislative and social - for its progressive realisation. A discussion of public health by scholars of various disciplines or even by scholars of the same discipline can easily recall an image of the discordant voices reminiscent of the biblical *Tower of Babel*\(^3\), or what one scholar refers to as

\(^1\) David R. Phillips, *Health and Health Care in the Third World* (New York: Longman, 1990) at 41 states that epidemiological transition assumes or implies a range of changes: in attitudes, education, diet, aspirations, urbanization, public health and health care and its technology. Basically, it is proposed that societies during modernization will move from a period of high birth and death rates and low life expectancy (perhaps 40 years of life expectancy at birth or even lower) to a stable period when life expectancy will have increased to around 70 years or longer, and death rates and birth rates will have become much lower, often approximately balancing each other numerically.


\(^3\) "Come, let us go down and confuse their language so they will not understand each other .... That is why it was called Babel - because there the Lord confused the language of the whole world", see Genesis 11:7-9 The Holy Bible (New International Edition, 1973).
"characteristics of a dinner party conversation that endeavours to recall the plot of The Two Gentlemen of Verona". Most lawyers confuse the terms public health, health care, primary health care, medical services and medicare. For instance, in the study The Right to Health in the Americas, Roemer argued that the phrase "right to health" is an absurdity because it implies a guarantee of "perfect health". She opted for the phrase "right to health care", which encompasses "protective environmental services, prevention, health promotion and therapeutic services as well as related actions in sanitation, environmental engineering, housing and social welfare". Professor Virginia Leary has pointed out that "such an extensive definition seems contrary to common understanding of the phrase "right to health care". The editors of the volume The Right to Health in the Americas recognised that the phrase "right to health" may be conceptually misleading and consequently suggested "a right to health protection" to include two components: a right to health care and a right to healthy conditions.

In the midst of non-unanimity of opinion over definition and basic components of public health by lawyers and scholars of other disciplines, this thesis charts a fuzzy landscape of multilateral health challenges in a paradoxically interdependent/globalising but sharply divided world. Notwithstanding the raging debate between the "positive" school of thought defines health ambitiously as "a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity". See for instance, Constitution of the World Health Organisation, opened for signature July 22, 1946 (Preamble) (defining health ambitiously in those terms).
and "negative" schools, this study combines the tenets of "health promotion", "primary health care" and "determinants of health" to explore the multiple dimensions of public health in a world polarised by socio-economic inequalities and disparities. Because these approaches are supportive of a 'positive' definition of health, this study explores public health broadly from an international legal perspective, and creates critical linkages between health, human rights, poverty, underdevelopment, the South-North divide, globalisation, multiculturalism, equity and fairness in the pursuit of health as a global public good.

[11] The negative school of thought defines health as "the absence of disease, impairment or infirmity". For a discussion of this school, see S. Nadasen, Public Health Law in South Africa (Durban: Butterworths, 2000).

[12] The Ottawa Charter for Health Promotion defines health promotion as "the process of enabling people to increase control over, and to improve their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and realise aspirations, to satisfy needs, and to change or cope with the environment. Health is...a resource for everyday life....Health is a positive concept emphasising social and personal resources, as well as physical capacities....Health promotion is not just the responsibility of the health sector, but goes beyond health lifestyles to well-being". See Ottawa Charter for Health Promotion, November 21 1986, adopted at the first International Conference on Health Promotion, held in Ottawa, Canada in November 1986, available at http://www.who.dk/policy/ottawa.htm (Visited April 8, 2001).

[13] The Alma-Ata Declaration on Primary Health Care 1978 defines primary health care as the "essential health care based on practical, scientifically sound and socially acceptable methods and technology made accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self reliance and self determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process". See Alma-Ata Declaration on Primary Health Care, September 12, 1978, adopted at the joint World Health Organisation and United Nations Children's Fund (WHO/UNICEF) sponsored international conference held in Alma-Ata, former USSR, Sept. 6-12 1978, "Health for All" Series No. 1 (Geneva: WHO, 1978), available at http://www.who.int/hpr/docs/almaata.html (Visited April 8, 2001).

There are many good reasons why the promotion of public health in a multilateral context deserves heightened interest and attention from scholars, national policy makers, multilateral institutions and civil society in an emerging ‘global neighbourhood’. Prominent among these reasons is the increased global interdependence between nation-states and populations. As people and goods cross national boundaries in volumes hitherto unknown in recorded history, so do disease pathogens permeate geo-political boundaries to threaten populations in distant places with unprecedented speed. Because of the phenomenon of globalisation and the consequent vulnerability of national boundaries, the erstwhile traditional distinction between national and international health is becoming increasingly obsolete. One consequence of globalisation is the mutual vulnerability of populations within the “global village” to the cross-border spread of deadly infectious diseases and other microbial threats. Microbes carry no national passports; neither do they recognise geo-political boundaries or state sovereignty. Propelled by travel, trade, tourism, the phenomenon of globalisation, and a host of other factors, public health threats occasioned by an outbreak of a disease in one part of the world could easily transcend national boundaries to threaten populations elsewhere.


15 See generally “Global Health Challenges”, Report of a Symposium by the Liu Centre, supra note 2 (stating that modern transportation mechanisms have facilitated the rapid movement of peoples and goods. If the economic influence is global, so can be the patterns of disease transmission. A global economy demands extensive travel by business persons, and permits extensive travel by tourists, in both instances in congested long-range passenger confinement on aircraft with closed atmospheres: germ incubators)

The world is fast becoming a single germ pool where there are no health sanctuaries or safe havens from pathogenic microbes. In sum, this inquiry uses the concept of mutual vulnerability to discuss the South-North health divide - disparities and unequal distribution of disease burdens between industrialised and developing worlds and the implications of these disparities for multilateralism. This study makes policy recommendations to narrow the apparent regime deficit between multilateral health policies and the realities of public health programs on the ground, especially in the developing world. In an interdependent world marked by the complexities of globalisation and socio-economic inequalities, every part of the world is vulnerable to the prevailing, emerging and re-emerging threats of disease. The mutuality of vulnerability therefore calls for genuine self-interest as nation-states grapple with the challenges of using multilateral legal and other governance mechanisms to forge a humane health order. Although the scope of this work is interdisciplinary because it draws from seminal works in public health and epidemiology, history, international relations, and development, it remains a dissertation in international law. Its primary domain is law; its focus is multilateral institutions, and its subject of analysis is international law's response to globalisation of diseases and health risks.

Chapter One sketches the parameters of the research problem(s), review of literature, clusters of research questions and methodology for the study. To explore the complex ramifications of the multilateralisation of public health, this study uses the terms mutual vulnerability (mutual threats posed by disease to all of humanity in an interdependent world), and vulnerability of multilateralism (the challenge of forging multilateral consensus on cross-border spread of disease). I argue that the two are
inexorably linked, and that the interaction between them paradoxically highlights the intriguing tenets of self-interest (mutual co-operation) and the frustrating dangers of isolationism (protectionism). From a review of the literature, Chapter One shows that international law has been at the margins in multilateral health discourse because of two main reasons. First, most lawyers who explore the vast terrain of health focus narrowly on segmented health issues as opposed to taking a holistic approach that theorises the relevance of law in evolving multilateral health governance mechanisms. Second, lawyers and public health scholars have yet to forge symbiotic ties on multilateral health discourse and governance. I explore the relevance of law in the protection and promotion of public health multilaterally, and argue for increased collaboration between international lawyers, epidemiologists and scholars of other disciplines relevant to public health. Chapter One also explains the methodology which this study uses to answer the clusters of research questions posed by the thesis. I combine critical, analytical, and descriptive analyses of interdisciplinary literature as well as policy documents of relevant multilateral health institutions, especially the World Health Organisation. I rely on social science qualitative interviews to study ethno-pharmacological and indigenous malaria therapies of rural populations in the developing world. Further, I use these therapies to assess the effectiveness of global malaria control strategies of the World Health Organisation.

Chapter Two focuses on the strange paradox of a global village in a divided world. To assess how socio-economic inequalities affect health, I conduct two levels of inquiry under the rubric of what I call ‘globalisation of poverty’. The first deals with the limits of international treaty provisions on human right to health, especially the
importance of financial and technical resources in realising the right to health under the International Covenant on Economic, Social and Cultural Rights (ICESCR) 1966. The second level of inquiry deals with the health-related impact of Structural Adjustment Programs (SAPs) prescribed by the international financial institutions, especially the World Bank, for most of the developing world. To break the recurring cycle of poverty, infection and illness, I explore emerging perspectives aimed at closing the contemporary South-North health divide by addressing paradigms that are better suited to promote public health in a diverse and multicultural world. Here, I am concurrently a student of Falk, Nader, Trubek and Snyder and the progressive schools of legal anthropology as well as law and third world development.

Chapter Three focuses on mutual vulnerability and globalisation of public health in an emergent global neighbourhood. It explores in detail the ramifications of mutual vulnerability: the erosion of geo-political boundaries by microbes and the consequent fragility of humans to succumb to microbial threats in an interdependent world. Historically, humans across cultures have dealt with disease and illness in a variety of ways. Although mutual vulnerability has been with humankind since at least the Plague of Athens in 430 BC, the use of international law as a governance weapon against mutual vulnerability is comparatively recent. It took more than two hundred years after the Treaty of Westphalia 1648 before France convened and hosted the first international sanitary conference in 1851. Cholera outbreaks in Europe in 1830 and 1847 were the

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catalysts for the earliest public health multilateral co-operation and infectious disease diplomacy. These outbreaks compelled European states to convene successive international sanitary conferences and consequently to use international sanitary conventions as governance mechanisms against the cross border spread of disease. To explain the dynamics of mutual vulnerability in the present era of multilateral crisis of emerging and re-emerging infectious disease (EIDs), I focus discussion on the re-emergence of tuberculosis and the so-called ‘airport’ or ‘imported’ malaria in the industrialised countries of the global North. Arguing that the distinction between national and international health has become obsolete, Chapter Three re-visits the ideals of self-interest to catalyse humane and fair public health multilateralism. Malaria and other diseases may have heavier mortality and morbidity burdens in the developing world, but they are no longer solely the exclusive problems of developing countries. Thus, the distinctions between ‘our disease’ and ‘their disease’, ‘us’ and ‘them’, have become anachronistic in multilateral health discourses and policy-making.

Because the complexities of mutual vulnerability are beyond the capabilities of any one country or group of countries, Chapter Four discusses the necessary multilateral approaches needed to check globalisation or transnationalisation of diseases and health risks under the rubric of the vulnerability of multilateralism. To better understand the gaps of multilateral co-operation in the present era, I discuss the politics of law and public health among sovereign states in nineteenth-century infectious disease diplomacy. Economic, strategic and other selfish interests of countries, all noticeable phenomena in the nineteenth century sanitary conferences, are still serious impediments to effective multilateralism in the present era. South-North politics at the World Health Organisation
and the acrimonious tone of the nuclear weapons debates at the World Health Assembly are recent examples of the contemporary vulnerabilities of public health multilateralism. Another important feature of nineteenth-century infectious disease diplomacy was the use of international law (sanitary treaties and conventions) as mechanisms to share epidemiological information on outbreaks and cross-border spread of disease. In the nineteenth-century, international law itself was engaged in complex manoeuvres with colonialism and colonised peoples across the world. Because of this I discuss the colonial legacies which nineteenth-century international health law (sanitary conventions) bequeathed to the contemporary international health order. In other words, has the legacy of the nineteenth century exacerbated contemporary South-North disparities, and thereby propelled the resurgence and cross-border spread of disease? Has the legacy of the nineteenth-century impeded third world innovations and indigenous therapies on health protection and health promotion? Has this legacy impeded the needed synthesis of the apparently antithetical third world traditional medical therapies and global health policies? This analysis re-positions international law as a post-ontological discipline to play a key role in the governance of multilateral health issues. I analyse two legal mechanisms used by WHO to govern global health issues: the International Health Regulations (IHR) (on infectious diseases) and the ongoing negotiations for a Framework Convention on Tobacco Control (FCTC), with a focus on the gaps in the enforcement of the IHR and the potential of the FCTC. Although the World Health Organisation has innovative treaty-making powers under its constitution, I argue that extreme use of legal strategies in multilateral health work by the WHO, while absolutely necessary, may not on its own deliver the ultimate dividends of health as a public good. In public health, law
is only a means to an end and not an end itself. What is needed is an effective combination of legal and non-legal strategies to facilitate epidemiological transition across a range of societies. Because the WHO has no history of enforcing legally binding treaties, I conduct a comparative overview of a treaty and another multilateral mechanism that govern global environmental issues: *Montreal Protocol on Substances that Deplete the Ozone Layer*, and the World Bank's *Global Environmental Facility*. Despite the shortcomings of these multilateral environmental regimes, I argue that in its use of international law, legal strategies, and interventions to pursue its health mandate, the World Health Organisation has some good lessons to learn from the enforcement mechanisms of these environmental regimes.

In Chapter Five, I explore the interaction between African traditional malaria therapies and the World Health Organisation's multilateral malaria control strategy: the Roll-Back Malaria Project. As a major partnership between governments, multilateral institutions, corporations and foundations, WHO's Roll-Back Malaria campaign must be assessed against the behavioural practices of rural populations in malaria endemic parts of the world to analyse the extent to which global partnerships respond to the constituencies they purport to serve. Also, traditional medicine of indigenous societies in most of Africa has often been dismissed as either witchcraft, quackery, sorcery, magic, or unscientific barbarism that is unfit for integration into the multilateral health policy framework. I assess these indigenous therapies, and argue that African traditional herbal medicine used for ages by local communities as therapies for malaria can be synthesised with, and integrated within, multilateral malaria control strategies. Contemporary multilateral governance of transnational problems like public health (malaria) is
witnessing a tension between a coalition of nation-states and another coalition of civil society groups and non-state actors. Policies incubated at multilateral forums by states as repositories of state power are increasingly viewed as harmful to a range of public goods: the environment, public health, and human rights. As a result of gaps between these global policies and realities on the ground, they are often characterised as ‘globalisation-from-above’. Applied to the interaction between indigenous malaria therapies of malaria endemic societies and WHO's Roll-Back Malaria, would a contemporary multilateral malaria control strategy be considered globalisation-from-above? The interviews I conducted with traditional healers, rural populations and western-trained physicians practising in rural communities in Nigeria suggest that there is a regime deficit between the global malaria control policy of multilateral institutions and the behavioural and ethno-pharmacological practices of rural populations in malaria endemic societies in Africa. Traditional medicine, which is not a central and integral part of WHO's Roll-Back Malaria Project is popular among rural populations in malaria endemic societies. The conundrum here is that despite the popularity of traditional medicine, the phenomenon of globalisation has started to erode traditional medical therapies in most of the developing world at an alarming speed, and is simultaneously doing little to place western medicines within the reach of these third world populations. This conundrum opens an opportunity for multifaceted dialogue across cultural, disciplinary and theoretical schools. The concern of these dialogues, which I call ‘constitutive approaches’, is the evolution of policy recommendations that would alter the global burden of diseases presently unequally distributed between populations of the industrialised and developing worlds.
Chapter Six discusses these multilateral policy recommendations. I coin the term *communitarian globalism* to focus the thrust of these recommendations on the active participation of every important player and actor in multilateral health governance: multilateral institutions, nation-states, non-state actors, and civil society. Because underdevelopment and poverty breed diseases, and because enormous resources are needed to re-build public health infrastructures across the world, I sketch the urgent collaboration that I foresee between the World Bank (because of its immense resources) and other multilateral institutions – the World Health Organisation (WHO) and the United Nations Children's Fund (UNICEF). The World Bank has been severely critiqued for its obsession with extreme neo-liberal policies - part of which I examine in Chapter Two - therefore I suggest that we search for commonalties between the bank's funded health programs and WHO's mandate along the lines of humane and equitable policies like the Alma-Ata Declaration on Primary Health Care. These commonalties will pave the way for a disease non-proliferation treaty: a recommendation of this thesis for a multilateral funding facility very similar to the multilateral fund regimes of the *Montreal Protocol* and the *Global Environmental Facility*. Coincidentally, this recommendation is now receiving its highest multilateral imprimatur in the form of the Global HIV and Health Fund jointly being proposed by UN Secretary-General Kofi Annan, the G-8 Summit and the United Nations General Assembly to curb the global threats of HIV/AIDS, Malaria and Tuberculosis. I discuss the potential problems and prospects of the global health fund regime and argue that in line with *communitarian globalism*, its *modus operandi* must recognise divergent national and socio-economic contexts. In line with multicultural approaches to health, the fund must draw from expertise among civil
society organisations and the United Nations system, as well as sustainable practices of populations that live with these diseases. The fund must be transparent and accountable to constituencies where the burdens of these diseases are heaviest. International law, I suggest, must play an important role in the governance of the fund. Its constitution and governing instruments must reflect equity, justice and fairness and must be sensitive to unequal disease burdens between the global South and the global North. Although this thesis argues very strenuously that the distinction between national and international health has become obsolete because of globalisation, and that mutual vulnerability compels multilateral approaches to cross-border disease spread, it does not suggest that nation-states will become completely irrelevant in a system of global health governance. Our present world-order is still composed of sovereign nation-states. Because of this, communitarian globalism foresees certain key roles for nation-states. The onus of basic curative, protective, preventive and promotional health-care services lies substantially on Governments in national jurisdictions. These services have multiple dimensions: basic sanitation and hygiene, resource-allocation decisions, poverty alleviation, food security, regulation of health insurance and other policy, legal, and administrative interventions. As I suggest, it is only when Governments begin to address these basic and essential health services within national jurisdictions that the transnational spread of disease and microbial threats in an inter-dependent world will start to diminish. Notwithstanding the continued relevance of the state, communitarian globalism - as I use it in this study - poses a serious challenge to the Westphalian system of multilateralism. The promise of non-state actors in global governance is boosted by the persistent exclusion of a sizeable part of humanity from the protective structures of the nation-state since the ascendancy of
the State from the Peace of Westphalia 1648 to the present day.\textsuperscript{21} Thus, the future of multilateral health governance should paradoxically look like a fragmented but unified fabric involving a multiplicity of actors – both states and transnational networks of civil society actors. Finally, I conclude that absolute fidelity to the protection of humanity's health in an interdependent world requires enormous sacrifices and multilateral approaches. Unintentional or wilful tolerance of an infectious disease in one part of the world constitutes a potential threat to populations in distant places. What ought we do to protect populations in the emergent global village from microbial threats? Neither isolationism nor protectionism has the capacity to provide solid defences against advancing microbial forces. Rather, the primacy of enlightened self-interest should guide both States and non-state actors to forge future multilateral ties and consensus on global health challenges in a divided world. This study is therefore an exploration of self-interest - its prospects and potentials for disease non-proliferation in our global neighbourhood.

\textsuperscript{21} See Richard Falk, \textit{supra} note 17 at 35.
CHAPTER ONE
THE CONCEPTUAL FRAMEWORK AND METHODOLOGY OF THE THESIS

A: THE CONCEPTUAL FRAMEWORK OF THE STUDY

I: THE RESEARCH PROBLEM(S):

That the world is a "global village"\(^1\) or a "global neighbourhood"\(^2\) is a truism that metaphorically underscores the increasing and inevitable interdependence of populations, markets and nation-states. Since the Peace of Westphalia in 1648, multilateralism has grappled with the multiple dimensions of the economic, health, social, and environmental vicissitudes of global interdependence. A plethora of globalizing forces has since emerged in the form of complex international airline networks, flows of foreign direct investment, ecological tourism, religious pilgrimages, international sports festivals, regionalism, and free trading blocs.\(^3\) But, almost simultaneously, the emergent global village is threatened by a surge in the number of refugees fleeing civil wars and conflicts, environmental and natural disasters, social and economic disparities between the South and the North, as well as the emergence, re-emergence, and prevalence of infectious diseases and other transboundary health hazards.

In the twenty-first century, very few, if any, urgent public health events are solely within the purview of national jurisdictions any longer. One obvious consequence of globalization is the increased risk of the international spread of diseases and hazards. People and goods are crossing national borders in massive

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numbers unparalleled in human history. In the field of international public health, it has been argued that the powerful impetus of globalisation undermines state sovereignty as power flows out of the formal apparatus of the state into the hands of industrialists, investment bankers, media moguls and transnational corporations. The pervasive impact of globalisation, which is apparent in telecommunications, manufacturing strategies, international trade, and global capital flows, has shattered the traditional distinction between national and international health. This distinction is no longer relevant because globalisation has enabled pathogenic microbes to spread illness and death globally with unprecedented speed.4

The fact that an outbreak of an infectious disease anywhere in an interdependent and increasingly globalising world poses a threat to populations everywhere makes multilateralism an inevitable option in the battle against diseases and pathogenic microbes. The World Health Organisation argues that infectious diseases now constitute a “world crisis”.5 Leading epidemiologists agree with the WHO.6 As observed by John M. Last,

dangers to health anywhere on earth are dangers to health everywhere. International health, therefore, means more than just the health problems peculiar to developing countries... There are many good reasons why we should be concerned about world health. The most obvious is self-interest: Some of the world’s health problems endanger us all...7

If ‘self-interest’ must compel or induce effective, fair and humane multilateral health co-operation, why then has so little been done in this regard? Put another way, why

have nation-states been largely reluctant to act together to salvage the global neighbourhood from the calamities of disease? The utility of these questions is twofold. First they reveal a strange paradox facing scholars and multilateral institutions: the paradox of simultaneously living in a global neighbourhood and a divided world. The first limb of the paradox projects an ideal of a fair, just and humane global neighbourhood, where all of humanity are inexorably part of a global compact tied by the bonds of human dignity and values. The second limb of the paradox projects an unfair global neighbourhood marked by unequal disease burdens on the populations in the South and the North: poverty and underdevelopment of over seventy percent of the world’s nation-states and populations, mainly in the global South.

Second, these questions hypothesise the apparent apathy and indifference of the global North (developed and industrialised world) towards global health challenges. This apathy and indifference is evidenced in the weakness of the contemporary international normative order on public health, and remains a major contributor to underdevelopment and the heavy disease burdens in the developing world of the global South. This inquiry strives to find support for this hypothesis in the bias, nature, limited scope, and colonial implications of the international sanitary regimes from 1851 to the formation of the World Health Organisation in 1948. This bias, I argue, is still manifest in present-day public health multilateralism and diplomacy. There is an imbalance in the priorities of multilateral institutions including

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8 I do not argue that every single health problem in the developing world constitutes a global problem that should be placed within the agenda of multilateralism. Nutrition, basic sanitation, housing, civil wars and political conflicts, environmental disasters, each affects human health in significant ways. It is the primary responsibility of the Government in every country, especially in the developing world, to respond to these health-related social problems. My concern in this thesis hinges on health problems that are far beyond the surveillance capacity and developmental capability of individual countries: those health problems that are being propelled by underdevelopment and globalisation in ways that threaten all populations within the global village irrespective of the jurisdiction or origin of the disease or pathogen in question.
the United Nations organs and specialised agencies with a mandate on global health
issues.

Today, the vicious threat posed by diseases and pathogenic microbes to our
global neighbourhood - more than ever before in the past five millennia - is predicated
on two slightly different but inexorably linked concepts: the *mutuality of vulnerability*
and the *vulnerability of multilateralism*.\(^9\) Mutual vulnerability\(^10\) refers to the
traditional, emerging and re-emerging threats which South-North\(^11\) disparities and
globalisation of diseases and health hazards pose to all populations in the global
neighbourhood irrespective of whether they live in the South or North. The re-
emergence of tuberculosis as a public health threat in Europe and North America in
the decade of the 1990s and the so called 'airport or imported malaria' used to
explain isolated malaria outbreaks in the global North, are examples of mutual
vulnerability of populations in an interdependent world. The emergence of new
diseases and re-emergence of old ones across the world constitutes a global crisis of
diverse and complex magnitude.

Vulnerability, which first affected national boundaries through the
globalisation of markets, now has a marked impact on populations through the

\(^9\) This rhetorical exploration of microbe-humanity interaction in an interdependent world as 'mutuality
of vulnerability and vulnerability of multilateralism', is inspired by a similar rhetorical exploration of
the inequities of the international system as "international order of poverty and poverty of the
international order" by Mohammed Bedjaoui, *Towards a New International Economic Order* (Paris:

\(^10\) The concept of mutual vulnerability in multilateral interdependence of nation-states is not new. What
is new about the concept as I use it in this study is its relevance in, and application to, the complexities
of transnationalisation of diseases and health hazards in a globalising world. For earlier use of the
concept of "mutual vulnerability" to explore the international political economy of development, See
Ivan L. Head, *On a Hinge of History: The Mutual Vulnerability of South and North* (Toronto: The
University of Toronto Press, in association with the International Development Research Centre,
1991); Jorge Nef, *Human Security and Mutual Vulnerability: The Global Political Economy of
Development and Underdevelopment*, 2\(^{nd}\) Ed., (Ottawa: IDRC, 1999). This study benefits from the
insightful analysis of the concept by Head and Nef.

\(^11\) Throughout this thesis, I will be using the term "South-North" as suggested by Ivan L. Head, *On a
Hinge of History: The Mutual Vulnerability of South and North*, Id., at 14. Head prefers "South-North"
as a more accurate reflection of the current international system and argues that the popular usage of
globalisation of diseases. From Thucydide's account of the Athenian plague of 430BC\textsuperscript{12} to cholera outbreaks in mid-nineteenth century Europe, down to contemporary infectious disease diplomacy, the mutual vulnerability of populations across national boundaries has become the dominant concept in public health discourses and policy-making agendas. Related to this is the twin concept of vulnerability of multilateralism, which I use to explain the gaps, shortcomings and politics of early and contemporary public health multilateralism.\textsuperscript{13} The politics, gaps and shortcomings of nineteenth-century public health multilateralism, which were dominant features at the first \textit{International Sanitary Conference} in 1851,\textsuperscript{14} are still conspicuous in twenty-first century public health multilateralism. The vulnerability of multilateralism, in the form of South-North politics, is still with the World Health Organisation – the United Nations specialised agency with a mandate to "act as the directing and co-ordinating authority on international health work".\textsuperscript{15} To assess how the vulnerability of multilateralism has affected the work and mandate of the World Health Organisation, I conduct two levels of inquiry. The first deals with selected issues of South-North politics at the proceedings of the World Health Assembly and the second offers a critical assessment of the WHO's on-going Roll-Back Malaria Project. My aim in the first level of inquiry is to determine the extent to which South-
North rhetoric and disparities have affected the effectiveness of a multilateral organisation like the WHO. My second level of inquiry explores the extent of the integration of indigenous medical therapies, and sustainable behavioural practices prevalent in the malaria-endemic societies (particularly in Africa) into WHO’s Roll-Back Malaria Project – an ongoing global multilateral initiative to cut malaria mortality and morbidity in the developing world. Since I agree with Richald Falk’s critique of contemporary market-driven global civilisation as “globalism-from-above”, the centrality of my assessment of the Roll-Back Malaria Project focuses on its integration with, or exclusion of, indigenous medical practices of populations in malaria-endemic African societies.

Thus, this study argues that the complex interaction of the mutuality of vulnerability and the vulnerability of multilateralism has impacted heavily on global health discourses and policy-making. Far from being effective, fair, or humane, public health multilateralism has remained at a crossroads. As nation-states navigate between the Scylla of protectionism driven by what they perceive as strategic interests, and the Charybdis of protection of public health, the gap between the global South and the global North in terms of disease burdens continues to widen. The impact of this gulf – a kind of development apartheid – between the South and the North takes its toll on millions of persons across the world. From the perspective of infectious diseases, both the mutuality of vulnerability and the vulnerability of multilateralism provide the catalysts for a reform of multilateral health co-operation. This thesis explores these two related concepts and charts a future multilateralism that is humane and responsive to the health needs of populations, especially in the developing world - what Richard

Falk has identified as global partnership that “fulfils the vision of unity and harmony”.  

The first task is to explore mutual vulnerability in a way that would induce genuine self-interest. To ask one simple question: if populations in the United States or Canada were in real danger of being infected by an outbreak of *ebola haemorrhagic fever* in Democratic Republic of Congo or *Chagas disease* in Bolivia (through global commerce and movement of people across national boundaries), would this induce sufficient self-interest from either the United States or Canada to assist in developing the surveillance capacity of public health facilities in either Bolivia or Congo? Would this perceived threat of *ebola fever* or *chagas disease* compel a *quia timet* transfer of resources from a developed to a developing country through a multilateral institution? Discussing mutual vulnerability from this perspective paves the way for a reconstructive inquiry, a reconstruction that strives to reform contemporary unfair public health multilateralism. As a response to the vulnerability of multilateralism, this reconstructive mission, *inter alia*, searches for alternatives and inevitably makes an argument for fairness, equity and humanistic approaches to multilateral co-operation in the global public health arena. In this endeavour, with some caveats I will be a student of Thomas Franck’s fairness discourse, Richard Falk’s humane world order and John Rawls’ theory of justice. If populations within countries - developed or developing, rich or poor,

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17. ibid.
22. Although the liberal scholarships of Franck and Rawls are compelling and persuasive, I am not completely wedded to their views as infallible pathways to humane, equitable and fair public health
strong or weak, South or North; are viciously threatened by diseases with a comparable degree of propensity - then mutual vulnerability would remain a persuasive catalyst capable of overriding the vulnerabilities of multilateralisation of public health in the twenty-first century. Although this initiative is beginning to receive some attention from multilateral institutions involved in the Roll-Back Malaria Project, more efforts and resources are still needed to salvage the global neighbourhood and its endangered populations from the threat of diseases and pathogenic microbes. Based on an assessment of available literature and contemporary multilateral approaches, this thesis strives to make policy recommendations for future normative global partnerships in the domain of public health diplomacy and the globalisation of diseases.

II: LITERATURE REVIEW

Public health is a subject within the scientific discipline of epidemiology. Has international law anything to do with epidemiology? Of what relevance is an international covenant, treaty, or rule to cross-border threats of diseases? Can public health effectively be the subject of international normative governance mechanisms? Can an international lawyer and an epidemiologist forge a collaborative alliance on multilateral health policy-making and scholarship? Most regrettably, the failure to address these questions has stultified scholarly progress and academic inquiry on a plethora of multilateral issues where international law and public health intersect. Evidence from the literature persuasively suggests that international lawyers have

multilateralism. Thus, I use the more critical approach of Falk to chart a constitutive theoretical and policy approach to health promotion in a divided world.


24 Epidemiology is defined as "the study of the distribution and determinants of health-related states or events in specified populations, and the application of this study to control of health problems". See
remained largely passive within the scholarly edifice of global public health. Multilateral public health institutions have also discarded international law as a useful operational tool in the evolution of global health policies. Epidemiologists, on the other hand, have often complacently analysed global health issues from the narrow parameters of medical science. Notwithstanding all of these shortcomings, this thesis argues that law and public health in the global arena is like the proverbial mansion with many rooms or a road traversed by many paths. International lawyers, most unfortunately, have confined themselves to the peripheries – either opting to sit in one of the rooms in the mansion or to simply stand on one of the paths. In exploring the vast terrain of multilateral health, most lawyers adopt segmented approaches to inexorably-linked and interdisciplinary public health issues. Overly legalistic, the bulk of seminal works by lawyers on bio-ethics, the human right to health, the human right to a healthy environment, the health implications of war and use of nuclear weapons, international trade and public health - often display an obvious lack of holistic and interdisciplinary approaches. Even within “mainstream multilateral health scholarship and policy-making”, extreme legalism remains a dominant feature in the works of the very few international lawyers who have explored the interaction of global public health and international law with commendable intellectual rigour. In her discussion of the mandate of the World Health Organisation, universal access to conditions for health, and the role of international health regulations in global infectious disease surveillance, Taylor drew heavily from WHO’s statistics on disparities in health

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25 I use the expression “mainstream multilateral health policy-making” to refer to multilateral approaches to, and normative governance of, cross-border health challenges that are beyond the capacity of one individual country or a group countries, including the effects of social and economic disparities within and among countries on multilateral health initiatives. These approaches and governance mechanisms involve a symbiosis of legal and non-legal interventions.
standards between rich and poor countries.\textsuperscript{26} Taylor’s critique of WHO’s reluctance to utilize law and legal interventions to facilitate its global health strategies implies that the essence of law and legalism in multilateral policy-making is teleological – that law holds a certain promise towards a significant reduction of disease burdens within and among countries.\textsuperscript{27} Fidler, one of the most prolific contemporary scholars of international law and public health, canvasses similar arguments for increased use of international law in multilateral health strategies.\textsuperscript{28} His recent work \textit{International Law and Infectious Diseases}\textsuperscript{29} sketches an international normative paradigm for globalization of public health. Using international law and international relations theoretical and historical frameworks, Fidler explores critical linkages between global public health and human rights, international trade, environmental issues, war and weapons. As put by Professor Ian Brownlie,

\begin{quote}
...Fidler has used international law as a framework within which to organise his study of the normative and institutional techniques employed by the international community in order to control and prevent the spread of disease. His legal expertise is infused by his knowledge of international relations thinking and techniques. The outcome is a successful study of considerable originality.\textsuperscript{30}
\end{quote}

Fidler’s treatise posits the challenge of emerging and re-emerging infectious disease threats as a challenge for the international community.\textsuperscript{31} His historical account of


\textsuperscript{27}ibid.


\textsuperscript{30}ibid “editor’s preface”.

\textsuperscript{31}ibid at 5-19.
multilateral health co-operation after mid-nineteenth century transboundary outbreaks of cholera in Europe vindicates the central argument of this thesis - that mutual vulnerability to disease and pathogenic threats in an interdependent world elevates public health to a high pedestal in the agenda of multilateralism. Thus, the second half of the nineteenth century emerged as an era of intensive public health diplomacy marked by a series of international sanitary conferences aimed at the exchange of epidemiological information on cholera and other disease outbreaks within Europe, harmonisation of quarantines, creation of an international surveillance system, and the creation of multilateral health organisations. One positive result of this multilateral endeavour was the evolution of the International Health Regulations (IHR) as the legal basis for global surveillance of certain infectious diseases as well as the groundwork for the establishment of international health organisations to enforce the emergent multilateral legal strategies for disease surveillance. Applying all of these to *microbialpolitik*, Fidler's term for "a mixture of the ordinary dynamics of international relations and the special dynamics produced by the challenges posed by pathogenic microbes", Fidler - like most lawyers - posits global infectious disease threats within international legal and treaty regimes: a combination of what he calls the "concept of global health jurisprudence" and a proposal for a WHO Framework Convention on Infectious Disease Prevention and Control. Although Fidler’s treatise looks comprehensive, it misses a key dimension in the international legal perspective

32 *ibid* at 21-52.
35 *ibid*.
36 *ibid*.
on global public health: a strong South-North component.\textsuperscript{37} The focus of this present inquiry is on international law and global public health from a somewhat different perspective: South-North disparities as a propelling factor in mutual vulnerability. South-North disparities and mutual vulnerability are peripheral to Fidler’s enquiry. In his discussion of ‘globalisation of public health’, he observed that,

\begin{quote}
The vulnerability States sense today is analogous to the vulnerability that forced nineteenth-century European States into international health co-operation and international law on infectious disease control.\textsuperscript{38}
\end{quote}

In his discussion of the history of international law in the control of infectious diseases, he argued that the development of multilateral public health co-operation in the nineteenth-century was motivated by fear of importation of non-European diseases (notably Asian diseases) into Europe.\textsuperscript{39} Despite the substantial anchorage of this study on South-North disparities - a perspective different from Fidler's, it nonetheless draws heavily from Fidler's insights on the history of public health co-operation through the nineteenth century international sanitary conferences. As well, this study benefits immensely from his application of international relations theories to microbialpolitik, colonial origins, and post-colonial implications of the nineteenth century international (Euro-centric) health order, and the relevance of international law (including international human rights treaties) to global health promotion and protection. While this thesis endorses the arguments for increased use of legal strategies in global health

\textsuperscript{37} Fidler himself recognised this fact when he wrote, “although the monograph provides a comprehensive international legal analysis of infectious diseases, it does not exhaust this topic. Each area of international law analysed is in flux, making it impossible to provide a definitive analysis. Another challenge was writing for not only international legal specialists but also public health experts who are generally unfamiliar with international law. Despite these problems, this monograph contributes to a neglected area of international legal, public health, and international relations scholarship and encourages others to explore this increasingly critical global issue”, \textit{ibid} at 4.\textsuperscript{38} \textit{Ibid} at 7.\textsuperscript{39} \textit{Ibid} at 28-35. South-North disparities and global health challenges received a more detailed attention from Fidler in an earlier article albeit from a strictly international relations perspective. See David P. Fidler, “Microbialpolitik: Infectious Diseases and International Relations (1998) 14 Am. Univ. Int’l Law Rev. 1.
policy-making as canvassed by Taylor, Fidler and other international lawyers, it goes
further to explore how South-North inequalities impact on the health of populations in
a sharply divided world. Law, I argue, may simply be a means to an end but not an
end in itself. Not discarding legal strategies entirely, I coin the term *communitarian
globalism* to argue for increased participation of global civil society in multilateral
health forums as well as the need for a ‘disease non-proliferation treaty’ through a
multilateral funding facility regulated by international law.

The apathy and disenchantment of international lawyers towards mainstream
multilateral health policy-making is not exactly shared by scholars of other academic
disciplines related to public health. Scholars of history, international relations,
development, and of course the undisputed owners of public health, epidemiologists –
have enriched vast areas of public health scholarship with more
incisive academic inquiries. From the discipline of history emerges the fact that cross-
border spread of epidemics is as old as humanity. The movement of populations
across national boundaries has always had disease implications for all of humanity.
One of the earliest recorded epidemics - the plague of Athens in 430 BC - medical

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historians tell us, resulted from cross-border movement of troops during the Peloponnesian war. The arrival of Columbus in the Americas in the fifteenth century marked the devastation of Native American populations by imported European diseases: measles, mumps, chicken pox, and scarlet fever.

From the perspective of international relations, commentators observe that the cross-border spread of infectious diseases constitutes a security threat deserving of urgent attention by governments as a top foreign policy issue. Development theorists and commentators argue that policies of powerful multilateral financial institutions like the World Bank and the International Monetary Fund (IMF) are hostile to their host social and economic environments in the developing world, the end result being "globalism-from-above" with adverse implications for, and deleterious effects on, the health of populations in their recipient countries. Recent trends in epidemiology use macro-economic models to explore the unequal distribution of the burdens of diseases and health risks in a world sharply divided by inequalities, poverty, and underdevelopment.

What emerges from these interdisciplinary perspectives is the obvious fact that a cross-border resurgence of diseases, as the World Health Organisation observes, now constitutes a global crisis that requires multilateral approaches. The relevance of these divergent perspectives makes this thesis interdisciplinary and enriches its analysis from both theoretical and policy angles. The history of multilateralism in the field of public health in nineteenth-century Europe provides the opportunity for an

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45 See Porter, supra note 40 at 46; Sheldon Watts, Epidemics and History: Disease, Power and Imperialism (New Haven/London: Yale University Press, 1997) 89-121.
46 See generally H. Nakajima, supra note 41, David P. Fidler, "The Globalisation of Public Health: Emerging Infectious Diseases and International Relations", supra note 41.
47 M. Chossudovsky, supra note 42.
intellectual exploration and deeper understanding of the colonial and post-colonial underpinnings of early international law and public health. It is through international relations perspectives that the politics and theoretical complexities of multilateralism and international regimes will be understood. And as international lawyers, our understanding of the dynamics of development equips us with additional skills to deeply appreciate and explain South-North disparities within the confines of our international legal domain.

Drawing from these interdisciplinary sources, the originality of this thesis - although palpable - is subject to a caveat. For one runs the risk of being charged with 'intellectual blasphemy' for claiming originality in international law on the vast terrain of South-North disparities. In fact the past fifty years have witnessed an unprecedented surge and accelerated momentum in the scholarly exploration of the multiple dimensions of South-North issues – development, human rights, sovereignty over natural resources, environment, culture and imperialism – with commendable intellectual rigour. This writer is therefore aware of seminal works by distinguished international jurists in this area of the law including many declarations and 'soft-law' mechanisms by multilateral institutions. Indeed the whole question of the New International Economic Order (NEIO) and the debate by southern and northern scholars on its existence or otherwise, and the contents of the Right to Development,

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fall within this broad construction of South-North scholarship. On all of these issues, this study can hardly ever claim originality. Rather, this thesis complements and builds on an existing body of South-North scholarship. It is innovative because of the various ways in which it:

(a) hypothesizes mutual vulnerability and the vulnerability of multilateralism as inseparable concepts in contemporary multilateral public health scholarship marked by South-North disparities.

(b) posits nineteenth century public health diplomacy within the colonial origins of, and post-colonial theories in international law.

(c) relies on mutual vulnerability and globalisation of diseases in an interdependent world to argue for procedural fairness and distributive justice within a humane international system.

(d) strives to develop cross-sectoral linkages between public health, human rights, colonial and post-colonial theories, politics, development, and international law.

(e) strives to create a prominent role for international law in the complex dynamics of the interface between humanity and diseases through the strengthening of multilateral surveillance capacity for diseases through an international funding facility.

(f) agrees with international relations scholarship that public health is a global public good and strives to find partnership and collaboration with universal international law to fulfil public goods’ vision of unity and harmony in the global neighbourhood.

(g) coins and uses the term ‘communitarian globalism’ to argue for an inclusive multilateral health framework that involves all important actors: multilateral institutions, state actors, non-state actors, and civil society, and

(h) explores the pros and cons of the phenomenon of globalisation in multilateral health discourse, and projects globalisation as paradoxically having the capacity to
integrate cultures and the tendency to erode traditional medical therapies in the developing world.

As already stated, international lawyers have explored global health challenges in segmented ways. This thesis strives to offer an interdisciplinary and holistic approach to health protection and promotion in a divided world. In this endeavour, combining theories and perspectives from a multiplicity of disciplines – history, international relations, international law, and development studies – will be an arduous intellectual task. Because development and underdevelopment affect public health in a variety of ways, and because global health scholarship can never be fully explored outside the context of development, I will largely heed the warning of Head that,

No algebraic formula will solve a problem if a host of variables is found on each side of an equation. If ‘development’ is susceptible of a range of definitions, as it is, and ‘international law’ is so often found in the eye of the beholder – or at least the textbook author – the topic invites a display of dipsy-doodling. ...Development is a tough concept to discuss with intellectual rigour – not because it is any more complex or elusive of definition than many others, but because everyone has his or her own view of what it is.\(^1\)

With this in mind, the interdisciplinary focus of this thesis lies only with such theories and perspectives from allied disciplines that are humanist and fairness oriented. Here, I contemplate theoretical perspectives aimed not only at deconstructing the inequities of the contemporary multilateral system, but also emerging inter-theoretical perspectives that recognise the immutable transnational bonds that tie all of humanity in a shared global compact. The legal, moral, and normative components of these

transnational humanitarian bonds come within the rubric of what Richard Falk has aptly called "the law of humanity". 52

III: CLUSTERS OF RESEARCH QUESTIONS

This thesis raises the following clusters of questions:

(a) To what extent was the mutual vulnerability of populations to infectious diseases a factor in the earliest multilateral co-operation in the field of public health? What legacy did early international law bequeath to the present, and how has this legacy affected indigenous ethno-medical therapies of societies in the developing world? How (if at all) did politics and strategic interests of nation-states (vulnerability of multilateralism) affect early multilateral health initiatives?

(b) Has international law played any role in the dynamics of the historical interaction between humanity, nation-states, and diseases? What role(s) can law and legal interventions play in contemporary public health multilateralism and scholarship?

(c) What impact(s) do South-North disparities (social and economic inequalities) within and among countries have on multilateral efforts aimed at protection and promotion of humanity’s health? In what ways do poverty and underdevelopment increase or diminish the propensity of mutual vulnerability in the global village?

(d) In view of (a) (b) and (c) above, what are the best possible interventions that would lead to a humane global health order? Is there any evidence that public health policies of multilateral institutions like WHO’s Roll-Back Malaria – are guilty of “globalism from above”? To what extent are indigenous medical practices (like traditional malaria therapies) of most societies in developing countries part of the core framework of multilateral malaria policies? How can public health programs on the

52 See Richard Falk, Law in an Emerging Global Village, supra note 16 at 33.
ground be effective, and how best can international or multilateral involvement contribute to their effectiveness? With respect to transnationalisation of diseases, does mutual vulnerability at present induce sufficient self-interest to commit scarce but moderate global resources towards the protection and promotion of health of populations? Is the state-centric Westphalian system still capable of effectively responding to every emerging multilateral health issue of our time and age or do we require a more inclusive multi-stakeholder participation based on animation of transnational civil society?

In an attempt to answer these questions, this thesis combines a number of approaches. For reasons that I will elaborate under research methodology, it is important to note here that I have not completely followed the strict rules of social science research methodology in answering each of these questions. For question (d) I will rely on interviews I conducted in a Nigerian rural community in December 2000 as well as my observations of traditional malaria therapies of populations in the same community to determine whether multilateral malaria policies like the WHO’s Roll-Back Malaria Project is ‘guilty of ‘globalism-from-above’. For the other questions I simply adopt critical and analytical approaches in my analyses of literature and the work of multilateral institutions.

**IV: EXPECTED RESEARCH FINDINGS**

The expected findings of this inquiry are that,

(a) Mutual vulnerability of populations to diseases and pathogenic microbes - although a persuasive factor since nineteenth century public health diplomacy - nonetheless has yet to induce genuine and sufficient self-interest in an interdependent
world of the twenty-first century. Reasons for this phenomenon is two-fold: first, the widening development gap between the South and North as documented by multilateral institutions, and second, the unequal distribution of the global burdens of disease on populations in developing and developed worlds. Twenty-first century infectious disease diplomacy seems not to have learnt sufficient lessons from its nineteenth century precursor when sheer protectionism and economic interests of European nation-states hindered affective collaboration to find multilateral solutions to cross-border outbreaks of cholera. In many ways, the industrialised world still draws an isolationist distinction between ‘their’ diseases and those of the developing world. It will be a fatal mistake for nation-states to fall back on the illusion of protectionism within the framework of contemporary inter-state relations as globalisation of diseases, global travel, trade and commerce, and migration, continue to erode national boundaries across the world. Nonetheless, the fascination which protectionism has for international scholarship is that it sounds like a vindication of the theory of realism in international relations. To a typical apostle of the realist school, if since the first International Sanitary Conference in 1851 the world cannot have an effective multilateral co-operation in the field of public health, then why still bother today? The realist school uses examples of this sort to assert that law and order is elusive in the relations between sovereign states because no multinational police force is present to enforce such laws among sovereigns in the global arena.

53 Here I concur with Professor David Fidler’s persuasive submission that “globalization provides diseases with opportunities to infect human populations across the planet almost as easily as infecting the family next door”, see “Return of the Fourth Horseman”, supra note 28.
55 See C.J.L Murray & A.D Lopez, Global Burden of Disease (Cambridge: Harvard University Press, 1996) (using what has emerged in public health literature as Disability Adjusted Life Years DAILYs to measure morbidity and mortality of selected communicable and non-communicable diseases in various regions of the world and finding the developing world, especially Africa, as lagging behind other regions).
Juxtaposing the realist argument with other contending schools of thought, the public health imperatives of our contemporary globalising and interdependent world are far too complex for any one single theory or school of thought to explain satisfactorily. As a way forward, only a cross-fertilisation of perspectives from various theories and disciplines will prove useful. Realism, liberalism and critical theories of international regimes must therefore inform one another.

(b) The first finding inevitably leads to the second – reform of public health multilateralism in an interdependent world. Here there are two identifiable interrelated issues. The first relates to the evolution of a humane multilateral health regime. The second focuses on projects, policies and programs of multilateral institutions that are often characterised as “globalism-from-above”.

(c) International law has been at the margins in the work of multilateral health institutions especially the WHO. Despite the ambitious definition of “health” in its constitution and the innovative legal powers bestowed on it when it was founded in 1948, the WHO has largely treated international law as a ‘no go area’. Dr. Allyn Taylor, Katarina Tomasevski and David P. Fidler, all international legal scholars, have strongly criticised WHO’s timidity and the organisation’s preferred use of

56 I explore the pros and cons of each of the dominant theoretical schools under what I categorise as "the wealth and poverty of theory". See infra pp187-196.
57 I borrowed this expression from Richard Falk whose arguments on a humane world order I completely concur with. See Falk, Law in an Emerging Global Village, supra note 16 at 29.
59 The legal powers of the World Health Organisation to adopt conventions, regulations and non-binding guidelines are contained in Articles 19-23 of its constitution. See Constitution of the World Health Organisation, ibid.
narrow medical-technical standards to pursue its health mandate. As observed by Fidler, the WHO isolated itself from general international legal developments in the post-1945 period. This isolation was not accidental but reflected a particular outlook on the formulation and implementation of international health policies. The WHO operated as if it were not subject to the normal dynamics of the anarchical society; it acted as if it were at the centre of a transnational Hippocratic society of physicians, medical scientists and public health experts. Regrettably, a window of opportunity seems to have been lost by WHO in the post-1945 years, which were marked by an exciting array of international legal developments that could have been of immense assistance to the organisation in pursuance of its global health mandate. Looking back comparatively with post-1945 global environmental multilateralism for instance, international environmental law has steadily developed into a mature area of inquiry that is now used to forge South-North consensus and collaboration on a range of environmental issues – ozone depletion, climate change, biodiversity, trade in endangered species, and marine pollution. This thesis offers a brief analysis of two multilateral environmental governance mechanisms - the Montreal Protocol to the UN Convention for the Protection of the Ozone Layer, and the World Bank's Instrument Establishing the Global Environmental Facility - and argues for the use of similar mechanisms in the domain of public health. Recognizing the uneven landscape for present day multilateral co-operation, these environmental governance mechanisms, inter alia, emphasise transfer of resources from the industrialised to the developing

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63 “International Law and Global Public Health”, ibid at 15. I agree with Fidler, especially his caveat that this critique of WHO does not mean that international law has the magic bullet against public health problems in the world today but rather to encourage WHO to integrate useful legal strategies in its work and take relevant international legal development more seriously.

world, equity, sharing and fairness. Whatever may be their shortcomings, these initiatives are still commendable because environmental issues, like public health, are global issues at the centre of a deep-rooted South-North acrimony.

(d) It follows from (c) above that if underdevelopment is responsible for either the non-existence or collapse of public health infrastructures in parts of the developing world, then resources (mainly financial) that would flow from any global sharing formula would be channelled towards the re-vitalisation of surveillance capacities in the developing world based on agreed rules. But where will these resources come from and which multilateral agencies will develop the rules to be used in their sharing? Obviously, WHO does not have the resources to rebuild national public health infrastructures in developing countries. In recent years, the World Bank has grown as a critically important player in the funding of public health projects in the developing world.\textsuperscript{65} A partnership of the World Bank, WHO and other relevant multilateral institutions, foundations and leading donor countries is inevitable in this endeavour. Mutual vulnerability and the vulnerability of multilateralism would be significantly diminished by a humane, fair and equitable WHO-World Bank led multilateral Instrument Establishing a Global Public Health Fund. This would operate in principle as a 'disease non-proliferation treaty'. By analogy it compares with similar funding mechanisms on international/multilateral environmental and marine pollution issues.

(e) Globalisation erodes ethno-medical therapies and behavioural practices on malaria and other prevalent diseases in most of the developing world. The conundrum of the prohibitive cost of western medicines and the simultaneous erosion of traditional medicine by the phenomenon of globalisation takes its toll on the health of

endangered populations. The complexity and dynamics of global patent law and liberalisation of international trade rules - in some ways - conspire to endanger public health in the developing world.

B: RESEARCH METHODOLOGY

This is a thesis in international law that uses public health as its subject of analysis. Although it reaches out to the social sciences and other relevant disciplines especially international relations, its domain remains international law. It combines legal research methodologies with minimal social science qualitative methods in the study of the interaction between multilateral malaria control policies and ethno-medical therapies in malaria endemic regions of the global South. It is worthwhile to issue a caveat on the ethnographic and qualitative aspects of my analysis of the WHO’s Roll-Back Malaria Project. These were based on facts and observations that emerged from interviews I conducted on rural populations and public health providers during my visit to a Nigerian rural community. Fraught with the danger of generalisation, facts and observations from the interviews should be limited to the socio-cultural context of the community where the interviews were conducted. However, there is a chance that since most developing countries, especially in the malaria endemic regions of Africa, still share some cultural, natural, climatic and social similarities, information from the Nigerian rural community may be used to critically analyse malaria control strategies of multilateral institutions like the WHO as they relate to most of Africa. Simply put, is Roll-Back Malaria guilty of globalism-from-above? The relevance of this question lies within Roll-Back Malaria’s tendency to either integrate or marginalise traditional medical practices and beliefs of a sizeable number of populations in the developing world (especially Africa) where malaria burdens (morbidity and mortality) are exceedingly high. These ethno-medical
practices are still preferred by a sizeable percentage of rural populations when they are infected by malaria. To the extent that this thesis never conducted any quantitative analysis, facts and observations from the Nigerian interviews will only be used to study and understand the social contexts of these populations, especially their behavioural practices with respect to malaria. A major advantage of qualitative methodology of this sort is that it allows the researcher to gain deeper insights into understanding, behaviour and trends of the group studied.\(^6\)

Complementary to the qualitative dimension of ethno-medical approaches to malaria are other methodological approaches – critical analysis of literature in search of useful deductions and use of secondary data from multilateral organisations to explain South-North disparities in the field of public health. In this endeavour this thesis is critical, analytical and interdisciplinary. The global scope of this work makes it impossible to collect data from every country. With some caveats I will rely on WHO’s Global Burden of Disease,\(^6\) which uses Disability Adjusted Life Years (DAILYs) to measure disease burdens in various regions of the world based on mortality and morbidity. The major caveat on the reliability of DAILYs is that many developing countries do not have official data on ailments, clinical cases, hospital admissions and cause of deaths. In his foreword to the Global Burden of Disease study, William Foege observed that,

\(^6\) In this sense I agree with P. Ellis that “the qualitative approach helps us to understand people as they interact in various social contexts and to define social reality from their own experience, perspective and meaning rather than from that of the researcher alone...It raises hitherto unasked questions, the answers to which afford deeper and sharper insights into how and why people participate as they do in a variety of social processes” quoted in J. Kitts & J.H Roberts, The Health Gap: Beyond Pregnancy and Reproduction (Ottawa: International Research Development Centre, 1996) 37. See also, World Health Organization, Qualitative Research for Health Programmes (Geneva: WHO, Division of Mental Health and Prevention of Substance Abuse, 1996).
\(^6\) See CJL Murray & A Lopez, supra note 48.
many developing countries find it difficult to acquire accurate mortality statistics, let alone morbidity and quality-of-life information...Many countries face difficulties in accurately determining infant mortality rates, or even AIDS and tuberculosis incidence and prevalence rates, let alone acquiring a comprehensive understanding of the total burden of disease...they face.\(^68\)

To this extent, data used in calculating DALYs in most of the developing world are, at the very best, estimates.

This thesis also draws heavily from the Pan-American Health Organisation (PAHO's) volumes on Health in the Americas.\(^69\) Why PAHO? PAHO membership presents a perfect setting for the study of South-North disparities and unequal disease burdens between developed and developing worlds in a multilateral context. This is because PAHO membership includes Canada and the United States – two of the most developed countries in the world – and some of the world’s least developed countries like Haiti, Honduras, Guatemala, and El Salvador. Disparities among the countries of the Americas continue to impact on health of populations in the region. As observed by the former Director of PAHO,

an understanding of the impact of regulations and institutions on the health sector in the Americas must necessarily be viewed in light of the problems the region faces - problems which differ in accordance of each society's level of development – and the challenge those problems pose. Because of the many differences and for the purpose of simplification, it is important to distinguish between the situation prevailing in the Hemisphere’s two most developed countries: Canada and United States of America, and in the developing countries of Latin America and the Caribbean.\(^70\)

In sum, the strength of this thesis lies in its combination of critical, analytical, descriptive, and qualitative approaches in analysing public health challenges in a sharply divided world marked by the poverty and underdevelopment of more than seventy percent of the world’s population. It is important to note that while this thesis is critical of contemporary multilateral initiatives under the rubric of vulnerability of

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multilateralism, I do not adopt the same approach used by critical legal scholars that admirably deconstructs mainstream legal thought but shies away from reconstructing viable alternatives.\textsuperscript{71} Rather, this thesis uses the vulnerability of multilateralism to deconstruct contemporary multilateral health co-operation in a divided world, and uses the concept of \textit{communitarian globalism} to re-construct the future of multilateral public health consensus.

\textbf{C: CONTRIBUTIONS OF THE STUDY AND THE THESIS}

This thesis, although anchored on international law, nonetheless makes overtures to the disciplines of public health, development, international relations, and to a limited extent the social sciences. As well, it explores a huge global issue – the globalization of public health and transnational spread of diseases in a divided world. Its interdisciplinary reach combines with its global scope to benefit international law, international relations, and development scholarships.

For the social sciences, the analysis of traditional medical therapies of non-western societies vis-à-vis WHO's Roll-Back Malaria Project raises an avalanche of questions on the ethnographic study of medical pluralism in divergent societies, cultures and social contexts. Following the canons of “law and anthropology”\textsuperscript{72} as well as “law and development”\textsuperscript{73} schools of thought, it is pertinent to raise the following questions: how is law related to other aspects of culture and social


organization, especially socio-cultural attitudes to disease and illness? Is it possible to
synthesize behavioural and ethno-medical practices in radically different cultures?
Applying all of these questions by analogy to the Roll-Back Malaria Project as well as
its perceived integration or exclusion of traditional medicine in Africa, this thesis
gives the social scientist useful tools for hypothesis generation and study of health
practices in non-Western societies. Thus lies the contribution of this inquiry to the
social sciences.

An exploration of the vulnerability of multilateralism underscores the gaps and
shortcomings of multilateral initiatives on global public health. From this perspective,
this thesis stands to benefit policy makers in the global multilateral institutions that
serve as incubators of global public health policies - the WHO, the FAO, the
UNICEF, the World Bank, the UNDP. Related to this is policy-making at the regional
and national levels. Although the thesis explores public health from a predominantly
global perspective, global surveillance for diseases and other urgent international
health events would be futile without core capacity and support at national levels. It is
only when humanist-oriented policy initiatives at national levels merge with global
humanist-oriented initiatives that South-North health disparities and unequal
distribution of disease burdens, and the global health divide will be narrowed.

Taken together, the potential contributions to be made by this thesis – to the
academic disciplines, to social science ethnographic study of medical therapies in
Africa where malaria is endemic, and to policy making in multilateral institutions –
combine to diminish the unfair distribution of the global burden of diseases across the
world. In very modest ways, this thesis uses mutual vulnerability of populations to the
threats of disease pathogens in an interdependent and globalizing world as the sine
qua non for the evolution of a humane multilateral health order.
CHAPTER TWO

THE PARADOX OF A GLOBAL VILLAGE IN A DIVIDED WORLD

A: OVERVIEW OF THE ARGUMENT

If health, as the Constitution of the World Health Organisation provides, is “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”¹, then the age-long health divide between the developed and developing worlds deserves pre-eminent attention from scholars and multilateral institutions. Quite paradoxically, global health challenges in the past decades have focused not only on the global health divide, but also simultaneously on the phenomenon of globalisation as a process that integrates nation-states, markets, cultures, and peoples across the world. Never before in history has humanity been so bonded together, and at the same time so sharply divided by underdevelopment, poverty, and an unequal distribution of disease burdens. This paradoxical matrix elicits variegated responses in the scholarship of public health. While there is unanimity of opinion that poverty and underdevelopment breed disease, the impact of globalisation on public health remains controversial and hotly contested. Viewed from one of its simplest positive connotations as a process towards the emergence of a borderless world, globalisation arguably reinforces the global neighbourhood metaphor. In this sense, the complex interaction of globalisation (in some ways the precursor of the emergent global neighbourhood) and development disparities (the precursor of a divided world) provides a good setting for the study of mutual vulnerability – the transnational threats of diseases in an interdependent world.

This thesis argues that either end of the paradoxical matrix spells doom for the health of humankind. Underdevelopment – the end product of poverty and disparities

between countries, breeds diseases and microbial pathogens; and globalisation on the other hand - the product of global commerce, travel and tourism, trade liberalisation, forced and unforced migration - enables disease pathogens to transcend national boundaries with ease. This crisis is not limited to infectious/communicable diseases. The burden of non-communicable diseases on populations as well points to poverty and underdevelopment as leading causes especially in the developing world. The paradox of a global village in a divided world is therefore inseparable from the challenges of public health. Both ends of the paradox affect public health in various ways and have therefore generated certain visible synergistic manifestations. Even within the related concepts of mutual vulnerability and vulnerability of multilateralism, the centrality of this paradoxical underpinning in the relations between nation-states and populations raises issues that are hardly recondite for public health. If, due to underdevelopment, surveillance capacity in a country either does not exist at all or breaks down, any subsequent disease event that emanates as a result of such ineffective national surveillance capacity could easily transcend national boundaries to render populations in distant places vulnerable. Within vulnerability of multilateralism, it is the disparity between the developed and developing worlds that has led to intractable South-North acrimony in most multilateral institutions including the World Health Organisation. The developing world has come to characterise the international system as unfair, inequitable and non-responsive to its developmental and public health needs.

If health, as has been persuasively argued, is a public good then global health policies must necessarily deal with the paradoxical variables of a global

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neighbourhood and those of a divided world, especially the various ways each of them impacts on health of populations. Health, like other global public goods, must meet two conditions. First, its benefits must have strong qualities of 'publicness' as marked by non-rivalry in consumption and non-excludability. Second, its benefits must be quasi universal in terms of countries (covering more than one group of countries), people (accruing to several, preferably all, population groups), and generations (extending to both present and future generations, or at least meeting the needs of current generations without foreclosing development options for future generations). Following these criteria, it is important to explore the extent to which socio-economic disparity between countries in a divided world excludes the 'underdeveloped', 'developing', 'poor' and 'third world' countries from sharing in the beneficial dividends of health as a public good in the global arena. This chapter explores this exclusion from the paradoxical matrix of 'a global neighbourhood and a divided world', and argues that both have contributed in various ways to mutual vulnerability and the vulnerability of multilateralism.

B: A GLOBAL NEIGHBOURHOOD?

The global neighbourhood metaphor describes the increasing and inevitable interdependence of nation-states and populations. Historically, links and contacts between populations for various purposes are as old as humanity itself. But the Peace of Westphalia 1648 - although Euro-centric - marked the evolution of the contemporary multilateral state system. The past fifty years have witnessed a phenomenal emergence of the reinforcing vicissitudes of a global neighbourhood: international airline networks, flows of foreign direct investment, ingenious discoveries in communication technology, ecological tourism, religious pilgrimages,

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international sports festivals, regionalism and free trading blocks, increased migrations, and global trade liberalisation. Each of these events erodes national boundaries and precipitates mutual spread of disease and pathogens.

Scholars, multilateral organisations and policy-makers explore the health implications of these reinforcing phenomena of global interdependence under the rubric of globalisation. Globalisation is variegated and multidimensional. Its multiple dimensions conspire with the uneven multilateral landscape in which it is practised to affect public health in many negative ways. For the majority of humanity to reap the fruits of health as a public good in the global village, there must be utmost respect for neighbourhood values - peace, respect for life and other human rights, lack of institutional and structural violence in the international system, justice and equity, mutual respect and caring, economic security, sustainable development, and access to basic necessities of life by the poor. These values are inexorably linked and interconnected. These linkages compel a further inquiry to see how globalisation has either respected or disrespected neighbourhood values, and how it has consequently impacted on public health. This thesis conducts this inquiry particularly on the human right to health and the health implications of prescriptions given to the developing world by international financial institutions such as the World Bank’s structural adjustment programs.

4 Because of the divergent complexities of globalisation, I will only focus on its health implications within the rubric of what I explore as ‘globalisation of poverty’ including two levels of inquiry that I conduct under that rubric. See infra pp54-71.
C: A DIVIDED WORLD?

The dawn of the twenty-first century is witnessing a polarisation of the world less by geo-political boundaries and ethno-cultural affinities, than by poverty and underdevelopment. Since the 1970s heralded economic disarray in most of the developing world, the gap between developed and developing worlds has widened at an alarming speed. In 1997 the United Nations Development Program (UNDP) reported that “the share of the poorest 20% of the world’s people in global income now stands at a miserable 1.1%, down from 1.4% in 1991 and 2.3% in 1960. It continues to shrink. The ratio of the income of the top 20% to that of the poorest 20% rose from 30 to 1 in 1960, to 61 to 1 in 1991 – and to a startling new high of 78 to 1 in 1994”. In 1998 the UNDP reported the widening gap and disparities not only among countries but also within countries. In 1960, the 20% of the world’s people who live in the richest countries had 30 times the income of the poorest 20%; by 1995 that figure had reached 82 times as much income. Income distribution even within industrialised countries shows disparities between rich and poor. In the worst case, Russia, the income share of the richest 20% is 11 times that of the poorest 20%. In Australia and the United Kingdom it is nearly 10 times as much.

In its World Development Report 1993, which focused on health, the World Bank classified countries into four major categories:

(i) Low Income Economies (including the two most populous countries on earth – India and China as well as most of Africa) with per capita GNPs of about $350 US in 1991;

(ii) Lower Middle Income Economies with per capita GNPs up to $2500 US;

(iii) Upper Middle Income Nations with per capita GNPs up to $3500 US; and
(iv) High Income Nations (mostly OECD countries) with per capita GNPs on average of $21,500. From this projection, it has been argued that about 3.1 billion, well over half of the world's population live in countries in the poorest group. A further 1.4 billion live in the lower-middle-income nations and 630 million in the upper-middle-income nations. About 820 million live in the high-income nations, which are rich in part because of their ability to exploit the resources, such as oil, minerals, and food, of poorer nations. Over eighty percent of the world's people live in nations that collectively have less than twenty percent of the world's wealth and productive capacity.

It is obvious that whatever criteria are used to classify countries, poverty and underdevelopment remain the two most important factors that divide countries and populations. As observed by Guy Arnold, "poverty is the single most important factor dividing the North and South". The term South-North and the dividing line between them has its own difficulties. The South is not socially, culturally and politically homogeneous, neither is the dividing line between the South and North an accurate geographical demarcation between the developing and the industrialised worlds. These differences notwithstanding, South-North has emerged as a popular

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11 Apart from income disparities, multilateral institutions use other criteria to classify countries: Gross National Product (GNP), infant mortality, life expectancy at birth, and Disability Adjusted Life Years (DAILYs).
12 To avoid the controversy that surrounds the use of the terms, 'first world' and 'third world', this thesis prefers the use of the term 'South-North' as a more convenient expression to explore contemporary global disparities. See generally Ivan L Head, On a Hinge of History: The Mutual Vulnerability of South and North (Toronto: The University of Toronto Press, in association with International Development Research Centre, 1991).
expression used in exploring a divided world. In 1990, the South Commission observed,

Three and half billion people, three quarters of all humanity, live in the developing countries....Together the developing countries – accounting for more than two thirds of the earth’s land surface area – are often called the Third World. We refer to them as the South. Largely bypassed by the benefits of prosperity and progress, they exist on the periphery of the developed countries of the North. While most of the people of the North are affluent, most of the people of the South are poor; while the economies of the North are generally strong and resilient, those of the South are mostly weak and defenceless; while the countries in the North are, by and large, in control of their destinies, those of the South are very vulnerable to external factors and lacking in functional sovereignty.14

If all of humanity were to be a single nation-state, the present South-North divide would have made it an ungovernable, semi-feudal entity, split by internal conflicts. A small portion would be prosperous and industrialised while most of it would be poor and under-developed.15 What then are the implications of a world divided by poverty and underdevelopment for global health challenges? How does poverty and underdevelopment impact on the health conditions of the three-quarters of all humanity who live in the South? The WHO Director-General put it succinctly thus, “poverty breeds infections; and infections breed poverty”.16 Poverty, according to the WHO, is the world’s most ruthless killer and the greatest cause of ill health and suffering. It is the main reason why babies are not vaccinated, clean water and sanitation are not provided, curative drugs and other treatments are unavailable, and mothers die in childbirth. Poverty is the cause of reduced life expectancy, handicap, disability and starvation. Poverty is a major contributor to mental illness, stress,

15 Ibid.
suicide, family disintegration, and substance abuse.17 The WHO argues further that "poverty wields its destructive influence at every stage of human life from the moment of conception to the grave. It conspires with the most deadly and painful diseases to bring a wretched existence to all who suffer from it".18

Another consequence of a divided world - global development apartheid - is the unequal distribution of the global burdens of disease on populations within the South and North.19 The current approach of Disability-Adjusted Life Years (DAILYs) quantifies burdens of illness and health risks globally, focusing on health discrepancies in various regions of the world. What emerges from this quantification of diseases and risks is that cumulatively the countries of the South lag behind those of the North. Risks harmful to health and the endemic nature of certain diseases that confront populations in the South abridge their life expectancy, increase the burdens of disease on them, and significantly impact on the quality of life they live.20 To give one basic example, a person who is born in Uganda, lives and dies there at 50 and was struck by malaria and other tropical diseases many times before his21 death, cannot be said to have lived 50 healthy years. Comparing the life of this Ugandan with a Canadian who lived for the same 50 years in Canada without the burdens of malaria and other tropical diseases, the quality of lives lived by both of them is not likely to be the same. A heavier disease burden may have impacted negatively on the quality of

18 Ibid.
19 The World Health Organisation, World Bank and the Harvard School of Public Health have jointly commissioned the global burden of disease study: a comprehensive assessment of mortality and disability from diseases, injuries, and risk factors in 1990 and projected to 2020. Measuring the disease burden by mortality and morbidity using Disability Adjusted Life Years DAILYs, the study divided the world into eight regions: established market economies (EME), formerly socialist economies of Europe (FSE), India, China, Other Asia and Islands, Sub-Saharan Africa, Latin America and the Caribbean, and Middle Eastern Crescent. See generally, The Global Burden of Disease and Injury Series, CJL Murray & A. Lopez (eds.), (Geneva: WHO, 1996).
20 Ibid.
21 I use "his", "her", "she" and "he" all through this thesis not in a gendered sense but generically.
life of the Ugandan, so much that it would be epidemiologically fallacious to say that he lived 50 healthy years. While the Canadian may have lived 50 healthy years or close to that, a heavier disease burden in Africa may have abridged the Ugandan’s healthy life-years from 50 to 35. This is not to suggest that the burden of such diseases like cancer, Alzheimer’s, flu, diabetes, sexually transmitted diseases, respiratory infections, cerebro-vascular and cardiovascular diseases, and the risk of such habits and injuries as tobacco use and road accidents do not impose heavy disease burdens on populations in the North. Rather this thesis argues that, comparatively, diseases that are endemic in most of the global South - malaria, American trypanosomiasis (chagas disease), African trypanosomiasis (sleeping sickness), dengue, onchocerciasis (river blindness), lymphatic filariasis, guinea worm, to name just a few - impose far heavier burdens on populations in the global South.

The WHO has identified the health implications of living in a divided world as an inequity that should stir the conscience of the world. According to 1993 calculations, a person in one of the least developed countries has a life expectancy of 43 years. In one of the most developed countries, it is 78 years. That is a difference of more than a third of a century. As of 1995, in a space of a day, passengers flying from Japan to Uganda leave the country with the world’s highest life expectancy – almost 79 years – and land in the one with the world’s lowest – barely 42 years. A flight from France to Cote d’Ivoire takes only a few hours, but in terms of life expectancy, it spans almost 29 years. A short air trip between Florida in the USA and Haiti represents a life expectancy gap of over 19 years. It is in the context of this South-North disparity that the health implications of globalisation and efforts to close the

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Supra note 9 at 2.
widening South-North gap will be discussed. Using this inquiry's paradoxical matrix of global neighbourhood in a divided world, the meaning, historical evolution and role of globalisation in the development of the South will be questioned in what I explore as globalisation of poverty, and two subsequent levels of inquiry made under it.

D: GLOBALISATION OF POVERTY: TWO LEVELS OF INQUIRY ON PUBLIC HEALTH AND SOUTH-NORTH DISPARITIES

As already stated, globalisation is complex and multi-dimensional. It means different things to different people in different places, and its scope and historical antecedents lie in the particular eyes of the beholder. The link between globalisation and health is even more complex. According to Yach & Bettcher,

the link between the lives of individuals and the global context of development is evident in another face of globalization, an often forgotten one: global health futures are directly or indirectly associated with the transnational economic, social, and technological changes taking place in the world. As a result, the domestic and international spheres of public health policy are becoming more intertwined and inseparable.

Similarly, Lee & Dodgeson observed that “an understanding of the linkages between globalization and health depends foremost on one’s definition of globalization and precise dating of the process”. There is an overwhelming literature indicating that the emergence of certain processes significantly erodes national boundaries, and as a result the sovereign state is incapable of controlling what occurs within its geo-

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political boundaries. These processes, which scholars explore as globalisation, encompass a breadth of issues: markets and trade liberalization, environment, culture, travel and tourism, information, computers, and telecommunications. The controversies of the meaning and definitional scope of globalisation are as formidable as the controversies of its precise dating. Here there are two competing schools - the ‘recent’, and the ‘ancient’. According to the recent school, globalisation is a concept of the 1990s propelled by the global nature of the activities of multinational corporations. In an introduction to a book, Ray Keily observed that,

The 1990s have seen a boom in writing about globalisation. According to one sociologist, .. .it is the concept of the 1990s, a key idea by which we understand the transition of human society into the third millennium.... Much of the debate surrounding globalisation has been extremely abstract. There is often a lack of clarity in definitions of the term, its novelty and how it is experienced by people throughout the world.

The ancient school argues that notwithstanding the emergence of new globalising forces in the global scene in the last one or two decades, globalisation has historical roots from the fifteenth century. If globalisation - as this thesis argues - connotes vulnerability of national boundaries, then the historical antecedents of trans-boundary impact of diseases makes the contention that globalisation ‘is the concept of the

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26 Lee & Dodgeson, define globalization as “a process that is changing the nature of human interaction across a range of social spheres, including the economic, political, social, technological, and environmental. This process is globalizing in the sense that many boundaries hitherto separating human interaction are being increasingly eroded. These boundaries – spatial, temporal, and cognitive – can be described as the dimensions of globalization” Id. at 215. According to David P. Fidler, “globalization refers to processes or phenomena that undermine the ability of the sovereign state to control what occurs in its territory”. See “The Globalization of Public Health: Emerging Infectious Diseases and International Relations” 1997 Vol.7 Ind. J. of Global Leg. Stud. 11. Gordon R. Walker & Mark A. Fox argued that “the key feature which underlies the concept of globalization ... is the erosion or irrelevance of national boundaries in markets which can truly be described as global”, G.R Walker & M.A Fox, “Globalization: An Analytical Framework” (1996) 3 Indiana Journal of Global Legal Studies 375.

27 See Fidler ibid; G. Walker & M.A Fox ibid.


1990s' less persuasive. In his account of the plague that ravaged Athens during the Peloponnesian War in 430 BC, Thucydides wrote that;

the plague first originated, so it is said, in Ethiopia above Egypt and then descended into Egypt and Libya and much of the Persian Empire. It fell suddenly upon Athens and attacked in the first instance the population of the Piraeus....Later it also arrived in the upper city and by this time the number of deaths was greatly increasing. The question of the probable origin of the plague and the nature of the causes capable of creating so great an upheaval, I leave to other writers, with or without medical experience....I caught the disease myself and observed others suffering from it.\(^{30}\)

The place of globalisation in South-North disparities and socio-economic inequalities among countries are hardly supportive of the argument that it is the concept of the 1990s. To come to terms with the root causes of contemporary global inequalities, questions must be asked about how globalisation – the erosion or vulnerability of national boundaries – affects the process of development, and consequently impacts on human health. From its simpler meaning to its diverse theoretical and practical complexities in the 1990s, globalisation is implicated in the hegemonic foundation of international law and relations among nation-states (civilised world) and the so-called primitive or uncivilised societies.\(^{31}\) It is an age-old systematic institutionalisation of polarisations, which came to climax in the 1990s through ingenious discoveries in communications and computer technology, massive flow of capital across national boundaries, and the colossal influence of multinational corporations with complicated global networks; global networks that have continued to globalize poverty. Because


\(^{31}\) I explore this argument in detail in subsequent chapters where I discuss the origin of multilateral co-operation in the field of public health. See *infra* Chapters Three and Four.
respect for human rights and dignity, especially the right to health, is one of the global neighbourhood values, and because underdevelopment and poverty impact on human health in a variety of ways, it is pertinent to understand how these emergent global forces have continued to globalize poverty. The double-edged inquiry that follows focuses on human right to health and development prescriptions by international financial institutions, and the various ways they affect human health in a divided world.

D(I): GLOBALISATION OF POVERTY AND THE HUMAN RIGHT TO HEALTH

There are two main reasons why the right to health deserves scholarly attention in connection with globalization of public health. The first relates to the obligation undertaken by State Parties to the International Covenant on Economic, Social and Cultural Rights (ICESCR) 1966 to “take steps individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources”, to realise the rights enumerated in ICESCR. The second reason - which is related to the first – involves the express provisions of international conventions on the right to health that recognise the financial and economic needs of developing countries. One example is the United Nations Convention on the Rights of the Child, which provides in Article 24(4) that in striving to realise the rights of children, states shall take “particular account...of the needs of developing countries”.

32 I am interested in the human right to health less from the intense debate by the schools of universalism and cultural relativism, but more from the impact of poverty and underdevelopment on an effective articulation of a viable right to health in international law.
The relevance of these approaches lies in the socially and economically holistic definition of health offered by the constitution of the World Health Organisation\textsuperscript{35} as well as in the impact of underdevelopment on human health. Taken together, these two factors point to the importance of economic development and financial resources to the realisation of right to health. Unfortunately, the right to health -and by extension all economic, social, and cultural rights- have been treated peripherally by policy-makers and multilateral institutions\textsuperscript{36}. To many, they are not rights but lofty wishes and mere statements of idealistic social desires. To others, they exist textually as ‘soft law’ but are so all-encompassing, indeterminate and vague that their actual meaning and contents are difficult to articulate. Tomaseveski argues that Article 12 of the ICESCR, which provides for the right to health, is imprecise and vague because “guaranteed access to health care services for all people remains an issue of disagreement. There is no agreement on the specific obligations of States in providing access to health care to all of its population, let alone whether it is obliged to undertake the provision of health care services at all”\textsuperscript{37}. It is difficult to overlook the imprecision that has characterised international normative provisions on health as a human right. A number of reasons can be advanced to explain why the human right to health (and most other economic, social and cultural rights) has been relegated to irrelevance and impotency. The first is the subordination of economic, social, and cultural rights to civil and political rights. Civil and political rights are frequently referred to as 'first generation' human rights, while economic, social and cultural


\textsuperscript{36} B. Toebes, “Towards an Improved Understanding of the International Human Right to Health” (1999) 21 Human Rights Quarterly 661 (arguing that although it is often asserted that all human rights are interdependent, interrelated, and are of equal importance, in practice, Western states and NGOs have tended to treat economic, social, and cultural rights as if they were less important than civil and political rights).

rights – including the right to health - are 'second generation' rights. Although the
fist/second generation distinction does not reflect a hierarchy of importance, it means
that civil and political rights are ‘first in time’.

The second reason relates to the way human rights have been construed in
Western liberal democracies, which unduly emphasise justiciability predicated on an
individual making a claim against the state, before a court or tribunal, seeking redress
for the violation of her rights. This construction raises the question whether a person
can prosecute a claim in a court or tribunal against the state based on the state’s
failure to guarantee him access to conditions necessary for health protection and
promotion.\(^38\) Put another way, the state is incapable of guaranteeing access to good
health to all of its citizens. Thus, the litmus test for any claim to qualify as a human
right is ‘justiciability’. A further reason relates to a glaring misunderstanding and
confusion among scholars on the meaning of such concepts as health, health care,
health services and medical services.\(^39\) In response to most of these contentions, a
persuasive literature has emerged from a formidable league of scholars aimed at
giving the right to health a concrete meaning in the international legal order.\(^40\)


way to think about human rights should de-emphasise justiciability and stress human dignity, indivisibility and interdependence of all human rights — civil, political, economic, social, and cultural.\(^{41}\) Of what relevance is voting in an election or enjoying freedom of expression (civil and political rights) to a woman in a rural village in Mozambique, Guatemala, or Burundi who is sick but cannot afford to buy aspirin? Does freedom of association mean anything to a man who, together with his family, is malnourished and cannot afford basic food, housing and health care? Indivisibility and interdependence of all human rights and a strong emphasis on human dignity, are the starting points for a re-conceptualisation of the right to health. Leary has developed seven key elements for a rights-based perspective on health. These include assertions that:

(i) conceptualising something as a right emphasises its exceptional importance as a social or public goal (rights as "trumps"),\(^ {42}\)

(ii) rights concepts focus on the dignity of persons;

(iii) equality or non-discrimination is a fundamental principle of human rights;

(iv) participation of individuals or groups in issues affecting them is an essential aspect of human rights;

(v) the concept of rights implies entitlement;

(vi) rights are interdependent;

\(^{41}\) For a recent intellectual account of these linkages and connectedness from development perspective, see Amartya Sen, Development as Freedom (New York: Anchor Books, 1999) stating, \textit{inter alia}, that the constitutive role of freedom relates to the importance of substantive freedom in enriching human life. The substantive freedoms include elementary capabilities like being able to avoid such deprivations as starvation, under-nourishment, escapable morbidity, and premature mortality, as well as the freedoms that are associated with being literate and numerate, enjoying political participation and uncensored speech.

\(^{42}\) Here she follows Ronald Dworkin's theory of rights as expounded in Taking Rights Seriously (Cambridge: Harvard University Press, 1978). Dworkin argued that when something is categorized as a right, it trumps up other claims or goods). Leary argues that the use of rights language in relation to health emphasizes the importance of health and health status. It does emphasize that health issues are of special importance given the impact of health on the life and survival of individuals. Leary, "The Right to Health in International Human Rights Law" (1994) 1 Health & Human Rights at 36.
(vii) rights are almost never absolute and may be limited, but such limitations should be subject to strict scrutiny.\(^{43}\)

In the same vein, Lawrence Gostin and Jonathan Mann proposed a human rights impact assessment for the formulation and evaluation of public health policies.\(^{44}\) This proposal would enable public health practitioners, human rights advocates, and community workers to explore the human rights dimensions of public health policies, practices, resource allocation decisions, and programs. The process includes a clarification of the public health purpose, an evaluation of the likelihood of the effectiveness of the policy, the target of the particular public health policy (including the risks of either over-inclusion or under-inclusion), and an examination of the proposed public health policy for possible human rights burdens.\(^{45}\) How then would the human rights burdens of public health policies be measured? Three important factors to be considered include the invasiveness of the intervention, the frequency and scope of the infringement, and the duration of the public health policy.\(^{46}\)

Beyond indivisibility and interdependence of all human rights, which represent the minimum core content of the right to health, governmental regulatory failures either to adequately address health hazards or provide access to basic health

\(^{43}\) V. Leary, *ibid.* The work of the United States based Physicians for Human Rights underscores the interdependence of all human rights. For instance, detention under inhuman conditions or torture inevitably affects the health of the person(s) detained or tortured. For a documentation of these linkages by the Physicians for Human Rights, see *The Taliban’s War on Women: Health and Human Rights Crisis in Afghanistan* (Boston/Washington DC: Physicians for Human Rights, 1998); *Human Rights and Health: The Legacy of Apartheid*, A. Chapman & L. Rubenstein (eds.), (New York: American Association for the Advancement of Science & Physicians for Human Rights, 1998) (discussing deaths in detention, racial discrimination in the health sector, and segregation in medical education under the apartheid system in South Africa).


\(^{45}\) *Ibid.*

\(^{46}\) *Ibid.*
services and information, have been identified as “a pattern of concentric circles” of the scope of the right to health. These concentric circles encompass governmental failures to regulate adequately public and private activities that pose threats to human health, failure to provide access to basic health services and information, and governmental responsibility to provide access to basic factors that affect health. As these emerging perspectives show, enormous efforts have been made to concretise the contents of the right to health in international law. Any inquiry aimed at unmasking the reason(s) why these efforts are still largely marginalized and peripheral in international policy-making would inevitably indict the current international system that has failed to adequately empower the United Nations Committee on Economic, Social and Cultural Rights to do its job effectively. Philip Alston, former Chair of the Committee summarised his frustrations in a detailed commentary:

The UN Commission on Human Rights devotes about five percent of its time to economic and social rights issues: other human rights bodies usually ignore them. The only body mandated to do work in this area, the UN Committee on Economic, Social and Cultural Rights, was established in 1987 on the implicit condition that it be ineffectual and inactive...As the Committee’s Special Rapporteur, I am keenly aware of its problems....We receive little institutional support from anyone. The UN secretariat provides only rudimentary clerical help; I myself typed about half of our report for lack of a secretary with word processing experience.

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47 See David P. Fidler, “International Law and Global Public Health”, supra note 40 at 40.
48 See the decision of the Inter-American Human Rights Commission in the case of the Yanomami Indians Case 7615, Inter-American Commission on Human Rights 24 OEA/Ser.L/iv/11.66, doc.10 rev.1 (1985). The Commission ruled that the Brazilian government’s road construction project in the Amazon violated the right of the Yanomami Indians to preservation of their health as enshrined in Article XI of the American Declaration of Human Rights. In permitting the massive penetration into the Indians’ territory of outsiders carrying contagious diseases that have infected the Indians and its failure to provide essential medical care to the affected Indians, the government of Brazil violated the right to health of the Yanomami Indians.
49 The World Health Organisation’s primary health care and its 1977 Alma-Ata Declaration on Health for All provides one benchmark against which to evaluate a government’s provision of basic public health services and information. WHO’s Health for All policy stressed public health education on prevention and control of diseases, adequate food and nutrition, safe water supplies and basic sanitation, maternal and child health, immunization against major infectious diseases, prevention and control of endemic diseases, appropriate treatment for common diseases and injuries, and provision of essential drugs. See Fidler, supra note 40 at 45 citing A.L Taylor, “Making the World Health Organisation Work: A Legal Framework for Universal Access to the Conditions for Health” (1992) 18 Am. J. of Law & Medicine 301 at 315.
50 Basic factors affecting health would include other social, economic and cultural rights affecting the right to health – education, housing, safe working environment, food and nutrition.
The International Labour Organisation and the World Health Organisation observe Committee sessions from time to time, but neither group has made a single serious contribution to its work. The Committee lacks expertise. The membership consists of attorneys general and diplomats who are nominated and elected and arrive at their positions through the spoils system – the prestige of a seat on the Committee, six weeks a year in Geneva (expenses paid). Of the eighteen elected members, only some are capable of a real contribution...51

If the right to health remains vague and indeterminate, it is not because it means nothing. It is rather because nation-states in the contemporary international system continue to stultify its progressive development by intentionally creating enforcement mechanisms that lack the capacity to articulate a practical human right to health.52

The UN Committee on Economic, Social and Cultural Rights has maintained its tradition of regular issuance of ‘general comments’ on state obligations under the right to health. Its most recent general comment is arguably ambitious and holistic.53

It states that the right to health is closely related to and dependent upon the realisation of other human rights as contained in the “International Bill of Rights”.54 These include the rights to food, housing, work, human dignity, life, non-discrimination, equality, prohibition against torture, privacy, access to information, and the freedoms of association, assembly and movement.55 General Comment NO.14 calls for coordinated efforts towards the realisation of the right to health to enhance interaction among all relevant actors including various components of civil society. Relevant

52 For a critique of the weak enforcement regime of human rights in international law generally, See Makau wa Mutua, “Looking Past the Human Rights Committee: An Argument for De-Marginalizing Enforcement” (1998) 4 Buffalo Human Rights Law Rev. 211 (arguing that many official international human rights bodies such as the Human Rights Committee are weak, timid and ineffectual).
55 “The Right to the Highest Attainable Standard of Health” (General Comment No.14), supra note 53.
international organisations – WHO, ILO, UNDP, UNICEF, UNFPA, the World Bank, regional development banks, IMF, WTO, and other bodies within the UN System – should co-operate effectively with States parties, building on their respective expertise, in relation to the implementation of the right to health at national levels. In particular, the international financial institutions, notably the World Bank and IMF, should pay greater attention to the protection of the right to health in their lending policies, credit agreements, and structural adjustment programmes. Although commendable for its vision and coverage, it is highly debatable whether General Comment No. 14 can radically change the behaviour of states with respect to their obligation under the right to health. Pessimism still looms large because many critically important issues remain unresolved. Conspicuous among these issues is the wealth disparity between states. Does the financial, technical and economic handicap of most developing countries hinder the realisation of the right to health? If answered in the affirmative as most scholars suggest, then what is the extent of an obligation (if any) owed by the rich and industrialised states under international human rights law to commit financial and economic resources toward the eradication of disease or promotion of health in a developing country? Does Article 2 of the International Covenant on Economic, Social, and Cultural Rights contemplate that countries have obligation(s) to aliens abroad? Amir Attaran put the question succinctly thus: Are States obliged to promote health abroad? International lawyers who are still trapped within the ‘decaying pillars’ of the Westphalian international system founded

56 Ibid.
57 A. Attaran, “Human Rights and Biomedical Research Funding for the Developing World: Discovering State Obligations Under the Right to Health” Vol.4 No.1 Health and Human Rights 26
58 The Treaty of Westphalia 1648 which ended thirty years of wars in Europe, reversed the subordination of European civil authorities to the Holy See, and led to the emergence of nation-states, is often cited by international scholars as the normative foundation of the modern international system. For an articulation of emerging global issues which threaten to dislocate a rigid state-model international system, see Mark W. Zacher, “The Decaying Pillars of the Westphalian Temple: Implications for International Order and Governance”, in Governance Without Government: Order and
strongly on relations between nation-states argue that such an obligation offends state sovereignty. Louis Henkin, a progressive and liberal-minded international scholar, has indicted the Westphalian state system that continues to use ‘the sword’ of state sovereignty against promotion of human rights abroad,

the failure of the international human rights movement to address the responsibility of a state for human rights of persons in other states may reflect only the realities of the state system. States are not ordinarily in a position either to violate or to support the rights of persons in other states. States are reluctant to submit their human rights behaviour to scrutiny by other states; states are reluctant to scrutinize the behaviour of other states in respect of their own inhabitants; surely states are reluctant to incur heavy costs for the sake of rights of persons in other countries...59

Although this view represents the ‘realities of the state system’, it seems antithetical to Article 2 of the International Covenant on Economic, Social and Cultural Rights that mandates states to take steps individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realisation of economic and social rights enshrined in the covenant. Is there an escape route from an extreme view of state sovereignty insofar as the vexed question of international assistance comes within the purview of Article 2 of ICESCR? Although this question raises a serious conundrum, it has nonetheless been answered in the affirmative by a sizeable number of commentators and multilateral institutions. A good scenario, according to Attaran, is where the resources and management employed to meet international obligations are wholly domestic and located within the donor-state.60 Henkin has argued persuasively that a rigid notion of state sovereignty can be circumvented in some

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60 A. Attran, supra note 57 at 35.
ways. A logical extension of this proposition is that an industrialised state is obligated to devote a certain percentage of its resources to - for instance - commission research that would target the health problems of inhabitants of another country that may be poor. While I endorse this view, I do not suggest that all is well with the language of Article 2(1) of the International Covenant on Economic, Social and Cultural Rights. The undertaking by a state party to,

\[
\text{take steps \ldots to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present covenant,}^{62}
\]

is vague, verbose and too encompassing. As argued by Robertson, “maximum of its available resources”, is a difficult phrase of two warring adjectives describing an undefined noun. “Maximum” stands for idealism and “available” stands for reality. “Maximum” is the sword of human rights rhetoric; “available” is the wiggle room for the state. The vagueness of this provision has offered an escape route to States Parties to the ICESCR, thus leading to the unfortunate conclusion that the right to health is an illusion. Virginia Leary remains one of the few legal scholars who persistently argue that Article 2(1) of the ICESCR can be interpreted ingeniously to give some meaning to it. This is without prejudice to the fact that it could be re-drafted in more practical language. All countries, Leary argues,

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61 Henkin, supra note 59 at 45 argues that wealthy states are morally obligated and should be legally obligated to help the poorer states to give effect to some socio-economic rights — rights to food, housing, education, health-care, and an adequate standard of living — merely through financial aid and without forcible intervention. See also, M.C.R Craven, The International Covenant on Economic, Social and Cultural Rights: A Perspective on Its Development (Oxford University Press, 1995) 376.
64 Leary, supra note 39 at 46.
have at least some "available resources"—even if severely limited in comparison with other countries. Hence, under the Covenant, all ratifying States are obligated to respect the right to health, regardless of their level of economic development. The same paragraph of the Covenant also refers to the possibility of States calling upon international assistance to achieve the respect for the right to health.  

Although Robertson's argument that the noun "resources" is undefined under the ICESCR can hardly be faulted, the pertinent question is whether the perceived vagueness surrounding the provisions of the ICESCR can be circumvented if we shift the focus, locus and paradigm of the right to health discourse from the ICESCR to other international normative or even soft-law mechanisms. This question stems from the perceived failure—in most of the developing world—of the 1978 WHO-UNICEF Alma-Ata Declaration on Health for All by 2000 (Alma-Ata declaration). In other words, since the provisions of the Alma-Ata Declaration are unambiguous, why did it fail to improve the health of populations mostly in developing countries? Although the answer is complex, the failure to realise Health for All by 2000 in most of the developing world raises the vexed question of resource transfer from rich to poor countries. The failure of 'resource transfer' frustrated the Alma-Ata Declaration, which to date remains one of the most pragmatic articulations of global health challenges including right to health discourse. The Pan-American Health Organisation (PAHO) observed that "the goal of Health for All by the year 2000 is...the most concrete and useful definition of the programmatic social right to health protection, and may more succinctly express the common view of the responsibility of the state for the health of its people."
An exploration of the right to health in global health scholarship, as this inquiry tries to do, reveals one undeniable fact: that wealth disparities between countries have stymied efforts to tackle global health challenges. The Alma-Ata Declaration captured these disparities in the following terms,

The existing gross inequality in the health status of the people between developed and developing countries as well as within countries is politically, socially and economically unacceptable, and is therefore of common concern to all countries.\textsuperscript{68}

The inability of the international system to narrow the development gap between the South and the North not only frustrated the ideals of the Alma-Ata Declaration, but also of pragmatic efforts to articulate a viable human right to health. In sum, I argue that this is one way through which the international system has continued to globalise poverty, which intentionally or accidentally exacerbates inequalities and avoidable turbulence within the global neighbourhood. The next level of inquiry focuses on yet another medium of resource transfer aimed at fostering development in the South—Structural Adjustment Programs—and their implications for the health of populations in the recipient countries.

\textbf{D(II): GLOBALISATION OF POVERTY, STRUCTURAL ADJUSTMENT PROGRAMS AND PUBLIC HEALTH IN THE GLOBAL SOUTH}

Structural Adjustment Programs (SAPs) prescribed by international financial institutions (IFIs) – the World Bank and the International Monetary Fund (IMF) – for most developing countries became intensely controversial in the 1990s.\textsuperscript{69} SAPs involve an economic liberalisation scheme founded more on market forces and strong private sector participation, and less on government intervention in the provision of social services. In particular, SAPs involve the removal of barriers to exports and

\textsuperscript{68} Declaration of Alma-Ata, \textit{supra} note 66.

\textsuperscript{69} David P. Fidler, “Neither Science Nor Shamans: Globalization of Markets and Health in the Developing World” (1999) 7 Indiana Journal of Global Legal Studies 191 at 204-206; David P. Fidler,
imports as well as an increased foreign investment in the economies of the developing world. As stated by Cleary, SAPs are closely identified with the ideological belief in the superiority of the market over economic planning.\textsuperscript{70} SAPs are rooted in an almost mystical faith in the private sector, which operating under freer domestic and external market conditions will provide the motive and power for a resumption of growth and development.\textsuperscript{71} The ideology of SAPs is, therefore, a revival of economic liberalism with market-oriented strategies, free-trade, and a minimal state intervention as its key elements.\textsuperscript{72} The controversy surrounding SAPs, particularly their linkage with poverty and public health in the developing world, has polarised scholars who have analysed SAPs from diverse disciplines – political science, economics, law and public health. A recent study argued that there is no conclusive evidence that SAPs cause poverty.\textsuperscript{73}

The divergence of scholarly opinions underscores the complexities of SAPs, and makes any attempt to analyse the interaction of SAPs and public health in the developing world a difficult task. To give a balanced view therefore, it is important to explore the pros and cons of SAPs, their implementation, and perceived impact on public health. Advocates of SAPs maintain that there is no alternative to SAPs and that adjustments have resulted in the stabilisation of most economies so that these countries can now repay their debt to IFIs. The recipient countries of SAPs are now able to restore credit, attract foreign investment, and reverse unsustainable economic


\textsuperscript{71} B.K Campbell & J. Loxley, eds., \textit{Structural Adjustment in Africa} (Hampshire, UK, Palgrave, 1989) 41.

\textsuperscript{72} D. Simon, \textit{supra} note 70 at 3.

policies that compelled the prescription of SAPs in the first place. It is undeniable that
the prescription of SAPs has a noble objective of propping up ailing economies
through sustainable economic policies. However, their implementation have led to
difficult socio-economic problems as a result of cuts in social programs: public health,
education, housing, and jobs. Michel Chossudovsky calls this “economic genocide”,
by which he means “a conscious and deliberate manipulation of market forces by
global institutions” – World Bank, IMF and World Trade Organisation (WTO). SAPs affect the lives of more than four billion people in the global South and
Chossudovsky observed that “this new form of economic domination – a form of
market colonialism – subordinates people and governments through the seemingly
‘neutral’ interplay of market forces”. The cumulative end result of the multiple
dimensions of SAPs, according to Chossudovsky, has been the collapse of internal
purchasing power, disintegration of families, closure of schools and health clinics, and
the denial of the right to primary education to millions of children. In many regions of
the developing world, World Bank reforms have precipitated the resurgence of
infectious diseases including tuberculosis, malaria, and cholera. In other
development prescriptions outside the boundaries of SAPs, IFIs are now confronted
with a strange paradox – the World Bank’s mandate of “combating poverty and
protecting the environment” and its support for large-scale hydroelectric and agro-
industrial projects. These projects speed up the process of deforestation, and the
destruction of natural environment, leading to the forced displacement and eviction of
several million people in the developing world.

ed., Negotiating Structural Adjustment in Africa (New York: UNDP, 1994); R. Lensink, Structural
74 Chossudovsky, ibid at 37.
75 ibid.
76 ibid.
77 ibid.
From the perspective of public health, especially, the epidemiology of infectious diseases, the adverse health effects of unsustainable development is underscored by the ‘balance model’ used by epidemiologists to study the emergence and re-emergence of infectious diseases. It refers to the interaction of three forces: agent (A), host (H), and environmental (E) factors. The balance model is based on the prediction that if a disease agent’s infectious ability increases, or its ability to survive becomes more efficient, epidemic outbreaks of illness will occur, even if all else among the three factors remain unchanged. Also included in the factors that precipitate disease in the interaction of these three forces are the modification of the host’s ability to resist disease (e.g. malnutrition, mass starvation, famine), and the modification of the environment (e.g. unsustainable construction of dams) to make it more conducive for infectious agents to develop and survive.\(^78\) Using the balance model, the World Health Organisation, for instance, observed that the alteration of the environment through the unsustainable construction of hydro-electric dams in China, Egypt, Ghana, and Senegal has led to an increase in *schistosomiasis* outbreaks.\(^79\) The public health implications of SAPs and similar development prescriptions by IFIs have become the subject of powerful critiques by leading scholars of humane world order. Richard Falk characterises contemporary market-driven global civilisation as having fallen victim of the logic of global capital; indifferent to the plight of the poor and jobless; insensitive in the face of oppression and exploitation; irresponsible with

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respect to the environment; and complacent about the crisis of sustainability that will be bequeathed to future generations born in the twenty-first century.\textsuperscript{80} Thus,

The current ideological climate, with its neo-liberal dogma of minimizing intrusions on the market and ‘downsizing’ the role of government in relation to the provision of public goods that compose the social agenda, suggest that the sort of global civilization that is taking shape will be widely perceived, not as a fulfilment of a vision of unity and harmony, but as a dystopian result of globalism-from-above that is mainly constituted by economistic ideas and pressures.\textsuperscript{81}

Acknowledging that the implementation of SAPs have not been as successful as intended, the World Bank stated that future strategies should include a “continuous pursuit of adjustment programs, which should evolve to take fuller account of the social impact of the reforms, of investment needs to accelerate growth, and of measures to ensure sustainability.”\textsuperscript{82} The indictment of SAPs as hurting the poor and as “globalism-from-above” maps the road for alternative approaches. Because most scholarly discourse on Third World development has been characterised as unnecessarily reactive in nature and deconstructive in scope,\textsuperscript{83} I will adopt an approach that synthesizes ‘deconstruction/reaction’ with ‘reconstruction’. The relevance of this approach in the global health domain stems from the need to narrow South-North disparities and reduce the persistent unequal global distribution of burdens of diseases between developed and developing worlds. The next part explores ways to narrow the ‘South-North health gap’ from relevant schools of thought in law.


\textsuperscript{81} Ibid.


\textsuperscript{83} See Karin Mickelson, “Rhetoric or Rage: Third World Voices in International Legal Discourse” (1998) 16 \textit{Wisconsin International Law Journal} 353 (asserting \textit{inter alia} that to the extent that a broader Third World approach to international law is recognized at all, it is ordinarily characterized as essentially reactive in nature).
Development is a concept that means different things to different people in different disciplines. As I have argued, one of the major criticisms of SAPs is that they are hostile to their host environments. They are prescriptions from a hierarchical paradigm and therefore alien to the social, economic, and cultural context of their recipient countries. This raises a number of questions, which many disciplines—law, political science, anthropology, economics, and sociology—are bound to answer in different ways. In the global arena, the concept of development acquires more complexity and elusiveness because of the strategic interests of nation-states fuelled by myopic protectionism and hard-nosed realism, as well as the acrimonious tone of the South-North debate on global issues in multilateral forums. Does it then mean that the concept of development is completely elusive? Viewed from global health challenges, the answer is clearly in the negative. It is now widely accepted that development in the global health context connotes such inexorably linked conditions as “peace, shelter, education, food, income, stable eco-system, sustainable resources, justice and equity.” Thus, “development is a process intended to better socio-economic conditions and to contribute to human dignity.” The goals of development—through the reduction of poverty—therefore, are to contribute to social, economic,


and political enrichment within a society and so reduce the likelihood of conflict within and among societies. The WHO Director-General argues that the road out of the vicious cycle of poverty, infection and illness begins with efforts that contribute to a person’s ability to meet basic needs. The problem does not end with having a working definition or an idea of what development entails. Definition may indeed be a means to an end, and not an end in itself. The real problem is that since the South-North health divide is intertwined with development, and development is a variegated concept from multidisciplinary perspectives, how then do we study different societies to ensure that development processes (including SAPs) are not hostile to public health? Put another way, how can development be humane within the context of global multiculturalism, diversities and medical pluralism across societies? If market-driven global civilisation, as Richard Falk argues, is “a dystopian result of globalism-from-above”, then the solution lies in exploring ways to adopt a bottom-up approach: globalisation-from-below. This would, inter alia, involve an effective integration of sustainable indigenous practices in the development process.

Although lawyers have studied these issues peripherally, seminal works from the schools of comparative law, law and development, and law and anthropology provide some useful legal insights. As Laura Nader put it:

while I do not believe that we can adopt a wholesale Western jurisprudential categories of law for use in non-Western cultures, it is possible that we could explicitly state that we are using an outline of Aglo-American common law, for example, against which or from which we view exotic legal systems. At least we would be clear about what our biases were.

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86 Ibid.
87 Gro Harlem Brundtland, “A Call for Healthy Development”, supra note 16 at 66.
88 Supra note 81.
Theorists of law and development remind us that theories of modernisation and dependency appear to reflect the ideological hegemony of Western capitalism and the dominant forces of contemporary imperialism. These theories assume that the developing world must necessarily follow a path roughly similar to that of the developed capitalist countries. Back in 1972, David Trubek argued that the so-called “core conception of modern law” has misdirected the study of law and development by asserting that only one type of law – that found in the West – is essential for economic, social, and political development in the Third World.

These legal theoretical perspectives are in pari-materia with emerging views in mainstream economics. With respect to SAPs and African economies, economists have moved from scholarship of reaction and deconstruction to an elaborate articulation of “African perspectives on adjustment”. In sum, the canons of this school of thought underscore the need, among others: to (i) make policy design sensitive to each individual country’s historical and initial conditions; and (ii) to evolve a sound policy framework to address the fundamental crisis of poverty and underdevelopment, and enable Africa to compete in a globalised world. To achieve this however, the state cannot be reduced to a passive entity as the World Bank insists. Rather, decisions, consultations, and debate are needed to identify sectors that

could yield long-term comparative advantages for African countries. It seems that the World Bank has begun to acknowledge the relevance of these emerging perspectives. In one of its numerous reports, the bank observed that “development practitioners from the North have often prepared programs for the South without the participation of local officials....These programs often inspire little commitment from the countries involved and as a result have often been ineffective”.

Taken as whole, alternatives to contemporary global development policies, whether in law or economics, underscore the need to re-design policies that would be sensitive to local conditions. In this regard, one issue that is critically important to this thesis is the interaction of traditional malaria therapies prevalent in African societies and malaria control policy of multilateral institutions. Can these traditional medical practices be synthesised with Western medicine vis-à-vis WHO’s ongoing campaign against malaria? Applying all of this to the South-North health divide, the need to evolve a humane multilateral health order remains a necessity that holds a certain promise towards the realisation of public health as a global public good.

**Summary of the Arguments: Are We Still in a Global Neighbourhood?**

This chapter argued that all of humanity is inexorably bonded by the values of human dignity that transcend geo-political and ethno-cultural boundaries. In our time and age, these bonds have continued to decay as a result of vicious forces of poverty and underdevelopment. Our contemporary international society where eighty percent of the world’s population is confined to the penitentiary of poverty, malnutrition, underdevelopment, food insecurity, inadequate housing, and environmental pollution

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is comparable to medieval feudalism. The paradox of global neighbourhood in a divided world is central to the challenges of health protection and promotion not as prophecy of doom, but as a strategy to rethink ways to salvage ‘our global health future’ by avoiding the avoidable errors of past decades. The beginning or end of every millennium provides an opportunity for stock-taking on multiple dimensions of global relations. The transition from the dusk of the twentieth century to the dawn of the twenty-first century presents humankind with a window of opportunity to rethink the complex socio-economic conditions that impact on humanity’s health in a multilateral context. In the dawn of the twenty-first century, there are old lessons to be relearned: the most basic being that all human life is of value. In subsequent chapters, I argue that all of humanity will be mutually vulnerable should we fail to relearn these lessons. I argue as well that contemporary multilateralism that remains insensitive to humane values, if unreformed, will adversely affect human health in parts of the developing world in ways that would continue to cause significant turbulence in the entire global neighbourhood. By analogy, when one part of the human body is sick, the whole body could hardly function properly; so it is that when one part of the global village is a reservoir of preventable diseases, the entire neighbourhood could be perpetually endangered.

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95 Ivan L. Head, supra note 12 at 215.
CHAPTER THREE
MUTUAL VULNERABILITY AND GLOBALISATION OF PUBLIC HEALTH IN THE GLOBAL NEIGHBOURHOOD

A: OVERVIEW OF THE ARGUMENT

Mutual vulnerability refers to the vicious threats posed to humans by diseases and pathogenic microbes in an interdependent world, the fragility of humans to succumb to those threats, and the obsolescence of the erstwhile traditional distinction between national and international health threats. A disturbing complexity of this microbe-humanity dynamic is that diseases traditionally thought to be limited to certain regions of the world have emerged in other regions, while diseases thought to be under control have re-emerged in the same regions with renewed vigour. Within the global neighbourhood, populations both in the South and North are now mutually vulnerable to the traditional and re-emerging powers of the microbial world. The globalising forces of trade and travel combine with the imperatives of human migrations caused by political conflicts, civil wars and environmental crisis, to propel both the efficacy of microbial threats and the complex dynamics of mutual vulnerability. Were disease pathogens to carry national passports or respect geo-political boundaries, the concept of mutual vulnerability would have – at best – been a national security issue within the domestic jurisdiction of nation-states. But the phenomenon of globalisation has shattered the illusions of protectionism.

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1 Most of the public health literature lumps emerging and re-emerging infectious diseases together as 'emerging infectious diseases' (EIDs). The U.S Centres for Disease Control and Prevention (CDC) defines EIDs as "diseases of infectious origin whose incidence in humans has increased within the past two decades or threatens to increase in the near future". See CDC, Addressing Emerging Infectious Disease Threats: A Prevention Strategy for the United States (Atlanta, Georgia: CDC, 1994) 1. See also World Health Organisation, World Health Report 1996: Fighting Disease, Fostering Development (Geneva: WHO, 1996) 15. This definition includes completely new diseases that have emerged and previously known diseases that have either re-emerged in their traditional locations or in new parts of the world.
and isolationism. An obvious consequence of globalisation is the increased vulnerability of national boundaries to microbial threats. As rightly observed by Nakajima,

in the late twentieth century, an era characterized by the globalization of the world’s political economy, the threat of infectious disease transmission across national borders and the expansion of the trade and promotion of harmful commodities, such as tobacco, represent transnational health problems....These issues pose threats to the security and well-being of citizens in all states....The fact that the political boundaries of sovereign states do not represent natural barriers to infectious agents or to harmful products underscores the need for interstate co-operation to address these global health issues.²

Globalisation is not the only factor that contributes to transboundary spread of emerging and re-emerging infectious diseases. The power of nature, complacency, the breakdown of surveillance capacities, and socio-economic and environmental degradation³ are also relevant factors.⁴ The culmination of these factors underpins a compelling necessity that the global society must revisit the ideals of self-interest.⁵

The concept of mutual vulnerability is not new in multilateral health challenges and governance. It has been with humankind from the earliest historical accounts of the

³ Within socio-economic and environmental factors that contribute to transboundary spread of EIDs, Fidler mentions and discusses social unrest and war, environmental degradation, changes in human behaviour, urbanisation, and poverty. See David P. Fidler, “Return of the Fourth Horseman: Emerging Infectious Diseases and International Law” (1997) 81 Minnesota Law Rev. 771.
⁴ ibid.
⁵ See House Report No. 706: Hearings Before the Committee on Foreign Relations, House of Representatives, 70th US Congress stating inter alia that “it has been observed that many deadly diseases, once considered to be indigenous to the Tropics may be and are carried to the Temperate Zones by various transmitting agencies, and there seem to become indigenous with no diminution in their virulence....Hence, each nation in more or less degree must become the keeper of its brother nations; this as a matter of self-protection if for no other reason” (my emphasis) quoted in Nakajima, supra note 2 at 319.
cross-border spread of diseases. Thucydide’s account of the Athenian plague of 430BC,\(^6\) *Bubonic Plague* (Black Death) in fourteenth century Europe,\(^7\) and the emergence of new diseases among native populations in the Americas following their ‘conquest’ by Europeans are all evidence of what one writer aptly calls “the microbial unification of the world”.\(^8\) The arrival of Columbus in the Americas marked the beginning of a new era in mutuality of vulnerability – a ‘discovery’ of ‘new worlds’ by the Old World. According to Porter, the meeting of far-flung peoples who had never previously had any contact had major consequences for epidemic infections. Europeans devastated Amerindian populations by bringing them into contact with the common diseases of the Old World. Infections such as smallpox, measles, mumps, chickenpox, and scarlet fever had a massive impact upon populations that had never experienced them before. The vulnerability of native populations in the ‘New World’ meant that pandemics decimated the Caribbean Indians, and swept through urbanized societies in Mexico; and Peru at a catastrophic rate.\(^9\) The ‘microbial unification of the world’ was almost concluded when

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\(^6\) Thucydides, *History of the Peloponnesian War*, op cit., (suggesting that plague originated from Ethiopia and spread through Egypt and Libya before it arrived Athens, as a result of movement of troops during the war).


\(^8\) Giovanni Berlinguer, “Health and Equity as a Primary Goal” (1999) Vol. 42 No.4 Development (Responses to Globalization: Rethinking Health and Equity) 17 at 18.

\(^9\) Dorothy Porter, *Health, Civilization and the State*, supra note 7 at 46; See also Giovanni Berlinguer, *Ibid*, at 18 arguing that the discovery (or conquest) of America by Europeans – a turning point in history – meant also the transition from the separation of peoples and diseases to mutual interchange and communication. Until that time, differences in environmental conditions and nutritional patterns, in social and cultural organization, in the presence or absence of biological agents and vectors of transmissible diseases, had produced markedly different epidemiological trends in the Old and New Worlds. Indeed smallpox, measles,
the Amerindian populations began to die out (in massive numbers) as a result of ‘imported’ European diseases, and Europeans began to replace their lost labour power with slaves from West Africa. West African slaves brought *falciparum* malaria to the Americas, and the water casks on the slave ships brought the mosquito that carried yellow fever. This triangular disease exchange between Europeans, Native Americans and Africans dynamically propelled mutual vulnerability in ways hitherto unknown in human history. Hays rightly observed that “since the sixteenth century the world has shrunk, with greater opportunities for the rapid movement of microbes to new populations”.

This chapter re-visits and explores the historical account of ‘transnationalisation’ of diseases, early and contemporary multilateral initiatives on public health, and argues that in a globalising world, mutual vulnerability is the single most important catalyst to re-kindle mutual self interest between the South and the North. I use the re-emergence of tuberculosis and the so-called ‘airport’ or ‘imported’ malaria in parts of the industrialised global North (especially North America and Europe) to explore mutual vulnerability in the present era of emerging and re-emerging infectious diseases (EIDs).

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10 *ibid.* For a good historical account of the decimation of Native Indian populations by smallpox in the post-Columbus Americas, as well as the complex interaction of the disease with populations in the Old and New Worlds, *See* Sheldon Watts, *supra* note 7 pp 89-121.

B: RETROSPECTIVE VISION: DISEASES, PEOPLES AND NATION-STATES
IN HISTORICAL PERSPECTIVE

The interaction between humanity and diseases is as old as human history. In his seminal work, *Plagues and Peoples*, McNeill argued that infectious disease which antedated the emergence of humankind will last as long as humanity itself, and will surely remain as one of the fundamental parameters and determinants of human history.\(^\text{12}\)

From time immemorial predating the invention of modern science, human societies across the world reacted to diseases in various ways. In the pre-Hippocratic\(^\text{13}\) period, the Jews, early Christians and pagans who formed part of the ancient Greek and Roman civilisations developed a variety of beliefs, practices and even folklore to deal with physical bodily disorders occasioned by disease.\(^\text{14}\) Likewise, societies in Africa, Asia and the Americas - prior to their contacts with European colonial powers – reacted to disease events in various natural, supernatural and superstitious ways. Zinsser observed that

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\(^{13}\) Hippocrates, who lived in the Greek Island of Cos, is often widely cited (not without controversy though) in public health literature as the founder of modern medicine. Dorothy Porter, *supra* note 7 at 15 argued that Hippocrates was probably an historical figure who lived some time between 460-361 BC. His ancient biographers, including Aristotle and Plato, praised him as a great and honoured physician, but it is uncertain whether he authored any of the collection of essays and text known as the Hippocratic Corpus. The Corpus was compiled by many authors, and absorbed the traditions of many of the Greek medical communities. Hippocratic medicine radically departed from the religious and mystical traditions of healing and stressed that disease was a natural event, not caused by supernatural forces. Hans Zinsser, in *Rats, Lice and History: A Chronicle of Pestilence and Plagues* (New York: Black Dog & Leventhal, 1963) at 112 observed that Hippocrates was probably not the first great physician of antiquity. It is likely that many skilful and sagacious medical men practised in ancient Egypt where, according to Herodotus, physicians were even more highly specialized than they are today, since they often limited themselves to a single organ of the body. There were dentists, as well as internists and surgeons. Hippocrates, however, is the first great physician from whom we have records and writings which show an approach to medical problems entirely analogous to our own.

\(^{14}\) J.N Hays, *supra* note 7 at 8.
before the time of the Greeks, the interpretation of infectious diseases was, in most instances, largely guesswork. This 'guesswork' - in part, due to inconclusive scientific proof of the cause of certain diseases - affected adversely nineteenth century efforts by European states to forge multilateral co-operation as panacea to mutual vulnerability.

Although, as already stated, mutual vulnerability historically dates back to – or even possibly predates – the Athenian plague of 430 BC, the earliest attempt to tackle its complex dynamics through multilateral initiatives is both relatively and comparatively recent. More than two hundred years after the evolution of modern nation-states - in Europe - through the normative instrument of the Peace of Westphalia 1648, infallible scientific proof of the exact cause of certain diseases (especially cholera) was still lacking. This lacuna not only provided a fertile opportunity to some European nation-states to object to early attempts at multilateral regulation of cholera by a series of international sanitary conferences and conventions; it also revived – in some ways – the various conceptions of disease held by populations in ancient times. In Goodman's words, “at the time when epidemic disease was thought to be a punishment from the gods, little could be done to prevent its spread save prayer and sacrifices”. It is in this context that mutual vulnerability and the evolution of nineteenth century multilateral initiatives on public health will be explored.

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15 Hans Zinsser, *Rats, Lice and History*, supra note 13 at 111.
C: MUTUAL VULNERABILITY AND THE EVOLUTION OF PUBLIC HEALTH
MULTILATERALISM

The microbial unification of the world, which was concluded by the European
conquest of the Americas and the transatlantic slave trade from Africa to America,
opened a new vista in microbe-human interaction. Across the world, pathogenic microbes
travelled long distances with unprecedented speed, permeated national boundaries with
ease, and constituted serious menaces to populations. Driven by the desire to protect their
populations, most nation-states introduced and enforced strict quarantine regulations.17
Goodman has identified three reactions by nation-states to the transboundary spread of
disease before 1851, when the first International Sanitary Conference was held. The first
was the predominant view that disease was a punishment from the gods that could only
be cured by prayers and sacrifices. The second was the isolation of a healthy society from
an unhealthy one through the practice of cordon sanitaire — to prevent either importation
or exportation of disease. The third was the practice of quarantine, which enabled
governments to isolate goods or persons coming from places suspected of suffering an
outbreak of disease to protect the community from disease importation.18 Goodman also
observed that between the fourteenth and nineteenth centuries nearly all ‘civilized’

17 For a history of the concept of quarantine, see B. Mafart & J.L Perret, “History of the Concept of
Quarantine” (March 1998) 58 Med. Trop. 14-20 (defining quarantine as a concept developed by society to
protect against the outbreak of contagious disease). Neville Goodman, supra note 16 at 29 states that
quarantine is a word derived from the forty-day (quaranta) isolation period imposed at Venice in 1403 and
said to be based on the period during which Jesus and Moses had remained in isolation in the desert. Paul
Slack’s “Introduction” in P. Slack & T. Ranger (eds.), Epidemics and Ideas: Essays on the Historical
Perception of Pestilence (Cambridge: Cambridge University Press, 1992) at 15 noted that quarantine
practices began in Italian city-states in the fifteenth century.
18 See Goodman, ibid at pp27-29, also summarised by David P. Fidler, International Law and Infectious
countries of the world adopted some form of quarantine control. This control consisted mainly of imposing an arbitrary period of isolation on the ships, crews, passengers and goods arriving from foreign ports believed to be reservoirs of major epidemic diseases, especially plague, yellow fever and later cholera. The incoherence and nuisance value of various quarantine regimes, and how their enforcement adversely affected movement of cargo and people, are better appreciated from a detailed account given by one scholar:

On disembarking, the Master of an infected or suspected ship was required to stand before an iron grille, swear on oath to tell the truth, and then throw the ship’s bill of health into a basin of vinegar. An official would then plunge the bill beneath the surface with the aid of iron tongs and, when it was judged to have been well soaked, remove it by the same means, lay it on the end of a plank, and thus present it to the “conservateur de la sante”, who would read it without touching it. Letters from the unfortunate sick or suspect passengers confined to a lazaret had to be thrown for a distance of ten paces, retrieved with long tongs, plunged into vinegar, and then passed through the flame and smoke of ignited gunpowder. The personnel of the lazaret wore wooden clogs and oilskin jackets, trousers and gloves.

The nuisance value of quarantine is also illustrated in popular art. In William Shakespeare’s Romeo and Juliet, an outbreak of infectious disease and a subsequent imposition of quarantine led to the isolation of Friar John on his way to Mantua. As a result of his isolation, Friar John was prevented from travelling to Mantua to deliver an important letter from Friar Lawrence to Romeo that his lover Juliet was not dead, but

19 ibid.
20 Norman Howard-Jones, The Scientific Background of the International Sanitary Conferences 1851-1938 (Geneva: World Health Organization, 1975) 11 quoting the English translation from J.P Papon, De la Peste ou les epoques ce fleau et les moyens de s'en preserver. Vol.II (Paris, 1800). Howard-Jones stated further that very similar precautions were prescribed in the quarantine regulations promulgated by the French Minister of Commerce in 1835. Article 614 stated that where there was need for surgical intervention, a surgical student should be “invited” to be incarcerated with the patient – students presumably being more expendable than doctors. The latter had to be separated from patients with “contagious” diseases by “at
only sleeping. Had Friar John not been isolated, the tragic deaths of Romeo and Juliet would have been avoided.\textsuperscript{21}

To what extent, if at all, were these extreme national protectionist policies effective in controlling the transboundary spread of disease? Did isolationism protect populations within national boundaries from microbial threats? Did extreme protectionism diminish mutual vulnerability in any significant ways? It took only two epidemics of cholera in Europe in 1830 and 1847 to expose the impotence of quarantine. European cholera epidemics de-mystified the myth that quarantine, \textit{cordon sanitaire} or other pre-existing domestic protectionist policies, at that time, provided a watertight defence against, or insulation from, diseases. These mid-nineteenth century epidemics not only decimated populations, they also wrote a new chapter in the whole concept of mutual vulnerability. For centuries, as Goodman observed, “cholera has been considered a disease, albeit terrible in its rapidity and high mortality, largely confined to Central Asia and particularly to Bengal.... But between 1828 and 1831 it passed out of India and spread rapidly to the whole of Europe and to the United States....”\textsuperscript{22} From Punjab, Afghanistan and Persia,

\footnotesize{least twelve metres". If the patient was too ill to approach the limit of this no-man’s land the doctor would prescribe supposedly suitable remedies on the basis of the report made by the student.}
\footnotesize{\\textsuperscript{21} William Shakespeare, \textit{Romeo and Juliet} (Dover Thrift Editions) (New York: Dover, 1993) Act V Scene II}
\footnotesize{Friar John: “Going to find a bare-foot brother out, One of our order, to associate me, Here in this city visiting the sick, And finding him, the ‘searchers’ of the town, Suspecting that we both were in a house Where an infectious pestilence did reign, Seal’d up the doors and would not let us forth; So that my speed to Mantua was stay’d”. (“Searchers of the town” are defined in the annotated note as “officers of the town responsible for public health during a plague”).}
\footnotesize{\textsuperscript{22} supra note 16 at 27.
It reached Moscow in 1830 and infected the whole of Europe, including England, by the end of 1831. It reached Canada and United States of America in the Summer of 1832. Another pandemic followed in 1847 and five others in the next fifty years. This was a new and terrifying disease to the western world and quarantines, even though at once tightened up under the pressure of public opinion and hence more vexatious than ever, seemed to be impotent to stop the spread. Just as within each national boundary fear of cholera overcame local jealousies and vested interests, so the nations were more inclined to consult together and try to devise measures against the common peril.\textsuperscript{23}

A second motivation for the evolution of multilateral co-operation in the field of public health lies in the exponential rise in international trade, travel and maritime commerce in post-Industrial Revolution Europe. The development of the steamship (about 1810), the railway (about 1830), and the construction of the Suez Canal in 1869 boosted trade and commercial transactions in nineteenth century Europe. With new commercial opportunities came new challenges. To facilitate transboundary movement of goods and populations, trade-hurting national quarantine regulations must necessarily be harmonised in a multilateral forum.\textsuperscript{24}

The inseparable but complex fusion of the interlocking factors of mutual vulnerability occasioned by cholera epidemics of 1830 and 1847, and the need to multilaterally harmonise quarantine regulations occasioned by the nineteenth century imperatives of trade, travel and maritime commerce catalysed the earliest ‘multilateralisation’ of public health. The trade-health dynamic of the evolution of

\textsuperscript{23} ibid.

\textsuperscript{24} See Javed Siddiqi, World Health and World Politics: The World Health Organization and the UN System (London: Hurst & Co., 1995) 14 arguing that “the new ease of travel and trade also transformed hitherto foreign epidemic diseases such as cholera into European scourges. One early response of European states to limit the spread of cholera involved the quarantining of shipping at different ports for months at a time. Arbitrary and unequal quarantine regulations at various ports inevitably created great burdens on the international trade of ....maritime nations such as Britain and France, whose fear of economic collapse
international health co-operation meant, as Siddiqi noted, that with one eye on the
common peril (cholera and other diseases), and the other on the worsening outlook for
their maritime trade, governments found themselves without any other option than to
attempt international collaboration against cholera and other epidemic diseases, including
plague and yellow fever.\textsuperscript{25}

At the initiative of France, eleven European states\textsuperscript{26} and Turkey were represented
at the first International Sanitary Conference, which opened in Paris on 23 July 1851.\textsuperscript{27}
From 1851 to the end of the nineteenth century, ten international sanitary conferences\textsuperscript{28}
were convened, and eight sanitary conventions were negotiated on mutual vulnerability:
the spread of infectious diseases (cholera, plague, and yellow fever) across European
boundaries and the harmonisation of inconsistent national quarantines.

Although most of the conventions were never ratified by the countries that
participated in the conferences, and thus never entered into force \textit{stricto sensu},
nonetheless nineteenth-century public health/infectious disease diplomacy signified the
necessity of tackling the cross-border spread of epidemics multilaterally. The ten
international sanitary conferences convened from 1851 to the end of the century thus

\textsuperscript{25} J. Siddiqi, \textit{ibid.} Also Howard-Jones, \textit{supra} note 20 at 11 stated that while the elaborate precautions of
quarantine imposed intolerable constraints upon travellers, what governments found most irksome were the
often disastrous hindrances to international commerce, and it was this concern that finally prompted the
European nations to meet to discuss to what extent these onerous restrictions could be lifted without undue
risk to the health of their populations. If, in the old colonial days, it was true that “trade follows the flag”, it
was equally true that the first faltering steps towards international health co-operation followed trade.
\textsuperscript{26} The States included Italian City States then known as the four Papal States: Sardinia, Tuscany and the
Two Sicilies. Others were Austria, Great Britain, Greece, Portugal, Russia, Spain, and France — the
convenor and host.
\textsuperscript{27} In this section, I am only concerned with mutual vulnerability as a motivating factor in the evolution of
multilateral health co-operation. The politics, frustrations and shortcomings of regulating the cross-border
spread of diseases, which were manifest in most of international sanitary conferences held from 1851 to the
early twentieth century will be discussed in the next chapter on “vulnerability of multilateralism”.

\textsuperscript{88}
transformed the second half of the nineteenth century into an era of intensive infectious disease diplomacy. One obvious consequence of this was the frequent use of international law to strengthen multilateral public health co-operation. The number of conferences convened and conventions/agreements/treaties negotiated should however not be confused with success or progress on the multilateral control of infectious diseases because, as Fidler rightly observed, it took states so long to arrive at a 'universal' regime on infectious disease control. Forty-one years and six European-led international conferences elapsed from the first International Sanitary Conference in 1851 before the first effective international convention (restricted to cholera) was adopted at the International Sanitary Conference held in Venice in 1892. According to Howard-Jones, this convention was the first tangible fruit of seven international conferences spanning 41 years. The seventh conference, of which this convention was the outcome, was only concerned with cholera and, more specifically, with the sanitary control of westbound shipping traversing the Suez Canal, most of which was British. Continental European countries were deeply concerned that the canal might be a conduit for the importation of cholera from India to Europe. History has proved these fears to be entirely groundless.

In 1897, the tenth International Sanitary Conference, held in Venice with a specific mandate, adopted preventive measures dealing with plague. Howard-Jones noted that the 1897 conference set a precedent chiefly because it dealt exclusively with plague. Most of the nine preceding sanitary conferences wasted an enormous amount of time

29 See Fidler, supra note 18 at 24.
30 ibid.
31 ibid.
32 Howard-Jones, supra note 20 at 65.
33 ibid.
discussing multilateral approaches to cholera. The mode of transmission of cholera and whether it was indeed a suitable subject for international consideration sharply divided delegates. For many years, there was no consensus on the etiology and mode of transmission of cholera until the ninth sanitary conference in 1894. The breakthrough on the etiology of cholera enabled countries to shift their attention from cholera to other diseases. At the 1897 sanitary conference on plague, Great Britain was criticised because of a spread of a serious and persistent epidemic of plague from Bombay to the north-west littoral of India. Austria-Hungary proposed the 1897 conference because it feared its Muslim subjects from the Mecca Pilgrimage might bring plague with them after being in contact with pilgrims from India. The 1897 conference led to an International Sanitary Convention dealing solely and exclusively with plague and signed by all the participating twenty sovereign powers except Denmark, Sweden/Norway, and the USA.

In 1903, both the 1892 and 1897 International Sanitary Conventions – dealing with cholera and plague respectively – were consolidated and replaced by a new convention. As the European states approached the end of the ‘long nineteenth century’ with intensive public health diplomacy, international conventions-treaties alone were neither capable of providing either the ‘magic bullet’ against mutual vulnerability or the ‘end of history’ of the infectious disease menace. The development of international regimes to govern transboundary disease surveillance coincided with the need to establish multilateral institutions to enforce the emergent regimes. The dawn of the twentieth century witnessed a more global spread of multilateral initiatives outside Europe. In 1902

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34 ibid.
35 ibid.
an International Conference of American States, held in Washington DC, established the first multilateral public health institution – the International Sanitary Bureau.\footnote{The International Sanitary Bureau is the precursor of the Pan-American Sanitary Bureau and the present Pan-American Health Organisation (PAHO).} In 1907, the bulk of the European States that negotiated the nineteenth century international sanitary conventions met in Rome and adopted an agreement establishing the Office International d’Hygiene Publique (OHIP) – International Bureau of Public Health – with a permanent secretariat in Paris. The inter-war years – traversing World Wars I and II – witnessed institutional deficiencies and rivalries in enforcing international health regimes. The Health Organization of the League of Nations (HOLN) in Geneva, the Pan-American Sanitary Bureau in Washington DC, and the Office International d’Hygiene Publique (OHIP) in Paris, existed independent and autonomous of each other, and each enforced sanitary or health conventions and treaties within their respective areas of competence.\footnote{According to Fidler, supra note 18 at 24 the intensity of effort continued in the twentieth century as the predominantly European efforts of the later half of the nineteenth century were joined by the diplomatic activity in the Americas to control infectious diseases.} Siddiqi observed that between 1920 and 1936, the OHIP rejected four proposals from the League of Nations to rationalize international activities, to eradicate any overlap in functions and to establish a single international health organization.\footnote{See Siddiqi, supra note 24 at 20 stating that the reason for OHIP’s intransigence is unclear even to leading scholars in the field like Norman Howard-Jones who observed in International Public Health Between the Two World Wars: The Organizational Problems (Geneva: WHO, 1978) 73 that there was a remarkable overlap in the membership of the OHIP (based in Paris) and the Health Organization of the League of Nations (HOLN) (based in Geneva), and so it was strange why a majority of member states in each organization were making proposals in Geneva that they themselves would later reject in Paris.} These international health institutions continued to operate independently of each other until the formation of the World Health Organisation in 1948 when OHIP was subsumed within the WHO, the Health Organization of the League of Nations (HOLN) having died with the League of Nations at the outset of World War II. Notwithstanding the setbacks suffered by these
institutions and the decades it took to conclude the earliest international sanitary
conventions, these efforts established one undeniable fact: that multilateral co-operation
was a useful tool against mutual vulnerability to microbial threats. In Fidler’s words,
the creation of the Pan American Sanitary Bureau (PASB) in 1902, the Office International d’Hygiene Publique (OHIP) in 1907, the Health Organization of the League of Nations (HOLN) in 1923, and the Office International des Epizooties (OIE) in 1924, put international co-operation on public health into institutional forms that facilitated greater inter-governmental collaboration than could be achieved through ad hoc conferences. A sign of this greater potential for co-operation is the expansion of PASB, OHIP, and HOLN into areas of public health not previously a topic of inter-governmental collaboration, such as expanding the number of infectious diseases subject to international co-operation, working on chronic diseases such as cancer, or studying nutrition. 39

Another major achievement of the multilateral approaches to the cross-border spread of epidemics at this period was the use of sanitary treaties and multilateral institutional mechanisms to create an international surveillance system, and to share epidemiological information. For instance, the 1903 International Sanitary Convention that consolidated notification duties of the 1893 and 1897 treaties required contracting parties to notify the other parties of the appearance of authentic cases of plague and yellow fever in their territories. 40 In fact the benefit of sharing epidemiological information with the corresponding obligation on states to notify of outbreaks in their territories was clearly within the scope of many of the sanitary conventions and also within the mandate of emergent multilateral health institutions. As observed by Fidler, the treaty establishing

39 Fidler, supra note 18 at 24.
40 Within the Americas, the 1905 Inter-American Sanitary Convention imposed notification duties for cases of cholera, plague, and yellow fever. In 1924 the Pan-American Sanitary Code provided for bi-weekly notification of ten specific diseases and such other diseases as the Pan-American Sanitary Bureau might add, and also for immediate notification of “plague, cholera, yellow fever, smallpox, typhus, or any other dangerous contagion liable to spread through...international commerce”. See Articles 3-4 Pan American Sanitary Code 1924.
the International Office of Epizooties (OIE) required contracting parties to notify it of certain infectious diseases of animals either in connection with first cases or at regular intervals.\footnote{ibid.} Because a functional international surveillance system was tied to the mandate of these international institutions, the Pan-American Sanitary Bureau was a core aspect of the Pan-American surveillance system. The International Office of Public Health (OIHP) played an important surveillance role after it was created in 1907. Surveillance was also part of the work and mandate of the Health Organisation of the League of Nations (HOLN).\footnote{ibid.} The precedent set by nineteenth century infectious disease diplomacy on mutual vulnerability – albeit hardly infallible – applies to contemporary multilateralism with respect to the mandate of the WHO and cross-border spread/threats of emerging and re-emerging infectious diseases.

**D: MUTUAL VULNERABILITY AND CONTEMPORARY PUBLIC HEALTH MULTILATERALISM**

It is difficult to articulate the complexities of the multiple dimensions of mutual vulnerability in contemporary public health multilateral co-operation which covers the decades from the formation of the World Health Organisation in 1948 to the present day. One useful way to explore mutual vulnerability in the contemporary era traversing the past fifty-two years would necessarily proceed from the present crisis of emerging and re-emerging infectious diseases (EIDs).\footnote{For a definition of emerging and re-emerging infectious diseases by WHO and CDC, see CDC, Addressing Emerging Infectious Disease Threats, supra note 1; WHO, World Health Report 1996, supra note 1.} Nonetheless, there is also a need to focus
discussion with particular reference to the sudden re-emergence of diseases like tuberculosis and malaria in Europe and North America.

In 1995, the United States government inter-agency Working Group on Emerging and Re-emerging Infectious Diseases (known as CISET Working Group) listed twenty-nine examples of new infectious diseases identified since 1973. The second category of EIDs includes diseases that have in the last twenty years re-emerged as public health problems. The CISET Working Group categorised re-emerging infectious diseases into three groups: (i) infectious diseases that have flared up in regions in which they historically appeared; (ii) infectious diseases that have expanded into new regions; and (iii) infectious diseases that have developed resistance to anti-microbial treatments and have spread through traditional and/or new regions because of such resistance. Tuberculosis is one disease that falls into each of the three categories of re-emerging infectious diseases. It is an old disease that has re-emerged as a major health problem in regions where it historically occurred, it has returned as a problem in both the South and the North, and certain strains of tuberculosis have developed strong resistance to antibiotics and other pharmaceutical treatments. WHO blames the crisis of re-emerging

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45 See CISET Report ibid identifying about twenty re-emerging infections including rabies, dengue and dengue hemorrhagic fever, yellow fever, malaria, plague, schistosomiasis, diphtheria, tuberculosis and cholera.

46 Fidler, supra note 3 at 779-780.
EIDs on what it calls "fatal complacency". The discovery of antibiotics, the feat of world-wide eradication of smallpox, and the progress made in rolling back the morbidity and mortality of poliomyelitis, leprosy, measles, guinea-worm, and neo-natal tetanus slowed down global health work with the optimism that the battle between humanity and the microbial world was being won by humans. This cautious optimism, argues WHO, has turned into a fatal complacency that is costing millions of lives annually. Consequently, diseases that used to be restricted geographically are now striking in regions once thought to be safe. Malaria and tuberculosis, for instance, are fighting back with renewed ferocity. Many of the most powerful antibiotics have been rendered impotent. In the contest for supremacy, observed the WHO, "the microbes are sprinting ahead. The gap between their ability to mutate into drug-resistant strains and man's ability to counter them is widening fast". To understand the crisis of EIDs in the context of mutual vulnerability, it is important to focus discussion particularly on tuberculosis and malaria, and then argue that factors that propel EIDs (including globalization of trade and commerce) have rendered the distinction between national and international health obsolete.

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47 See WHO, supra note 1 at 1.
48 ibid.
49 ibid.
50 I focus on tuberculosis and malaria not because they are the most important or unique among the emerging and re-emerging infectious diseases listed in the CISET Report, but simply because it is impossible to discuss in detail all the new and old diseases that are emerging and re-emerging across national boundaries. Tuberculosis and malaria are used here simply as examples to rethink the dynamics of mutual vulnerability.
(I) THE RE-EMERGENCE OF TUBERCULOSIS AS A THREAT IN THE GLOBAL NORTH

Tuberculosis is a contagious disease that spreads through the air. There are many types of tuberculosis, but only people who have pulmonary tuberculosis are infectious. When an infected person coughs, sneezes, talks or spits, he propels TB germs – bacilli – into the air. An inhalation of a small number of bacilli germs leads to an infection. The WHO estimates that tuberculosis kills 2 million people annually.\(^{51}\) It is further estimated that between 2000 and 2020, nearly one billion will be newly infected, 200 million people will get sick, and 35 million will die from TB – if control is not strengthened.\(^{52}\) The WHO estimates that the majority of TB sufferers live in the developing world, particularly in South-East Asia, Western Pacific and Africa.\(^{53}\)

A disturbing phenomenon is the fact the TB has formed a lethal partnership with HIV/AIDS.\(^{54}\) According to WHO, the AIDS virus damages the body's natural defences – the immune system – and accelerates the speed at which tuberculosis progresses from a harmless infection to a life threatening condition. TB is already the opportunistic infection that most frequently kills HIV-positive people. Of an estimated 1 million HIV-related deaths in 1995, about one-third might have been due to tuberculosis. While only 9% of the total of 3 million tuberculosis deaths in 1995 were related to AIDS, the

\(^{51}\) WHO, supra note 1 at 26-27.
\(^{52}\) See "Tuberculosis", WHO Fact Sheet No. 104 (Revised April 2000), also available on the online at: http://www.who.int/inf-fs/fac104.html (visited 28 July 2000).
\(^{53}\) World Health Report 1996, supra note 1 at 27.
percentage is expected to reach 17% in 2000. A second disturbing phenomenon about the global TB crisis is the emergence of strains of TB that are resistant to available drugs. The WHO defines "drug-resistant tuberculosis" as a case of tuberculosis (usually pulmonary) excreting bacilli resistant to one or more anti-tuberculosis drugs. If properly treated, the WHO believes that tuberculosis is curable in virtually all cases, provided it is not caused by bacteria resistant to a range of drugs. Incomplete or inappropriate treatment has spawned the development of strains that are resistant to drugs. If untreated, the disease is fatal in half the cases. Non-vaccinated babies are most vulnerable to developing the severest forms after becoming infected.

Of relevance to mutual vulnerability in contemporary multilateral health cooperation is the fact that morbidity and mortality of tuberculosis in Europe and North America in the decades of the 1950s to 1970s were very low as TB was close to complete elimination as a public health threat. Today it has re-emerged with brutal force in these substantially industrialised continents as a major public health problem. Quoting from the 104th Congressional Hearings on Emerging Infections, Fidler observed that in the 1980s and 1990s, New York City public health officials waged a battle to contain a reappearance of TB. Immigration of tuberculin-infected persons from developing

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57 World Health Report 1996, supra note 1 at 28. The WHO recommends the Directly Observed Treatment Short-Course (DOTS) – an inexpensive strategy, which involves detection of TB cases through low-cost sputum smear tests followed by 6-8 months of treatment with a combination of inexpensive drugs.
58 ibid.
59 Fidler, supra note 3 at 780-781 quoting a statement of Dr. Margaret H. Hamburg, Health Commissioner of New York City in "Emerging Infections: A Significant Threat to the Nation's Health: Hearings Before the Senate Committee on Labor and Human Resources" (104th US Congress, 1995).
countries to New York City has been widely cited as a leading cause of the re-emergence of TB in New York. This makes TB an infectious disease that has expanded from places where the disease is fairly common to a new environment relatively free from the disease. The WHO has reported that TB outbreaks have been increasing in the United States from the mid-1980s. TB had declined in the US from 84,300 cases in 1953 to 22,200 in 1984. But from 1985 to 1993 the number of cases increased by fourteen percent. Of the 25,300 cases reported in 1993, seventy-three percent were among racial and ethnic minorities. Recent outbreaks in the United States have included several of the multidrug-resistant forms in hospitals and prisons with mortality of up to seventy percent.

In Canada, although the overall infection ratio is low, the spread of multidrug-resistant strains of tuberculosis is also on the rise. The threat is becoming apparent in the culturally diverse city of Toronto, where about three percent of TB cases are multidrug-resistant. Dr Richard Bedell, a Vancouver doctor, has offered persuasive reasons why the global TB threat is indeed a Canadian problem. From the perspective of mutual vulnerability, he argues thus,

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62 See Helen Branswell, “Drug-resistant Strains of TB Global Threat, WHO Warns” in The Recorder & Times (Brockville, Ontario: 24 March 2000) quoting Dr. Howard Njoo, Director for tuberculosis-prevention and control at Health Canada’s Laboratory Centre for Disease and Control. Dr. Njoo, inter alia, was quoted as arguing that “TB bacilli don’t respect borders”, and that Canada is not immune. It’s spreading round the world and certainly Canada is impacted by that.
I can think of three levels on which people might take an interest in tuberculosis. The first is self-interest: Can it affect me or my loved ones? The second is obligation: What ought we do as a country? The third I call the 'will for supererogation': What is good to do even if we are not obligated to do it? I want to address the failures to interest the world (including Canadians) on these levels. Canada is a diverse society and many Canadians come from countries with a high prevalence of TB. As well, Canadians travel extensively for business and tourism, often visiting countries with high TB rates. 

...You have only to share the same air in a room, a bus or an aircraft with someone who has infectious TB to have some risk of infection.63

In Europe the morbidity and mortality rates of TB have also increased astronomically in the past two decades. In Denmark and Germany for instance, the percentage of TB patients resistant to a single drug rose by fifty percent in 1996.64 New outbreaks of TB have occurred in Eastern Europe after about forty years of steady decline in TB mortality.

(II) 'IMPORTED' AND 'AIRPORT' MALARIA IN EUROPE AND NORTH AMERICA

Malaria is endemic in ninety-one countries, mainly in Africa, where it is one of the biggest contributors to the burdens of disease. The WHO estimates that annually there are 300-500 million clinical cases of malaria, and between 1.5 million and 2.7 million deaths.65 Malaria's capacity to undermine the ability of infected people to work links it to poverty and socio-economic development. Malaria is caused by species of parasites belonging to the genus *Plasmodium*. It is transmitted by a bite of an infected female


65 World Health Report 1996, supra note 1 at 47.
mosquito of the genus *anopheles*. Early symptoms include fever, shivering, aches and pains in the joints and headache.\(^{66}\) In *falciparum* malaria, infected red cells can obstruct the blood vessels of the brain, causing cerebral malaria, which is often lethal. Other vital organs can also be damaged with fatal consequences.\(^{67}\) Malaria has been eradicated in the entire industrialised world. The failure of the World Health Organization’s efforts to globally eradicate malaria in the 1970s, and the present endemicity of the disease in the global South (mainly in Africa), has given the mistaken but fatal impression that malaria is simply an African problem.

Cases of “imported malaria” and so called “airport malaria”\(^{68}\) have increased in Europe and North America and other regions of the world where the burden of malaria has been historically low. The differences between the South and the North on the burdens of malaria are still vast, with an overwhelming majority of malaria morbidity and mortality occurring in Africa. Nonetheless 'airport malaria' can no longer be neglected as infectious agents ignore national borders and increasingly find their way to Europe.\(^{69}\) According to the WHO, there have been reports of a surprising number of malaria deaths in northern countries following unrecognized infection through a blood

\(^{66}\) *ibid.*

\(^{67}\) *ibid*. See also, WHO, *Severe Falciparum Malaria: Transactions of the Royal Society of Tropical Medicine and Hygiene Volume 94 Supplement 4* (Geneva: WHO, 2000) stating *inter alia* that “any patient with malaria who is unable to swallow tablets, has any evidence of vital organ dysfunction, or a high parasite count is at increased risk of dying. The exact risk depends on the degree of abnormality, age, background immunity, and access to appropriate treatment”.

\(^{68}\) For a distinction between “imported malaria” and “airport malaria”, *See N.G Gratz, et al, “Why Aircraft Disinsection?” (2000) 78 The International Journal of Public Health 995* stating that “the most direct evidence of transmission of disease by mosquitoes imported on aircraft is the occurrence of airport malaria, i.e. cases of malaria in and near international airports, among persons who have not recently travelled to areas where the disease is endemic or who have not recently received blood transfusions. Airport malaria should be distinguished from imported malaria among persons who contract the infection during a stay in an area of endemcity and subsequently fall ill”.

\(^{69}\) G. Capdevila, “Malaria-Carrying Mosquitoes Hitch Rides on Air Planes” *Inter Press Service Tuesday 22 August 2000*. 
transfusion or a one-off mosquito bite near an international airport. Brussels, Geneva, and Oslo have all had recent cases of airport malaria.\(^{70}\) Cases of airport malaria in Europe that mostly occur in the absence of anamnestic signs of any exposure to the malaria risk are often difficult to diagnose.\(^{71}\) From 1969-1999 confirmed cases of airport malaria have been reported in France, Belgium, Switzerland, United Kingdom, Italy, USA, Luxembourg, Germany, The Netherlands, Spain, Israel, and Australia.\(^{72}\)

Cases of imported malaria have also spread from endemic areas to non-endemic regions due to the increase in global travel, tourism and human migration. Epidemiological data in Europe suggest that 1,010 cases were imported into the countries of the European Union in 1971; 2, 882 in 1981; about 9, 200 cases in 1991, and 12, 328 cases in 1997.\(^{73}\) In 1993, some thirty years after the eradication of malaria in the former USSR, some 1, 000 cases of malaria were registered in the Russian Federation and in the newly independent states: Belarus, Kazakhstan, Ukraine, Azerbaijan, Tajikistan, Turkmenistan, and Uzbekistan.\(^{74}\) In the United Kingdom, a total of 8, 353 cases of imported malaria were reported between 1987 and 1992. A breakdown of this figure shows that UK nationals who visited their friends and relations in malaria endemic regions accounted for forty-nine percent of the cases, visitors to the UK accounted for...


\(^{71}\) WHO Regional Office for Europe, Strategy to Roll Back Malaria in the WHO European Region (Copenhagen, Denmark: WHO, Europe, 1999) 6. N. Gratz, et al, supra note 68 at 998 argue that airport malaria is particularly dangerous in that physicians generally have little reason to suspect it. This is especially true if there has been no recent travel to areas where malaria is endemic.

\(^{72}\) See Gratz, ibid, for a detailed discussion of individual cases of airport malaria in Europe as well as useful references and a review of public health literature that focuses on the problem.

\(^{73}\) WHO Regional Office for Europe, supra note 71 at 6.

\(^{74}\) ibid.
nineteen percent, tourists accounted for sixteen percent, while immigrants and expatriates accounted for eleven and five percent respectively.\textsuperscript{75}

Although this thesis is focused on TB and airport malaria, mutual vulnerability is not limited to these two diseases. Between 1994 and 1999, the WHO identified about thirty-five unexpected outbreaks of emerging and re-emerging infectious diseases.\textsuperscript{76} Among these outbreaks is the appearance of West Nile Fever in New York City, which caught public health officials by surprise.\textsuperscript{77} These outbreaks, as well as the cross-border spread of TB and malaria through global travel, trade, and trans-border human migrations, syllogistically provide the premise for an irrefutable conclusion: the distinction between national and international public health threats has become obsolete and anachronistic in an interdependent world. Malaria, TB and indeed a majority of the emerging and re-emerging diseases may have heavier burdens in the global South, but they are no longer the exclusive problems of the South.

\textbf{E: THE OBSOLESCENCE OF THE DISTINCTION BETWEEN NATIONAL AND INTERNATIONAL HEALTH IN A GLOBALISING WORLD}

There is unanimity among scholars of public health, policy-makers, and multilateral institutions that the reasons for outbreaks of new diseases and the re-emergence of old ones thought to be under control are varied and complex. The US Centers for Disease Control and Prevention (CDC) identified eight demographic and environmental conditions that favour the spread of infectious diseases. These include (i)

\textsuperscript{75} WHO, \textit{Removing Obstacles to Healthy Development}, \textit{supra} note 70 at 52 using data from Behrens, \textit{Travel Morbidity in Ethnic Minority Travellers}.
\textsuperscript{76} \textit{ibid}.
global travel (ii) globalization of food supply and centralized processing of food (iii) population growth and increased urbanization and crowding (iv) population movements due to civil wars, famines, and other man-made or natural disasters (v) irrigation, deforestation, and reforestation projects that alter the habitats of disease-carrying insects and animals (vi) human behaviors, such as intravenous drug use and risky sexual behavior (vii) increased use of antimicrobial agents and pesticides, hastening the development of resistance, and (viii) increased human contact with tropical rain forests and other wilderness habitats that are reservoirs for insects and animals that harbor unknown infectious agents.  

These eight factors are similar to the ones that have featured prominently in the epidemiological literature.  

One obvious consequence of these factors, as the WHO noted, is the fact that "national health has become an international challenge. An outbreak anywhere must now be seen as a threat to virtually all countries, especially those that serve as major hubs of international travel".

Travel, as we have seen from Thucydides account of the Athenian Plague in 430BC, and from the European conquest of the Americas, is not a recent factor in transnational spread of disease. In the Middle Ages, rats infested by plagues were shipped from one continent to another on board ships. Before the discovery of aircraft, the volume of travel and migration across national boundaries increased so much that quarantine...
practices became ineffective.\textsuperscript{81} However, the discovery of air traffic has witnessed a surge in global travel with a propensity for disease spread that is unparalleled in human history. Back in 1993, it is estimated that 500 million persons crossed international borders on board aircraft.\textsuperscript{82} Today, this number has soared to 1.4 billion persons. The opportunities for travel to spread disease have likewise increased. Travel has contributed to the cross-border spread of malaria, yellow fever, plague, cholera, tuberculosis, influenza, HIV/AIDS, Lassa fever, smallpox, hantaviruses, gonorrhea, syphilis, and many other diseases.\textsuperscript{83} Fidler observes that the potential for global pandemics fuelled by the ease of travel is illustrated by the AIDS virus. The opportunities offered a virulent airborne pathogen by air travel are perhaps even more frightening.\textsuperscript{84}

The implication of transboundary spread of disease by air travel and other factors that propel EIDs is that public health has become globalized. Transboundary disease spread now constitutes a global crisis, which requires the pooling of efforts and resources by nation-states in a multilateral context. In no other sphere of global relations is the global village metaphor more practical than contemporary 'public health diplomacy' with its twin offshoots: the permeation of national boundaries by disease pathogens and the consequent vulnerability of populations within those boundaries to microbial threats. The contemporary crisis of EIDs offers incontrovertible proof that the distinction often drawn between national and international health has in fact become anachronistic. Malaria,

\textsuperscript{81} D. Fidler, \textit{supra} note 3 at 965.
\textsuperscript{82} \textit{ibid}.
\textsuperscript{83} \textit{ibid}.
\textsuperscript{84} \textit{ibid} quoting Laurie Garret, "The Return of Infectious Disease" (Jan-Feb. 1996) Foreign Affairs 66 who noted the 1918-1919 global influenza pandemic that killed 22 million people and queries thus "how many more victims could a similarly lethal strain of influenza claim in 1996, when some half a billion passengers will board airline flights?"
dengue, yellow fever, HIV/AIDS, plague and indeed any disease in any part of the world today must be seen as global problems. This vision is nothing new; it is self-interest.

F: SUMMARY OF THE ARGUMENTS: SELF INTEREST RE-VISITED

This Chapter argued that the interaction between humanity and disease pathogens is as ancient as human history itself. The evolution of modern nation-states, and the consequent institution of strict isolationist and protectionist domestic policies, neither diminished the potency of microbial pathogens nor the degree of vulnerability of populations to disease. From the Treaty of Westphalia, 1648 to nineteenth century public health diplomacy, down to the present day, neither diseases nor pathogenic microbes have shown any respect for political and geographical lines drawn on a map. Many diseases originally endemic in certain regions of the world have re-emerged in other regions due to a host of factors. Given that all of humanity is now mutually vulnerable to cross-border threats of disease, does it make sense to maintain a distinction between diseases of the South and those of the North? Or as queried by two scholars, why should powerful countries such as the United States look beyond their own narrow self-interests with regard to transnational public health policy? The widely cited report of the US Institute of Medicine, America’s Vital Interest in Global Health, provides some answers founded on self-interest: the direct interests of the American people are served when the United States promotes world health. In partnership with other countries and multilateral institutions, the United States can become a leader in global health, especially in the areas

of research and development, surveillance, education, co-ordination, and training.\textsuperscript{87} Placing the vision of self-interest squarely within world health, mutual vulnerability is antithetical to either isolationism or protectionism. The 'us' and 'them', 'our disease' and 'their disease' distinctions, have become anachronistic. All of humanity is now an inseparable part of a shared global compact. "Our common health future"\textsuperscript{88} depends on "innovative, intersectoral interventions, involving a high degree of international co-operation and political will".\textsuperscript{89} Neither parochial foreign policy objectives anchored on isolationism and protectionism, nor endless rhetoric in the face of glaring global health dangers, can salvage our global neighbourhood from the 'coming plague'. The next chapter discusses the gaps in multilateral health diplomacy and co-operation, shortcomings of multilateral health institutions, and the foreseeable critical role international law must play to re-mould the emergent social fabric of multilateral health challenges.

\textsuperscript{87} \textit{ibid.}

\textsuperscript{88} I borrowed this expression from D. Yach & D. Bettcher, \textit{supra} note 85 at 738.

\textsuperscript{89} H. Nakajima, "Global Disease Threats and Foreign Policy", \textit{supra} note 2 at 330.
CHAPTER FOUR
VULNERABILITY OF MULTILATERALISM AND GLOBALISATION OF
PUBLIC HEALTH IN THE GLOBAL NEIGHBORHOOD

A: OVERVIEW OF THE ARGUMENT

Multilateralism is vulnerable to what nation-states perceive as favouring their strategic interests. The broad range of issues encompassed within, and the wide terrain covered by, what constitutes strategic interests according to the subjective judgement of each country inevitably politicises multilateralism. 'Politicisation', in turn, produces visible gaps and adverse impacts that destabilise multilateral initiatives. Crisis in multilateralism is not a new phenomenon. Siddiqi observed that strains arise for a number of reasons, including disagreements over political issues, philosophical approaches, and more mundane issues such as proper ways to administer, staff, finance and prioritize programs and policies within multilateral organisations.¹ Public health multilateralism is no exception. It is not insulated from politicisation and other age-long destabilising vicissitudes of multilateral co-operation. Like multilateral initiatives to forge consensus on other global issues – ozone depletion, climate change, biodiversity conservation, and food security – public health multilateralism is subject to the vagaries and vulnerabilities of politics as well as other difficult challenges of forging a common agenda on multilateral health protection and promotion. But, because the bulk of literature and policy-work on global health challenges emanates substantially from the disciplines of

epidemiology and public health, international legal scholars have not fully explored the
dimensions of these vulnerabilities exhaustively. Focusing on infectious diseases and
international relations, Fidler coined the term *microbialpolitik* to describe the
international politics produced as states attempt to deal with pathogenic microbes
multilaterally. In this sense, *microbialpolitik* points to the ordinary dynamics of
international relations mixed with the special dynamics produced by the nature of the
microbial world. Although *microbialpolitik* is within the parameters of what I
contemplate as 'vulnerabilities of public health multilateralism' in this chapter, politics
nonetheless is just one limb of this dynamic.

This chapter argues that since the first International Sanitary Conference in 1851,
multilateral health diplomacy has grappled with complex regime deficits - confusion and
ignorance of etiologies of certain diseases as well as gross under-utilisation of legal,
normative and regulatory approaches to cross-border spread of disease. There is also a
glaring institutional incapacity for the enforcement of the extant, but skeletal
legal/regulatory regime, and an acrimonious South-North engagement in the proceedings
of multilateral health institutions. For purposes of coherence and clarity, this chapter
discusses the dynamics of these vulnerabilities in two broad categories. First, I discuss
the impact of 'politicisation' on early multilateral health initiatives traversing the entire
second half of the nineteenth-century until the formation of the World Health
Organization in 1948, an era marked by intensive infectious disease-public health
diplomacy. Second, I discuss the shortcomings of contemporary public health
multilateralism covering the post-1948 years since the formation of the WHO.

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2 David P. Fidler, “Microbialpolitik: Infectious Diseases and International Relations” (1998) 14 American
University International Law Rev. 5.
These two epochs present enormous but varied challenges for multilateral health initiatives. To articulate these varied challenges, I focus discussion particularly on:
(i) colonial and post-colonial implications of nineteenth-century multilateral health order,
(ii) the impact of trade and economic interests of leading European states during the evolution of public health multilateralism and how these interests affected cross-border regulation and multilateral governance of diseases and related public health risks,
(iii) the relevance of international law in contemporary multilateral health governance, and,
(iv) selected South-North issues at the World Health Assembly, the supreme policy making organ of the World Health Organisation.

The assertion that "if in the old colonial days, it was true that trade follows the flag; it was equally true that the first faltering steps towards international health cooperation followed trade"\(^3\) - underscores the enormous challenges that economic interests of countries continue to pose for multilateral health governance from 1851 to the present day. What is the relevance of exploring the shortcomings of multilateral public health cooperation since 1851? It paves the way for innovations to emerge. This chapter does not discuss innovations per se; nonetheless its discussion of multilateralism sets the stage for innovative approaches to global health governance that I articulate in subsequent chapters.

A plethora of factors exerted a marked influence on nineteenth-century public health co-operation. Chief among these factors were the lack of infallible scientific proof of the etiology of diseases that were to be regulated by International Sanitary Conventions, and the maritime/commercial interests of leading shipping countries at the time. These two factors—in many ways—adversely affected the process and task of getting sovereign states to agree on the text of a treaty that was, inter alia, to regulate the cross-border spread of diseases via the harmonization of national quarantines that were hurting trade and travel across Europe. Howard-Jones observed that in convening the first International Conference in 1851, the French Government was inspired by the eminently reasonable desire that international agreement should be reached on the standardisation of quarantine regulations aimed at preventing the importation of cholera, plague and yellow fever. Smallpox was then such a universal disease that it was not to be brought within the scope of international sanitary legislation until seventy-six years later. Lofty and admirable as the French initiative may have been, it was not surprising that “its outcome was compromised by inherent and insuperable difficulties; the delegates, whether physicians or diplomats, were equally innocent of any knowledge of the etiology or mode of transmission of the diseases under discussion”. The majority view at the conference was that plague and yellow fever were in some ways communicable from the sick to the healthy, but it was otherwise with cholera. G.M Menis, the Austrian medical delegate to

4 ibid.
5 ibid.
the conference declared that he was under instructions from his government to discuss only plague and yellow fever. Austria, according to him, had tried quarantine measures against cholera which far from opposing the ravages of the disease, only made it more frightening and fatal. According to Menis, it was the opinion of the most eminent physicians of the Austrian Empire that cholera was "a purely epidemic disease". This view received support from J. Sutherland, the British Medical delegate who argued similarly that in England cholera was believed to be "purely epidemic", and therefore quarantine measures had no efficacy against it. Ignorance of the etiology of cholera, which polarised delegates at the 1851 conference, re-invented the age-long rivalry and raging debate between the public health theories of "miasmism" and "contagionism" as modes of transmission of disease. The divergent views expressed by delegates deeply interlocked with the overall commercial interests of participating countries. Thus, it was in the interest of Great Britain as a leading maritime power at that time to follow 'miasmism' school of thought and argue that either quarantine or any other international regulatory regime was meaningless against cholera because it was not a contagious disease. This view was supported by France, which also derived enormous shipping benefits from the Suez Canal then under its jurisdiction and control. Quarantine, whether at the national or international level was going to hurt their shipping interests. Little wonder then that the 1851 International Sanitary Conference achieved absolutely nothing.

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6 For a discussion of the submission of Menis, see N. Howard-Jones, ibid at 12.
7 For a discussion of the submission of Sutherland, see N. Howard-Jones, ibid at 12.
8 Miasmists argued that diseases were caused locally by filth and foul air. This is the traditional Hippocratic view. See J. Longrigg, "Epidemic, Ideas and Classical Athenian Society", in Epidemics and Ideas: Essays on the Historical Perception of Pestilence, T. Ranger & P. Slack, eds., (Cambridge: Cambridge University Press, 1992) 36.
9 Contagion theorists argued that diseases were transmitted directly from an infected person to a healthy person. See Brain Pullan, "Plague and Perceptions of the Poor in Early Modern Italy", in T. Ranger & P. Slack, ibid at 101.
simply because the participating countries could not strike a balance between public health and their shipping/commercial interests. Both the draft International Sanitary Convention and the International Sanitary Regulations annexed thereto were never ratified by any of the eleven countries. As put by Howard-Jones,

From the point of view of practical results, the first International Sanitary Conference was a fiasco. Everyone went on doing in their own what they had done before. Yet there was more to it than that. The fact that the conference took place established the principle that health protection was a proper subject for international consultations even though international health co-operation was for many years to be limited to defensive quarantine measures. The French Government of the time had planted a seed that was not to germinate for some forty years and then, after a complicated cycle of development, to blossom more than a half century later into the World Health Organization.10

The destabilising impact of commercial and other interests of countries on multilateral health co-operation and governance did not end with the 1851 conference. It was a phenomenon that was ever present in subsequent sanitary conferences in the nineteenth century even after substantial scientific progress had been made to prove the etiology of cholera by pioneer epidemiologists: John Snow, William Budd, Filippo Pacini, and Robert Koch. For instance, the sixth International Sanitary Conference held in Rome in 1885 and the seventh conference held in Venice in 1892 remarkably unveiled the commercial rivalry between Britain and France. France claimed that cholera was always imported to Europe from British India especially Bombay, and therefore proposed tougher sanitary measures onboard westward-bound ships from the Red Sea traversing the French controlled Suez Canal. Because four-fifths of all the ships passing through the

10 supra note 3 at 16. See also J. Siddiqi, supra note 1 at 15 stating that "while the official objective of the first Conference was stated as the desire to regulate in a uniform way the quarantine and lazarettos in the Mediterranean, the national motives for participation were primarily political and commercial, with public
canal were British, and in 1884 seven hundred and seventy of those ships arrived at British ports from India, Britain threatened to divert all its ships away from the Suez Canal. Siddiqi observed that problems also occurred “when Persian and Turkish sensitivities were offended by the claim that cholera was endemic within their borders. They considered any call for tougher quarantines of ships leaving Persian and Turkish ports to be an infringement of their sovereignty”.

That these interests hampered early attempts at multilateral health governance is trite. In an era characterised by intensive public health diplomacy and series of sanitary conferences, Fidler aptly observed that “forty-one years and six European-led international conferences elapsed from the first… conference in 1851 until the first effective international convention saw the light of day in the 1892 International Sanitary Convention. The Conventions negotiated in 1851, 1859, 1874, and 1884 never became effective”. What is conspicuous in the dynamics of politics, law and public health vis-à-vis sovereignty and multilateral regulation of disease in the nineteenth century is the slow but inevitable process of forging a multilateral agenda on the cross-border spread of disease. The fact that countries navigated between the Scylla of commercial interests and the Charybdis of multilateral regulation of diseases by an international treaty paradoxically proved both intriguing and frustrating. This oscillation in the nineteenth century provides an opportunity to explore the failures, gaps and inadequacies of contemporary multilateral initiatives on public health. To facilitate a good understanding of the 'failures, gaps and inadequacies' of the contemporary era, however, nineteenth-

health being merely an accidental issue. The primacy of concerns about shipping over those about public health was no secret...."

11 ibid.
century public health multilateralism must necessarily be scrutinised against the backdrop of colonial legacy and post-colonial discourse in international law. The reason for this is not far-fetched. It was the clear intent of the nineteenth-century sanitary conferences to use international legal governance mechanisms – conventions, treaties and regulations - in the battle against diseases and pathogenic microbes. These multilateral health governance mechanisms (conventions, treaties, and regulations) evolved at a time when the 'law of nations' was engaged in series of complex manoeuvres with colonialism and colonised people across the world.

C: NINETEENTH-CENTURY PUBLIC HEALTH MULTILATERALISM: ITS COLONIAL ORIGINS AND POST-COLONIAL UNDERPINNINGS.

Multilateral health co-operation in the nineteenth century was founded on a state-centric model of internationalism which received its imprimatur from the Treaty of Westphalia 1648. The state-centric as well as the Euro-centric flavour of the Westphalian system has been the subject of intense scholarship. The Westphalian model notwithstanding, international legal historians and theorists trace the colonial origins of international law back to the fifteenth and sixteenth centuries, when Europe 'discovered' the "new world of the Americas": the intercourse between Spaniards and American Indians following the voyages of Columbus. Interestingly, the beginning of the Columbian era in the fifteenth century, as I argued already, remains central in global health discourse because it marked the 'microbial unification of the world' or what most

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medical historians call "the Columbian exchange". In post-colonial discourse, the fifteenth and sixteenth centuries are important because the interaction between the new and old worlds became the driving force behind the polarisation of the world between 'civilised' and 'uncivilised,' 'primitive' and 'modern' people; a polarisation that received the tacit approval of leading international legal scholars at that time. International law maintained this questionable dichotomy during the Peace of Westphalia in 1648. At the dawn of the nineteenth century, the civilised-uncivilised construct was firmly entrenched in the vocabulary of international law in the relations between nations and peoples. The Westphalian model, inter alia, continues to raise colonial and post-colonial questions in ways that illuminate contemporary international law scholarship. The nineteenth century, within which ten international sanitary conferences were convened, was marked by complex manoeuvres within the law of nations. The law not only carried with it the baggage of a despicable distinction between the 'civilised and uncivilised'; 'primitive and modern', which it inherited from the fifteenth century; it was also confronted with the difficult questions of how to rationalise the European partition of Africa and the conquest of large parts of Asia, and the Pacific. As eloquently stated by one scholar,

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15 See A. Anghie, supra note 13; A. Rubin, supra note 13 for a brilliant discussion of the interaction between the Spaniards and American Indians and how Francisco De Vitoria, a leading international legal scholar of the time rationalised that interaction legally.
Following the industrial revolution in Europe after the late eighteenth century, in the nineteenth century the international community to a large extent had virtually become a European one on the basis of either conquest or domination. By about 1880, Europeans had subdued most of the non-European states, which was interpreted in Europe as conclusive proof of the inherent superiority of the white man, and the international legal system became a white man’s club, to which non-European states would be admitted only if they produced evidence that they were civilised.16

This view accords with the often-cited Mohammed Bedjaoui’s categorisation of classic international law as a ‘predatory economic order’ obliged to assume the guise of oligarchic law governing the relations between civilised states, members of an exclusive club.17 Classic international law “consisted of a set of rules with a geographical basis (it was a European law), a religious-ethical inspiration (it was a Christian law), an economic motivation (it was a mercantalist law), and political aims (it was an imperialist law).”18 Another feature of nineteenth-century international law was the triumph of positivism as the dominant analytical tool by lawyers.19 Thus, nineteenth-century positivist international law developed an elaborate vocabulary for denigrating (non-European) uncivilised peoples, presenting them as suitable subjects for conquest to further the “civilising mission”.20

The juxtaposition of this peculiar context of the nineteenth century with the desire of European states to regulate the cross-border spread of disease by a multilateral sanitary treaty (convention) raises series of questions: how international were the nineteenth

18 ibid at 49-50.
20 Ibid.
century international sanitary conferences? How universally applicable were the international sanitary conventions that emerged from these 'Euro-centric' sanitary conferences? How inclusive or exclusive were the evolutionary processes through which the international sanitary conventions emerged? It is incontrovertible that most of the developing world, almost all of Africa and many parts of Asia and the Pacific were under European colonial rule in the nineteenth century. The question per se is not whether this undeniable state of affairs – the fact that the sanitary conferences excluded a sizeable percentage of peoples then under colonial rule – is a strong vitiating element that could render those international sanitary conventions nugatory.\(^{21}\) The relevant question rather is whether the dichotomy of 'civilised' and 'uncivilised peoples/societies sanctioned by nineteenth century international law as well as the triumph of positivism as the dominant analytical tool for international lawyers contributed, or is still contributing, to the present public health turbulence in the global neighbourhood. In other words, what legacy did the nineteenth century bequeath to international lawyers of today and their discipline, and in what way(s) has this legacy affected multilateral health initiatives? Has the legacy of the nineteenth-century exacerbated contemporary South-North disparities, and thereby propelled the emergence and cross-border spread of diseases and other public health

\(^{21}\) This question is beyond the scope of this thesis. However it has been the subject of detailed inquiry by leading international scholars from the developing world. See R.P Anand, New States and International Law (Delhi: Vikas Ltd., 1972) arguing that in the nineteenth century Asian states were incapacitated to play any active role in the development of international law during the most creative period of its history. Anand argued further that many rules of international law that emerged in the nineteenth-century were explicitly devised to facilitate the economic exploitation of non-European territories. T.O Elias, Africa and the Development of International Law, 2nd Revised Ed., (The Hague: Martinus Nijhoff, 1988) arguing that African peoples were excluded in the deliberations at the Berlin Conference 1884-85, where Africa was partitioned between the leading European powers: France, Britain and Germany. C.F Amarasinghe, State Responsibility for Injury to Aliens (1967), cited in Ivan L. Head, “The Contribution of International Law to Development” (1987) Canadian Yearbook of International Law Vol. XXV 29 at 31, arguing that international law in its early stages was developed by states that had more or less similar standards of economic development, and that accepted the colonial principle. This makes it natural for some of the new states to challenge some rules of international law.
risks? Has the legacy of the nineteenth-century impeded emerging innovations in health protection and promotion from the developing world? Has the legacy of the nineteenth-century accelerated or impeded the synthesization of developing world traditional healing and ethno-medical approaches with multilateral health policies?  

These questions raise two inter-related issues in contemporary health governance: persistent/systematic exclusion, and power/hegemony in the relations between nation-states and peoples. Persistent/Systematic exclusion is an indicator that the global North has continued to discover the global South, and has done so many times over even in the twentieth and twenty-first centuries.  

It is this continuous discovery that leads to persistent exclusion of public health therapies/practices from the South in multilateral forums. As the next Chapter argues, this persistent exclusion has led to the dismissal of indigenous biomedical and ethno-biological and pharmacological practices in parts of the developing world as magic, sorcery, superstition, and unscientific/uncivilised or primitive barbarism unfit for integration into the corpus of the multilateral health framework. The continuous discovery of the developing world is analogous to Edward Said’s ingenious work Orientalism, by which he meant, inter alia, a style of thought based upon ontological and epistemological distinctions made between the Orient and (most of the time) the Occident.  

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22 These questions logically follow Antony Anghie’s well-founded observation that “the question of the enduring effects on non-European societies of the history of exclusion is related to the issue of the legacy of the nineteenth-century for the discipline as a whole”. See A. Anghie, supra note 19 at 73.

23 See Ivan I. Head, On a Hinge of History: The Mutual Vulnerability of South and North (Toronto: The University of Toronto Press, in association with the International Development Research Centre, 1991) 10 arguing that “the North has discovered the South many times, and it has given the South a variety of names sometimes in error. Curiosity, greed, fear, evangelic fervour, the zeal to civilize: the motivation for contact has ranged from the loftiest to the most base. The North assumed that modernization is desirable, and has thus interpreted Northern dominance as earned. Records of the odysseys of discovery were written by or about the adventurers, not by those discovered”.

institution for dealing with the Orient – dealing with it by making statements about it, authorising views of it, describing it by teaching it, settling it, ruling over it: in short, Orientalism as a Western style for dominating, restructuring, and having authority over the Orient.”

Power/hegemony implicates nineteenth-century international law as the forerunner and precursor of contemporary power relations in multilateral interdependence between nation-states. Hegemonic and colonial foundations of nineteenth-century international law set the stage for the institutionalisation of contemporary global inequalities. One country, one vote, may be the de jure rule to be followed in the proceedings of multilateral institutions including the World Health Organisation, but there is de facto inequality between member states. In a recent article, Fidler called this power/hegemony in the relations between states “a kinder, gentler system of capitulation”. It is important to note that nineteenth century public health is long gone by, and now belongs to the dustbin of history, but its colonial and hegemonic legacies still abound. These legacies afford us a window of opportunity to study contemporary public health multilateralism: the mandate of the World Health Organisation, selected South-North issues in the proceedings of the Organisation, and WHO’s limited use of international legal strategies in global health governance.

25 Ibid.
26 David P. Fidler, “A Kinder, Gentler System of Capitulations? International Law, Structural Adjustment Policies, and the Standard of Liberal, Globalized Civilization” (2000) 35 Texas Law Journal 327 (defining capitulations basically as a system of extraterritorial jurisdiction and power wielded by European States and the US in the territories of non-European countries, and categorising the Structural Adjustment Policies of the World Bank and the IMF as capitulatory in nature. Fidler argued further that both past capitulatory and present capitulatory regimes were supported by international law, and that the standards of civilisation supporting capitulation were visible in nineteenth-century international law).
D: VULNERABILITIES OF CONTEMPORARY PUBLIC HEALTH
MULTILATERALISM: SOUTH-NORTH POLITICS AT THE WORLD HEALTH
ASSEMBLY

The World Health Organisation was founded on 7 April 1948 when its constitution earlier adopted at the 1946 International Health Conference in New York, USA, entered into force. The objective of the organisation is the "attainment by all peoples of the highest possible level of health". In order to achieve this objective, the Organization shall, inter alia;

(i) act as the directing and co-ordinating authority on international health work,
(ii) propose conventions, agreements, and regulations, and make recommendations with respect to international health matters, and to perform such duties as may be assigned to it that are consistent with its objective,
(iii) promote and conduct research in the field of health,
(iv) establish and revise as necessary international nomenclatures of diseases, causes of death and public health practices, and
(v) develop, establish and promote international standards with respect to food, biological, pharmaceutical and other products.

In performing these global health governance functions, the WHO is often bogged down by South-North disagreements on a range of issues that traverse public health, disarmament, politics, human rights, cultural diversity and even the admission of entities not fully recognised as states by the international community. In recent years, the

vulnerabilities of public health multilateralism in the guise of South-North debate at the World Health Assembly have, *inter alia*, focused on the following issues:

(i) the admission of Palestine and Taiwan as members of the WHO,

(ii) the health conditions of the Arab population in the occupied Arab territories including Palestine,

(iii) repercussions on health of economic and political sanctions between states,

(iv) an international code for the marketing of breast-milk substitutes, and,

(v) the health and environmental consequences of the use of nuclear weapons by states.

Since I cannot discuss the dynamics and complexities of each of these South-North issues vis-à-vis the mandate of WHO, I shall focus on the South-North dimensions of the nuclear weapons debate at the World Health Assembly as a microcosm of the larger politicisation of contemporary public health multilateralism since the WHO was founded.

The debate and politicisation of the link between nuclear weapons and public health at the World Health Assembly dates back to the early 1970s. In May 1973, the twenty-sixth World Health Assembly – conscious of the potentially harmful consequences for the health of present and succeeding generations from any contamination of the environment resulting from nuclear weapons testing – passed Resolution WHA26.57 on nuclear testing. Recognising that fall-out from nuclear weapons tests is an uncontrolled and unjustified addition to the radiation hazards to which humanity was exposed, the Assembly expressed serious concern that nuclear weapon testing has continued in disregard of the spirit of the treaty banning nuclear
weapons tests in the atmosphere, outer space and under water. Recalling two important provisions of the WHO Constitution that,

(i) the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic and social conditions, and

(ii) the health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and states;

Resolution WHA26.57 deplored all nuclear weapons testing which results in such an increase in the level of ionizing radiation in the atmosphere and urged its immediate cessation.

In 1979, the thirty-second World Health Assembly passed Resolution WHA32.24 entitled “The role of physicians and other health workers in the preservation and promotion of peace”. Resolution WHA32.24 noted the UN General Assembly resolutions on the maintenance and strengthening of peace, extension of détente, averting of the threat of nuclear war, prohibition of the development of new types of weapons of mass destruction, banning of aggressive military conflicts, and attaining of the objectives of true disarmament. The Assembly urged the Director-General of the WHO to prepare a report on the further steps which WHO, as a United Nations specialised agency, would take in the interests of international socio-economic development, and also with the aim of assisting in the implementation of the UN resolutions on the strengthening of peace,

détente, and disarmament. Pursuant to Resolution WHA34.38 of May 1981, the Director General of WHO established an International Committee of Experts in Medical Sciences and Public Health, which in 1984 published a report on "effects of nuclear war on health and health services". The expert committee concluded – among others – that it is impossible to prepare health services to deal in any systematic way with any catastrophe or cataclysm resulting from nuclear warfare, and that nuclear weapons constitute the greatest immediate threat to the health and welfare of humanity.

In the early 1990s, the debate on public health consequences of nuclear weapons at the World Health Assembly became a serious South-North issue. The reason for this is not far-fetched. In the 1990s, developing countries (mostly non-nuclear powers) that sponsored resolutions on nuclear weapons and health at the World Health Assembly sought to move from 'soft-law' approach (non-binding resolutions of the World Health Assembly) to a legally binding/obligatory norm. This move, which was to start with an advisory opinion of the International Court of Justice on the legality of the use of nuclear weapons by states was vehemently opposed by those developed countries that possessed nuclear weapons. Thus, in the early 1990s, the politics of nuclear weapons

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30 A similar resolution; WHA34.38 was passed by the World Health Assembly in May 1981 requesting the WHO Director-General to continue collaboration with the Secretary General of the United Nations and with other governmental and non-governmental organisations in establishing a broad and authoritative international committee of scientists and experts for the comprehensive study and elucidation of the threat of thermonuclear war and its potentially baneful consequences for the life and health of peoples of the world. For a text of Resolution WHA34.38, see WHO, Handbook of Resolutions and Decisions, ibid pp.397-398.


32 This was ironical because the end of the cold war in the early 1990s expectedly would have facilitated global consensus on effective non-proliferation of nuclear weapons.

33 Advisory Opinions of the International Court of Justice are not legally binding, but nonetheless serve as authoritative and persuasive interpretations of treaty and customary international law on issues within the competence of the UN General Assembly and specialised agencies of the United Nations system.
almost tore the WHO apart. The Organisation suffered a credibility crisis when nuclear weapons states threatened to withhold their financial and other contributions to the WHO if it went ahead with the nuclear weapons debate. To focus discussion particularly on the vulnerabilities of multilateral public health to south-north acrimony, I sketch how the forty-sixth World Health Assembly in May 1993 was entrapped in the South-North politics of the health and environmental effects of nuclear weapons, and whether indeed the WHO could seek an advisory opinion on nuclear weapons from the International Court of Justice.

In 1993, the forty-sixth World Health Assembly of the WHO voted to request an advisory opinion from the International Court of Justice framed thus: “In view of the health and environmental effects, would the use of nuclear weapons by a State in war or armed conflict be a breach of its obligations under international law including the WHO Constitution?”. Ms. Lini, the delegate of Vanuatu, expressed a view typical of a majority of the countries of the south that voted massively in favour of the resolution. Vanuatu, she argued,

had sponsored the draft resolution in order to be consistent with its principles and its commitment to safeguarding the future of the global environment and of the human race.... Any nuclear accident, any atmospheric testing, and any nuclear weapon deployment not only affected health and the environment but could also threaten the survival of humanity through its impact on the food chain.... Vanuatu had sponsored the draft resolution aimed at obtaining the view of the International Court of Justice on the use of nuclear weapons because it saw such use not only as a health issue but also as a threat to humanity.  

34 See Speech of Ms. Lini, 46th World Health Assembly: Summary Records of Committees p260, WHA46/1993/REC/3 (May 12, 1993) (hereafter Summary Records). In support of Vanuatu, the delegate of Zambia argued that requesting an opinion from the International Court of Justice was a “gesture that would have tremendous impact on the world’s nuclear status. As the prevention of nuclear proliferation merely served to maintain or even increase the nuclear arsenals of the nuclear countries while hindering other states from obtaining such weapons, the focus should be on their complete abolition”. See Summary Records, ibid at 259.
Mexico, a non-nuclear state – but paradoxically and geographically - a developing country in the global North, voted in favour of the resolution because “non-nuclear weapon states had a nuclear sword of Damocles hanging over them and were powerless to change the situation”.\(^{35}\)

Nuclear weapon states, led by the United States, countered and argued at the World Health Assembly that the question of legality and illegality of the use of nuclear weapons is an arms control question that is beyond the public health mandate of the World Health Organisation. The draft resolution on legality of nuclear arms, the US delegate argued, “would push the WHO into debates about arms control and disarmament that are the responsibility of other organisations in the United Nations system as well as other multilateral bodies”.\(^{36}\) After intense debate on South-North lines, the forty-sixth World Health Assembly by a vote of 75-33 (with five abstentions) voted in favour of requesting an advisory opinion from the International Court of Justice on the legality of the use of nuclear weapons. On 8 July 1996, the International Court of Justice declined to give the Advisory Opinion requested by the World Health Assembly of the WHO, and ruled that the legality of the use of nuclear weapons was *ultra vires* the public health mandate of the WHO as provided in its constitution.\(^{37}\)

\(^{35}\) *Ibid* at 259.

\(^{36}\) See Speech of Mr. Boyer, US delegate to the 46\(^{th}\) World Health Assembly, Summary Records, *ibid*, 273.

\(^{37}\) See *Legality of the Use by a State of Nuclear Weapons in Armed Conflict, Advisory Opinion*, (1996) ICJ Reports 4 at p66 (WHO Opinion). I am not concerned in this thesis with an international legal analysis of the court’s ruling/opinion to determine if it was rightly decided or given *per incuriam*. I am only concerned with the South-North dimension of the debate at the 46\(^{th}\) World Health Assembly that preceded its journey to the ICJ. International legal scholars are sharply polarised on whether the opinion expressed by the court was right or wrong. In a recent volume, Professors Laurence Boisson de Chazournes & Philippe Sands have dealt with the divergent views of eminent international lawyers on the soundness or otherwise of the nuclear weapons decisions of the International Court of Justice. See L.B de Chazournes & P. Sands, *International Law, the International Court of Justice and Nuclear Weapons* (Cambridge: Cambridge University Press, 1999) (with contributions from leading scholars: Richard Falk, Thomas Franck, Virginia Leary, David Kennedy, M. Koskenniemi, George Abi Saab, et al).
The nuclear weapons debate at the World Health Assembly presented enormous challenges (including a credibility crisis) for the WHO as a specialised agency of the United Nations system. Nonetheless, it paved the way to re-think the relevance of international law in global health governance because the debate raised broad questions traversing disarmament, international humanitarian law, international peace and security, use of force, public health, and protection of the global environment, all within the fuzzy confluence of law and politics. Nuclear weapons arguably may not be \textit{stricto sensu} public health issues, but an avalanche of global public health issues that are squarely within the mandate of the WHO also raise similar broad questions like nuclear weapons. What role(s) then should international law play in this emergent global health fabric vis-à-vis the mandate of a multilateral institution charged with directing and co-ordinating international health work? I explore this question in what follows as 'International Law and Governance of the Mandate of the World Health Organization'. I conduct two levels of inquiry on two governance mechanisms used by the WHO to pursue its multilateral public health mandate: the International Health Regulations (IHR) and the Framework Convention on Tobacco Control (FCTC).

**E: INTERNATIONAL LAW AND GOVERNANCE OF THE MANDATE OF THE WORLD HEALTH ORGANISATION: TWO LEVELS OF INQUIRY**

There are two major reasons why the relevance (or otherwise) of international law in health governance deserves attention in scholarship and in a multilateral policy-making framework. The first is the maturity and complexity of contemporary international law and its simultaneous transformation from a defensive ontological discipline\textsuperscript{38} to a creative

\textsuperscript{38} International law as a defensive ontological discipline compelled lawyers to defend the very existence of their discipline by debating whether international law is law, politics or morality. See Thomas M. Franck, \textit{Fairness in International Law and Institutions} (Oxford: Clarendon Press, 1995) 6.
post-ontological discipline capable of regulating and governing every conceivable global issue of our time. With respect to global health governance, post-ontological international law, for instance, enables us to assess the fairness and effectiveness of the law in regulating the cross-border spread of diseases and health risks in a divided world through a 'disease non-proliferation treaty'. Outside the realm of infectious diseases, other transnational health problems arising from tobacco control and international trade in illicit drugs and narcotics also require multilateral regulation. L'hirondel and Yach have identified such global health problems as tobacco use, misuse of anti-microbial drugs, international trade in blood and human organs, standards for biological and pharmaceutical products, and xenotransplantation, as issues that require the intervention of international law in the pursuit of the WHO’s mandate. Almost coterminous with international law’s post-ontological transformation is the fact that the structure and dynamics of international relations force states to use international law in international health co-operation. Thus international law must necessarily play an active role in the distribution of the dividends of public health protection as a public good in a sharply divided world.

39 International law as a creative post-ontological discipline enables lawyers to ask questions about the fairness of international law and its effectiveness/legitimacy in regulating emerging global issues. See Thomas M. Franck, ibid.

40 Here I remain a student of Thomas M. Franck whose fairness discourse argues that “international law has matured into a complete legal system covering all aspects of relations among states.... The challenge of space exploration has joined with the degradation of the earth’s environment ... to entice or compel individuals and governments to think in terms of our common destiny: to counter humanity as a single gifted but greedy species, sharing a common, finite, and endangered speck of the universe.... These factors have drawn humanity into a circle, seized our attention, and empowered the law makers”. See Thomas M. Franck, ibid.


42 See generally, David P. Fidler, “Return of the Fourth Horseman: Emerging Infectious Diseases and International Law” (1997) 81 Minnesota Law Rev. 788, David P. Fidler, supra note 12 at 21 arguing that “historically once public health problems entered the realm of the international system, states turned to international law as a tool to develop common rules, institutions and values”.
A second reason to explore international law’s relevance in global health governance relates to the need for a critical assessment of the historical evidence and realities of the formidable role that international law played in forging consensus on cross-border health problems at the nineteenth-century international sanitary conferences. Opinions expressed by international scholars are almost unanimous that post-1948 international health developments have sustained a systematic marginalisation of international legal mechanisms; a phenomenon that is clearly antithetical to the use of treaties and conventions in nineteenth-century public health diplomacy.43

Taken together, these two factors would hardly explain WHO’s present timidity – unlike the other United Nations specialised agencies - in using international legal mechanisms (treaties) to pursue its global health mandate. In over fifty years of its history, the WHO has under-utilised its enormous and innovative legal powers as provided in its constitution. Article 19 of the Constitution of WHO gives the organisation treaty-making powers very similar to that of most multilateral institutions. It provides that,

43 Allyn Taylor in a 1992 seminal article asserted that “WHO has had only limited success in stimulating national implementation of universal health service programs, in part because the organization has paid insufficient attention to the role that legislation can play in the Health for All Strategy”. See A.L Taylor, “Making the World Health Organization Work: A Legal Framework for Universal Access to the Conditions of Health” (1992) 18 American Journal of Law & Medicine 302. Fidler argues that “the WHO is facing an international legal tsunami that will require a sea change in its attitude towards international law. WHO’s lack of interest in international law does not reflect the historical experience of states and international health organizations prior to World War II. While WHO has been accused of focusing too little on international law, international relations prior to World War II were plagued by too much international health law”, see D.P Fidler, “The Future of the World Health Organization: What Role for International Law” (1998) 31 Vanderbilt Journal of International Law 1079. See also Katarina Tomasevski, “Health”, O. Schachter & C.C Joyner, (eds.,) United Nations Legal Order Volume II (Cambridge: Cambridge University Press, 1995) 859 (arguing that WHO’s Eighth General Programme of Work covering the period 1990-1995 does not even mention international law. The paucity of health law developed by the WHO could lead to an impression that health protection is not susceptible to legal regulation were it not for its expansion elsewhere, including the United Nations, both in quantity and in the range of issues it covers).
the Health Assembly shall have the authority to adopt conventions or agreements with respect to any matter within the competence of the Organization. A two-thirds vote of the Health Assembly shall be required for the adoption of such conventions or agreements, which shall come into force for each Member when accepted by it in accordance with its constitutional processes.\textsuperscript{44}

Although there is nothing expressly or implicitly innovative about Article 19, some scholars argue that when combined with the ambitious objective of the WHO, "the attainment by all peoples of the highest possible level of health", and WHO's equally ambitious definition of health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity", Article 19 provides the WHO with virtually limitless treaty-making power that surpasses any treaty power possessed by the organisation's precursors: the Pan American Sanitary Bureau, the International Office of Public Health, and the Health Organization of the League of Nations.\textsuperscript{45}

Article 21 of the WHO Constitution provides for an innovative treaty-making and norm-creating procedure that is novel in the practice of multilateral institutions: the power of the World Health Assembly to adopt legally binding regulations concerning:

(a) sanitary and quarantine requirements and other procedures designed to prevent the international spread of disease;

(b) nomenclatures with respect to diseases, cause of death and public health practices;

(c) standards with respect to diagnostic procedures for international use;

(d) standards with respect to the safety, purity and potency of biological, pharmaceutical and similar products moving in international commerce;


\textsuperscript{45} See David P. Fidler, \textit{supra} note 43 at 1087.
(e)advertising and labelling of biological, pharmaceutical and similar products moving in international commerce.\textsuperscript{46}

Article 21 is innovative because it dispenses with the time-wasting treaty-making procedure whereby states – like parties to a contract in domestic law - have to sign and ratify treaties before they are legally bound by such treaties. Article 21 procedure gives the health assembly the power to adopt legally binding regulations without the positive act of consent by states as symbolised by the time-hallowed practice of signature and subsequent ratification.\textsuperscript{47} For Regulations adopted under Article 21, there is equally an innovative procedure of 'contracting out' in Article 22. Such Regulations shall come into force for all Member States after due notice has been given of their adoption by the Health Assembly except for such Members as may notify the WHO Director-General of a rejection or reservation(s) within the period specified in the notice.\textsuperscript{48} Articles 21 & 22 of the WHO Constitution have been described as creating a quasi-legislative procedure that constituted a radical departure from the conventional international rule making and norm-generation in the late 1940s when the WHO was founded.\textsuperscript{49}

Under Article 23 of the WHO Constitution, the Health Assembly shall have the authority to make recommendations with respect to any matter within the competence of the organisation. The relevance of international law in global health governance can only be exhaustively explored within the scope of the legal, constitutional and treaty-making processes.

\textsuperscript{46} Art. 21 Constitution of the WHO, \textit{ibid} note 44.


\textsuperscript{48} Article 22 Constitution of the World Health Organisation, \textit{supra} note 44 at 6.

powers of the WHO: Article 19 (conventional treaty-making power), Article 21 (radically innovative legislative power to adopt legally-binding regulations), and Article 23 (power to make non-binding recommendations).

For decades, an intense debate has raged among scholars and policy-makers on the possible reason(s) why the WHO has continued to under-utilise its innovative legal powers since 1948. Put another way, should the WHO as a specialised and technical agency within the United Nations system adopt legally binding approaches or indeed use international law in the pursuit of its global health mandate? There are two clear schools to this debate: lawyers on the one side, and doctors/epidemiologists on the other side. Expressing a view typical of the lawyers, Fidler in a recent critique argued that post-1945 WHO operated as if it were at the centre of a transnational Hippocratic Society. In his words,

WHO was isolated from general developments concerning international law in the post-1945 period. This isolation was not accidental but reflected a particular outlook on the formulation and implementation of international health policy. WHO operated as if it were not subject to the normal dynamics of the anarchical society; rather, it acted as if it were at the centre of a transnational Hippocratic society made up of physicians, medical scientists, and public health experts. The nature of this transnational Hippocratic society led WHO to approach international public health without a legal strategy. Similarly Taylor argued that "WHO's traditional reluctance to utilize law and legal institutions to facilitate its health strategies is largely attributable to the internal dynamics

50 See my discussion of Hippocrates and the influence he had on modern medicine and epidemiology, supra Chapter Three, p82 at note 13.
51 David P. Fidler, “International Law and Global Public Health” (1999) 48 University of Kansas Law Review 1 at 15. See also K. Tomasevski, supra note 43 at 859 (strongly critiquing WHO’s overt bias in favour of non-binding and non-legal norms built upon ethical rather than legal principles. Also submitting that an important reason for WHO’S bias for non-binding rules is the traditional reluctance of the medical profession to submit itself to the rule of law. Beginning in the eighteenth century, medical associations developed codes of professional behaviour. Self regulation presumes the exclusion of lay persons, thus
and politics of the organization itself. In particular, this unwillingness stems, in large part, from the organizational culture established by the conservative medical professional community that dominates the institution”.

The view of the doctors/epidemiologists in the debate is understandably influenced by the giant strides made by science in proving the germ theory correct. Once epidemiologists understood how humans were infected by disease, they automatically turned to diagnosis and healing, and not to international law as a solution. International lawyers who are very critical of WHO’s non-legal approaches to global health work recognise this point. Fidler put it succinctly:

The common argument used to explain WHO’s antipathy towards international law is that WHO is dominated almost exclusively by people trained in public health and medicine, which produces an ethos that looks at global health problems as medical-technical issues to be resolved by the application of the healing arts. The medical-technical approach does not need international law because the approach mandates application of the medical and technical resource or answer directly at the national or local level.

Science catalysed the development of international health law in the 1890s because it provided the breakthrough needed to facilitate agreement by states on common rules and values. But in the contemporary era, the antibiotic revolution impeded the development of international health law because doctors and public health officials go directly after microbes rather than seek recourse to international legal regimes on global

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52 Allyn L Taylor, supra note 43 at 303. See also, Alison Lakin, “The Legal Powers of the World Health Organization” (1997) 3 Medical Law International 23 (discussing the underdeveloped but potentially influential normative function of the WHO and whether the Organization could more effectively utilise its constitutional legal powers to pursue its role as director and advocate of international health).

53 David P. Fidler, supra note 43 at 1099.
health issues. Little wonder then that as early as 1948, Sir Wilson Jameson, President of the first World Health Assembly showed very scant respect for international law when he asserted,

Let us face the facts and refrain from a discussion of legal technicalities into which we, as an assembly of public health experts, are perhaps hardly competent to enter.

It is by no means an easy task to synthesise the tensions raised by the legal and medical/epidemiological schools of thought; the reach and grasp of each has its pros and cons. Nonetheless, it is important to note that a strong emphasis on medical-technical ethos with a glorified celebration of the healing art would amount to an undue medicalization of public health. Public health is broader and more encompassing than medicine, although medicine is part of public health. Recalling the expansive definition of health in the WHO Constitution as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity", then linkages must be created between public health and poverty, underdevelopment, human rights, food scarcity, environmental protection, wars and weapons of war (both nuclear and conventional), civil conflicts, natural disasters, international trade, and globalisation as each of these affects human health. On each of these issues that have indelible fingerprints on the global health fabric, international law has played a formidable role in forging agreements between states, and these agreements must in turn feed into global health governance with respect to the mandate of the WHO. In retrospect, the post-1945

54 ibid.
55 OR 13 1948 (Records of the First World Health Assembly, 1948) p77. Sir Wilson Jameson was responding to legal issues and reservations raised by US membership of the WHO.
56 Aude L’hirondel & Derek Yach, supra note 41 at 83 has identified international human rights law, international environmental law, international trade law, law of the sea, international maritime law, intellectual property law, law of bioethics, as areas of international law relevant to WHO’s global health mandate. David P. Fidler's International Law and Infectious Diseases, supra note 12 creates similar
decades since the birth of the United Nations have witnessed the evolution of international legal mechanisms on human rights (including the right to health), global environmental issues, humanitarian law, and food and agriculture among others. WHO seems to have missed out of these exciting normative developments and regime-creations relevant to public health. Neither did it take any active part in the creation of these regimes by other international agencies nor did it exercise its treaty-making and constitutional/legal powers to initiate the creation of its own health regimes.

Having critiqued WHO’s limited use of international law, it is important to warn of the dangers and limitations inherent in advocating extreme legalistic approaches to multilateral health governance. In the public health context, law may simply be a means to an end, not an end itself. Fidler agrees as much that “world health through world law, is just as fanciful a notion as the ridiculed slogan of ‘world peace through world law’. Law is ultimately an instrument in human affairs, not an end in itself.... Neither international law nor global health jurisprudence provides a magic bullet against public health problems in the world today”.57 In reconciling the tensions between legal and medical approaches, placing global health governance within the normative ambit of international law is extremely important, but legalism must necessarily be matched with incentives that would significantly induce compliance with such legal rules and norms.

Before comparing global health governance mechanisms with similar mechanisms on global environmental issues where financial and technical assistance have been used as incentives to induce compliance, it is important to briefly analyse two legal/regulatory

57 David P. Fidler, supra note 51 pp1 &57.
approaches used by WHO in pursuit of its mandate: the International Health Regulations (IHR) and the ongoing negotiations for a WHO Framework Convention on Tobacco Control (FCTC).

(I) FIRST LEVEL OF INQUIRY: INTERNATIONAL HEALTH REGULATIONS (IHR)

The historical evolution of the International Health Regulations\(^58\) (hereafter “IHR”) dates back to the mid-nineteenth century when epidemics of cholera overran Europe between 1830 and 1847. These epidemics paved the way for subsequent public health diplomacy and multilateral initiatives. In 1948 when the Constitution of the World Health Organisation came into force, a series of multilateral sanitary conventions and sets of regulations were already in force, and being enforced by autonomous and independent multilateral organisations - the International Office of Public Health (in Paris), the Health Organisation of the League of Nations (in Geneva), and the Pan-American Sanitary Bureau (in Washington, DC). In 1951 WHO, pursuant to its legal powers under Article 21 of its constitution adopted the International Sanitary Regulations – the product of nineteenth century public health diplomacy. The WHO renamed these regulations the International Health Regulations (IHR) in 1969, and slightly modified them in 1973 and 1981. Since then, the IHR have been in force representing the first legally binding treaty adopted by WHO, and one of the earliest multilateral treaties strictly focusing on global surveillance for communicable diseases. As of 1997, the IHR were legally binding on all WHO’s 194 Member States except Australia. The IHR are a regulatory surveillance

mechanism for the sharing of epidemiological information on the transboundary spread of three infectious diseases: cholera, plague and yellow fever. Their fundamental principle is to ensure 'maximum security against the international spread of diseases with a minimum interference with world traffic'. To achieve this purpose, the IHR provide for binding obligations on WHO Member States to notify the Organisation of any outbreaks of cholera, plague and yellow fever in their territories.\textsuperscript{59} Notifications sent by a Member State to WHO are transmitted to all the other Member States with acceptable public health measures to respond to such outbreaks. This is part of WHO's surveillance mandate for the global spread of infectious diseases aimed at providing maximum security against transnational proliferation of diseases.

The IHR list maximum public health measures applicable during outbreaks, and provide for rules applicable to international traffic and travel. These measures cover the requirements of health and vaccination certificates for travellers from areas infected by these three diseases to non-infected areas; deratting, disinfecting and disinsecting of ships and aircraft as well as detailed health measures at airports and seaports in the territories of WHO Member States.\textsuperscript{60} The reason why measures listed in the IHR are the maximum measures allowed in outbreak situations is to protect the country that suffers an outbreak against the risk of overreaction and unnecessary embargoes, which could be imposed by contiguous neighbours, trading partners and other countries. These embargoes are often damaging economically, with severe consequences on tourism, traffic and trade.

\textsuperscript{59} For detailed provisions of the IHR on the obligation to notify WHO of outbreaks of these diseases and the sharing of epidemiological information contained in the notifications to other Member States, see Articles 2-13 of the IHR, \textit{ibid.}

\textsuperscript{60} See David P. Fidler, \textit{supra} note 12 at 61 stating that the IHR seek to provide WHO Member States with maximum protection against the importation of infectious diseases. To achieve this objective, the IHR establish a global surveillance system for the diseases subject to the regulations, require certain types of
Outbreak situations therefore require a multilaterally measured and evidence-based response founded on sound public health reasoning by a neutral multilateral organisation like the WHO.

Airports and seaports in the territories of WHO Member States shall have a core surveillance capacity and capabilities to detect and contain outbreaks of the diseases subject to the IHR. Articles 14-22 of the IHR require every port and airport to be provided with pure drinking water and wholesome food supplied from sources approved by the health departments of Member States.\textsuperscript{61} Every port and airport shall be provided with an effective system for the removal and safe disposal of excrement, refuse, waste water, condemned food, and other matter dangerous to public health.\textsuperscript{62} There shall be an organised medical and health service staff, equipment and premises, and facilities for the prompt isolation and care of infected persons, in as many ports and seaports as practicable.\textsuperscript{63} Also, as many ports and seaports as possible shall have facilities for disinfection, disinsecting, deratting, bacteriological investigation, collection and examination of rodents for plague infection, collection of food and water samples and their despatch to a laboratory for examination.\textsuperscript{64} Other core surveillance facilities required at ports and seaports by the IHR include, adequate personnel competent to inspect ships,\textsuperscript{65} designation of certain airports as sanitary airports for purposes of yellow

\textsuperscript{61} Article 14(2) IHR.
\textsuperscript{62} Article 14(3) IHR.
\textsuperscript{63} Article 15 IHR.
\textsuperscript{64} Ibid.
\textsuperscript{65} Article 17 IHR.
fever vaccination and related health measures,\textsuperscript{66} and measures against malaria and other diseases of international epidemiological importance.\textsuperscript{67}

Part IV of the IHR (Articles 23-49) makes detailed provisions for health measures applicable to international traffic and the procedure for their application. Article 25 contains precautionary provisions on the application of these measures. It provides that disinfection, disinsecting, deratting, and other sanitary operations shall be carried out so as:

(a) not to cause undue discomfort to any person, or injury to his health;
(b) not to produce any deleterious effect on the structure of a ship, an aircraft, or a vehicle, or on its operating equipment;
(c) to avoid any risk of fire.

In carrying out these operations on cargo, goods, baggage, containers and other articles, every precaution shall be taken to avoid any damage. Part V provides for detailed, but specific, surveillance measures on the three diseases subject to IHR: cholera, plague and yellow fever. For example, Article 52 provides that every state shall employ "all means within its power to diminish the danger from the spread of plague by rodents and their ectoparasites". On yellow fever, vaccination against yellow fever may be required of any person leaving an infected area on an international voyage.\textsuperscript{68} A person in possession of a valid certificate of vaccination against yellow fever shall not be treated as a suspect, even if he has come from an infected area.\textsuperscript{69} The IHR also require a master of a sea-going vessel making an international voyage - when required by the health authority.

\textsuperscript{66} Article 18 IHR.
\textsuperscript{67} Article 19 IHR.
\textsuperscript{68} Article 66(1) IHR.
\textsuperscript{69} Article 66(3) IHR.
in charge of a port – to complete and deliver to the health authority of that port a
Maritime Declaration of Health, which shall be countersigned by the ship’s surgeon if
one is carried on board.\textsuperscript{70} The master and the ship’s surgeon, if one is carried, shall
supply any information required by the health authority as to health conditions on board
during the voyage.\textsuperscript{71}

An assessment of the effectiveness and enforcement of the IHR by WHO reveals
that the IHR have been unsuccessful as a global surveillance tool. Many reasons account
for the ineffectiveness of the IHR. Chief among these is the fear of excessive measures
from other countries if a country suffering an outbreak of cholera, plague or yellow fever
notifies WHO of any such outbreak. Recent examples abound. Cholera epidemics in
South America, which were first reported in Peru in 1991, were estimated to have cost
over $700 million in trade and other losses.\textsuperscript{72} In 1994, a plague outbreak in India led to
$1.7 billion losses in trade, tourism and travel as a result of excessive embargoes and
restriction imposed on India by other countries.\textsuperscript{73} Commenting on the Indian plague and
the embargoes that followed it, Taylor stated that such excessive measures included
closing of airports to aircraft that were arriving from India, barriers to importation of
foodstuffs, and in many cases the return of Indian guest workers even though many of
them had not lived in India for several years.\textsuperscript{74} Most recently, the European Community

\textsuperscript{70} Article 77(1) IHR.
\textsuperscript{71} Article 77(2) IHR.
\textsuperscript{72} David L. Heymann, “The International Health Regulations: Ensuring Maximum Protection with
Minimum Restriction” 13 (Unpublished Manuscript, Program Materials on Law and Emerging and Re-
Emerging Infectious Diseases, Annual Meeting of the American Bar Association, 1996) (on file with the
author).
\textsuperscript{73} Ibid.
\textsuperscript{74} Allyn L. Taylor, "Controlling the Global Spread of Infectious Diseases: Toward a Reinforced Role for
the International Health Regulations (1997) 33 Houston Law Rev. 1348 citing David Heymann, \textit{ibid. See}
also, Laurie Garret, “The Return of Infectious Diseases”, Foreign Affairs Jan-Feb. 1996 73-74 (stating that
India lost almost two billion dollars as result of excessive measures following the plague outbreak).
(EC) imposed a ban on the importation of fresh fish from East Africa following the outbreak of cholera in certain East African countries. At the time of the EU ban, fish exports from the affected East African countries, Kenya, Mozambique, Tanzania and Uganda to EC countries stood at $230 million. The EU was their biggest trading partner for fresh fish.

Other reasons often cited for the ineffectiveness of the IHR include WHO’s inexperience in the creation and enforcement of legal regimes, the IHR’s inability to adapt to changing circumstances in international traffic, trade and public health, the IHR’s limited coverage of only three diseases, and the breakdown, and in many cases, glaring non-existence, of core surveillance capacity and facilities in many WHO Member States. Senior officials of the WHO admit that the utility of the IHR as a global surveillance regime is of doubtful validity. Fluss, the retired Chief of Health Legislation of the WHO argued,

the inconsistency of the earlier regime (for the control of the international spread of diseases) under the succession of conventions and agreements was apparent: none of these sanitary agreements entirely replaced each other, they did not take account of new methods available for the control of the diseases they covered, and they were not framed to deal adequately with the greatly increased volume and speed of international traffic.

In 1968, WHO’s Deputy Director-General stated that the IHR’s objective of avoiding

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75 See European Commission, Decision 97/878/EC, (1997) at 64, European Commission, Decision 98/84/EC at 43.
76 See Fidler, supra note 12 at 80.
77 According to Boris Velimirovic, “Do We Still Need International Health Regulations?” (1976) 133 Journal of Infectious Diseases 478 at 481, “Is there much sense in the maintenance of rules if they are not observed – if they are disregarded or more or less systematically broken – without any consequences for those who deviate”.
78 ibid, arguing that the IHR lags behind medical, trade and travel advances.
excessive and unnecessary quarantine measures has failed. In 1974, the Chief of WHO's Epidemiological Surveillance of Communicable Diseases stated that the value of the IHR in ensuring minimum interference with world traffic was questionable.

Because the IHR have become a 'toothless sleeping treaty', but paradoxically one that cannot easily be banished to the dust-bin of public health history, the forty-eighth World Health Assembly in May 1995 passed a resolution calling on the Director-General of WHO to start a process of IHR revision. Fidler noted that “the decision to revise the IHR came in response to the increasing concerns about emerging and re-emerging infectious diseases and the inadequacy of the existing IHR to deal with these growing problems”. Taylor commented that “revision and expansion of the IHR to provide a basis for effective national, regional, and global action is imperative to prevent the spread of emerging infectious diseases. The Regulations have not been revised in over fifteen years and do not regulate procedures for management of highly infectious new diseases and resurgence of deadly old diseases”.

Pursuant to the World Health Assembly resolution, the WHO in December 1995 held an informal consultation of experts on IHR revision. Taylor observed that the group of experts did not include any lawyers with expertise in international legislation. The expert group proposed a range of amendments

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81 ibid, quoting E. Roelsgaard, “Health Regulations and International Travel” (1974) 28 WHO Chronicle 265. See also Fidler, supra note 12 at 68 (stating that the WHO Constitution does not provide for any sanction against a Member State that fails to comply with a binding regulation enacted under Article 21).
84 Allyn L. Taylor, supra note 74 at 1346.
86 supra note 74 at 1350.
to the IHR, and in February 1998, the WHO circulated to its Member States a provisional
draft of revised IHR. The most important of the amendments was the expansion of
diseases subject to the regulations beyond plague, yellow fever and cholera. In particular,
the requirement to report these three diseases should be replaced by immediate reporting
of defined disease syndromes of urgent international importance as well as
epidemiological information for their emergence, prevalence and control. These
syndromes are grouped into six categories: acute haemorrhagic fever syndrome, acute
respiratory syndrome, acute diarrhoeal syndrome, acute jaundice syndrome, acute
neurological syndrome, and other notifiable syndromes. In the draft, all cases of acute
haemorrhagic fevers must be reported immediately. For the other syndromes, only clusters
that are of urgent international importance should be reported. Five factors determine if a
cluster of syndromes is of urgent international importance. These include: rapid
transmission of the syndrome in the community, unexpectedly high case fatality ratio,
newly recognised syndrome, high political and media profile, and trade/travel
restrictions.

Another change in the Provisional Draft of the IHR related to the power of the
WHO to request information from Member States based on information WHO received
from other reliable sources: WHO Collaborating Centres, non-governmental
organisations, mass media, other international organisations, and other countries.
Previously the WHO never had this power; it simply waited for a Member State to notify
it of an outbreak. The rationale behind this proposal is that few, if any, disease outbreaks
can be hidden because of extensive global media networks. Innovations in

87 Since I do not intend to deal with all the changes proposed by the expert committee, I focus on just two
of the changes: reporting of syndrome instead of diseases, and the need for the WHO to use information on
communications technology have rendered state sovereignty irrelevant in disease outbreaks. Independent global outbreak monitoring sources now abound. One example is the Global Public Health Information Network (GPHIN), an electronic surveillance system developed by Health Canada. According to field epidemiologists at the WHO, GPHIN continuously monitors some 600 sources, including all major news wires, newspapers, and biomedical journals. The system focuses its search on communicable diseases but will soon cover non-communicable diseases, food and water safety, environmental health risks, and the health impact of natural disasters.\(^88\) WHO field epidemiologists rely on outbreak information from GPHIN, but have developed steps to verify such information before publishing it in WHO’s authoritative Weekly Epidemiological Record.\(^89\) Other internet-based information providers on disease outbreaks include ProMED; a private initiative of the Federation of American Scientists’ Program for Monitoring Emergent Infectious Diseases that creates a global system of early detection and response to disease outbreaks\(^90\) and PACNET, an internet-based information provider on disease outbreaks in the Pacific region. The implication of these innovations is that disease outbreaks can no longer be hidden under the veil of state sovereignty.

As prelude to the submission of the Provisional IHR Draft to the World Health Assembly for adoption under Article 21 of the WHO Constitution, the WHO conducted a pilot study in randomly selected countries to test the efficacy of syndrome reporting and outbreaks obtained from other reliable sources if a country fails to report an outbreak directly to WHO.\(^88\) See Thomas W. Grein, et al., “Rumours of Disease in the Global Village: Outbreak Verification”, (2000) 6 Emerging Infectious Diseases 97.

\(^89\) ibid.

\(^90\) ProMed maintains ProMed-mail: a free electronic mail list with subscribers from over 150 countries. Subscribers numbering over 15,000 report and discuss outbreaks of infectious diseases. For a discussion of
other changes proposed in the IHR. The pilot study exposed the gaps and highlighted
difficulties of syndrome reporting. The study revealed that syndrome-reporting was
highly unpopular in both developed and developing countries where they were tested.
Many developing countries lacked core surveillance capacity for early detection of
clusters of the categorised syndromes in the IHR draft. For developed countries with
good surveillance capacity, turning a known disease into a syndrome was highly fanciful.
To paraphrase one Swedish epidemiologist, if there is an outbreak of cholera and public
health authorities know that it is cholera, why turn a known case of cholera into acute
diarrhoeal syndrome or rename it something else?\textsuperscript{91} The IHR revision is still an ongoing
process at the WHO. While syndrome reporting has not been totally discarded, Member
States additionally will continue to have the opportunity to notify WHO of diseases
specifically by name if they choose that option. Where an entirely new outbreak occurs
like the first case of \textit{ebola haemorrhagic fever}, a Member State will have an option to
notify by syndromes of the outbreak in question. The present trend at the WHO on the
IHR revision is for all 'urgent international public health events' to be reported by
Member States. An algorithm of what constitutes an urgent international public health
event is being developed. One certain scenario is that not only outbreaks of infectious
diseases will be notifiable pursuant to new IHR, public health risks like the emergence of
clusters of anti-microbial resistance, and aspects of food safety-related outbreaks will also
be notifiable pursuant to the IHR.

\textsuperscript{91} View of Dr. Johan Giesecke, Professor of Epidemiology, Karolinska Institute of Public Health,
Stockholm, Sweden and formerly Head of the IHR Revision Team at the WHO, Geneva. (Interview with
the author, 30 April 2000 in Geneva).
There are many critically important issues to be addressed if revised IHR are to succeed as an effective infectious disease surveillance tool. Commentaries by international scholars are no less formidable on these important pre-conditions for effective IHR. Focusing on improving compliance with the IHR, Taylor makes a case for the use of supervisory mechanisms. She argued that,

International supervisory mechanisms are extensively used throughout the UN system and have proven to be an effective and widely accepted form of affecting compliance with international commitments ... One effective and increasingly common form of international supervision is a system of auditing or fact-finding in which state reporting is accompanied by independent fact-finding and critical review by an independent monitoring body.... To counter the recognized weaknesses of reporting systems, some international treaty regimes supplement this procedure by an auditing process in which an independent monitoring body can obtain a measure of independent verification of state reports and critically review such reports.\(^\text{92}\)

Fidler holds a similar view in his critique of WHO's non-use of international legal strategies.\(^\text{93}\) Despite the ingenuity of these contentions, the Provisional IHR Draft and indeed the entire ongoing IHR revision process has failed to address one critical issue: the non-existence or collapse of public health surveillance capacities in many countries and the enormous amount of resources urgently needed to rebuild them.\(^\text{94}\) Global health governance in a world sharply divided by socio-economic disparities calls for increased use of regulatory mechanisms, but these regulations must address the pernicious effects of poverty and underdevelopment that plague the collapse of public health surveillance

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\(^{92}\) Taylor, \textit{supra} note 74 at 1357 (stating that new monitoring mechanisms are now widely used by UNECSO, WIPO, ILO, UNEP and the UN Human Rights Commission).

\(^{93}\) See generally, David P. Fidler, \textit{supra} note 43 at 1079.

\(^{94}\) David Fidler, \textit{supra} note 12 at 73 (stating that the IHR Provisional Draft proposes expanding notification duties without confronting the dilemma of financial and technological resources facing the developing world).
capacity in many developing countries today. The World Bank acknowledged that enormous resources are needed to improve public health in developing countries. The bank subsequently prescribed a minimum package of essential clinical services that would include sick-child care, family planning, parental and delivery care, and treatment of tuberculosis and sexually transmitted diseases (STDs). In many under-developed countries - Burundi, Chad, Haiti, Guinea-Bissau and many others - foreign aid accounts for more than twenty percent of health sector spending. What is needed therefore is a re-focusing of legal regimes that would emerge in the global health context to emphasise incentives for compliance. As stated by Fidler,

Today, the attention being generated on emerging and re-emerging infectious diseases, comes mainly from the developed world, which fears the spread of infectious diseases from the developing world ... Developing states need massive financial and technical assistance to deal with endemic diseases more than rules to prevent their diseases from travelling to the developed world.

The inseparable linkage between IHR, collapse of public health infrastructures, trade and other economic embargoes during outbreaks raises the question of incentives for compliance. To paraphrase Thomas Franck, why do powerful nations obey powerless rules? Incentives remain one of the factors that induce compliance. Leading

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95 Although I will address this argument in detail in the concluding chapter where I discuss a proposal for a global public health fund, I have also dealt with it in another forum with respect to compliance with WHO’s International Health Regulations, See O. Aginam, “Are We Our Brother’s and Sister’s Keepers: Africa and Public Health Challenges in a Divided World” (Unpublished; Paper presented at the Berkeley/Stanford Joint Center for African Studies Spring Conference, “Health & Society in Africa”, April 24, 1999, Stanford University, USA) (on file with the author).
97 Ibid.
100 In this context, I use “incentives” broadly to include tangible benefits - financial, technical and human resources; and intangible benefits – health as a public good and a psychological feeling that compliance
international lawyers have explored the philosophical and jurisprudential dimensions of obligation in the international system. The erudition of Oscar Schachter, Louis Henkin, and Thomas Franck in this area of international scholarship is remarkable. In a seminal article published in 1968, Schachter enumerated thirteen theories often used by international lawyers as the basis of international obligation, and suggested that "in all these cases the traditional sign-posts of legal obligation have limited utility, at the very least they call for further analysis". Louis Henkin argued that the threat of sanctions is not always the primary reason why states observe or disobey international rules. States will comply with international law if it is in their best interest to do so. They will disregard law or obligation if the advantages of violation, on a scale of balance, outweigh the advantages of observance. Thomas Franck's fairness discourse in the international system synthesizes the imperatives of determinate/unambiguous rules with distributive justice; international law's fairness in the distribution of global resources anchored on the Rawlsian scheme of "moderate scarcity".

Applying these views analogously to the IHR, what incentives in the IHR would induce WHO Member States to comply with their provisions? This question is complex

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101 O. Schachtter, "Towards a Theory of International Obligation" (1968) 6 Virginia Journal of Int'l Law 301 (enumerating the following basis of obligation in international legal scholarship: consent of states, customary practice, a sense of "rightness" – the juridical conscience, natural law and natural reason, social necessity, the will/consensus of the international community, direct intuition, common purposes of the participants, effectiveness, sanctions, systemic goals, shared expectations as to authority, and rules of recognition).

102 Louis Henkin, How Nations Behave: Law and Foreign Policy (New York: Columbia University Press, 1979) 49. For the IHR, it is a matter of argument whether the advantages of observance – the formulation of maximum health measures by the WHO - outweigh the disadvantages: trade, and other economic embargoes that could cost a country billions of dollars.

103 See generally, Thomas M. Franck, supra note 99.
because no single factor on its own can radically change the behaviour of the WHO Member States with respect to the IHR. While the WHO needs to step up its present ineffective enforcement strategy of the IHR, it must also strive to develop sufficient incentives to induce compliance by Member States. The present negative rewards of notification: trade, travel and economic embargoes must give way to a positive rewards - human, financial and technical assistance to WHO Member States that lack core public health capacity to deal with outbreaks. During outbreaks, the WHO must rigorously defend its global health mandate where other Member States impose unnecessary trade and travel embargoes outside the measures issued by the WHO. Regrettably the WHO has consistently shied away from this important advocacy strategy and has used it only once to fight the EU ban of fresh fish from East Africa following a cholera outbreak in certain East African countries.\textsuperscript{104} A combination of this type of positive advocacy and assured promise of incentives may significantly improve the 'compliance pull' of the new IHR.

\textsuperscript{104} During the EU ban of fresh fish from East Africa as a result of a cholera outbreak in three East African countries, WHO exercised its global health mandate by issuing a strong statement condemning the EU ban as a punitive measure not based on any sound epidemiological principles. The WHO statement influenced the EU to lift the ban and to settle the case that was already heading to the dispute settlement panel of the World Trade Organization. See WHO, “Director-General Says Food Import Bans Are Inappropriate for Fighting Cholera”, WHO Press Release WHO/24, February 1998.
(II) SECOND LEVEL OF INQUIRY: WHO FRAMEWORK CONVENTION ON TOBACCO CONTROL (FCTC)

Negotiations by WHO Member States for a Framework Convention on Tobacco Control (hereafter "FCTC") directly implicate the relevance of international law in global health governance. In May 1999, the World Health Assembly, the governing body of the WHO, adopted (by consensus) Resolution WHA52.18 urging the Director-General of WHO to start a process of multilateral negotiations on a WHO Framework Convention on Tobacco Control. In its 53-year history, the FCTC process is the first time that WHO is exercising its treaty-making powers under Article 19 of its Constitution.

Tobacco use is one of the leading causes of preventable deaths, and a leading contributor to burdens of disease globally. There are over 1.25 billion smokers in the world, and it is estimated that about four million people die yearly from tobacco-related diseases. Although tobacco use is a leading cause of premature death in industrialized countries, the epidemic of tobacco addiction, disease and death is continuing to shift rapidly to developing countries. Leading tobacco multinationals targeted growing markets in Latin America in the 1960s, the newly industrialized economies of Asia (Japan, The Republic of Korea, Taiwan and Thailand) in the 1980s, and have increasingly

107 ibid. See also A.L Taylor, “An International Regulatory Strategy for Global Tobacco Control” (1996) 21 Yale J. Int'l. Law 257 (stating that the absence of effective domestic regulation of tobacco in developing countries has created a lucrative opportunity for transnational tobacco companies to target such countries.
targeted women and young persons in Africa in the 1990s. As succinctly put by Fidler, “Western tobacco companies succeeded in riding the waves of international trade law, liberal triumphalism and globalizing Western culture in penetrating the markets and lungs of millions of people in the developing world”. It is now increasingly evident that a 'double jeopardy' looms large for developing countries because the burden of a tobacco epidemic will be added to their already heavy morbidity and mortality burdens from communicable diseases like malaria and TB. Today a majority of smokers live in developing countries (800 million); most are men (700 million) and 300 million are Chinese. At current levels of consumption, the tobacco epidemic is expected to kill up to 8.4 million people per year by 2020, with 70% of these deaths occurring in developing nations. If current consumption patterns remain unchecked, within the next 30 years tobacco use will be the leading cause of premature deaths world-wide.

Tobacco use is medically associated with a range of diseases and fatal health conditions including lung and bladder cancers, heart diseases, bronchitis and emphysema, and increased antenatal and prenatal mortality. WHO states that the nature of the smoking epidemic varies from country to country. In developed countries, cardiovascular disease – particularly ischaemic heart disease – is the most common smoking-related

\[\text{In many of the poorer states, aggressive tobacco promotion by the tobacco industry and Western states simply overwhelms underfunded national tobacco control efforts.}\]


111 Ibid.
cause of death. In populations where cigarette smoking has been common for several decades, about 90% of lung cancer, 15-20% of other cancers, 75% of chronic bronchitis and emphysema, and 25% of cardiovascular disease at age's 35-69 years are attributable to tobacco. Tobacco-related cancer constitutes 16% of the total incidence of cancer cases – and 30% of cancer deaths – in developing countries, while the corresponding figure in developed countries is 10%. Smoking is also associated with about 12% of all tuberculosis deaths. WHO suggests that this could be because a lung damaged by tobacco may offer a supportive environment for the infectious tuberculosis bacillus. For non-smokers, inhalation of tobacco smoke – passive or second hand smoking – poses serious health risks. Exposure to other people’s smoking is associated with a risk of lung cancer, and several other health ailments in children - infant death syndrome, low birth weight, intrauterine growth retardation, and children’s respiratory disease.

The political economy of tobacco and its regulation poses difficult challenges not because a tobacco epidemic is more complex than the series of similar transnational problems that have been effectively regulated in the past decades. It is so because the WHO-FCTC will confront very difficult questions on a number of issues: liberalization of global trade rules, the powerful influence and enormous wealth of tobacco multinationals as evidenced by their aggressive marketing strategies world-wide, the economic dependence of some developing world economies on tobacco farming as

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113 ibid.
114 ibid. For a more detailed study of tobacco smoke on children, See WHO-Tobacco Free Initiative, International Consultation on Environmental Tobacco Smoke (ETS) and Child Health (Consultation Report), 11-14 January 1999 (Geneva: WHO-Tobacco Free Initiative, 1999) enumerating the following: respiratory health and middle ear disease, pneumonia, worsening of asthma, foetal growth, sudden infant death syndrome (SIDS), neuro-developmental effects, cardiovascular effects, and childhood cancers as the medical effects of tobacco smoke on children.
foreign exchange earner,\textsuperscript{115} and the complexity of harmonising cigarette taxes, policies and advertisements within domestic jurisdictions, and multilaterally. A global tobacco treaty could therefore easily bump into the global trade arena where the World Trade Organization (WTO) now holds sway as a strict enforcer of age-long trade rules such as 'national treatment' and 'most favoured nation' principles.\textsuperscript{116} Article XX(b) of the General Agreement on Tariffs & Trade (GATT) provides that trade-restricting measures necessary to protect human health are justifiable if those measures do not constitute arbitrary or unjustifiable discrimination between countries. In practice, striking the required delicate balance between trade and public health, especially with tobacco, has proved recondite. A case in point is the \textit{Thai Cigarettes Case} (United States v. Thailand),\textsuperscript{117} where the United States challenged – before a GATT panel - the prohibition of importation of foreign cigarettes by Thailand as an unjustifiable and discriminatory trade restriction that violated (national treatment principle) Article XI of the GATT. The US argued further that the real objective of the Thai tobacco ban was not the protection of public health in Thailand but to create a monopoly for Thai tobacco and protect Thai-made cigarettes from foreign competition. Thailand relied on Article XX(b) of the GATT and argued that the import ban was designed to protect public health in Thailand;

\textsuperscript{115} Zimbabwe, Malawi, Kenya and many other countries in Africa, and in South and Central America are tobacco growing and exporting countries. The WHO is now holding talks with the Food & Agriculture Organization of the United Nations (FAO) and the World Bank to develop an effective and workable crop substitution policy for these countries. Detailed scientific study as well as financial and technical assistance is needed to substitute other cash crops for tobacco in these countries.

\textsuperscript{116} The aim of these two related trade rules is to prevent discrimination against imported goods in the domestic markets of WTO Member States. Based on the national treatment principle, a WTO Member State shall not treat a foreign company less favourably than its national companies and shall accord imported goods or goods made by foreign companies the same treatment it gives to goods manufactured by national companies. Based on the most favoured nation principle, a WTO Member State shall extend the best tariffs and policies it gives to a trading partner to all other WTO member countries.

smoking was harmful to health, and opening the Thai market to imported cigarettes would lead to more smoking, deaths and increased medical costs. Rejecting the argument of Thailand, the trade panel ruled that Thailand’s practice of permitting the sale of domestic cigarettes while not permitting the importation of foreign cigarettes was an inconsistency with the General Agreement that does not come within the ambit of public health exception in Article XX(b).

It appears that WHO’s Tobacco Free Initiative, the unit responsible for the FCTC, is versed in the difficult complexities of the unfolding tobacco-public health-international law dynamic with respect to the WHO's tobacco treaty. As argued by two scholars actively involved in the FCTC process,

trade liberalization and market penetration have been linked to a greater risk of increased tobacco consumption, particularly in low- and middle-income countries... The tobacco industry has also taken advantage of direct forms of market penetration in cash-hungry governments of poor countries via direct foreign investment, or other strategic partnering with domestic companies.... As the vector of the tobacco epidemic, the tobacco industry is well aware of the characteristics of globalization and is attempting to manipulate globalization trends in its favour.\(^\text{118}\)

Notwithstanding these difficult questions bordering on trade liberalization and public health consequences of tobacco use, negotiations for WHO's FCTC have made considerable progress. In May 1999, the World Health Assembly established a working

\(^{118}\) A.L. Taylor & D. Bettcher, \textit{supra} note 110 at 924. Dr. Douglas Bettcher is the Co-ordinator of the Framework Convention on Tobacco Control Team at WHO headquarters, Geneva. Dr. Allyn Taylor is External Legal Adviser, Tobacco Free Initiative of WHO, and Adjunct Professor of Health Policy at Johns Hopkins University. \textit{See} also A.L. Taylor, \textit{supra} note 107 at 257 (arguing that the tobacco multinationals have focused not only on gaining entry into closed national markets throughout the world, but also on blocking the imposition of national regulations that restrict the advertising or sale of cigarettes. Political pressure by major Western tobacco-exporting states, particularly the United States, has forced open markets and expanded advertising in importing countries. Western pressure has also led to a number of changes in the developing and newly industrialised countries that have reduced the price and increased the demand for cigarettes).
group to analyze potential elements to be included in the tobacco treaty, and an Inter-
Governmental Negotiating Body (open to WHO's 191 Member States) to negotiate and
draft the proposed WHO Framework Convention on Tobacco Control and related
protocols. The Tobacco Free Initiative of the WHO prepared background documents for the working group enumerating possible elements to be covered by the Framework
Convention and other elements of subsequent protocols. Draft elements of the
Framework Convention include preamble, principles and objectives, obligations,
institutions, implementation mechanisms, law making processes and final clauses
(signatories, reservations, ratification and withdrawal). Potential elements for subsequent
related protocols include: cigarette prices and harmonization of taxes, measures against
smuggling, duty-free tobacco products, tobacco advertising and sponsorship, reporting of
toxic constituents of tobacco products, packaging and labelling, tobacco and agricultural
policy, sharing of information. Negotiations on these issues by the inter-governmental
negotiating body of over 135 WHO Member States are almost concluded. As the WHO
Framework Convention on Tobacco Control is expected to be concluded and presented to

120 See for instance, Daniel Bodansky, “What Makes International Agreements Effective? Some Pointers to
Behind the International Framework Convention on Tobacco Control: Lessons From the Code on
123 Over 150 delegates from these countries met in Geneva in October 2000, April and October 2001 for negotiations.
the World Health Assembly in May 2003, it is too early in the day to forecast its potential success or failure. Nonetheless there are two very important facts that have emerged from the FCTC process. First, the FCTC is based on infallible epidemiological evidence that tobacco is harmful to health, and therefore needs to be globally regulated because of the global networks of tobacco conglomerates. According to WHO Director-General Gro Harlem Brundtland, "we need an international response to an international problem". Secondly the FCTC represent a radical change of approach by the WHO in pursuing its global public health mandate. After decades of neglect of international law, WHO has decided to exercise its constitutional and treaty-making power to negotiate a legally binding multilateral treaty for the first time in over fifty years of its history. The WHO FCTC and related protocols - if carefully negotiated to tackle most of the complex tobacco issues - may not be just another international treaty but as the WHO Director-General stated, "a product and a process and a public health movement... a pathfinder in public health".

The WHO has now stepped into a terrain that the organisation historically is unfamiliar with: the use of international treaties to tackle a multilateral health issue. It is therefore useful to conduct a comparative assessment of similar mechanisms used in the governance of multilateral issues in the environmental context. This comparative

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124 WHO has stated that "since about 1950, more than 70,000 scientific articles have left no scientific doubt that prolonged smoking is an important cause of premature mortality and disability world-wide". See WHO, The World Health Report 1999: Making a Difference (Geneva, WHO, 1999) 66. See also, The World Bank, Curbing the Epidemic: Governments and the Economics of Tobacco Control (Washington, DC: The World Bank, 1999).
125 Dr. Gro Harlem Brundtland, Speech at Seminar on Tobacco Industry Disclosures, WHO, Geneva, 20 October 1998 (on file with this author). See also A.L Taylor, supra note 107 at 257 (stating that the global tobacco epidemic is international in origin, has international repercussions, and necessitates collaborative, multilateral action).
126 WHO Director-General Gro Harlem Brundtland, Speech at the WHO’s International Conference on Global Tobacco Control Law: Towards a WHO Framework Convention on Tobacco Control, New Delhi, India, 7 January 2000 (On file with this author).
overview is necessary because WHO’s Framework Convention on Tobacco Control is being patterned after a similar framework convention process on global environmental issues: climate change and ozone depletion. Also I have argued that the disparities between the developed and developing worlds compel a re-focusing of emergent global health regimes to resuscitate collapsing or non-existent public health surveillance structures across the developing world. Both the IHR and FCTC – WHO’s two governance mechanisms - must grapple with the persistent question of financial and technical assistance to developing countries. Global environmental treaties, though hardly infallible, have addressed these questions more elaborately. WHO, in its enforcement of a revised IHR and FCTC (when it is concluded) would have to learn the resource-sharing dynamics of global environmental regimes being enforced by other multilateral organisations. I now proceed to assess this resource-sharing formula under the Convention for the Protection of the Ozone Layer and the World Bank’s Global Environmental Facility (GEF).
In the late 1970s and early 1980s, it became obvious that ozone depletion was a serious global issue that neither unilateral nor regional approaches could solve. After many years of intensive diplomacy under the auspices of the United Nations Environment Programme (UNEP), the Vienna Convention for the Protection of the Ozone Layer was adopted on March 22, 1985.

The Ozone Convention is basically a framework. It contains no legally binding commitments for countries to cut the levels of their CFC emissions because as Birnie and Boyle pointed out, it was difficult for states to agree in 1985 on proposals for more specific measures to control ozone depletion. The convention noted that ozone depletion was a global problem that required international co-operation because of the

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127 For a full text of the Ozone Convention, See (1987) 26 International Legal Materials 1529.
128 According to A. Kiss & D. Shelton, International Environmental Law (New York: Transnational Publishers, 1991) at 231, "Ozone is a form of oxygen, containing one more atom than the oxygen breathed in the atmosphere. Ozone produces harmful consequences at certain altitudes, particularly on plants. In contrast, stratospheric ozone, whose strongest concentrations are found between 20 and 25 kilometres above earth, filters a part of the sun's ultraviolet radiation which otherwise would cause harm to different forms of life on earth".
129 A. Kiss & D. Shelton, Id., at 232 citing a study by the United Nations Environment Programme (UNEP), and also A. K Biswas, The Ozone Layer (1979) state that because all living beings have lived under the protection of the ozone layer, and the ozone plays a critical life-support role for all living beings on earth, its depletion risks an increase in the number of human skin cancers, harm to eyes, and other unforeseen biological consequences.
130 Ibid at 232 observing that "the main cause for reduction of the ozone layer is the utilization of chlorofluorocarbons. ...The emissions of chlorofluorocarbons, if they continue at 1977 levels, will result within twenty years in a five percent reduction in the ozone layer".
serious risks it posed to human health and the environment. It contains general obligations for co-operation between states for further research, systematic observation, and exchange of information. Like most framework conventions, the Ozone Convention established basic principles and a permanent organ for further negotiation of related binding protocols. In 1987, the Montreal Protocol on Substances that Deplete the Ozone Layer was adopted. The Montreal Protocol and its subsequent London Amendments set an important precedent in governance of global issues because of the special treatment given to developing countries. The London Amendments endorsed a multilateral fund regime consisting of voluntary contributions from industrialised to developing countries. Because of the enormous costs involved in phasing out certain CFCs and other substances by 2040, the Multilateral Fund covers incremental costs incurred by developing countries that switch to ozone-friendly technologies. The Multilateral Fund regime was instrumental in creating a functional system. Since the fund became operational in 1991, it has financed the development of 39 country programs. Nine of these programs represent approximately twenty percent of controlled substances by developing countries – including China, Mexico, Brazil, Malaysia, Egypt and Jordan. The main organ of the Fund is an Executive Committee of 14 members, seven of whom are selected by developing country States Parties to the Montreal Protocol, and the other seven by industrialized States Parties. The Committee monitors the

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133 Article 2.
136 Birnie & Boyle, supra note 132 at 211.
138 ibid.
implementation of operational policies and guidelines, the disbursement of resources, and
develops the budget of the Fund and eligibility criteria for funding. Decisions are taken
by consensus, and if no consensus is reached, by a two-thirds majority of the Parties
present and voting.\textsuperscript{139} Despite the limits of the obligation to report information pursuant
to Article 7 of the Protocol, the Ozone Convention and the Montreal protocol have
contributed positively to the governance of a global environmental problem: ozone
depletion. The view has been expressed that both the Ozone Convention and the Montreal
Protocol "have created one of the most elaborate and sophisticated models of
international control and supervision for environmental purposes".\textsuperscript{140}

II: THE WORLD BANK: INSTRUMENT ESTABLISHING THE GLOBAL
ENVIRONMENTAL FACILITY (GEF)\textsuperscript{141}

The Global Environmental Facility was originally set up in 1990 as a three-year
pilot study between the World Bank, the United Nations Environment Programme
(UNEP) and the United Nations Development Programme (UNDP) with an initial sum of
$1.2 billion. Its objective was grant financing of global environmental projects. Some
scholars assert that the multilateral fund regime of the Montreal Protocol on Substances
that Deplete the Ozone Layer influenced the GEF.\textsuperscript{142} After the United Nations
Commission on Environment and Development (UNCED) process, the Rio Conference
on Environment and Development 1992 – an aftermath of UNCED – adopted a range of

\textsuperscript{139} \textit{ibid}.


\textsuperscript{141} For a full text of the Instrument Establishing the Global Environmental Facility, \textit{See} (1994) 33
International Legal Materials 1273.

\textsuperscript{142} A. Kiss & D. Shelton, \textit{supra} note 137 at 47.
global environmental treaties and soft-law declarations. At Rio, treaties on climate change and biodiversity were opened for signature. A non-binding statement of principles on global forests was declared. Agenda 21 – a program of action by the international community addressing major environmental and development priorities leading into the 21st century was adopted. The implementation of these treaties and the 'soft-law' declaration posed enormous financial and technical challenges in most countries. As a result, a decision was taken at the Rio Conference on Environment and Development to restructure the existing Global Environmental Facility (GEF) in accordance with the principles of universality, transparency and democracy. A new Instrument was adopted in March 1994. Birnie and Boyd state that “its general function is to provide funding to help developing countries meet agreed incremental costs of measures taken pursuant to UNCED Agenda 21 to achieve agreed global environmental benefits with regard to climate change, biological diversity, international waters, and ozone layer depletion. It is also specifically designated for these purposes in the Ozone Layer, Climate Change and Biological Diversity Conventions”. The GEF secretariat is located at the World Bank. The Bank uses the facility to assist countries whose annual

147 Agenda 21 is a volume with 40 chapters, 115 topics covered in 800 pages. It has four main parts covering socio-economic dimensions, conservation and resource management, civil society participation, and implementation mechanisms.
148 Supra note 132 at 666. See also, A. Kiss & D. Shelton, supra note 137 at 47 (stating that GEF is intended to assist developing countries in addressing four global environmental issues: climate change, stratospheric ozone depletion, loss of biological diversity, and pollution of international waters)
per capita income is below $4,000. UNDP and UNEP are involved with training, technical assistance, research and maintenance of consistency with international environmental treaties and norms. GEF has funded many environmental projects in developing countries and has been hailed by scholars for its equitable treatment of developing countries based on the concept of "common but differentiated responsibility". The governing body of GEF is a Council composed of thirty-two members with a balance of developed and developing countries. Decisions require a double majority of 60 per cent of all members plus a majority of 60 per cent (by contribution) of all donors. Notwithstanding its imperfections, the GEF has emerged as a major funder of global environmental issues that threaten all of humanity.

Global environmental governance – through the GEF and Montreal Protocol – has used international treaties to foster co-operation and consensus in a divided world. Environmental problems such as climate change and ozone depletion are similar to public health problems such as infectious diseases and the tobacco epidemic. They are all global issues that threaten populations irrespective of national boundaries. It is therefore imperative to explore the adaptation of governance mechanisms like the GEF and Montreal Protocol in the global health context.

G: SUMMARY OF THE ARGUMENTS

I have argued that 'multilateralisation' of public health in a world order composed of sovereign nation-states is prone to the complexities of politicisation based on strategic and other interests of countries. Part of this politics is fuelled by South-North disparities as illustrated by the nuclear weapons debate at the World Health Assembly. A plethora of other political issues, as I have argued, inhibits contemporary multilateral health cooperation. Nonetheless, emerging perspectives have failed to explore the role(s) that international law has long begun to play in forging consensus on multilateral environmental issues and to seek ways to create a similar role for international law in the global health context. With its current revision of the International Health Regulations (IHR) and ongoing negotiations for a global tobacco treaty, WHO seems to be waking up from decades of neglect of international law. The success of each of these emerging legal strategies – IHR and FCTC - requires an enormous amount of human, technical and financial resources within countries, and a sustained advocacy and political will on the part of WHO. The principle of common but differentiated responsibility on which both the GEF and Montreal Protocol are based recalls the often-ridiculed maxim of "in terms of contribution; from each according to his wealth, and in terms of distribution; to each according to his need". All of humanity is now closely interconnected in a world fast becoming a single germ pool. As a result, poverty, underdevelopment, or a classical interpretation of state sovereignty should never be used as a 'sword' to kill multilateral solutions to global problems. Conversely, the GEF and Montreal Protocol have shown that poverty and under-development between countries can indeed serve as a 'sword' with which to attack transnational threats. Though hardly infallible, it is important to note
that those environmental governance mechanisms (GEF and Montreal Protocol) emerged through the instrumentality of international law. International law itself may not provide the sole miraculous road-path to a desired global health sanctuary, but it must play a formidable role in the dynamics of microbe-humanity interaction. Politicisation of multilateral initiatives has been a dominant phenomenon of internationalism from earliest historical accounts, and will remain an important factor in coming decades. Nonetheless, within the global social milieu of public health, poverty, under-development and politics, international law emerges as an important post-ontological tool to strategize the contemporary turbulent multilateral health order based on an equitable distribution of 'moderate but scarce' multilateral resources.
CHAPTER FIVE

CASE STUDY: GLOBAL MALARIA POLICY AND ETHNO-
PHARMACOLOGICAL-TRADITIONAL MEDICAL THERAPIES FOR
MALARIA IN AFRICA

A: OVERVIEW OF THE ARGUMENT

This chapter discusses global malaria control policy and its relationship with “ethno-medicine”\(^1\) or “ethnopharmacology”\(^2\) in Africa. The relevance of ethno-medical or ethnopharmacological approaches to a tropical disease like malaria remains controversial despite volumes of seminal works, series of international conferences and elaborate multilateral eradication/control strategies the disease has generated in past decades. One source of this controversy is science. In certain aspects of Western scientific discourse, African traditional medicine – including ethno-medical malaria therapies - is easily dismissed as unscientific belief, magic, superstition, ritual, barbarism, witchcraft, or sorcery. Staugard argues that throughout history, an ambitious search for physical, social and mental well-being has pre-occupied the minds of humankind in all cultures. As a result, two systematic responses to ill-health and disease have since

\(^{1}\) Ethnomedicine is defined as “the study of different ways in which people of various cultures perceive and cope with illness, including making a diagnosis and obtaining therapy”, see H. Fabrega, “The Need for an Ethnomedical Science”, (1975) Vol. 189 Science No.4207 at 969.

\(^{2}\) Reacting to the question, what is ethnopharmacology?, Peter A.G.M. De Smet, in his famous work Herbs, Health and Healers: Africa as Ethnopharmaceutical Treasury (Berg en Dal, The Netherlands: Afrika Museum, 1999) p11 states that; “from time immemorial, man has valued the plant kingdom and animal kingdom as sources of bioactive products…. Some of these traditional plant and animal substances are purely magical. They have no relevant pharmacological (i.e. drug-like) effects, which can be produced in a laboratory setting. Many substances have a measurable pharmacological action, however, which corresponds well to their traditional application. The scientific discipline which explores this pharmacological basis of traditional drugs and poisons is called ethnopharmacology. Its focus ranges from the first-hand observation of native drug practices (by early travellers and anthropologists) through the identification of crude ingredients and their constituents (by botanists, zoologists and chemists) to the evaluation of wanted and unwanted drug effects (by pharmacologists and toxicologists)”. \n
emerged. One is the modern system of medicine founded by Hippocrates and his pupils on the Greek Island of Kos, and the other is traditional medicine, which is as old as humankind in all cultures. From ancient times, the two systems have co-existed, albeit with hostility. Staugard states that modern medicine has often demonstrated its hostility towards traditional health care by categorising it either as "quackery" or "witchcraft". This categorisation arises from the often mistaken Western conception of traditional medicine that sees the herbalist, diviner, magician, and faith healer as belonging to one single and indivisible health delivery compartment devoid of methodological or analytical scientific investigation. Before the 1970s, Sindiga observed that most studies concerned with African traditional medicine linked it with beliefs, religion and rituals. Such studies, pioneered by the structural functional school of British anthropology uncritically concluded that African disease aetiologies were basically moral, social and devoid of any scientific insights and assessment. In a recent work, De Smet wrote that "many Western doctors and pharmacologists believe that ethnopharmacology yields nothing but armchair amusement". In contrast, since 1972, the World Health Organisation has consistently called for an effective integration of traditional medicine into the fabrics of national health care systems of Member States. Notwithstanding WHO resolutions, however, multilateral health policy still suffers a serious 'regime

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6 De Smet, *supra* note 2 at 11.
7 The 1972 World Health Assembly Resolution WHA29.72 noted the huge manpower reserve constituted by traditional medical practitioners. The 1977 World Health Assembly Resolution WHA30.49 called on Member States to explore the utilization of traditional medicine in their health care systems. The 1978 the World Health Assembly Resolution WHA31.33 noted the medicinal value of medicinal plants in the health systems of many developing countries.
deficit' on the interaction of African ethnopharmacological practices and multilateral malaria control policy.

In our time and age, there are two persuasive and inexorably linked reasons why ethno-medicine is relevant to global malaria policy. The first is global multiculturalism and its implications for the health therapy of populations across various cultures of the world. The second reason relates to the cost and affordability of health care in Africa where ethno-medical therapies for malaria may be readily available at a cost the community can afford while orthodox (Western) malaria medicines are not. In a multicultural world, every society – in the developing world and elsewhere - deals with illness and disease in a variety of ways. Ethno-medicine has no unifying theme across societies; thus the therapies it provides vary from one society or culture to another. Ethno-medical knowledge of plants by indigenous people across societies and cultures has, long served as crucial sources of medicines either directly as therapeutic agents, as starting points for the elaboration of more complex semi-synthetic compounds or as synthetic compounds. In most African societies, multiculturalism has given rise to what some scholars call “medical pluralism” – the existence in a single society of differently designed and conceived medical systems. Such systems exist together, and may either compete with,
or complement, one another. Populations in the developing world resort to both traditional medicine and Western medicine simultaneously for the same illness or at different times for different illnesses. It has been observed that “African peoples believe in traditional medicine and it is not uncommon to see patients in hospitals permitting themselves to be treated by modern medicine during the day and having recourse to the recipes of traditional medicine at night”. Juxtaposing ethno-medicine with Western medicine, the holistic approach of traditional medicine to the art of healing is one important factor that has continued to endear it to many of its followers and adherents: a sizeable eighty percent of the population in most African rural areas. As persuasively argued by one scholar of ethno-medical approaches in Africa:

The holistic concept in traditional medicine is commendable, in that the patient’s mind and soul as well as body are considered together during treatment. … One increasingly important aspect of the African worldview is the belief that human beings cannot be separated from nature. There is therefore no overwhelming desire to conquer the natural world or dominate it … African worldview is eco-centric … It binds humans and the rest of nature together with the same umbilical cord.

Mbiti, a renowned scholar of African Religions and Philosophy, argued that diseases and misfortunes are regarded as having social and religious foundations. The treatment process must therefore go beyond merely addressing their symptoms but also their social

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13 Maurice M. Iwu, “Preface”, in Peter A.G.M De Smet, supra note 2 at 9.
implications as well as strategies to prevent their reoccurrence. Some scholars dismiss the holistic nature of traditional medicine as falsehood. As observed by Phillips,

> stereo-types suggest, for example, that traditional medicine is holistic, whilst modern medicine sees only the disease. This might be true in relatively isolated, small-scale societies, but in large Asian and African villages and towns, there is probably almost as much impersonal treatment by traditional healers as there is by practitioners of modern medicine. The holistic appeal of traditional medicine – that it considers the patient as a whole person, in his or her domestic and social setting – may in fact be perpetuating a false image.

The holistic appeal of traditional medicine is a cultural-relative phenomenon just as ethno-medical therapies differ across societies and cultures. There may be instances where the relationship between the traditional healer and patient is impersonal. Nonetheless, it needs to be pointed out that, for instance in Africa, the dominant world-views as well as the concept of personhood as philosophised by scholars like Mbiti and Kalu favour the holistic flavour of traditional medicine. Linked to the holistic nature of ethno-medical therapies in the developing world, is the prohibitive cost of orthodox Western malaria medicines, emergence of strains of malaria that resist available (Western) drugs, and disinterestedness of leading transnational pharmaceutical

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16 In Africa, according to Mbiti, the individual's needs, rights, joys and sorrows are woven into a social tapestry that denies singular individuality. Traditional medical practitioners symbolise the hopes of society: hopes of good health, protection and security from evil forces, prosperity and good fortune, and ritual cleansing when harm or impurities have been contracted. See Mbiti, *supra* note 14 pp141 & 171.

17 Ogbu Kalu has argued that "...crucial to indigenous traditions is a religious cosmology with an awareness of the integral and whole relationship of symbolic and material life. Ritual practices of the cosmological ideas which underpin society cannot be separated from the daily round of subsistence practices,... By sacralizing nature, indigenous worldviews purvey an ideology which is at once more eco-sensitive, eco-musical and devoid of the harsh flutes of those who see nature as a challenge to be conquered, exploited and ruled. They see the environment not in terms of competing interests but as the playing field on which all other interests intersect". See O. Kalu, "The Gods Are to Blame", (Unpublished)
companies to research affordable malaria drugs because of the poor return on investment. All of these factors conspire to make traditional medicine relevant and popular for malaria treatment in African rural communities. Traditional medical therapies for malaria are popular in these communities primarily because of their relative cheapness as well as availability and accessibility — within these societies - of traditional healers that apply them. Using social science qualitative interviews, this chapter assesses the veracity of these facts squarely from the views and behavioural practices of populations in a Nigerian rural community. I use the emergent perspectives from these interviews to argue for an integration of traditional malaria therapies as parts of multilateral initiatives on malaria control.

In sum, this Chapter argues that those traditional therapies for malaria that are popular among populations in malaria endemic areas should be moved from the periphery to the core of global malaria policy. At present, there is a sizeable volume of literature on ethno-biological/medical knowledge of indigenous populations across the world from an intellectual property perspective.18 The concern of this chapter is outside the realm of intellectual property of indigenous medical knowledge. I am largely concerned with fashioning an inclusive and holistic malaria globalism founded on Richard Falk’s concept of “globalism-from-below” to counter the contemporary exclusive and peripheral public

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18 I use the term “indigenous populations” in this context to broadly refer to populations in any society or community (especially in the developing world) that serve as customary custodians of bio-diversity and bio-medical resources available in that society or community as opposed to the use of the term in the North American legal context to refer to Native Indian populations.

health globalism founded on “globalism-from-above”. The urgency of this endeavour stems from the present conundrum facing populations in the developing world whereby globalization will likely erode traditional medical therapies and at the same time either do nothing to place western medicines within their reach or synthesise their traditional therapies with multilateral malaria control policy.

B: WHO’S ROLL-BACK MALARIA CAMPAIGN: ITS MISSION AND VISION

The WHO launched a global campaign to eradicate malaria in 1955. By 1969, when it abandoned the eradication campaign and strategy, malaria was completely eradicated from the industrialised countries where it was hitherto endemic. Parts of Asia and Latin America witnessed significant reduction in its morbidity. In Africa, WHO’s eradication campaign was focused on only three countries: Ethiopia, South Africa and Zimbabwe because “eradication was considered not yet feasible in other countries”. Globally, Africa continues to bear the heaviest burden of malaria mortality and morbidity. Malaria is most serious in the poorest countries and among populations living under impoverished conditions. It undermines the health and welfare of families, endangers the survival of children, debilitates the active populations and impoverishes individuals and countries. Malaria is therefore a health problem that is inexorably

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23 Ibid.
linked with the social and economic development of African societies. According to WHO, "malaria and underdevelopment are closely intertwined.... The disease causes widespread premature death and suffering, imposes financial hardship on poor households, and holds back economic growth and improvements in living standards."²⁴

In the early 1990s WHO changed its malaria policy from eradication to control. The first Global Malaria Control Strategy was endorsed at a Ministerial Conference on Malaria Control convened by the WHO in Amsterdam in 1992. The United Nations General Assembly endorsed it in 1994, and the United Nations Economic and Social Council adopted its action plan in 1995. The four basic elements of the global malaria control strategy include:

(i) provision of early diagnosis and prompt treatment;
(ii) planning and implementation of selective and sustainable preventive measures including vector control;
(iii) early detection, containment and prevention of outbreaks;
(iv) strengthening of local capacities in basic and applied research to promote the regular assessment of each country's malaria situation, particularly the ecological, social and economic determinants of the disease.

WHO's global malaria control strategy since 1992 was presumably subsumed into the Roll Back Malaria campaign launched in 1998 by Dr. Gro Harlem Brundtland when she became WHO Director General. Roll Back Malaria consolidates the experience of the

past 20 years, and is committed to cutting the burden of malaria in endemic areas by half by 2010. Roll Back Malaria is a partnership of agencies: the World Health Organization, the World Bank, the United Nations Children’s Fund, and the United Nations Development Programme. Major development agencies from the US, Canada, Sweden, the EU, Netherlands, France, Germany, Belgium and Italy, as well as foundations and research institutes, maintain close links with Roll Back Malaria.

Roll Back Malaria has six basic elements:

(i) evidence-based decisions using surveillance, appropriate responses and building of community awareness;

(ii) rapid diagnosis and treatment;

(iii) multiple prevention: better multi-pronged protection using insecticide-treated mosquito nets, environmental management to control mosquitoes, and making pregnancy safer;

(iv) focused research to develop new medicines, vaccines and insecticides and to help epidemiological and operational activities;

(v) co-ordinated action for strengthening existing health services, policies and providing technical support; and

(vi) harmonised actions to build a dynamic global movement.25

One of the often-cited reasons for the resurgence of malaria in Africa and other malaria endemic regions is drug resistance. WHO argues that “the potentially lethal malaria parasite *Plasmodium falciparum*, has shown itself capable of developing resistance to nearly all available anti-malarial drugs. Chloroquine, perhaps the best ever anti-malarial

drug, and certainly the most widely used, is now failing against *falciparum* malaria in most areas of the tropical world.” As a result, investment in the production of effective and affordable malaria drugs is an integral part of the Roll Back Malaria project. Prior to Roll Back Malaria, the Multilateral Initiative on Malaria (MIM) in Africa was launched in Dakar, Senegal in January 1997 as a coalition of the public and private sectors to promote malaria research in Africa. As part of the Initiative, a Task Force on Malaria Research Capability and Strengthening in Africa focusing on the needs of malaria endemic countries is being co-ordinated by the United Nations Development Programme (UNDP), the World Bank and WHO’s Department of Tropical Diseases Research. With a budget of about $3 billion annually, the main research areas to be funded are antimalarial drug policy and chemotherapy, epidemiology, pathogenesis, vectors, health systems and social science. 

In November 1999, another public-private partnership for the discovery of new anti-malarial drugs, Medicines for Malaria Venture (MMV), was launched in Geneva as a new but autonomous partner to Roll Back Malaria. Initial co-sponsors of the MMV are the World Health Organisation, the International Federation of Pharmaceutical Manufacturers Associations (IFPMA), the World Bank, the UK Department for International Development (DFID), the Swiss Agency for Development and Cooperation, the Global Forum for Health Research, Rockefeller Foundation, Global Roll Back Malaria Partnership, and The Netherlands Ministry of Development Co-operation. The goal of the MMV is to secure – on the average – the registration of one new antimalarial drug every five years. This will require raising US$15 million annually by 2001.

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26 WHO, *supra* note 24 at 52.
and US$30 million annually thereafter. According WHO Director-General Dr. Gro Brundtland,

MMV has been created because the increased costs of developing and registering pharmaceutical products, coupled with the prospects of inadequate commercial returns, have resulted in the withdrawal of the majority of research-based pharmaceutical companies from R&D investment in tropical diseases and especially from discovery research activities."^^28

MMV offers a new approach. It is a partnership that brings together the pharmaceutical industry with its knowledge and expertise in drug discovery and development and the public sector with its expertise in basic biology and field studies. It is also argued that MMV is the response of the private and public sectors to the growing crisis of malaria and the high priority given to rolling back malaria by the WHO and other partners. Through MMV, the private and public sectors are able to bring together the best of each other’s strengths, and contribute to the Roll Back Malaria goal of halving the global malaria burden by the year 2010 and sustaining this effort in the future."^^29

MMV is an entrepreneurial non-profit venture legally incorporated as a foundation under Swiss law. It will negotiate licensing agreements with its partners that recognise intellectual property rights. The major goal of these agreements will focus on the commercialisation of products/medicines for low income populations at affordable prices. A royalty income may accrue to MMV on products that earn significant returns for MMV’s commercial partners. These returns will feed back into MMV’s fund to offset the need for future donations."^^30

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29 Ibid.
30 For general information about MMV and how it operates, see http://www.malariamedicines.org (visited 2 April 2001).
Roll Back Malaria and MMV are important and innovative milestones in multilateral public health. They represent a collaborative public-private partnership to tackle a disease that arguably attacks the poor with its heaviest health and economic burden endemic within Africa. Nevertheless, both Roll Back Malaria and MMV – as global policies - must be analysed against the perceptions of local populations in Africa whose disease these policies strive to tackle. If the global policy and the behavioural practices of populations in malaria endemic societies are antithetical, then an effective synthesis must be canvassed to close the regime deficit. With an aim to synthesise any apparent or foreseeable antithesis, I analyse traditional medical approaches to malaria based on the perceptions of interviewed populations in a rural community in Southeastern Nigeria.

C: TRADITIONAL MEDICINE AND MALARIA IN SOUTHEASTERN NIGERIA: THE VOICES OF RURAL POPULATIONS

In December 2000, I conducted semi-structured (depth/focused) interviews on traditional malaria therapies in a sample rural population: a small group of twenty-five unevenly divided men and women. The interviews focused substantially on behavioural practices and approaches of the interviewed group to malaria. The interviews were

31 See G. Yamey, “Global Campaign to Eradicate Malaria”, 322 British Medical Journal (2001) 1191 (stating that the Roll Back Malaria Campaign has had two major successes. Firstly, it has built an impressive partnership of the United Nations and development agencies, the World Bank and International Monetary Fund, governments, the private sector, researchers, and non-governmental organisations. Secondly, it has raised the visibility of a neglected disease – one that causes at least 3,000 deaths a day and that slows down economic growth by 1.3% per year in endemic areas).
32 This part of the thesis is based on interviews I conducted among rural populations in Southeastern Nigeria in December 2000.
33 The interviews were conducted in Ekwulobia, a rural community located about 120 kilometres from Enugu - the old capital of Eastern Region, Nigeria. Choice of the community was informed by the fact that the author was born there, speaks the same mother tongue as residents (Igbo language), and understands their cultures and customs. They never perceived the author as a foreigner, but rather felt at ease to answer
supplemented by detailed conversations I had with two traditional healers (experts on ethno-medical diagnosis and therapies for malaria) as well as a medical doctor trained in Western medical sciences that all reside within the same community as health care providers.34 These interviews and conversations were conducted primarily with an aim to gain deeper insights into the traditional medical therapies as well as attitudes, beliefs and practices of the interviewed population to malaria. This study investigates the importance of these traditional therapies to local communities and argues for their integration into global malaria policies.

My interviews were based on the use of an interview guide: a written list of questions to be covered during the interviews.35 As observed by WHO, depth/focused interviews assume enough prior exploration of the topic to enable the researcher to formulate the relevant questions that relate to the topic to be investigated.36 The present investigation therefore builds on previous studies on similar issues in Southeastern Nigeria. In a study conducted in 1999, Okafor identified 55 plants used in traditional medicine by 75% of rural populations that inhabit the low-lying Ibo heartland in Eastern Nigeria.37 Local people use these plants as therapies for a plethora of diseases and health conditions including malaria, fever and its symptoms.

34 The two traditional healers and almost all the interviewees within the group requested anonymity. To protect their privacy, I shall use only coded names where necessary as opposed to their real names. The Western-trained physician I interviewed is Dr. IPS Okafor, Medical Director, St. Victoria Hospital & Maternity, Ekwulobia.
35 See WHO, Qualitative Research for Health Programmes (Geneva: WHO, Division of Mental Health and Prevention of Substance Abuse, 1996) 12. For the list of basic but non-exhaustive questions the author used in these interviews, See Appendix.
36 Ibid.
In the present study, every interviewee admitted to have had malaria many times in the past, an incontrovertible proof that malaria was a common ailment that attacked local populations intermittently in areas where it is endemic. An overwhelming 90% of interviewees said they knew they had malaria if they start having such symptoms as pain, severe fever, aches (joint aches and headaches), loss of appetite, vomiting, dizziness, and fatigue. Although their responses are diverse and variegated, the popularity of traditional medicine is conspicuous when interviewees described the actions they took to obtain diagnosis and therapies when they suspect they have malaria. About 65% consult traditional healers that predominantly use natural herbs and roots as curative therapies. About 25% rely on immediate self-help by seeking to buy western drugs from vendors popularly called “patent medicine dealers”. The remaining 10% consult medical doctors in clinics and hospitals located in the community. The two groups that either rely on self-help or consult medical doctors in clinics/hospitals admitted having also consulted traditional healers in the past for treatment. Reasons for resorting to traditional medicine - according to interviewees - ranged from its relative cheapness to the ready availability and accessibility of traditional healers in the community. Consistent with the views of the interviewees, Salako has observed that,

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38 The symptoms each of them described to me correspond to almost the same symptoms that Western medical science associate with malaria. See for instance, WHO, Management of Severe Malaria: A Practical Handbook 2nd edition (Geneva: WHO, 2000) 1. Each interviewee described these symptoms to me in detail in the Igbo language.

39 I was also informed of this by Dr. IPS Okafor, Medical Director, St Victoria Hospital, Ekwulobia, Nigeria in an interview held on 18 December 2000. Okafor stated that about 40% of his malaria patients are brought to the clinic with very severe and sometimes life-threatening cerebral malaria after having visited traditional healers in search of therapies or trying self-help without success.
in many parts of Africa, unofficial health care systems and operators exist side by side with the official system and include herbal healers, medicine vendors and spiritual healers. These alternative systems are usually more readily accessible and cheaper than the formal system, and many patients seek treatment from these groups first, turning to the official system only when they fail. There is a clear need to improve the formal system so that it becomes more accessible, acceptable and affordable to ordinary people and thus becomes their first choice.40

Contrary to the dominant school of thought that traditional healers are secretive and often unwilling to divulge their therapies, two of them interviewed by this author were open and went as far as showing the author a collection of herbs and roots which they use as malaria therapies. These therapies are diverse and varied. The healers had a local name for every herb, bark or root, and each therapy is administered in a variety of ways: some of the herbs and roots are boiled or cooked and the patient uses the hot water residue to bathe. Some elements (mainly roots and barks of trees) are recommended by the healers to be taken with a moderate amount of alcohol, mainly local gin. Most other herbs are recommended by the healers to be boiled with food and taken with lunch or supper. The difficult question was how the healers knew that those herbs and roots had medicinal value. They reiterated the view that over the ages, traditional medicine was handed down from generation to generation through lineage, family or even oral tradition, and that before Western medicine arrived in Africa simultaneously with colonialism, the traditional use of herbs for therapies was already established and widely used. Championing this school of thought, Dr. Raymond Arazu, a Catholic priest and a leading traditional healer who uses indigenous herbs for multi-disease curative therapies in eastern Nigeria observed that,

the plants which God created are there for our needs – their roots, the leaves and so on. From time immemorial, everywhere people have used these means to cure sick people. There are about five different kinds of plants whose leaves when used in the proper way cure ulcer…. I am only following what my people….were doing before this modern craze for petrochemical drugs which have seemingly replaced the herbs.41

Observations and responses from healers and interviewees that adhere to traditional medicines revealed two sets of related facts. First, malaria is a very common, endemic but life-threatening ailment of the populace. Almost everybody knows what it is, or at least could guess correctly its symptoms, and they call it iba in their mother tongue, Igbo.

Second, traditional herbs exist – and are readily available - within the community’s forest and biodiversity resources for its treatment. These facts are consistent with the predominant worldview of the Ibo ethnic group in Eastern Nigeria as mirrored by the world acclaimed novelist Chinua Achebe in his famous work Things Fall Apart.42 To illustrate how this worldview relates to traditional and contemporary malaria therapies, it is useful to reproduce Achebe’s depiction of Okonkwo - the hero and lead character – as a repository of this ethno-medical knowledge on malaria. Achebe wrote,

Okonkwo turned on his side and went back to sleep. He was roused in the morning by someone banging on his door. “Who is that?” he growled. He knew it must be Ekwefi. Of his three wives Ekwefi was the only one who would have the audacity to bang on his door. “Ezinma is dying,” came her voice, and all the tragedy and sorrow of her life were packed in those words. Okonkwo sprang from his bed, pushed back the bolt on his door and ran into Ekwefi’s hut. Ezinma lay shivering on a mat beside a huge fire that her mother had kept burning all night. “It is iba,” said Okonkwo as he took his machete and went into the bush to collect the leaves and grasses and barks of trees that went into the making of medicine for iba. Ekwefi

42 Chinua Achebe Things Fall Apart (New York: Anchor Books, 1994). Achebe’s work is unassailably the most vivid account of the pre-colonial worldview and culture of the Ibo ethnic group in popular art and, by extension, that of most pre-colonial African societies.
knelt beside the sick child, occasionally feeling with her palm the wet, burning forehead. *Ezinma* was an only child and the center of her mother’s world ... *Okonkwo* returned from the bush carrying on his left shoulder a large bundle of *grasses and leaves, roots and barks of medicinal trees and shrubs*. He went into *Ekwefi’s* hut, put down his load and sat down. “Get me a pot,” he said, “and leave the child alone.” *Ekwefi* went to bring the pot and *Okonkwo* selected the best from his bundle, in their due proportions, and cut them up. He put them in the pot and *Ekwefi* poured in some water. “Is that enough?” she asked when she had had poured in about half of the water in the bowl. “A little more ... I said a little. Are you deaf?” *Okonkwo* roared at her. She set the pot on the fire and *Okonkwo* took up his machete to return to his *obi*. “You must watch the pot carefully,” he said as he went, “and don’t allow it to boil over. If it does its power will be gone.” He went away to his hut and *Ekwefi* began to tend the medicine pot almost as if it was itself a sick child. Her eyes went constantly from *Ezinma* to the boiling pot and back to *Ezinma*. *Okonkwo* returned when he felt the medicine had cooked long enough. He looked it over and said it was done. “Bring me a low stool for *Ezinma*,” he said, “and a thick mat.” He took down the pot from the fire and placed it in front of the stool. He then roused *Ezinma* and placed her on the stool, astride the steaming pot. The thick mat was thrown over both. *Ezinma* struggled to escape from the choking and overpowering steam, but she was held down. She started to cry. When the mat was at last removed she was drenched in perspiration. *Ekwefi* mopped her with a piece of cloth and she lay down on a dry mat and was soon asleep.43

The type of ethno-medical therapy described by Chinua Achebe abounds in every society and culture across malaria endemic parts of the world. They have existed for ages and are still alive in our time and age. They have a sizeable number of adherents and many men and women, like *Okonkwo* in Achebe’s *Things Fall Apart*, are repositories of such knowledge. I have shown that in a rural community in eastern Nigeria, it is alive, viable and available. It interacts with modern medicine in an environment of medical pluralism. For these reasons, it is pertinent to evaluate the interaction between traditional malaria therapies and global malaria control policy. This evaluation will be conducted within the frameworks of 'globalisation-from-above' and 'globalisation-from-below, two emergent

43 Ibid. pp75-76, 85-86 (emphasis added by this author).
concepts on humane global governance.

D: GLOBAL MALARIA CONTROL STRATEGIES: GLOBALISATION-FROM-ABOVE OR GLOBALISATION-FROM-BELOW?

Richard Falk coined the terms “globalisation-from-above” and globalisation-from-below” as operational paradigms to explore the dimensions of emergent global governance in a world order marked by the Westphalian model of statehood. Contemporary global governance has witnessed tensions between states on the one side and a coalition of transnational civil society on the other. Global policies incubated at multilateral forums by states acting as harbingers and repositories of political power within geopolitical boundaries often run counter to civil-society oriented ideals. Falk proposes a framework aimed at animation of civil society in relation to a transnational agenda involving human rights, environmental protection, public health, social and economic justice, disarmament, and other substantive areas in which global market forces and states were perceived to be endangering human well-being. These civic pressures constitute a formidable challenge to governments to be more protective of global public goods. The multiple dimensions of this civic-society challenge come within the rubric of globalisation-from-below. In a sharp contrast, the contemporary global social and environmental agendas are often detrimental to a range of public goods. This latter

45 Falk, Law in an Emerging Global Village, Ibid. at 276.
phenomenon, driven by market forces in coalition with most governments, is attributed to
globalisation-from-above.\textsuperscript{46}

Globalisation-from-below, in the sense that Falk uses the term, does not constitute
a kind of teleological cosmopolitanism. In essence its agenda does not foresee the
extinction of the Westphalian State, neither does it project the nation-state as completely
irrelevant in global governance dynamics. Rather it projects a proposal for an urgent
symbiotic framework based on dialogue between emergent transnational civic society
pressures/forces and states as repositories of political leadership and power. Relying on
political/legal theorists like Koskenniemi and Habermas, Falk argues that,

Dialogue is not just words, but the foundation of communicative action—that is the essence of democratic practice.\textsuperscript{47} ...Given the structure of international society, and its continuing adherence to a strong doctrinal view supportive of sovereign rights, the most appropriate role for the jurist is to avoid the temptations of apologetics or of utopianism, neither relinquishing juridical autonomy to the political domain nor setting forth legalistic positions that are dismissed as pathetic fantasy by those entrusted with the responsibilities of political leadership.\textsuperscript{48} ...International law and lawyers can best contribute to the prospects of fashioning a more humane type of global civilization by self-confidently entering the dialogic space between entrenched power and transnational social forces, acknowledging the relevance of both, but subordinating their autonomy to neither.\textsuperscript{49}

Applied analogously to the interaction between people or civil society-oriented traditional malaria therapies (globalisation-from-below) and malaria control policies of multilateral

\textsuperscript{46} Ibid. at 276.
\textsuperscript{49} Ibid, 276-277.
agencies like the WHO (globalisation-from-above), the pertinent question is to explore whether the dialogue between the two as argued by Falk, and theorised by Habermas, has occurred, is indeed occurring now, or will likely occur in the near future. It is beyond doubt that traditional medicine is generally endorsed by WHO, and that it has called on countries to integrate it within their national health care systems. In its World Health Report 2000 that focused on improving the performance of health systems, WHO defined a health system to include “all the activities, whose primary purpose is to promote, restore or maintain health”. Formal health services, including the professional delivery of personal health attention and actions by traditional healers, according to WHO, are clearly within the boundaries of this definition. In a seminal article, David Nabarro, former Project Director of Roll Back Malaria at WHO stated that,

within developing countries, the private sector (whether in the form of a licensed medical practitioner, private pharmacy, or traditional healer) is very often the main source of advice and treatment for all people, including the poor. Government health services will need to acknowledge this and develop better ways of working with and regulating the different types of practitioners to provide essential public health services.

Despite this tacit recognition of traditional medicine by WHO, it is curious that nothing in either WHO’s Roll Back Malaria Programme or its partner Medicines for Malaria Venture (MMV) expressly mentions the integration of traditional malaria therapies as part of their operational frameworks. As already stated, the vision of Roll Back Malaria and Medicines for Malaria Venture (MMV) is commendable for its collaborative public-

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50 See Resolutions of the World Health Assembly on traditional medicine, supra note 7.
52 Ibid.
private sector partnership in global governance aimed at a disease that has not only been long neglected, but one that substantially attacks poor people in underdeveloped parts of the world. Nevertheless, this vision remains fundamentally flawed so long as its reach and grasp exhibit a propensity that systematically relegates traditional medical therapies to the peripheries. The prevailing emphasis on insecticide-treated bed nets (in the case of Roll Back Malaria) and production of malaria drugs every five years (in the case of Medicines for Malaria Venture) has forced the WHO to pursue a corporate agenda by entering into agreements and joint ventures with corporate entities. These agreements cloak the corporate entities involved with a sacrosanct juristic and corporate veil marked by absolute and limitless autonomy and finality that can neither be challenged by WHO member states nor transnational civil society networks. Yamey observed that one problem with huge global partnerships like Roll Back Malaria is that they end up being accountable to nobody. One function of reporting their meetings and activities is to expose them to some sort of scrutiny and help them become accountable to those they serve\textsuperscript{54}. In this sense, Roll Back Malaria and Medicines for Malaria Venture are both guilty of globalisation-from-above.

As a way forward, I propose an immediate, urgent dialogue between civil society-oriented traditional approaches to malaria and governments within national jurisdictions in malaria endemic countries. The dialogue within countries would aim at what I call “the scientification of traditional malaria therapies”\textsuperscript{55}. What emerges from the dialogue within

\textsuperscript{54}G. Yamey, \textit{supra} note 31 at 1192.

\textsuperscript{55}This proposal is not entirely novel because many countries have since initiated a process of harmonising traditional medical therapies with Western medicine. This is done by incorporating aspects of traditional healing practices, mainly with herbs and roots that are scientifically proven to have medicinal value as part of the national health care systems. See for instance, J.I Durodola, \textit{Scientific Insights into Yoruba Traditional Medicine} (Owerri/New York/London: Trado-Medic Books, 1986) (analysing aspects of Yoruba traditional medicine in Western Nigeria for which scientific evaluation has been made); S. Nadasen, \textit{Public
countries will now transcend national jurisdictions to forge further transnational dialogues to evolve an inclusive malaria globalism based on multi-stakeholder participation. My proposition for scientification of traditional malaria therapies does not necessarily mean that 'scientification' will follow the analytical progression and methodology of western science. I argue that science, in some sense, is multicultural. Multiculturalism of science, for instance, applies to traditional herbal medicine in most parts of the developing world. Most of the herbs used by populations for ages in Africa, Asia and Latin America as therapies for ailments have now been universally acclaimed as medicinally and scientifically effective. As Roht-Arriaza rightly observed,

Indigenous and local communities have a long history of using plants for almost all needs, including food, shelter, clothing, and medicine. Common remedies used today were often first developed by healers prior to contact with industrial societies. Yet, although many of today’s drugs and cosmetics originated from the stewardship and knowledge of indigenous and local communities, that knowledge remains unrecognized and unvalued until appropriated from those communities by Western corporations or institutions.56

Roht-Arriaza cites many examples of appropriation of indigenous scientific knowledge including quinine, a well-known and universally acclaimed cure for malaria, which comes from the bark of the Peruvian cinchona tree.57 Andean indigenous populations used quinine as a cure for fevers, supposedly learning of its medical efficacy by observing feverish jaguars eating it.58 Other notorious examples include the rosy

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57 Ibid.
58 Ibid.
periwinkle plant, unique to Madagascar, which contains properties that combat certain cancers. The anti-cancer drugs vincristine and vinblastine have been developed from the periwinkle, resulting in over $100 million in annual sales for Eli Lilly and virtually nothing for Madagascar.\textsuperscript{59} In the same fashion, a barley gene that resists the yellow-dwarf virus has been the product of breeding and cultivation by Ethiopian farmers for centuries. Scientists and farmers in the United States patented the barley variety and now receive enormous profits from its current cultivation in the US, but the Ethiopian farming communities that originally developed the variety receive nothing.\textsuperscript{60}

In other aspects of traditional medicine where the multiculturalism of science cannot easily be established and extrapolated across diverse cultures, there is need for further and continuous dialogue between civil society networks and states to forge a synthesis. In other words both trans-governmental and trans-civil society cross fertilisation of ideas are urgently needed. This may be the only viable pathfinder to humane global health governance founded on an activation of people-oriented medical therapies that conforms to the canons of globalisation-from-below. Relevant to the entente between civil society networks and nation-states is a further cross fertilisation across relevant legal and political theories on global health governance and regimes.

\textsuperscript{59} Ibid.
\textsuperscript{60} Ibid.
E: CONSTITUTIVE APPROACHES: THE WEALTH AND POVERTY OF THEORY IN MULTILATERAL HEALTH GOVERNANCE

Multilateral governance of health issues traverses a broad range of legal and political theories and disciplines. Since I have dealt with aspects of these theoretical approaches in preceding Chapters,\textsuperscript{61} this part is a constitutive framework that offers a holistic and multidisciplinary theoretical template of the entire thesis. Multidisciplinary theoretical grounding of multilateral health governance is important because it facilitates a viable cross-fertilisation of ideas between various schools. No one single political or legal theory – on its own – provides a comprehensive and satisfactory analysis of all multilateral health problems confronting the world today. From the perspective of jurisprudence/legal theory, Bodenheimer reminds us that,

\begin{quote}
The subject of jurisprudence is a very broad one, encompassing the philosophical, sociological, historical, as well as analytical components of legal theory.\textsuperscript{62}
\end{quote}

In a multilateral context, Bodenheimer’s analytical components of legal theory implicate what scholars of international relations (political scientists) study under the rubric of theories of international regimes. Can law and order be maintained and enforced in the interaction between sovereign states? What factors (if any) motivate states to find multilateral solutions to multilateral problems like the menace of pathogenic microbes and infectious diseases? I discuss the dominant theories of international regimes, apply them to questions of fairness in the international system, and assess their relevance or

\textsuperscript{61} See my brief discussion of theories of modernisation, development, dependency and anthropological study of law, \textit{supra} pp72-76, the basis of obligation in international law, \textit{supra} pp146-148, the post-colonial discussion of nineteenth-century infectious disease diplomacy, \textit{supra} pp114-119, and a critique of the Westphalian model of statehood based on Falk’s “globalism-from-above”, \textit{supra} pp181-184.

otherwise in global health governance. Realism, Liberalism and Marxism are often presented as the three dominant theories of international regimes. Scholars of international relations concede that these schools are not rigidly compartmentalised because “each of these traditions includes many variants, which frequently overlap in complicated ways such that identifying their key features is a difficult and controversial task.”

Realism postulates an international system - composed of political entities (i.e. nation-states) that are primarily driven by pursuit of selfish interests, survival and/or maximisation of power. Hedley Bull’s classical description of the realist view of international relations based on the Hobbesian tradition characterises “international relations as a state of war of all against all, an arena of struggle in which each state is pitted against every other. International relations, on the Hobbesian view, represent pure conflict between states and resemble a game that is wholly distributive or zero-sum: the interests of each state exclude the interests of any other”.

In this sense; advocates of realism do not deny the existence of multilateral regimes, but they see in those regimes vicissitudes of hegemony and anarchy that propel states to pursue their selfish interests and maximise power instead of common interests and values. Juxtaposing this canonical exposition of realism with global health governance, especially the leading roles played by the European powers in the nineteenth century public health diplomacy, Fidler observes that realists will likely argue that in nineteenth century public health diplomacy,

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...the great powers’ interests converged to produce co-operation and international law, but raw fear and concern for trade stimulated these developments, not altruism. When the developed countries managed to get infectious diseases under control within their territories, international health co-operation and law deteriorated. The IHR's history can be read as a classic story of realism: States have ignored international law to protect their national interests.  

In present day multilateral initiatives on public health, realist scholars would still argue that the rising global concern about infectious disease threats emanates from the fear of great powers that these threats will adversely affect populations within their borders and their economic opportunities abroad.  

Liberalism, although multifaceted, has its roots in the writings of seventeenth century political philosophers and economists. The canons of liberalism are founded on the promotion of human freedom and dignity based on the establishment of conditions for peace, justice and prosperity. These liberal ideals are not teleological; there is no foreseen 'end of history' by liberals for humanity to attain perfect freedom. Liberalism concedes that discord and coercion are characteristics of multilateral interaction between states, but states are able to strike an accord because of 'mutualities of interests and non-coercive bargaining'. Mutual co-operation is the key to the maximization of possible benefits and minimization of possible dangers of interactions and interdependencies between states.  

Thus the liberal tradition is committed to political and economic strategies founded on democratisation, free trade and market capitalism. In the late eighteenth century, Immanuel Kant, one of the influential liberals at the time argued that the essential nature

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66 Ibid.
68 Ibid.
of international politics lies in trans-national social bonds that link individual human beings who are citizens of republican states. The dominant theme of international relations as a relationship of states is only apparent, he argued. The real relationship is the relationship of all human beings in the community of humankind, which will erode and sweep away the system of states. The growth of cosmopolitan law would subsequently enhance international peace and co-operation.\(^69\) The classic Kantian model of international liberalism has been critiqued. Hedley Bull wrote that,

> In Kant's own doctrine there is of course ambivalence as between the universalism of *The Idea of Universal History from a Cosmopolitanical Point of View* (1784) and the position taken up in *Perpetual Peace* (1795), in which Kant accepts the substitute goal of a league of 'republican' states.\(^70\)

Liberalism's anchorage on 'mutualities of interests and non-coercive bargaining' offers a better explanation for a multilateral regulation of cross-border spread of diseases and health risks by states. Mutual vulnerability, the obsolescence of state sovereignty/national boundaries to threats of diseases and pathogens in an emergent global village, liberals argue, is a multilateral problem that requires a multilateral approach by states anchored on mutual/self interests. Liberals admit that international law and multilateral institutions, two important mechanisms needed to forge multilateral consensus, have not been profoundly effective. Nonetheless, as stated by Fidler,

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\(^70\) Hedley Bull, *supra* note 64 at 310. Zacher & Matthew, *supra* note 63 at 112 state that "while Kant's commitment to progress in international relations is indisputable, his image of the ultimate form that universal peace would assume has been the subject of disagreement. Whether one reads in Kant a future world of co-operative states or some form of world government, it is clear that, like earlier liberals, he accepted a strong, but gradually diminishing role for power relations and the use of force".
In the case of infectious diseases, States have learned that international co-operation and international law best serve national interests because the nature of the challenge from the microbial world demands such a strategy given the structure of the international system. The convergence of national interests, is not, thus, grounded only in hegemonic desires; it is based on a scientific and political foundation that involves powerful and weak States alike - both of which face the threat of infectious diseases.\(^\text{71}\)

Even when international regulatory approaches to diseases like the World Health Organisation's International Health Regulations (IHR) have not functioned effectively, the principles behind such norms and regimes still receive tacit recognition by states. One critique of liberalism with respect to multilateral health regimes focuses on its endorsement of democratisation, international trade liberalisation, market capitalism and the role of non-state actors in global governance. This has astronomically increased the global influence and networks of multinational corporations, the operations of which propel the spread of diseases and health risks that in turn prove difficult to regulate multilaterally. Multinational corporations, like in the case of tobacco, deploy their sophisticated global networks and enormous resources to create an anarchical global society by undermining multilateral efforts aimed at regulating the public health harm of their products and activities.\(^\text{72}\) Thus liberalism, in a well-intended aim to generate and distribute wealth via trade liberalisation, sometimes suffers a derailment that ends up equipping the private sector (transnational corporations) with enormous powers and influence that may adversely impact on health of populations within and among nations.

\(^{71}\) D. Fidler, *supra* note 65 at 297.

Critical theorists explore the international system from the perspective of socio-economic injustices and inequalities in the relations among sovereign states. Although arguably there is no articulate Marxist approach to international law,\textsuperscript{73} critical theory is nonetheless substantially founded on the Marxist claim that the "mode of production determines the nature of social and economic relations within political entities and among them. Domestic and international politics are fundamentally about the struggle for wealth among economic classes".\textsuperscript{74} As a variant of Marxism, critical theorists use the struggle among the economic classes in society to explore the disparities and inequalities among nations in the international system. Factors that propel the spread of diseases and microbes globally are rooted in poverty, underdevelopment and other facets of social and economic inequalities.\textsuperscript{75} Critical scholars thus argue that the contemporary international system is fundamentally predatory and coercive. Globalisation - an emergent phenomenon in the international system - is essentially an engine of poverty and underdevelopment; an enterprise aimed at continued entrenchment of hegemony in the relations between rich and poor states, and a framework that is non-responsive to the status quo of global development apartheid among nations. As argued by Chimni,

\textsuperscript{73} See B S Chimni, "Marxism and International Law: A Contemporary Analysis" (February 6 1999) Economic & Political Weekly 337 (stating that despite the critical role international law has come to play in building and sustaining the contemporary international system, Marxists have entirely neglected its study. While an attempt was made in the former Soviet Union to articulate a Marxist approach to international law, its content was dictated less by Marxism-Leninism than by the need to rationalise Soviet foreign policy).

\textsuperscript{74} M Zacher & R Matthew, supra note 63 at 108.

\textsuperscript{75} For a detailed application of critical theory to emerging and re-emerging infectious disease threats, see P Farmer, "Social Inequalities and Emerging Infectious Diseases" (1996) 2 Emerging Infectious Diseases 259.
Since the early 1980s, the advanced capitalist world has, under the guidance of the hegemonic transnationalised fractions of its bourgeoisies, and with the assistance of the transnationalised fractions of national capital in the third world, pushed through a series of changes in international economic law which lay the legal foundation for capital accumulation in the era of globalisation. These changes appear to have two principal objectives: (i) to extend and deepen world-wide the rule of capital through the removal of local impediments; and (ii) to dismantle international laws of distribution which are based on the principle of market intervention.\(^{76}\)

Because the sovereign state is viewed as coercive, critical scholars foresee an ultimate overcoming of states and an eventual triumph of qualified cosmopolitanism. In his "discourse ethics", for instance, Devetak proposes a global framework in which principles of political action can be universally and democratically arrived at through cosmopolitan political and moral discourse.\(^{77}\) Critical theory's linkage of emerging transnational infectious disease threats with inequalities in the international system has some merit, nonetheless its proposal of a modified version of cosmopolitanism remains largely utopian. Cosmopolitanism raises a host of complex questions for the present world-order composed of sovereign states. Complete erosion of sovereign states and enthronement of the cosmopolitan world-order model is definitely no solution to global infectious disease threats.

The dominant theories of regimes - as explored in this part - point to an irresistible conclusion. No single theoretical framework comprehensively explains all the ramifications of multilateral regulation of the cross-border spread of diseases and health risks. The present South-North divide with its implications for the health of populations within the emergent global village implicates the reach and grasp of liberalism, realism

\(^{76}\) B.S Chimni, *supra* note 73 at 339.

and critical theories of regimes. It is neither exclusively power/strategic interests (as argued by realists), common interests/values (as argued by liberals and neo-liberals), nor cosmopolitanism (as argued by critical theorists) that would lead to a humane global health governance. Each theory is both rich and poor in some sense. Fidler put it succinctly that "in their respective interpretations of microbialpolitik, both realism and liberalism have strengths and weaknesses; and it is ill-advised to proclaim a victor". I refer to these strengths and weaknesses as 'the wealth and poverty of theory in global health governance'. Wealth and poverty of theory is not a demurrer for a wholesale dismissal of the relevance of theory in forging a multilateral consensus on infectious disease and other health threats. It is rather an incentive that propels a compelling need for a symbiosis and cross-pollination of ideas across the boundaries of the dominant schools of international regimes: liberalism, realism and critical theory. Have liberals anything to learn from realists and vice versa? Can the critical school inform realism in anyway? To many hard-nosed realists, liberals or critical scholars, this is an invitation to anarchy because its impracticality is comparable to teaching English grammar with German words - an unholy alliance. One useful way to explore the complexities of theories of regimes is to apply them to fairness discourse in multilateral health challenges. In no other discourse is this theoretical symbiosis necessary than the vexed question of 'fairness' in the distribution of dividends that accrue from health protection as

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78 Fidler, supra note 65 at 298.
a global public good. In other words, how does each of these theories play into the
fairness question in global health challenges? Can any one of the dominant theories, on
its own, lead to humane global distribution and allocation strategies for health protection
and promotion that satisfy the preconditions of fairness? On fairness discourse in
international law and international institutions, Franck wrote,

The fairness of international law, as any other legal system, will be
judged, first by the degree to which the rules satisfy the
participants' expectations of justifiable distribution of costs and
benefits, and secondly by the extent to which the rules are made
and applied in accordance with what the participants perceive as
right process.

This dual-dimensional aspect of fairness discourse, Franck categorises as, "the
substantive" (distributive justice) and "the procedural" (right process). Following John
Rawls A Theory of Justice, Franck identifies "moderate scarcity" and "community" as the
two structural pre-conditions of a fairness discourse. Applied to global health
challenges, social contract philosophy embedded in liberalism explains aspects of
multilateral interaction between states. However, a further enquiry is needed to explain
the present South-North divide, persistent poverty and underdevelopment in the global
South (which impact on health of populations), unequal global distribution of disease
burdens among populations in the developed and developing worlds, and the near
collapse or non-existence of core public health surveillance capacity in many developing
countries. Thus Franck's social contractarian internationalism (neo-liberalism) comes

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79 Here - with some caveats - I am a student of Thomas Franck whose influential work on fairness uses
liberal social contract philosophy to explore distributive as well as procedural justice in the interaction
between states. See Thomas M. Franck, Fairness in International Law and Institutions (Oxford: Clarendon
Press, 1995).

80 Ibid. at 7.

81 Ibid.

82 Ibid.
within what I explore under the rubric of *communitarian globalism* in the next chapter. However, as a constitutive framework, my proposal cannot rest on neo-liberal ideals alone. It makes overtures to the realist school that explain the hegemony, politics and power relations between weak and powerful, small and big states in the evolution of *communitarian globalism*, especially my proposal for a disease non-proliferation treaty through a multilateral health fund. *Communitarian globalism* also makes further overtures to the critical school that best explains South-North disparities and global social inequalities. Thus, 'wealth and poverty of theory' is a window of opportunity that cross-fertilises the dominant regime theories aimed at evolving a holistic and humane global health order, as opposed to segmented theoretical approaches to international regimes prevalent in contemporary international law and international relations scholarship. The essence of "wealth and poverty of theory" as I use it in this context, is not teleological; it does not foresee an ultimate and perfect harmony between the dominant schools of international regimes. It merely offers a holistic theoretical framework for the study and reform of global health governance to secure a common health future.

**F: SUMMARY OF THE ARGUMENTS**

One of the formidable challenges of multiculturalism is to reconcile the vicious tensions between the core of multilateral health policies and the peripheries. Using multilateral malaria control policy as the subject of analysis and enquiry, this chapter explored the relevance of indigenous malaria therapies in a medically pluralistic world - a global policy universe where public health presents variegated challenges that continue to require multilateral and multicultural approaches. What emerges from this analysis is a largely irreconcilable tension between the core - global malaria control policy, and the peripheries - indigenous malaria therapies widely used by populations in malaria
endemic regions of the developing world. Because the core and the peripheries are bound
together, any degree of tension in their co-existence inevitably leads to turbulence in
global health governance. In an attempt to strike a harmony between malaria control
practices at the core and peripheries, this chapter identified three useful approaches:
'scientification' of traditional medical therapies in the developing world, global
governance mechanisms that respect globalisation-from-below, and cross fertilisation of
ideas among the dominant theoretical schools of international regimes.

The core of these approaches lies in the activation of people or civil society-
oriented approaches to multilateral health governance. Ethno-medicine is not just magic,
superstition or witchcraft, but an age-old health delivery system widely used in the
present day by a sizeable percentage of populations in the developing world. Because
alternative medical therapies are either unaffordable to, or unpopular among, these
populations, continued relegation of African ethno-medicine to the peripheries of global
malaria regime is intensely 'discriminatory'. The vision of contemporary multilateral
malaria control strategies – the Roll Back Malaria Campaign and Medicines for Malaria
Venture – albeit commendable, ought to be accountable and responsive to the
constituencies they serve: indigenous communities in malaria endemic societies
especially in Africa where the burden of the disease is heaviest. How best then can this
regime deficit be closed? We need a more inclusive and multi-stakeholder approach to
multilateral malaria control policy. The interviews with local populations conducted by
this author have shown the existence of affordable therapies that have long been
neglected by multilateral institutions. To ensure stability and peace in the global
neighbourhood, innovative approaches to global health governance must harmonise the
tensions between the core global malaria regime and traditional therapies at the peripheries in a way that projects globalisation of public health not as a predatory, but a humane, fair and equitable enterprise.
A: OVERVIEW OF THE ARGUMENTS AND A SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS.

In the preceding Chapter, I adopted Franck’s two structural preconditions of fairness discourse: "moderate scarcity" and "community". "Moderate scarcity" underscores the fact that global resources are never in short supply. Therefore a fair and equitable distributive regime stands to protect and promote the health of populations in the emergent global village. "Community" underpins a conglomeration of political entities and actors in the global arena: a sine qua non for the evolution of a fair regime for the distribution of global resources aimed at public health promotion and protection. Thus, ‘moderate scarcity’ and ‘a community of political entities’ are inseparable in fairness discourse. As Franck observed,

Between the polarities of plenitude and deprivation is a vast spectrum of conditions in which everyone cannot have everything they want, but where there is enough to meet "reasonable" expectations if the goods are allocated by an agreed rule which is perceived to be fair. ... Moderate scarcity is a necessary, but not a sufficient, precondition for fruitful fairness discourse. There must also be a shared sense of the identity of those entitled to a fair share; there must be an ascertainable community of persons self-consciously engaged in a common moral enterprise. The members of such a community participate not only in the sense of receiving a share of each allocated good or obligation, but they also participate in determining the rules by which the shares are allocated. There must, in other words, be a moral community engaged in formulating itself as a 'rule community'.

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Although I largely agree with Franck, I coin the term *communitarian globalism* to explore in further detail the multiple dimensions and complexities of sharing scarce but moderate global resources based on consensus and agreed rules in a multilateral forum. In the face of advancing microbial threats, *communitarian globalism* represents a pool of efforts and resources by states, non-state actors and multilateral agencies towards the protection of public health and the prevention of cross-border spread of diseases. Why communitarian? It is communitarian because it recognises the inherent risk of mutual vulnerability of populations within geo-political boundaries of nation-states if these states - rich or poor, big or small - fail to co-operate. Simultaneously, *communitarian globalism* recognises the benefits that would flow to populations from a humane global co-operative paradigm based on the ideals of fairness, justice and equity. Why is it global? Its globalism stems from the complex nature of contemporary international health where the phenomenon of globalisation has significantly eroded the erstwhile traditional distinction between national and international health risks. *Communitarian globalism*, as I use it in this context, will not, of course, provide the magic bullet against every global health challenge. However, it will facilitate multilateral consensus on public health threats and significantly reduce the burdens of diseases on vulnerable populations. One of its numerous complexities raises the conundrum of pooling resources on an unequal basis and formulating rules for the allocation of those resources based on equality of all participants, including states and non-state actors. In other words, in terms of the contribution of resources ‘from each state according to its wealth’, a multilateral forum for formulating the rules for allocation of the pooled resources should be based on juridical equality of all the actors. This may smack of injustice by "treating unequal
actors equally". Notwithstanding this apprehension, this thesis has extensively explored the concept of mutual vulnerability to illuminate the tenets of self-interest as a catalyst that compels a re-conceptualization of global health disparities, including mutual vulnerability to pathogenic microbes. Stark disparities in the levels of wealth, health and development among populations, I argue, is supportive of a modified version of the often discredited maxim ‘in terms of contribution, from each according to her/his wealth, and in terms of distribution, to each according to his/her need’ in global health discourse.

As a way forward, I explore communitarian globalism by earmarking its relevant parameters and critical actors: the World Health Organisation, the World Bank, other multilateral institutions, nation-states, civil society and foundations. The urgency of a disease non-proliferation treaty is a critical factor that animates this study's proposal for a multilaterally administered Global Health Fund. The sense of community starts with civil society networks within nation-states. But, because disease pathogens and other microbial threats have now become globalised, the sense of community necessarily transcends national geo-political boundaries to include powerful multilateral institutions like the World Bank that wields enormous influence on countries, especially in the global South. Communitarian globalism seeks to answer the concluding question that I pose for this study: what ought we to do in order to protect and promote human health and well-being in a world sharply divided by inequalities and levels of development? International law, its lawyers and multilateral institutions, in the present post-ontological era of international law, must strive to create a fair and humane multilateral health regime. Utmost fidelity to this ideal compels this study to make modest proposals: a disease non-proliferation treaty, future WHO-World Bank collaboration, a multilateral funding
facility for global health promotion, health care reform, and the role of state actors and
global civil society in *communitarian globalism*.

**B: COMMUNITARIAN GLOBALISM: A PROPOSAL FOR WHO-WORLD BANK COLLABORATION**

Since the early 1990s, the World Bank has emerged as the leading funder of public health projects in the developing world. With its *World Development Report 1993, Investing in Health*, the bank has emerged as an indispensable actor in global health issues. Last observed that, "the World Bank's recognition of the relationship between economic development and health is an important contribution if it leads to greater investment in material and human resources to improve health". The World Health Organisation and other multilateral institutions (especially within the United Nations system) involved in international health issues – the United Nations Children's Fund (UNICEF), the United Nations Development Programme (UNDP), the Food and Agriculture Organisation of the United Nations (FAO), the United Nations Fund for Population Activities (UNFPA), the United Nations Fund for Drug Abuse Control (UNFDAC), the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the United Nations High Commissioner for Refugees (UNHCR) - must now pursue transparent partnerships with the World Bank. The bank's relevance in these partnerships is anchored on two advantages it presently enjoys: the enormity of financial resources it

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4 See “Global Health Challenges”, Report of a Symposium by the Liu Centre for the Study of Global Issues, Vancouver, Canada, 5 March 1999 at 10, stating that protocols for an effective global surveillance system properly falls within the ambit of the World Health Organisation but would likely depend for financing and co-leadership on the World Bank. In global health terms, such a system will depend for its effectiveness upon the enthusiastic participation of all United Nations members. The need is so great and
is able to muster, and the colossal influence it wields in most developing countries. In a sense, these types of partnerships are not entirely new in global health work. They already exist on a limited basis, and on segmented global health issues as manifested in the Joint United Nations Programme on HIV/AIDS and WHO's Roll-Back Malaria Project. What is needed, however, is an inclusive multi-stakeholder participation, transparency, and accountability of these partnerships to the constituencies they serve. With the involvement of the World Bank in these partnerships, the need for transparency and accountability will be at the top of the agenda. This is because the Bank has been criticized for its wholesale endorsement of an undiluted liberal and neo-liberal capitalistic agenda: limited state intervention, strong private sector participation and unqualified triumph of market forces. As Larkin observed,

What we are now seeing is the growing influence of the World Bank as a major funder for health in the poorer countries and one which already eclipses that of the WHO and UNICEF. Its influence has grown steadily throughout the 1980s and 1990s as bank loans for health quadrupled. Its activities now reach into health service financing and delivery, and the prioritisation of programmes along cost-effective lines. ... Given its policies of a diminished role for the state and the privatisation and marketisation of health services as well as the leverage it can exert through its support for structural adjustment, the possibilities for equity-based health services are certainly in doubt. A major cause for concern must be its lack of accountability and the disproportionate weight accorded to the richer countries in the exercise of voting rights, as well as its current commitment to neo-liberal-type policies.

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6 See my critique of WHO's Roll-Back Malaria partnership on similar grounds, supra at p183.

7 M. Larkin, "Global Aspects of Health and Health Policy in Third World Countries", R. Keily & P. Marfleet (eds.), in Globalisation and the Third World (London/New York: Routledge, 1998) 104-105. For a recent criticism of the uncontrollable power of international financial institutions especially the World Bank and International Monetary Fund from an international legal perspective, see Antony Anghie, "Time
Since I endorsed similar criticisms with respect to the Bank’s structural adjustment policies in Chapter Two, it logically follows that the Bank has to modify its obsession with an extreme neo-liberal agenda. As a potential critically important partner in *communitarian globalism*, the Bank’s vision has to radically shift from extreme neo-liberal marketisation of healthcare to the more humane Primary Health Care approach endorsed by the WHO if the dividends of health as a public good are to be within the foreseeable reach and grasp of a majority of the world’s endangered populations. In fact, the World Bank’s neo-liberal approach to health promotion and delivery is antithetical to the World Health Organisation’s Primary Health Care approach. In its World Development Report 1993 *Investing in Health*, the Bank recognised the necessity of a paradigm shift from extreme market approaches to WHO-UNICEF endorsed Primary Health Care; one that recognises the effects of social inequalities, poverty and underdevelopment on health of populations within and among nations. The Bank departed from its insistence on a diminished role for the state by identifying three rationales for a major government role in the health sector:

(i) the need for governments to encourage behaviours that carry positive externalities and to discourage those with negative externalities so as to facilitate the enjoyment of health-related services such as control of contagious diseases as public goods,

(ii) provision of cost-effective health services to the poor in an effective and socially acceptable approach to poverty reduction as endorsed by the WHO/UNICEF Alma-Ata Declaration on Primary Health Care 1978, and,
(iii) the need for government action to compensate problems of uncertainty and insurance market failure. Governments have an important role to play in regulating private health insurance, or mandating alternatives in order to ensure widespread coverage at affordable costs.  

Other common grounds between the World Bank's and WHO's approach to multilateral health promotion include the recognition of HIV/AIDS as a threat to development, reducing the abuse of tobacco, alcohol and drugs, environmental influences on health, and health system reform in developing countries based on medical pluralism, and the promotion of diversity and competition. With respect to provision of health care services to the poor in a social context where a multiplicity of health systems interlock, the Bank noted that in countries like Bangladesh, Kenya, Thailand and many others, governments are supporting the work of traditional birth attendants in safe pregnancies and of traditional healers in controlling infectious diseases like malaria, diarrhoea, and AIDS. In line with the tenets of mutual vulnerability with emphasis on the global threat of HIV/AIDS, the Bank warned that,

The world can do more to deal with the global challenge of AIDS. No country is immune from a future HIV epidemic, and the costs of delay are high. A global coalition is needed that will encourage and assist governments to take bold action before it is too late.

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9 ibid.

10 ibid.

11 ibid at 106
Although local conditions vary from one social context to another, the overall public health vision of the Bank is nonetheless articulated in what it calls "the essential public health package", the highlights of which include,

(i) an expanded programme on immunization including micronutrient supplementation,
(ii) school health programs to treat worm infections and micronutrient deficiencies and to provide health education,
(iii) programs to increase public knowledge about family planning and nutrition, self-cure or indications for seeking care, and about vector control and disease surveillance activities,
(iv) programs to reduce consumption of tobacco, alcohol, and other drugs, and
(v) AIDS prevention programs with a strong component on other Sexually Transmitted Diseases (STDs).

Earmarking the commonalties between the health vision of the World Bank and the mandate of WHO (including the other relevant agencies within the UN System) - as this Chapter does - is extremely important because these commonalties determine the success or doom of future partnerships between the Bank and multilateral health institutions. Despite these commonalties, questions still abound about the World Bank's transparency as well as the over-powering influence of the chief donor countries. I now explore the possible effects the Bank's non-transparency will have on the Bank's involvement in a multilateral health funding facility, especially my proposal on evolving the rules for the fund based on the juridical equality of all relevant actors.

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12 ibid.
13 ibid.
Because poverty and underdevelopment are root causes of disease and illness, I propose a global health fund, a disease non-proliferation multilateral facility that *inter alia* targets the improvement of prevention strategies as well as a core capacity for multi-disease surveillance, and accessibility of curative therapies to vulnerable populations across the world. Quite recently, proposals for a multilateral health funding facility have gained significant support and accelerated momentum within the United Nations system, other multilateral agencies, regional groupings, civil society and leading scholars. Propelled by the limited successes recorded by the World Bank’s Global Environmental Facility (GEF) and the Montreal Protocol on Substances that Deplete the Ozone Layer, advocates of a similar funding facility in the health sector recognise microbial threats as global issues. All leading scholars as well as bilateral and multilateral institutions share a unanimity of opinion that the collapse or non-existence of public health surveillance infrastructures in many countries requires an enormous degree of resources: financial, human and technical. A disturbing dimension of this scenario is that the world has become one single germ pool; a microbial unified village with no safe sanctuary from disease. In an era of mutual vulnerability occasioned by the globalisation of diseases and health hazards, the propensity for the spread of disease in the global village underscores the need for a disease non-proliferation treaty with a focused and co-ordinated funding mechanism. Quite ironically, mutual vulnerability in the past ten years, instead of catalysing increased multilateral funding commitments for global health issues, has witnessed a steady decline in health funding. In 1990, a study by the Commission on Health Research for Development stated that,
An estimated 93 percent of the world's burden of preventable mortality (measured as years of potential life lost) occurs in the developing world. Yet, of the $30 billion global investment in health research in 1986, only 5 percent or 1.6 billion was devoted to the health problems of developing countries. For each year of potential life lost in the industrialized world, more than 200 times as much is spent on health research as is spent for each year lost in the developing world.\textsuperscript{14}

Although the World Bank quadrupled its lending for health in the late 1980s and early 1990s, it nonetheless observed that such aid to middle-income countries, as well as similar aid from the other development banks, is non-concessional lending and that a considerable increase would inevitably involve a hardening of terms and conditions.\textsuperscript{15}

Against the backdrop of crisis in multilateral funding for health, the United Nations Development Programme (UNDP) in 1998 queried why so few financial resources are dedicated to advancing human development in countries where the need is greatest. Donor countries allocate a mere $55 billion to development co-operation - only 0.25% of their GNP of $22 trillion. Official development aid is now at its lowest level since statistics started. The share to the least developed countries continues to decline.\textsuperscript{16}

Linking disease burdens to development, Sachs, an advocate of a global health fund, argues that "global donor support of $10-20 billion per year, much less than 0.1% of the combined $25 trillion gross national product (GNP) of rich nations, would save millions of lives each year and would enable Africa to escape from a downward spiral of disease and economic collapse".\textsuperscript{17} Thus, poverty and underdevelopment affect health by limiting access to health services, sanitation, adequate nutrition and housing, while poor health

\textsuperscript{15} \textit{Investing in Health} supra note 2 at 166.
\textsuperscript{17} Jeffrey D. Sachs, "A New Global Commitment to Disease Control in Africa" (May 2001) 7 Nature Medicine 521.
adversely impacts economic growth through a multiplicity of channels.\textsuperscript{18} The conundrum of multilateral health funding crisis is stark: if epidemics of global proportions could take countries with the best surveillance capacity by surprise, then the magnitude of similar outbreaks in countries like Chad, Guinea Bissau, Burkina Faso, Haiti, Honduras, Guatemala, and Tanzania, with more than half of their entire health expenditures dependent on aid, can only be imagined. Therefore, it is not too late in the day for "the global donor community - governments, multilateral agencies, foundations and individual philanthropists - to support a concerted attack on killer infectious diseases...including HIV/AIDS, tuberculosis and malaria".\textsuperscript{19} To make a difference, the emerging coalition must be a co-ordinated global effort as opposed to the disparate and segmented funding strategies of the past years.\textsuperscript{20}

The crisis in multilateral funding to curb the proliferation of microbial threats, and calls for the establishment of a global health fund received a significant boost lately. In July 2000, the Okinawa Summit of G-8 countries pledged a fund regime with a focus on HIV/AIDS, tuberculosis, and malaria. The G-8 pledge was to boost and sustain political engagement and financial commitment, ease the procurement of commodities, and commit new partners to the battle against microbes. At Okinawa, the G-8 leaders set a goal to reduce the number of HIV and AIDS cases in the 15-24-age bracket by 25% in 2010. They also set 2010 target goals for malaria and tuberculosis. In April 2001, at the Organisation of African Unity summit on HIV/AIDS, Tuberculosis and other related

\textsuperscript{18} \textit{ibid.}
\textsuperscript{19} \textit{ibid.}
\textsuperscript{20} \textit{ibid} at 522. Sachs cites the example of Bill Gates, whose $750 million aid to the Global Fund for Children's Vaccines reinvigorated programs for childhood immunisation and stirred the conscience of international agencies towards a better co-ordinated Global Alliance for Vaccines Initiative (GAVI).
infectious diseases, held in Abuja, Nigeria, UN Secretary-General Kofi Annan called for
the establishment of a global fund on AIDS and Health. Annan argued that the best cure
for all diseases is economic growth and broad-based development. Disease, like war, is
not only a product of underdevelopment, but also one of the biggest obstacles preventing
the development of societies in Africa. He identified five broad objectives in the global
battle against HIV/AIDS and other related infectious diseases as:

(i) Prevention aimed at halting and reversing the spread of the virus to safeguard the
present and future generations,

(ii) Prevention of the cruelest, most unjust infections - those from mother to child,

(iii) Putting care and treatment within everyone's reach,

(iv) Effective delivery of any future scientific breakthroughs across societies, and

(v) Protection of those made most vulnerable to the epidemics especially orphans.

As a means of achieving these objectives, Annan, inter alia, proposed the creation
of a Global Fund dedicated to the battle against HIV/AIDS and other infectious diseases.
The Fund must be structured in a way to ensure that it responds to the needs of the
affected countries and people. The Fund regime must draw from the advice of the best
experts in the world - whether they are found in the United Nations system, in
governments, in civil society organisations, or among those who live with HIV/AIDS or
are directly affected by it. The African Summit led to the Abuja Declaration and Plan of
Action to curb the spread of HIV/AIDS and other related infectious diseases in Africa.

\[21 \text{ See } \text{Speech by Kofi Annan to the African Summit on HIV/AIDS, Tuberculosis and other Related Infectious Diseases, Abuja, Nigeria, 24-27 April 2001 (On file with the author). Also available online at UN web site http://www.un.org/News/Press/docs/2001/SGSM7779R1.doc.htm (visited 10 May 2001).}
\[22 \text{ibid.} \]
The Declaration also called on donor countries to complement Africa's resource mobilisation efforts to fight the scourge of HIV/AIDS, TB and other related infectious diseases.\textsuperscript{25} The Abuja Declaration and Plan of Action urged donor countries to, \textit{inter alia}, fulfil the unrealised target of 0.7% of their GNP as Official Development Assistance (ODA) to developing countries.\textsuperscript{26} The Declaration also made a commitment to explore and develop potential traditional medicine and traditional health practices in the prevention, care and management of these diseases. Further, it endorsed the creation of a Global AIDS Fund capitalised by the donor community of a sum of $10 billion, accessible to all affected countries to enhance the operationalisation of Action Plans, including accessing anti-retroviral programmes in favour of African populations.\textsuperscript{27}

At the fifty-fourth World Health Assembly held in Geneva in May 2001, UN Secretary-General Kofi Annan reiterated his call for the establishment of a Global AIDS and Health Fund with a focus on the five objectives articulated in his speech at the African summit.\textsuperscript{28} At the Assembly also, WHO Director-General, Dr. Gro Harlem Brundtland outlined a number of emerging principles that have guided proposals for a global health fund as:

\begin{itemize}
\item \textit{ibid.}
\item \textit{ibid.}
\item See ABUJA Declaration on HIV/AIDS, Tuberculosis and other Related Infectious Diseases, OAU/SPS/ABUJA/3, made pursuant to the African Summit on HIV/AIDS, Tuberculosis and other Related Infectious Diseases, 24-27 April 2001.
\item \textit{ibid.}
\item \textit{ibid.}
\item Kofi Annan, "Poverty: Biggest Enemy of Health in the Developing World", Speech to the 54\textsuperscript{th} World Health Assembly, Geneva, Switzerland, 17 May 2001 (on file with this author). Also available online at \textless http://www.un.org/News/Press/docs/2001/sgsm7808.doc.htm\textgreater (Visited 25 May, 2001).
\end{itemize}
(i) Additionality: the fund should not replace existing funding mechanisms, but add value in terms of resources and outcomes to what is already happening.

(ii) It must support national level decisions and leadership and simultaneously ensure transparency and accountability.

(iii) The Fund must support on-going national development processes such as national HIV/AIDS strategies.

(iv) It should promote voluntary and private sector participation including full involvement of civil society in the preparation of submissions and implementation of programmes.

(v) The need for a multi-sectoral action drawing on high-level national political support.

(vi) The Fund should contribute to increasing the coherence and effectiveness of development assistance through the strengthening of existing government-donor coordination mechanisms.

(vii) It has to be innovative by encouraging new ways of working and ensuring that funds are disbursed both rapidly and wisely.

(viii) The need for streamlined management; applications for funding should not require new and elaborate planning processes.

(ix) The Fund must recognise the differences of divergent national contexts.

(x) Successive tranches of funding reward good performance.

(xi) The Fund should operate in the context of international agreements including Trade Related Intellectual Property Rights (TRIPS) and the safeguards included in it, and finally,
If the Fund is to help in delivering equitable health outcomes, it must operate with equity in mind: equity in process and equity in allocation of resources.\(^{29}\)

The proposed Global AIDS and Health Fund received its highest multilateral imprimatur at the United Nations General Assembly Special Session held in New York, 25-27 June 2001. In a declaration of commitment to HIV/AIDS entitled “Global Crisis-Global Action”, the General Assembly categorised the devastating scale and impact of global HIV/AIDS epidemic as ‘a global emergency’, constituting one of the most formidable challenges to human life and dignity as well as to the effective enjoyment of human rights.\(^{30}\) The declaration noted that the threat of HIV/AIDS undermines social and economic development across the world and affects all levels of society – national, community, family and individual. The General Assembly Declaration affirmed a commitment by Governments to address HIV/AIDS crisis by recognising that:

(i) Leadership by Governments in combating HIV/AIDS is essential and their efforts should be complemented by the full and active participation of civil society, the business community and the private sector at the national, regional/sub-regional, and global levels.

(ii) Effective prevention strategies need to be strengthened to achieve internationally agreed global prevention and reduction of HIV/AIDS prevalence among vulnerable groups.

(iii) Care, support and treatment are fundamental elements of an effective response to the global HIV/AIDS epidemic.


\(^{30}\) See “Global Crisis-Global Action”, Declaration of Commitment on HIV/AIDS adopted by the United Nations General Assembly Special Session, New York, 25-27 June 2001 (on file with the author); also
(iv) The realisation of human rights and fundamental freedoms for all of humanity is essential to reduce vulnerability to HIV/AIDS, and respect for the rights of people living with HIV/AIDS drives an effective response.

(v) Vulnerable groups must be given priority in response especially through the empowerment of women.

(vi) Children orphaned and made vulnerable by HIV/AIDS need special assistance.

(vii) The social and economic impact of HIV/AIDS should be alleviated, thus to address HIV/AIDS is to invest in sustainable development.

(viii) There is at present no known cure for AIDS, therefore further research and development is crucial.

(ix) Conflicts and disasters contribute to the spread of HIV/AIDS. Countries should develop and begin to implement national strategies that incorporate HIV/AIDS awareness, prevention, care and treatment elements into programmes that respond to emergency situations, recognising that populations destabilised by armed conflict, humanitarian crises or natural disasters, including refugees and internally displaced persons - particularly women and children - are at increased risk of exposure to HIV infection.

(x) Resources provided for the global response to address HIV/AIDS must be substantial, sustained and geared towards achieving results. Establishment of a global HIV/AIDS and Health Fund is a matter of urgency, in order to finance an urgent and expanded response to the epidemic based on an integrated approach to prevention, care, support and treatment, and to assist Governments in their efforts to combat HIV/AIDS. Mobilisation available online at <http://www.un.org/ga/aids/coverage/FinalDeclarationHIVAIDS.html> (Visited 4 July 2001).
of contributions to the Fund should target private and public sources with a special appeal to donor countries, foundations and the business community, including pharmaceutical companies, the private sector, philanthropists and wealthy individuals.

(xi) It is essential to monitor progress made towards realising the objectives of the declaration at the national, regional and global levels.31

At their 2001 Summit held in Genoa, Italy, the G-8 countries re-affirmed their commitment to a Global Health Fund to combat HIV/AIDS, Malaria, Tuberculosis and other related infectious diseases. In their final declaration in Genoa, the G-8 countries - in response to the United Nations General Assembly appeal for resources - committed $1.3 billion to the proposed Global Fund to fight HIV/AIDS, Malaria and Tuberculosis. To the G-8, the Fund will be a public-private partnership based on contributions from countries, private sector, and foundations. The Fund will promote an integrated approach, emphasising prevention in a continuum of treatment and care, and its operation will be based on principles of proven scientific and medical effectiveness, rapid resource transfer, low transaction costs, and light governance with a strong focus on outcomes.32

That the proposed Global AIDS and Health Fund has been persuasively endorsed by agencies of the United Nations system, a special session of the UN General Assembly, the G-8 Summit, civil society and non-governmental organisations, and leading scholars, offers proof that it is an idea whose time has come. However an avalanche of difficult and formidable challenges still abounds, especially on the modus operandi of the Fund. Will the Fund be managed squarely under the auspices of the UN system or outside? Will

31 Ibid.
it be fair for unequal donors and contributors to have equal votes in managing the Fund? How best can the Fund regime draw on the expertise from a number of sources—multilateral agencies, research institutions, countries, and civil society? How can the indelible fingerprints of equity and fairness impress the Fund regime? Who elects members of the Fund’s management team? How can the Fund best represent societies and cultures across the world fairly and equitably? Will the scope of the Fund expand in the future to cover other global health threats outside HIV/AIDS, Malaria and Tuberculosis? Fund regimes on other multilateral issues inevitably confront similar questions. In exploring these questions I highlight what I foresee as the prospective (by no means exhaustive) basic tenets of a Global Health Fund regime as well as the foreseeable objections to these tenets from an international legal perspective.

D: INTERNATIONAL LAW AND GOVERNANCE OF THE GLOBAL HEALTH FUND

Among the deluge of proposals for the establishment of a multilateral health Fund, there is unanimity on two important managerial issues. First, the Fund should be managed independently outside the framework of the United Nations agencies and other multilateral institutions. In essence, it must enjoy a considerable degree of independence and autonomy outside the excessive bureaucracy of most existing multilateral institutions. Second, because the proposed Fund is an innovative partnership between developing countries, donors and multilateral agencies both within and outside the UN system, its management must be transparent and accountable to its global,

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33 This does not mean that specialised agencies of the United Nations like the World Health Organisation will not be part of the fund regime. The various mandates and expertise of these organisations make them
regional, national and local constituencies. It should be based on a broad, multi-
-stakeholder inclusiveness involving all the relevant actors in both the donor and recipient
countries. The Fund regime - like multilateral health treaties - should serve as an
intermediate vehicle in the ultimate delivery of public health dividends as public goods to
the poor and vulnerable across the world. The new Global Health Fund should be
managed by an independent international Executive Council or Board composed of
experts whose integrity and expertise are beyond question on health, development and
international legal issues. Their selection or election should broadly represent the geo-
political regions of the world across donor and recipient countries. Countries in several
geographic regions should use their relevant existing channels of co-operation - PAHO,
NAFTA, OAU, OAS, EU, APEC, ASEAN, to name a few - to nominate or elect the
required number of experts to represent their region in the Executive Council of the
Global Health Fund. In this endeavour, it is important that non-state actors - civil society
organisations - are given an opportunity to participate in the selection or election process
of council members.

In drawing up guidelines and other governance mechanisms on health
project/programme funding, the Council should draw from relevant expertise within
multilateral institutions: the World Health Organisation, research institutions, national
disease surveillance centres like CDC, civil society and international non-governmental
organisations working in the areas of health, development and poverty alleviation.
Because the global burden of diseases and health risks is unevenly distributed across the
world, project or programme funding guidelines and decisions should take into account

important players on global health issues. What is being suggested is a framework that is more participatory
and inclusive of other actors and stakeholders.
the peculiar needs of societies within the regions that have the heaviest mortality and morbidity burdens of diseases. Decisions of the Council or Board shall be reached by a simple majority of members. To ensure transparency and accountability to its constituents, the Council shall publish periodic reports accessible to any interested person, government or organisation, and organise public hearings open to delegates from countries and civil society. It should be sensitive to public opinion of the global health and development communities, maintain the highest attainable standard of financial and managerial probity, and demonstrate a considerable degree of sensitivity to divergent social and economic contexts across societies and cultures as well as to the different perceptions of health in these societies.

To date, the two leading exponents of governance mechanisms for the Global Health Fund similar to the ones I have proposed are Dr Gro Harlem Brundtland, Director General of the World Health Organisation, and Professor Jeffrey Sachs, Chair of the WHO Commission on Macroeconomics and Health and Director of the Harvard Centre for International Development. Brundtland proposed a small Executive Board, representing all constituencies (developing country governments, donor governments, foundations, corporate and other private sector donors, civil society and NGOs, UN agencies and the Bretton Woods institutions), to determine strategic priorities and criteria for decision-making. Recommendations on which the Board acts should be based on broad-based consultations with governments and civil societies of those countries that

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36 See J. Sachs, supra note 17.
37 See Brundtland, supra note 35.
will use the fund, the governments and the civil societies of those countries that will contribute to the fund, the private sector and foundations who are encouraged to contribute, and international agencies.\textsuperscript{38} Sachs suggests that the Fund should be under the leadership of the World Health Organisation, with a strong backing by the leading biomedical and public health institutions such as the National Institutes of Health (NIH) and Centres for Disease Control in the United States and comparable bodies in other countries.\textsuperscript{39} The basic mechanism for the Fund should build in scientific review as a central mechanism including operational monitoring, evaluation and audits.\textsuperscript{40} Governments of developing countries would submit plans for disease control to be vetted by independent expert scientific review committees. Based on the recommendations of the expert review committees, a plan would either trigger financing from the Fund or would be returned to the country for further work and possible funding at a later stage.\textsuperscript{41} Part of the operational guidelines of the Fund or terms of reference should focus on encouraging governments to draw upon their own national experts in the design and implementation of programs.\textsuperscript{42}

Although details of the governance mechanisms of the Global Health Fund are being exhaustively worked out, its central tenets as manifested in the opinions of advocates such as Kofi Annan, Jeffrey Sachs, and Gro Harlem Brundtland accord with the canons of \textit{communitarian globalism}. These proposals emphasise broad-based multi-stakeholder consultations founded on a South-North \textit{entente}, multi-cultural approaches to

\textsuperscript{38} \textit{ibid.}
\textsuperscript{39} See Sachs, \textit{supra} note 17.
\textsuperscript{40} \textit{ibid.}
\textsuperscript{41} \textit{ibid.}
\textsuperscript{42} \textit{ibid.}
health, and an inclusive civil society participation both in the selection of, and representation on, the Executive Council of the Fund. In considering projects and programmes for funding, broad-based consultations as suggested by these publicists would recognise each individual country's peculiar social, political and economic contexts as animated by civil society networks in order to guard against globalisation-from-above. Because the bulk of contributions to the Fund are pledged by industrialised countries and influential groups like the G-8, the desired South-North inclusiveness of the Fund regime faces a possible legal objection based on *nemo dat quod non habet*\(^43\) rule, and a political objection based on a perception that donor countries ought to control the allocation of funds. Donor countries and agencies may seek to dominate the Fund regime as of right, arguing that most recipient countries contributed little or nothing to the Fund. Formidable as this view might be, it will be important to re-visit the collective ideals of mutual vulnerability, globalisation of diseases, and self-interest as possible defences as well as arguments in favour of giving developing countries equal status in managing the Fund.

**E: MUTUAL VULNERABILITY, GLOBALISATION OF DISEASES AND SELF INTEREST AS DEFENCES**

As already argued, mutual vulnerability,\(^44\) globalisation of diseases\(^45\) and enlightened self-interest,\(^46\) are powerful factors that animate new thinking on global health challenges. To bridge the contemporary global health divide and the uneven distribution of diseases and pathogens within and among nations in the global village,

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\(^{43}\) “No person can give that which he does not have”, *see* H.C Black, *Black's Law Dictionary* 6\(^{th}\) ed., (St. Paul Minn: West Publishing Co., 1990) 1037.

\(^{44}\) *Supra* Chapter 3.

\(^{45}\) *Ibid.*

\(^{46}\) *Ibid.*
these factors should influence the outcome of the emerging global health funding mechanism. Cumulatively, the central tenet of these three factors - microbial permeation of, and pathogenic disrespect for, national boundaries - provides an opportunity to tackle the transnationalisation of diseases multilaterally. On a balance of scale, protectionist agendas on global health challenges ideally should not blur visionary, broad-based approaches. In respect of the emerging global health funding facility, donor countries and agencies must necessarily work together with the developing world on a synergistic basis to avoid lessons of the past decades when aid was frequently tied to conditionalities alien and hostile to the environment in recipient countries. A synergistic relationship, as I use it in this context, is one founded on self-interest because the tolerance of disease in even the remotest part of the world constitutes a threat to populations everywhere. As Brundtland rightly observed,

> Enlightened self-interest compels industrialised country governments and private corporations to do what it takes to drastically reduce the current burden of disease in the developing world. To do so will be good for economic growth, be good for health and be good for the environment. Not only for the three billion people who have yet to benefit from the technological and economic revolution of the past fifty years - but for us all.

If narrowly defined, as opposed to enlightened, self-interest emerges as the dominant principle to guide the Global Health Fund, then the Fund will ultimately be another haphazard policy that leaves humanity multilaterally defenceless against formidable threats of global pathogenic forces. Because I have argued in support of a Fund regime that is based on multi-stakeholder participation, it is important to further explore the role

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that countries and non-state actors - especially civil society - should play in *communitarian globalism*.

**F: COMMUNITARIAN GLOBALISM AND NATION-STATES**

The argument that the phenomenon of globalisation has rendered the erstwhile distinction between national and international health obsolete does not suggest that the nation-state will, or has indeed become completely irrelevant in global governance; neither does it diminish the important role countries are envisaged to play in *communitarian globalism*. Rather, such arguments elevate transnational health threats in an inter-dependent world to a critically important pedestal so high on the agenda of multilateralism that state-actors will feel compelled to explore their multiple dimensions. The reality is that our contemporary world-order is still predominantly structured on a coalition of nation-states. In the discourse of *communitarian globalism*, therefore, the onus of basic curative, protective, preventive, and promotional health care services, falls substantially on governments within national jurisdictions. The dimensions of these services are multiple: resource-allocation decisions, basic sanitation and environmental hygiene, food security, poverty alleviation, the regulation of medical insurance and health-care delivery. Other factors include equity and ethical issues, the assessment and reform of health systems, sustainable development, legislative interventions in health care delivery, public health education, the maintenance of core capacity for disease surveillance, and a range of critical social and economic decisions. In all of these, governments within national jurisdictions are very important actors in making critical

choices and decisions. The World Bank has articulated these variegated challenges to governments in three broad categories,

(i) Since overall economic growth - particularly poverty-reducing growth - and education are central to good health, governments need to pursue sound macroeconomic policies that emphasize the reduction of poverty. They also need to expand basic schooling, especially for girls, because the way in which households, particularly mothers, use information and financial resources to shape their dietary, fertility, health care, and other life-style choices has a powerful influence on the health of household members.

(ii) Governments in developing countries should spend far less - on average, about 50 percent less - than they now do on less cost-effective interventions and instead double or triple spending on basic public health programs such as immunizations and AIDS prevention, and on essential clinical services. A minimum package of essential clinical services would include sick-child care, family planning, prenatal and delivery care and treatment of tuberculosis and STDs. Low-income countries should redirect current public spending for health and increase expenditures (by government, donors, and patients) to meet needs for public health and the minimum package of essential clinical services for their populations; less reallocation would be needed in middle-income countries.

(iii) Because competition can improve quality and drive down costs, governments should foster competition and diversity in the supply of health services and inputs. This includes, where feasible, private supply of health care services paid for by governments or social insurance. There is scope for improving the quality and efficiency of government health services through a combination of decentralization, performance-based incentives for managers and clinicians, and related training and development of management systems.
Strong government regulation is crucial, including regulation of privately delivered health services to ensure safety and quality and the regulation of private insurance to encourage universal access to coverage.\textsuperscript{48}

This broad tripartite categorization of the role of governments in health care delivery shares some synergy with the tenets of health promotion,\textsuperscript{49} WHO's Primary Health Care,\textsuperscript{50} and what has emerged in public health literature as "health determinants".\textsuperscript{51} Each of these approaches requires critical legislative, policy, regulatory, and other interventions by governments. Keeping faith with these interventions and challenges adds value to \textit{communitarian globalism}. Garrett was obviously correct when she stated recently that,

Health, broadly defined, may not qualify as a right of every human being. But the essentials of public health most assuredly were human rights. Every government in the world knew by 2000 – irrefutably – that an unfiltered, unclean drinking water system could kill children. Every government knew that black market sales of antibiotics fuelled emergence of deadly drug-resistant microbes. No political leader could believably deny knowledge that allowing unfettered tobacco advertising and sales in his or her country would destroy the lungs, hearts and other vital organs of the smoking citizenry. Leaders could no longer deny that an HIV-loaded syringe, passed from one person to another, was every bit as dangerous as a loaded gun. Ignorance might have protected world leaders in the mid-twentieth century, but after the millennium it would be difficult to dodge a charge of negligent homicide against a national leader who deliberately shunned provision of safe drinking water in favor of military or grandiose development expenditures. Trust and accountability: above all else, these were the pillars of public health.\textsuperscript{52}

\textsuperscript{48} The World Bank, \textit{supra} note 2 at 6-7.
\textsuperscript{49} The Ottawa Charter for Health Promotion 1986 provides, \textit{inter alia}, that health promotion is not just the responsibility of the health sector, but goes beyond health lifestyles to well being. \textit{See Ottawa Charter for Health Promotion, supra} at page 5 note 12.
\textsuperscript{50} The WHO/UNICEF Alma-Ata Declaration on Primary Health Care 1978, \textit{inter alia}, provides that Primary Health Care forms an integral part of a country's health system and of the overall social and economic development of the community. \textit{See WHO/UNICEF Declaration on Primary Health Care 1978 supra} at page 5 note 13.
It is only when national health systems begin to show effective capacities for health promotion and disease surveillance - through sound governmental interventions - that multilateralism stands to dismantle all the microbial arsenals and reservoirs for disease proliferation within the global village. Therefore, “an early role of government should be that of setting unequivocal, uncontestable health objectives and launching massive campaigns to make them understood”.

**G: COMMUNITARIAN GLOBALISM, NON-STATE ACTORS AND GLOBAL CIVIL SOCIETY**

In this day and age, the Westphalian state-centric model of multilateralism faces formidable challenges and a foreseeable assault from non-state actors and global civil society. This notwithstanding, some scholars dismiss the idea of a "global civil society" as an amorphous concept. This school, as Wapner observed, argues that global civil society, 

...is not the embodiment of humane governance.... It is populated by forces that have less benign intentions. Indeed, it is a complicated arena marked by competition among various groups that uphold conflicting interests and work to advance them.... It is comprised of many who believe that they have humanity's well-being in mind when, in fact, they are operating from a purely private, self-interested perspective.

54 I use the term "global civil society" not in a restrictive sense that merely refers to non-governmental organisations, but in the broad sense suggested by Paul Wapner as "that domain of associational life that exists above the individual and below the state yet across state boundaries through which people experience the virtues of sociality and represent themselves in a social context". See Paul Wapner, "The Normative Promise of Nonstate Actors: A Theoretical Account of Global Civil Society", in P. Wapner & Lester Ruiz, eds., *Principled World Politics: The Challenge of Normative International Relations* (Lanham: Rowman & Littlefield Inc., 2000) 261 at 266.
55 *ibid.*
Worse still, only few studies explain the mechanics by which activities in global civil society engage the structures that govern global collective life; few studies present a theoretical understanding of power in global civil society and analyse it in a way that clarifies its ability to shape widespread thought and behaviour. Notwithstanding the pessimism that the global civil society is an innovative partner and actor in global governance, it is now widely accepted that multilateral governance of global issues can no longer rest exclusively on a world-order composed of a coalition of sovereign states. Ferguson and Mansbach rightly observed that, "various factors account for the upsurge in non-state identities, not least of which is the declining importance of territory as a source of power and prosperity. The proliferation of transnational and global networks of de-territorialized communities has further reduced the relevance of territory in global politics." An obvious aim of the coagulation and conglomeration of these transnational global networks remains the ultimate realisation of what Falk calls "the law of humanity". According to Falk,

The character of the law of humanity is not self-evident. It could mean law that is enacted by and for the peoples of the world, as distinct from the elites who act in law-making settings on behalf of states....In this sense, then, states are not regarded as appropriate agents for the development of the law of humanity, it depends on civil society to establish new forms of law-creation and law-application.

Because the limits of the Westphalian system compel a re-assessment of contemporary global governance mechanisms, my proposal of communitarian globalism foresees a

56 ibid.
59 ibid.
more inclusive and active involvement of non-state actors in multilateral health policy-making. From this perspective, the effect of inter-cultural and theoretical dialogues that I proposed in Chapter Five is therefore dual-dimensional. First, such cross-theoretical/cultural dialogues explore the shortcomings of contemporary multilateral governance regimes (the Westphalian system). Second, they support an innovative agenda that strengthens the present haphazard *locus standi* of non-state actors in the governance of multilateral health issues. In this sense, I agree with Wapner that,

> The promise of global civil society rests on the normative commitment toward humane governance. At bottom, humane governance is about managing the affairs of public life in a democratic fashion by which energies of people are co-ordinated to solve certain dilemmas and realise the many virtues that are possible in a collective setting.

The promise of civil society in humane governance is further boosted by the perceived exclusion, by the state, of a sizeable part of humanity from its protective structures during most of the period of the ascendancy of the state from the Treaty of Westphalia 1648 to the present day. In recent years, multilateral governance of the environment, nuclear weapons, landmines and small arms, the recently created International Criminal Court, biological/chemical weapons, and many other regimes, all bear footprints of the

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60 Many multilateral institutions including the United Nations organs and specialised agencies grant observer status to civil society organisations. Article 71 of the Constitution of the World Health Organisation provides that the WHO may, on matters within its competence, arrange for consultation and co-operation with non-governmental international organisations, and with the consent of the Government consult with national organisations, governmental or non-governmental. See generally, Principles Governing Relations Between the World Health Organisation and Non-Governmental Organisations, Resolution WHA40.25 adopted by the Fortieth World Health Assembly, reproduced in World Health Organisation, *Basic Documents* (Geneva: WHO, 1996) 74.


participation of civil society and non-state actors. On some of these multilateral issues, non-state actors have demonstrated commendable leadership potentials as well as the zeal to influence global public opinion. In the health context, global civil society should be obliged to play the multiple roles of critic, watchdog and collaborator in multilateral health policy-making, application, enforcement, advocacy and monitoring. International non-governmental organisations like the International Committee of the Red Cross, Oxfam International, Greenpeace, Medecines Sans Frontieres - to name a few, can play more active roles in global health governance than they do now. Short of having an equal vote with states in multilateral health forums, multilateral institutions should tap their expertise and use their critiques to re-construct health governance paradigms. This way, the web of transnational bonds across cultures and societies on a plethora of common health problems already emerging will be strengthened. For as Falk put it, Transnational social forces provide the only vehicle for the promotion of the law of humanity, a normative focus that is animated by humane sustainable development for all peoples - North and South - and seeks to structure such commitments by way of humane geogovernance (that is, governance protective of the earth and its peoples that is democratically constituted, both in relation to participation and accountability, and that is responsive to the needs of the poorest twenty percent and of those most vulnerable)....

Thus, the domain of communitarian globalism as I propose in this study is, paradoxically, a fragmented but unified fabric. Its scope traverses a wide terrain of a multiplicity of


64 Falk, supra note 58 at 38.
actors - multilateral institutions, states, civil society/non-states actors – all independent entities, yet each symbiotically united with the others to ward off microbial threats in the global village.

**H: FIDELITY TO HUMANITY’S HEALTH: BRIDGING THE SOUTH-NORTH HEALTH DIVIDE – PROPHYLAXIS FOR A HUMANE HEALTH ORDER**

It is now almost universally accepted as definite that the resurgence and transnational spread of deadly infectious diseases and other related health hazards constitute one of the most vicious threats to humanity at the dawn of the twenty-first century. Humane multilateral health governance requires multiple actors - nation states, multilateral institutions, private and corporate sectors, foundations and civil society. These actors must make critical choices within the transient window of opportunity that mutual vulnerability has offered humanity. Despite infallible epidemiological evidence that,

...in the modern world, bacteria and viruses travel almost as fast as money. With globalization, a single microbial sea washes all of humankind.,

apostles of isolationism and protectionism continue to dismiss discourses of transnational microbial threats as either false alarm or frivolous prophecy of doom that must be taken with a pinch of salt. A disease-free world is definitely utopian and unachievable. But a disease non-proliferation global village is achievable and within the reach of humankind if critical choices and sacrifices along the lines suggested by this thesis are made. The dawn of the century marks an important beginning: a massive search for the needed ‘prophylaxis’ to prevent a re-occurrence of the mistakes of the past decades, and to re-

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configure the contours and boundaries of a humane health order in the years ahead. As explored in this study, globalisation, socio-economic inequalities within and among nations, respect for human rights especially dignity of the person, inter-cultural and theoretical dialogues are all subsumed within the complexities of this endeavour. Without the slightest pretence that this task would be easy, human interdependence as well as the corresponding interconnection of humanity's health across societies teaches many lessons, the most important being that we desperately need to re-build damaged trust. In a world that at present exhibits essential features of medieval feudalism - where eighty percent of the world population has access to less than fifteen percent of global resources - reconstruction of social trust to promote human health faces very formidable challenges. As Garret recently wrote,

To build trust, there must be a sense of community. And the community must collectively believe in its own future. At the millennium much of humanity hungered for connectedness and community *but lived isolated, even hostile, existences*. Trust evaporated when Tutsis met Hutus, Serbs confronted Kosovars, African-Americans worked with white Americans or Estonians argued with Russians. The new globalization pushed communities against one another, opening old wounds and historic hatreds, often with genocidal results. It would be up to public health to find ways to bridge the hatreds, *bringing the world toward a sense of singular community in which the health of each one member rises or falls with the health of all others.*

Garret's sense of a singular but isolated community of humanity comes within what I explored as the 'paradox of a global village in a divided world'. Difficult as the task of re-building multilateral trust may be, it remains the critical first step towards a humane global health order. In the absence of such trust - trust that mandates every human being and every country to see the damage of another person's health as his own or another

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country’s disease as its own – the modest policy recommendations of this thesis would be futile. Because all of humanity is now an inseparable part a unified global compact, the recommendations of this study will only be achievable in a multilateral setting of social contractual trust. In his work, *World Citizenship: Allegiance to Humanity*, Nobel Laureate Joseph Rotblat reminds us that,

> The most important problems facing the human race today are global problems. This is what is meant by global interdependence. ...A parochial attitude to world affairs, insensitivity to the destruction of the environment, a lack of compassion for fellow human beings, insufficient imagination to see the dangers that lie ahead: all will condemn the human race to a chaotic and violent future.

Without an iota of doubt, public health threats come within the contemplation of Rotblat’s ‘global problems’. What then is the most effective prophylaxis for a humane multilateral health order in a divided world devoid of mutual trust and a respect for humanity? We ought to do that which seems to be fair. Call it obligation, moral or legal, owed by wealthy countries to the poor; call it equity, fairness or justice in multilateralism; or humane governance that aims to narrow South-North disparities. At the dawn of the twenty-first century, the best prophylaxis that stands to protect and promote our endangered ‘common health future’ is enlightened self-interest. Its indelible fingerprints and visible imprimatur abound in almost every society, culture, religion, and in every social milieu where human beings interact with one another including the multilateral public health arena.

Post-ontological international law, with its bold claims to universal protection of human rights, and the enhancement of human dignity, is indispensable in re-constructing

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68 *ibid* at 1.
the damaged public health trust in the relations of nations and peoples. In this endeavour, the fairness of the law should no longer be assumed. Its interventions should effectively deliver the dividends of good health to the poor and vulnerable across the world. At the dawn of the twenty-first century, a range of millennial challenges confronts humanity’s health. These challenges compel us to comprehensively re-assess the mechanisms with which international law responds to multilateral health promotion and governance. Will twenty-first century international law and its scholars opt to remain passive in the face of advancing microbial forces? One certain fact, however, is that multilateral health governance comes within the boundaries of contemporary international law. Therefore, international law’s perceived passivity in global health discourse in the past years must now be reconciled, and aligned with the need for a paradigm shift: one that recognises the synergy that law and public health disciplines have long shared on the promotion, and enhancement of human life and dignity. The reach and grasp of the law in this endeavour must match the expectations of the vulnerable constituents of the global village: those that live their daily lives with the heaviest burdens of infectious and non-communicable diseases.
A: BOOKS
Achebe, C; Things Fall Apart (New York: Anchor Books, 1994)
Anand, R.P; New States and International Law (Delhi: Vikas Ltd., 1972)
Appiah-Kubi, K; Man Cures, God Heals: Religion and Medical Practice Among the Akans of Ghana (USA: Allenheld & Osmun, 1981)
Arnold, G; The End of the Third World (New York: St. Martins Press, 1993)
Basch, P; A Textbook of International Health (Oxford: Oxford University Press, 1990)
Bedjaoui, M; Towards a New International Economic Order (Paris: UNESCO, 1979)
Benedick, R; Ozone Diplomacy (Cambridge, MA: 1991)
Campbell, B.K & Loxley, J; Structural Adjustment in Africa (Hampshire: Palgrave, 1989)
Crosby, A.W; The Columbian Exchange: Biological and Cultural Consequences of 1492 (Westport, Connecticut: Greenwood Press, 1972)
de Chazournes, L & Sands, P; International Law, the International Court of Justice and Nuclear Weapons (Cambridge: Cambridge University Press, 1999)
Evans-Pritchard, E.E; Witchcraft, Oracle and Magic Among the Azende (Oxford: Oxford University Press, 1937)
Falk, R; On Humane Governance: Towards a New World Politics (College Park, PA: Penn. State University Press, 1995)
Frank, T.M; Fairness in International Law and Institutions (Oxford: Clarendon Press, 1995)
Geest, W; (ed.,) Negotiating Structural Adjustment in Africa (New York: UNDP, 1994)
Hasenclever, A; et al; eds., Theories of International Regimes (Cambridge: Cambridge University Press, 1997)
Head, I.L; On a Hinge of History: The Mutual Vulnerability of South and North (Toronto: The University of Toronto Press, in association with the International Development Research Centre, Ottawa, 1991)
Held, D; Introduction to Critical Theory: Horkheimer to Habermas (London: Hutchinson, 1980)
Hilts, P.J; *Smokescreen: The Truth Behind the Tobacco Industry Cover-Up* (Reading, MA: Addison-Wesley Co. 1996)
Howard-Jones, N; *International Public Health Between the Two World Wars: The Organizational Problems* (Geneva: WHO 1978)
Koskenniemi, M; *From Apology to Utopia: The Structure of International Legal Argument* (Helsinki: Finnish Lawyers' Publishing Group, 1989)
Lensink, R; *Structural Adjustment in Sub-Saharan Africa* (New York: Addison-Wesley, 1996)
Leslie, C & Young, A; *Paths to Asian Medical Knowledge* (Berkeley/LA: University of California Press, 1992)
Mkandawire, T & Soludo, C.C; *Our Continent, Our Future: African Perspectives on Adjustment* (Ottawa: IDRC in conjunction with Council for the Development of Social Science Research in Africa, CODSSRIA, 1999)
Nadasen, S; Public Health Law in South Africa (Durban: Butterworths, 2000)
Narayan, D; et al; Voices of the Poor Crying Out for Change (Washington, D.C: The World Bank, 2000)
Robertson, R; Globalization, Social Theory and Global Culture (London: Sage, 1992)
Said, H.M; Medicine in China (Karachi: Hanidard Academy, 1965)
Shakespeare, W; Romeo and Juliet, Dover Thrift Editions (New York, Dover, 1993)
Simpson, G.E; Yoruba Religion and Medicine in Ibadan (Ibadan: Ibadan Univ. Press, 1980)
Smith, G & Naim, M; Altered States: Globalization, Sovereignty and Governance (Ottawa: IDRC, 2000)
Sohn, L & Buergenthal, T; eds.; The Movement of Persons Across Borders (American Society of International Law; Studies in Transnational Legal Policy No. 23, 1992)
Stuagard, F; Traditional Medicine in Botswana (Gaborone: Ipelegang Publishers, 1985)
The South Commission; The Challenge of the South (Oxford: Oxford University Press, 1990)
Wapner, P; Environmental Activism and World Civic Politics (New York: SUNY, 1996)
Waters, M; Globalization (London: Routledge, 1995)
Watts, S; Epidemics and History: Disease, Power and Imperialism (New Haven/London: Yale University Press, 1997)
Webber, M; Economy and Society Vols. I & II; Roth, G & Wittich, C; eds., (Berkeley/Los Angeles: University of California press, 1978)
Zinsser, H; Rats, Lice and History: A Chronicle of Pestilence and Plagues (New York: Black Dog and Leventhal, 1963)

B: ARTICLES, BOOK CHAPTERS AND CONFERENCE PAPERS
Aginam, O; "Are We Our Brother's and Sister's Keepers: Africa and Public Health Challenges in a Divided World", Proceedings of Berkeley/Stanford Joint Centre for African Studies Spring Conference, Stanford University, 24, April, 1999
Ampofo, O & Johnson-Romauld, J.D; "Traditional Medicine and Its Role in the Development of Health Services in Africa", Technical Discussions of the 25th, 26th & 27th Sessions of the WHO Regional Office for Africa (Brazzaville, Congo: WHO 1957) 51
Anand, R.P; " Development and Environment: The Case of Developing Countries" (1980) 24 Indian J. of Int'l Law 1
Anghie, A; "Finding the Peripheries: Sovereignty and Colonialism in Nineteenth Century International Law" (1999) 40 Harvard International Law Journal 1
Attaran, A; "Human Rights and Biomedical Research Funding for the Developing World: Discovering State Obligations Under the Right to Health", Vol.4 No.1 Health & Human Rights 26
Berlinguer, G; "Health and Equity as a Primary Goal" (1999) Vol 42 No.4 Development: Responses to Globalization - Rethinking health and Equity 17
Chimni, B.S; “Marxism and International Law: A Contemporary Analysis” (Feb., 6 1999) Economic & Political Weekly 337
Connoly, G.N; "Worldwide Expansion of the Transnational Tobacco Industry" (1992) 2 Journal of the National Cancer Institute 29

Fabrega, H; "The Need for an Ethnomedical Science" (1975) 189 Science 969


Farmer, P; “Social Inequalities and Emerging Infectious Diseases” (1996) 2 Emerging Infectious Diseases 259


Fidler, D.P; "The Globalization of Public Health: Emerging Infectious Diseases and International Relations" (1997) 5 Indiana J. of Global Legal Studies 1

Fidler, D.P; "Return of the Fourth Horseman: Emerging Infectious Diseases and International Law" (1997) 81 Minnesota Law Rev. 771


Fidler, D.P; "International Law and Global Public Health" (1999) 48 The Univ. of Kansas Law Rev. 1

Fidler, D.P; "Neither Science Nor Shamans: Globalization of Markets and Health in the Developing World" (1999) 7 Indiana J. of Global Legal Studies 191


Geertz, C; "Local Knowledge: Fact and Law in Comparative Perspective", in *Further Essays in Interpretive Anthropology* (New York: Basic Books, 1989)

Grein, T.W; et al; "rumours of Disease in the Global Village: Outbreak Verification" (2000) 6 Emerging Infectious Diseases 97
Head, I.L; "The Contribution of International Law to Development" (1987) Vol.XXV Canadian Yearbook of International Law 29
Jamar, S.D; "The International Human Right to Health" (1994) 22 Southern Univ. L.R 1
Keily, R; "Globalisation, (Post-)modernity and the Third World", in Keily, R & Marfleet, P; eds., Globalisation and the Third World (London/new York: Routledge, 1998)
Kennedy, D; "Primitive Legal Scholarship" (1986) 27 Harvard International L.J 1
Larkin, M; "Global Aspects of Health and Health Policy in Third World Countries", in Keily, R & Marfleet, P; Globalisation and the Third World (London: Routledge, 1998)
Leary, V; "The Right to Health in International Human Rights Law" (1994) 1 Health & Human Rights 25
L' hirodel & Yach, D; "Develop and Strengthen Public Health law" (1998) 51 World Health Statistics Quarterly 79
Lifson, A; "Mosquitoes, Models, and Dengue" (1996) 347 Lancet 1201
Mafart, B & Perret, J.L; "History of the Concept of Quarantine" (March 1998) 58 Medicine Tropicale 14
Matthews, J; "Power Shift" (1997) 76 Foreign Affairs 50
Mickelson, K; "Rhetoric or Rage: Third World Voices in International Legal Discourse" (1998) 16 Wisconsin International Law Journal 353
Nakajima, H; "Global Disease Threats and Foreign Policy" (1997) Brown J. of World Affairs 319
Okafor, O.C; "The Concept of Legitimate Governance in the Contemporary International Legal System" (1997) 44 Netherlands International Law Rev. 33
Plotkin, B.J & A.M Kimball; "Designing the International Policy and Legal Framework for the Control of Infectious Diseases: First Steps" (1997) 3 Emerging Infectious Diseases 1
Robertson, R.E; "Measuring State Compliance With the Obligation to Devote the Maximum Available Resources to Realizing Economic, Social and Cultural Rights" (1994) 16 Human Rights Quarterly 693
Rubin, A; "International Law in the Age of Columbus" (1992) 39 Netherlands Int'l. L.R 5
Sachs, J; “A New Global Commitment to Disease Control in Africa” (May 2001 Nature Medicine 521
Salzberg, S; "The Social Model of Mental Health Care and Law in Comparative Context", Proceedings of World Congress, World Federation for Mental Health, August, 1993
Schachter, O; "Towards a Theory of International Obligation" (1968) 6 Virginia J. of International Law 301
Sharpe, W.R; "The New World Health Organization" (1947) 41 Am. J. of Int'l Law 509
Snyder, F.G; "Law and Development in the Light of Dependency Theory" (1980) 14 Law & Society 723
Taylor, A.L; "Controlling the Global Spread of Infectious Diseases: Towards a Reinforced Role for the International Health Regulations" (1997) 33 Houston Law Rev. 1326
Toebes, B; "Towards an Improved Understanding of the International Human Right to Health" (1999) 21 Human Rights Quarterly 661
Trubek, D; "Towards a Social Theory of Law: An Essay on the Study of Law and Development" (1972) 8 Yale Law Journal 1
Walt, G; "Globalization of International Health" (1998) 351 Lancet 434
Woodall, J, "Outbreak Meets the Internet: Global Epidemic Monitoring by Pro-MED Mail" (1997) 1 SIM Quarterly: Newsletter of the Society for the Internet in Medicine 1
Yamey, G; "Global Campaign to Eradicate Malaria" (2001) 322 British Med. J. 1191
C: REPORTS OF MULTILATERAL INSTITUTIONS, SYMPOSIUM/CONFERENCE REPORTS, WEB (INTERNET), SECONDARY AND MISCELLANEOUS DOCUMENTS

Aran, K; Poverty: Biggest Enemy of Health in Developing World, Speech to the 54th World Health Assembly, Geneva, Switzerland, 17 May 2001, also available online at <http://www.un.org/News/Press/docs/2001/sgsm7808.doc.htm>


Bedell, R; Tuberculosis is a Canadian Problem, The Globe and Mail (Toronto, Tuesday, 21 March, 2000)

Bioresources Development and Conservation Programme (BDCP), Report of the International Conference on Traditional Medicine in HIV/AIDS and Malaria, 5-7 December, 2000; also available online at <http://www.bioresources.org>


Brundtland, G.H; “Globalization as a Force for Better Health”, Lecture at the London School of Economics, 16 March, 2001

Capdevila, G; Malaria-Carrying Mosquitoes Hitch Rides on Air Planes, Inter-Press Service (Tuesday, 22 August, 2000)


Committee on Economic, Social and Cultural Rights, (High Commission for Human Rights); The Right to the Highest Attainable Standard of Health, General Comment No. 14, 4 July, 2000

Editorial Commentary, Outbreak Not Contained: West Nile Virus Triggers a re-evaluation of Public Health Surveillance, Scientific American (April, 2000) 20


Harvard Law School, Economic and Social Rights and the Right to Health, An Interdisciplinary Discussion held at Harvard Law School, September 1993


United States Centers for Disease Control (CDC), *Addressing Emerging Infectious Disease Threats: A Prevention Strategy for the United States* (Atlanta, Georgia: CDC, 1994)

United States Centers for Disease Control (CDC), *Preventing Emerging Infectious Diseases: A Strategy for the 21st Century* (Atlanta, Georgia: CDC, 1998)


World Health Organization (Regional Office for Europe), *Strategy to Roll Back Malaria in the WHO European Region* (Copenhagen, Denmark: WHO, Europe, 1999)


World Health Organization, *Qualitative Research for Health Programmes* (Geneva: WHO, Division of Mental Health and Prevention of Substance Abuse, 1996)

World Health Organization, *Tuberculosis*, WHO Fact Sheet No. 104 (Revised April, 2000); also available at http://www.who.int/inf-fs/fac104.html

APPENDIX

Non-Exhaustive List of Questions Used for Semi-Structured (Depth/Focused) Field Interviews in South-Eastern Nigeria, 13-30 December, 2000

A: Non-Exhaustive Basic Questions Used in Conversations with Rural Populations and their Behavioral Practices on Malaria

I: What is your name and where do you live?

II: What is your age?

III: Have you ever suffered from malaria?

IV: If the answer to (iii) is yes, how do you know you had malaria? Could you kindly describe the symptoms you had that made you conclude your sickness was malaria?

V: What is your very first and immediate decision whenever you fall sick and conclude (because of the symptoms) that you have malaria?

VI: What factors inform your decision either to pursue self-help (self diagnosis), visit a traditional healer or decide to see a physician after concluding that you have malaria?

VII: Do you ever combine visits to the traditional healer, the physician and (or) self-help in any one single incident of suspected malaria attack?

VIII: Can you re-collect the number of times you have visited either a traditional healer or a physician for malaria in the past two years?

IX: How long does it take you to get to the traditional healer’s home or clinic to obtain diagnosis and therapies if you decide on that option?

X: How long does it take you to get to the physician’s clinic if you decide on that option?

XI: Can you give an estimate of the financial cost of getting what you consider an effective prescription and medicines from a traditional healer?

XII: Can you give an estimate of the financial cost of getting what you consider an effective prescription and medicines from a physician?

XIII: Describe generally how you take the therapies prescribed by a traditional healer and your general feeling about these therapies?
B: Non-Exhaustive Basic Questions Used in Conversations with Two Traditional Healers on the Traditional Malaria Therapies theyPrescribe to Rural Populations.

I: What is your name and where do you live?

II: How long have you practiced traditional medicine in this community? Has traditional medical practice always been your primary and only profession?

III: How did you learn the practice? Did you attend any formal institution or is your family or lineage a repository of such knowledge?

IV: When a patient visits you, how do you diagnose malaria? What factors or symptoms inform your decision? Could you describe the kind of therapies you prescribe to your patients for malaria?

V: How did these therapies come about? How did you discover them as cures for malaria and its symptoms?

VI: Do you ever refer any patient to go for laboratory tests or to see a physician under any circumstance?

VII: Has any patient ever told you that he/she visited a physician before coming to seek your therapies?

VII: On the average, what do you charge to treat an uncomplicated single case of malaria?

VIII: How often does a patient visit you for malaria in a single year?

IX: Have you ever had a patient with very severe complications (e.g. cerebral malaria)? (Here I describe to the traditional healers what cerebral malaria means and its symptoms in their native language)

X: When you use herbs, barks or roots of trees, what informs your decision that the particular herb, bark of root provides a cure for malaria?
C: Non-Exhaustive Basic Questions used in Conversations with Trained Physicians on Behavioral Patterns of Rural Populations to Malaria Diagnosis in both Traditional Medicine and the Formal Health-Care Delivery System

I: How long have you practiced medicine in this rural community?

II: From your professional experience, could you describe the patterns of behavior of rural populations within the community where your clinic is located with respect to malaria?

III: When a patient visits your clinic and you diagnose malaria, would it be a possibility that the patient had earlier visited the traditional healer before visiting your clinic?

IV: In your opinion, what do you think makes traditional medicine one of their popular choices in this community?

V: What is your average medical bill for treating an uncomplicated case of malaria in your clinic?

VI: Do traditional healers ever refer patients to you for laboratory tests or for any other purpose?

VII: Do you ever refer cases to a traditional healer?

VII: Is there any kind of link or collaboration (formal or informal) between you and any of the traditional healers in this community?

VIII: In professional terms, how would you describe the therapies administered by traditional healers for malaria?

IX: How often do you see patients who consistently mix traditional medicine with therapies from the formal health-care stem such as the one you offer?

X: In professional terms, how would you assess the burden of malaria in this community in terms of prevalence, rapidity of infections, mortality and morbidity?