Globalism, Regionalism, or Both: Health Policy and Regional Economic Integration in Developing Countries, an Evolution of a Legal Regime?

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INTRODUCTION

Regional economic integration organizations have become pivotal tools in the promotion of international trade, investment, and trade liberalization. The emergence of new regionalism and international actors' newfound reliance on regional institutions have focused on the role of regional integration in the promotion of social and economic welfare. Where in the past, regional integration was utilized to meet specific policy objectives such as security or economic orientation, the newfound reliance on regionalism constitutes a comprehensive and multidimensional integration process. The new regional frameworks encompass not only trade and economic developments, but also environ-
mental and social policies, and security cooperation. Regional integration organizations have steadily multiplied in the developing world and their roles have continued to expand. The development of the World Trade Organization (WTO) legal regime, the expanding influence of the European Union (EU), as well as the implementation of a powerful North American Free Trade Agreement (NAFTA) have, together, provided the impetus for other developing nations to expedite the organization of their own regional institutions. The expanding role of regionalism and rapid organization of regional institutions have also involved attempts to incorporate some, albeit limited, social welfare initiatives alongside core economic integration measures.

The WTO legal regime has played a key role in the world's increasing reliance on regionalism. Regional economic integration organizations continue to liberalize trade by lowering tariffs as provided under Article XXIV of GATT. Important regional integration organizations in the developing world include the Caribbean Community (CARICOM), the Association of South East Asian Nations (ASEAN), the African Union (AU), the Common Market for Eastern and Southern Africa (COMESA), the Mercado Comun del Sur (MERCOSUR), the Southern African Development Community (SADC), the Economic Community of West African States (ECOWAS), and the East African Community (EAC).

Recent transnational developments and international concern over the linkage between health and international trade have pushed discussions on the health implications of trade liberalization to the forefront of the regional integration organizations' social policy agendas. While GATT law has always recognized the link between trade and health, recent developments have raised


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concerns over the detrimental impact of global and regional trade regimes on the protection of public health. The health implications of rapid trade liberalization have gained even further attention due to the increase of disease epidemics around the world. With the adoption of the Doha Declaration on the TRIPS Agreement and Public Health, the issue of health and trade continues to mobilize health and legal advocates to push for the development and implementation of international trade law regimes that protect, rather than undermine, public health.

While a great deal of scholarly writing has discussed the linkage between health and trade in the context of the WTO legal regime, commentators have paid little attention to the increasing role of regional integration organizations in developing countries. Increasingly, regional organizations in the developing world are shaping health policy through the use of legal regimes, policies, and governance mechanisms. Accordingly, this article examines the increasing role of regional integration organizations in shaping a legal regime of health protection in developing countries. The article is divided into four main parts.

Part I is introductory and discusses the public health challenges currently facing developing countries. Part II maps out several dimensions of global health law, particularly the role of World Health Organization (WHO) law, the law promulgated by the health agency of the United Nations (UN). Part II also discusses the intersection of health policy and WTO law. The scope of WHO law and WTO law provide comparative lessons for deciphering health law and policy within the corpus of laws, policies, and practices of regional integration organizations. Part III is a general discussion of regionalism and describes existing health policy within the legal regimes of some key regional organizations including the AU, the ECOWAS, the ASEAN, and the Caribbean Community. Part IV provides concluding remarks on the future prospects of health policy in the context of new regionalism. This article concludes that the predominant focus of regional economic integration in developing countries is the pursuit of free trade and other economic advantages. Despite the existing trade bias, reg-

5. See WHO & WTO, supra note 3, at 23.
7. See WHO & WTO, supra note 3; see also M. Gregg Bloche & Elizabeth R. Jungman, Health Policy and the WTO, 31 J.L. MED. & ETHICS 529, 529-45 (2003) (discussing the negative health impact of international trade endorsed by the WTO and its associated agreements).
ional economic integration organizations in developing countries are beginning to pay increasing attention to health protection.

I. BACKGROUND

A. HEALTH AND REGIONAL INTEGRATION: THE HEALTH CHALLENGES IN DEVELOPING COUNTRIES

The basis for integration of public health policy into the evolving political and legal dynamics of developing countries is complex. In critical legal studies, a society's established system of rules and entitlements may never accommodate certain communal ideals. Alongside the organization of government and running of economies, established societies have long been called upon to provide its citizenry with communal entitlements. Scholars commonly advance the idea that individual rights rest on two supports: property rights, which threaten to reduce some individuals to a direct dependence on others, and political and civic rights and welfare entitlements, which pose no such threat. Social situations in which individuals stand in a relationship of heightened mutual vulnerability and responsibility towards each other warrant the development of legal principles and entitlements providing for society's public welfare.

Currently, populations in the developing world are facing situations of heightened vulnerability. Developing populations are increasingly confronted with major transnational public health disasters as a result of increased travel, the rise of harmful environmental factors, modern communications, and technological change. Developing countries and regions are increasingly mu-


10. See Obijiofor Aginam, Global Village, Divided World: South-North Gap and Global Health Challenges at Century's Dawn, 7 IND. J. GLOBAL LEGAL STUD. 603, 627 (1999) (suggesting that the developed countries must recognize the mutuality of vulnerability in globalization of poverty through international institutions).

tually susceptible to various public health threats that now transcend national borders. To meet the growing threat, concerted transnational measures are needed, including the pooling of resources, expertise, manpower, and the development of enabling laws, internationally and regionally, that will in turn spur national action to counter disease. The resurgence of ebola in Central Africa, and more recently the Marburg fever in Angola, the spread of Avian flu in Asia and into Europe, and outbreaks of SARs in Asia, show that disease knows no boundaries. As a result of the growing need for transnational health cooperation in developing countries, the emerging factors that have increasingly placed health on the global agenda deserve greater focus among developing countries. Regional economic integration organizations can play a significant role in this regard.

Many scholars advance the widely supported view that trade liberalization improves social welfare and promotes economic development in developing countries. Still, many scholars dissent

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18. *See* JOHN H. JACKSON, THE WORLD TRADING SYSTEM: LAW AND POLICY OF INTERNATIONAL ECONOMIC RELATIONS 310 (2nd ed. 1997); *see also* WHO, CMH,
from this view arguing that developing countries have not fully benefited from the globalization of trade due to their unequal trading potential under the WTO's legal regime. Globalization has also undermined public health protection in developing countries. This effect has been accentuated by a lack of strong financial, technical, and legal mechanisms to counter the ill effects of globalization in developing countries. While globalization and transnational trade have positive benefits, they have also contributed to the international transfer of infectious disease agents and harmful products. For example, the increasingly heavy regulation of tobacco companies in developed nations has led to the patterned flight of tobacco companies into developing countries with lax or no tobacco regulatory measures. Regional trade regimes have continued to drive trade liberalization within their spheres of operation. Because developing countries have not fully benefited from the world trading system, the resource base for addressing public health problems remains minimal. While globalization and free trade may have accelerated economic growth and public health in the developed world, many developing countries continue to miss out on the positive benefits of global markets and increased free trade.

supra note 12, at 75.

19. See, e.g., Chantal Thomas, Poverty Reduction, Trade, and Rights, 18 AM. U. INT'L L. REV. 1399, 1399–1424 (2003) (stating that developing-country governments are pressing for the removal of trade barriers from developed-country markets, arguing that such barriers not only contravene the spirit of a liberal international trade order but stand as devastating obstacles to the developing-country pursuit of economic growth and modernization).

20. See David P. Fidler, The Globalization of Public Health: Emerging Infectious Diseases and International Relations, 5 IND. J. GLOBAL LEGAL STUD. 11, 12 (1995) (contending that the emergence and reemergence of infectious diseases is attributable to globalization, which undermines the sovereign state's ability to protect the public from such diseases); see also Derek Yach & Douglas Bettcher, The Globalization of Public Health, I: Threats and Opportunities, 88 AM. J. PUB. HEALTH 735, 737 (1998) (stating that globalization has strongly influenced the domestic health systems, prompting the need for a transnational agenda).

21. See Yach & Bettcher, supra note 20, at 735.


23. See Susan Demske, Trade Liberalization: De Facto Neo-Colonialism in West Africa, 86 GEO. L.J. 155 (1998) (showing that the marginalization of African economies has continued throughout the 1990's and that Africa's share of global investment and trade has fallen dramatically).

24. See Ruth L. Gana, Prospects for Developing Countries Under the TRIPs Agreement, 29 VAND. J. TRANSNAT'L L. 735, 737 (1996) (arguing that developing countries are conflicted between their desire to participate in the multilateral trade system and the concomitant requirement to relinquish some of their sovereign freedom).
Furthermore, the controversy over the international legal control of intellectual property has shown how a global legal regime can undermine public health in developing countries. Many developed countries continue to prioritize international patent protection to the detriment of combating public health crises in developing nations. Because most health problems are international in nature, a global solution to improve public health in developing countries is necessary.

Poor health and poverty are intertwined in developing countries. Poverty breeds disease and ill health leads to poverty. Social theories of disease and public health explain that socioeconomic status and other social factors of the general population influence health. Those who command the most resources are best able to avoid risk and disease and are in the best position to mitigate the consequences of disease. Poverty has played an important part in perpetuating the inequitable effects of disease in developing countries. Various studies have clearly demonstrated the link between health and increased economic development. In addition to the problem of poverty, the healthcare systems of many developing countries are also strained. Accordingly,
international cooperation remains a major survival line for harnessing resources and public health expertise in developing countries.\textsuperscript{29} Today, many of the public health threats in the developing world are viewed not just as health threats but also as a threat to the economic development of developing nations.\textsuperscript{30} For example, in developing countries, the portions of the population afflicted with AIDS are generally the most productive ranks of society.\textsuperscript{31} As such, public health threats weaken developing economies and jeopardize development prospects in poor countries.\textsuperscript{32}

Health is also considered a global public good and could also be argued to be a regional public good.\textsuperscript{33} Scholars have considered health as a global public good arguing that the prevention of an infectious disease in an individual also provides a significant positive externality by reducing risk of infection to others.\textsuperscript{34} The economic effects of disease such as loss of productivity and income have both domestic and external negative economic effects. Health as a public good must henceforth be promoted through both global and regional efforts including an important role for international law in health protection.\textsuperscript{35} Against this background, regional organizations have a unique role in promoting the determinants for health and quality health policy.

B. THE INEQUITABLE DISEASE BURDEN IN DEVELOPING COUNTRIES.

Populations in developing countries now face a growing public health threat from both communicable and non-communicable diseases.\textsuperscript{36} According to the WHO Commission on Macroeconomics and Health, the health prospects of the poorest

\begin{itemize}
\item \textsuperscript{29} See id. at 53.
\item \textsuperscript{30} See id. at 30.
\item \textsuperscript{32} See WHO, CMH, supra note 12, at 31.
\item \textsuperscript{33} See Richard Smith et al., Global Public Goods for Health: Health, Economic and Public Health Perspectives, 7 (2003) (adopting the UNDP definition of a global public good as a public good with benefits that are strongly 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 current and future generations, or at least meeting the needs of current generations without foreclosing development options for future generations).
\item \textsuperscript{34} Id.
\item \textsuperscript{35} Id. at 179.
\end{itemize}
billion people in the world could be radically improved by targeting a small set of conditions and diseases. These diseases and conditions include HIV/AIDS, malaria, tuberculosis, maternal and perinatal conditions, childhood diseases, and tobacco-related diseases. Developing countries now face not only high mortality and morbidity rates as a result of spreading diseases, but also related economic, social, and environmental problems. The shortage of skilled public health personnel, many of whom have emigrated to the North, only serves to compound the problem. Moreover, the diminishing resources and health budgets in developing countries mean that the funding and expertise needed to combat the increasing public health threat is minimal or entirely lacking. Unfortunately, coherent public health legislation in developing countries has been sporadic. Developing nations are in great need of international cooperation to protect their populations from disease. The WHO projects a grim outlook for the public health prospects in the developing world. The developing world continues to bear a disproportionate burden of disease and malnutrition, even in spite of significant global health care breakthroughs achieved in the twentieth century. Despite the efforts of the WHO and other international organizations, there is much evidence that a wide health gap exists and will continue to worsen unless multilateral efforts are taken to solve the inequity. Brief discussions of recent major public health epidemics in the developing countries underscore the gravity of the problem.

1. HIV/AIDS

The AIDS epidemic is an unprecedented public health disaster and the predominant public health problem facing developing countries today. The statistics provided by the WHO and the Joint United Nations Program on AIDS (UNAIDS) are shocking. The epidemic has claimed twenty million lives since its

37. WHO, CMH, supra note 12, at 42.
38. See id. at 39 (discussing the problem of skilled workers fleeing or dying and leaving the community without the necessary aid).
39. See id. at 76 (projecting that governmental tax cuts will make it harder to fund public expenditure for health).
40. See WHO 1999, supra note 36, at 67 (estimating that over seventy percent of smoking-related deaths will be in the developing world).
41. See WHO, CMH, supra note 12, at 40.
42. See id. at 88 (discussing differential drug pricing as an effective method to address the health gap issue).
HIV/AIDS has continued to spread remarkably and its prevalence has doubled since the early 1990s. Africa south of the Sahara alone has approximately ten percent of the world's total AIDS population, with twenty-five million people living with the disease. The infected population in Africa south of the Sahara makes up close to two-thirds of all people living with HIV. In 2004, in Africa alone, about three million people died due to HIV/AIDS. In Asia alone, an estimated 7.4 million people now live with HIV and approximately 500 thousand people died of AIDS in 2003. UNAIDS has underscored the devastating impact of AIDS on the social, economic, and demographic underpinnings of development in developing countries. The detrimental developmental impact of the disease only makes fighting AIDS more difficult. The developmental impact of AIDS is even more pronounced in the African countries that have lost the social and economic progress made in the last decade. In developing countries, AIDS infection rates among women and children continue to rise. AIDS is also responsible for weakening workforces and curtailing economic strength. Trade and investment opportunities in developing countries are declining because investors fear relocating in disease-ridden areas. Potential investors also fear the absence of a healthy labor force. AIDS is also placing enormous stress on an already over-burdened health infrastructure in developing countries.

43. UNAIDS, supra note 31, at 13.
44. Id. at 23–24.
45. International scholars and practitioners are increasingly substituting Sub-Saharan Africa for Africa south of the Sahara, because the former terminology is not entirely correct. ROBERT STOCK, AFRICA SOUTH OF THE SAHARA: A GEOGRAPHIC INTERPRETATION (James L. Newman ed., 1995).
47. Id.
48. UNAIDS, supra note 31, at 26. The UNAIDS also warns that despite recent efforts to combat disease, an even more gruesome public health disaster lies ahead, unless major and dramatic action is taken. Id.
49. See id. at 8–9 (stressing that far from leveling off, the epidemic is on the rise in many countries in Sub-Saharan Africa and Asia, among others).
54. See UNAIDS, supra note 31, at 136–37 (estimating that ninety-three percent of the total health expenditures on AIDS constitute private out-of-pocket expenses).
AIDS has also become a security concern for the international community. Accordingly, UNAIDS has promoted a human rights approach to fighting the disease. Importantly, regional human rights mechanisms can play a key role in this strategy. Thus, AIDS is a problem for the whole international community and requires efforts at the international, regional, and national levels.

2. Tobacco

Many of the major public health threats facing the developing world today are tobacco-related diseases. Researchers have now scientifically proven that tobacco is a causal factor of over twenty-five different diseases. Rates of tobacco-related disease are estimated to be rising in the developing world. Tobacco-related diseases kill 4.9 million people each year worldwide. If current trends remain constant, the toll is expected to double in the 2020s. Astonishingly, seventy percent of tobacco-related deaths will occur in developing countries. Moreover, seventy-five percent of the 1.2 billion smokers in the world today reside in developing countries. Statisticians project that the smoking population in developing countries will continue to increase.

55. See D. Bettcher & K. Lee, Globalization and Public Health, 56 J. EPIDEMIOLOGY & COMMUNITY HEALTH 8, 11 (2002). A school of thought is emerging that promotes moving health issues, such as AIDS, onto the security agenda. Such a move, it is argued, would shift the focus away from balance of power politics and self-help in international relations toward the attainment of a more secure and humane international society. See, e.g., WHO 2003, supra note 26, at xi, 25, 79 (denoting the clear link between global health and global security).


57. See WHO 1999, supra note 36, at 65.


59. Id.

60. Id.; see also RICHARD PETO ET AL., MORTALITY FROM SMOKING IN DEVELOPED COUNTRIES: 1950–2000 (1994).


Increasingly, the tobacco industry is abandoning the regulated cigarette markets of the developed world for the unregulated markets of the developing world. The globalization of the tobacco industry has further enhanced the industry's trade, marketing, and reach in developing countries. The tobacco industry has succeeded in penetrating hitherto unregulated developing country markets due to the increasing trade liberalization spurred by the legal regimes of the WTO and regional trade organizations in the developing world. Many trade agreements have made it easier for tobacco companies to expand their markets in Asia, Africa, Latin America, and the Pacific Island States. As a result, the tobacco pandemic continues to be a problem in the developing world and international legal cooperation is needed.

3. Malaria

Another important public health problem in the developing world is malaria. The health burden resulting from malaria is enormous. At the end of 2004, 107 countries and territories had areas at risk of malaria transmission. Approximately 3.2 billion people lived in areas at risk of malaria transmission. In 2004, between 350 and 500 million clinical cases of malaria were reported worldwide, and over one million people die annually from the disease. About ninety percent of these deaths occur in Africa south of the Sahara where young children are most affected. In addition to Africa, malaria is prevalent in Asia, as well as in Central and South America. Malaria outbreaks also occur frequently in large parts of the Indian Peninsula, Sri Lanka, and parts of the Middle East, Southeast Asia, and Northwest Africa.

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64. See id.

65. Id. at 347–54; see also William Onzivu, The Public Health Implications of the Association of South East Asian Nations (ASEAN) Legal Regime on Tobacco Control, 4 AUSTL. J. ASIAN L. 160, 160 (2002).


68. Id. at 11.

69. Id. at 45–49. The epidemic areas are subject to irregular rapid increases in incidence, usually related to the season and population movements, whereas in the endemic areas of these regions, malaria transmission occurs continuously over many years. See id. at 91–212.
Several forces have combined to produce a resurgence of malaria in the developing world. These factors include civil conflict, large-scale human migrations, climatic and environmental change, inadequate and deteriorating health systems, and growing insecticide and drug resistance.\(^7\)

The economic cost inflicted by malaria is high. Most malaria-stricken countries are also the world’s most impoverished countries. In the developing nations of Africa south of the Sahara, the average household spends between two and twenty-five dollars a month on malaria treatment, in addition to fifteen dollars on malaria prevention each month.\(^1\) The adverse economic impact of malaria in these countries is also great. The economic effects include productivity losses as a result of premature mortality and inefficiency attributable to spells of sickness and absenteeism from schools.\(^2\) Like HIV/AIDS, the prevalence of malaria in developing countries scares away potential development opportunities by making certain regions of the country unsuitable for habitation. The disease effectively deters international trade, foreign investment, and tourism in developing nations.\(^7\) Furthermore, the rapid increase of resistance to antimalarial drugs all but ensures the longevity of the public health threat, as safe, effective, and affordable options diminish.\(^4\) The importance of international cooperation cannot be overstated. International and regional legal initiatives can play a pivotal role in malaria control in developing countries.

4. Tuberculosis

One of the greatest public health threats in developing countries today is tuberculosis (TB). TB is a contagious disease

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70. WHO, CMH, supra note 12, at 74.
72. Vasant Narasimhan and Amir Attaran decry the low international assistance for malaria control, showing that the total amount of international aid dedicated to malaria control, from the twenty-three richest donor countries plus the World Bank, stagnated at about $100 million annually since the start of WHO’s Roll Back Malaria in 1998. Vasant Narasimhan & Amir Attaran, Roll Back Malaria? The Scarcity of International Aid for Malaria Control, 2 MALARIA J. 8 (Apr. 15, 2003), available at http://www.malariajournal.com/content/pdf/1475-2875-2-8.pdf. This lack of increasing funding threatens WHO’s efforts to largely eradicate malaria by 2010. Id.
73. Id.
that spreads through the air.\textsuperscript{75} When infectious people cough, sneeze, talk, or spit, they propel TB germs known as bacilli into the air. Accordingly, migration facilitates widespread infection. Air travel and other transport play an important role in facilitating the spread of TB. TB has thus become an international problem. Like HIV, malaria, and tobacco-related diseases, developing countries bear the heaviest burden of TB deaths each year.\textsuperscript{76} Despite this disproportionate incidence in the developing world, TB is also spreading into Europe, especially Eastern Europe. In 2003, an estimated 4.4 million new and relapsed cases of TB were reported to the WHO.\textsuperscript{77} Unsurprisingly, the highest rates of incidence, eighty-two percent of global TB cases, were reported from the WHO African region, the WHO Southeast Asian region, and WHO Western Pacific region.\textsuperscript{78} In 2000, nine percent of all new TB cases reported in adults were directly attributed to HIV infection, but the proportion was much greater in the WHO African Region (thirty-one percent) and some industrialized countries, notably the United States (twenty-six percent).\textsuperscript{79} In 2000, an estimated 1.8 million people died from TB.\textsuperscript{80} In South Africa alone two million adults were co-infected with both TB and HIV.\textsuperscript{81}

The spread of TB, especially in developing countries, has significant human rights, social, and economic implications. The forty-fourth World Health Assembly (1991) emphasized the growing importance of TB as a public health problem and recognized the potential for cost-effective control of the disease by reducing poverty and providing access to effective treatment options.\textsuperscript{82} Additionally, a global comprehensive strategy called Directly Observed Treatment (DOTS) was introduced by the

\textsuperscript{77} Id.
\textsuperscript{78} Id. See also Elizabeth L. Corbett et al., \textit{The Growing Burden of Tuberculosis: Global Trends and Interactions With the HIV Epidemic}, 163 ARCHIVES OF INTERNAL MED. 1009 (2003).
\textsuperscript{79} Corbett, \textit{supra} note 78, at 1009.
\textsuperscript{80} Id.
\textsuperscript{81} Id.
WHO to control the TB epidemic. The DOTS strategy is defined as a package including the following five objectives: commitment of governments to a national tuberculosis program, the effective detection of cases through examination of patients with suspected TB in general health services, standardized short-course chemotherapy with first line drugs, the regular and uninterrupted supply of all essential anti-tuberculosis drugs, and a monitoring system for program supervision and evaluation. By 2000, 148 countries had adopted the strategy. However, the high costs of TB treatment and care for those infected with the disease continues to make the need for international cooperation in regards to medical resources, treatment, and expertise important.

II. INTERNATIONAL LAW AND HEALTH COOPERATION IN DEVELOPING COUNTRIES

A. GLOBAL HEALTH LAW, AN INTRODUCTION

The invocation of international law is becoming an increasingly important strategy to promote global public health. One characteristic that makes international law so helpful is the variety of international legal instruments, institutional frameworks, and dispute settlement mechanisms available at both the global and regional level. The recognized body of international health law refers to several multilateral treaties, rules, regulations, and dispute settlement mechanisms that all contribute to promote public health. International health law seeks to address concerns over human reproduction, infectious diseases, tobacco and narcotics, food safety, and others. International health law is also linked with other areas of international law such as human rights law, environmental law, trade law, and labor law. Due to the international nature of contemporary public health issues, there is an increasing interrelationship between global


85. See Sterling, Lehmann & Frieden, supra note 84.

frameworks and regional or subregional institutions that are designed or have evolved to address public health policy problems. In the areas of international trade law, environmental law, and human rights,\textsuperscript{87} global and regional organizations have already designed legal frameworks to address interrelated policy matters. These various legal instruments have had an enormous impact on the state of public health in the developing world.\textsuperscript{88} The international legal framework designed to improve public health in developing countries will be inevitably interlinked with regional, sub-regional, and national institutional frameworks directed at the same ends. Most developing countries are members of both global institutions and regional geopolitical groups.\textsuperscript{89} The proliferation of distinct regional and global legal instruments that both negatively and positively affect public health calls for the reorientation of existing regional laws and policies to promote public health, not undermine it. Various international actors such as the WHO and the UN, in addition to global and regional actors, have continued to promote public health in developing countries through law, policy, and practice.\textsuperscript{90}


\textsuperscript{88} Daniel Bodansky, What Makes International Agreements Effective? Some Pointers for the WHO Framework Convention on Tobacco Control, at 24–30, WHO/NCD/TFI/99.4 (1999), available at http://whqlibdoc.who.int/hq/1999/WHO_NCD_TFI_99.4.pdf. While a significant improvement in the state of the ozone layer cannot be expected, there is evidence that its rate of deterioration is decreasing and that concentrations of some ozone depleting substances are beginning to decline. \textit{Id.} In this regard, the global consumption of chlorofluorocarbons, the main cause of ozone depletion, declined by more than seventy percent between 1986 and 1996. \textit{Id.} This is expected to result in gains for protection of public health.


The organizations have had varying degrees of success. The sporadic legal, policy, and practical actions of global and regional actors have contributed to health promotion in developing countries. Unfortunately, regional and sub-regional actors' primary interest has been economic integration; health protection has been relegated to the periphery despite the mounting public health epidemics that continue to threaten the developing world. While developing countries have had mixed levels of success combating public health threats, the EU's promulgation of a body of community health law demonstrates the ability of regional integration organizations to promote quality public health policy within a regional framework. However, in the present era of globalization of public health, the international community will naturally continue to cooperate in an attempt to combat diseases by employing legal mechanisms at both the global and regional levels.

The protection of public health is a policy goal advanced by various international legal instruments, including some of the constitutive instruments of regional integration organizations. At the global level, for example, the United Nations Children's Fund used the Convention on the Rights of the Child to promote child health. Similarly, the United Nations Environment Program (UNEP) has developed a number of environmental treaties that have implications for public health in that the mechanisms enshrined in such treaties can be utilized to promote human health. Environmental agreements with positive public health provisions include the Vienna Convention for the Protection of the
Ozone Layer\textsuperscript{95} and the Montreal Protocol on Substances that Deplete the Ozone Layer.\textsuperscript{96} Both have achieved an agreement to curtail ozone depleting substances thus protecting public health.\textsuperscript{97} The United Nations Framework Convention on Climate Change\textsuperscript{98} and the Rotterdam Convention on the Prior Informed Consent Procedure for Certain Hazardous Chemicals and Pesticides in International Trade\textsuperscript{99} are also treaties that positively impact public health.\textsuperscript{100} Recently, UNEP developed the Stockholm Convention on Persistent Organic Pollutants.\textsuperscript{101} The improvement of public health is a major objective of the treaty.\textsuperscript{102} Developing countries continue to participate as contracting parties in implementing these instruments. Some of these agreements have contributed to improved health protection by providing frameworks for addressing some environmental health threats and providing financial, technical, and other forms of assistance to developing countries.\textsuperscript{103} The United Nations Children’s Fund (UNICEF), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the United Nations Development Programme (UNDP), the Office of the United Nations High Commissioner for Human Rights (OHCHR), the UNAIDS, and a number of regional organizations in both the northern and southern hemispheres have contributed to the broadening of global health law and policy.

Finally, it is important to note that global treaties have often


\textsuperscript{97} Id. Article two of the Vienna Convention for the Protection of the Ozone Layer provides that the objective of the Convention is “to protect human health and the environment against adverse effects resulting or likely to result from human activities which modify or are likely to modify the ozone layer.” Vienna Convention, supra note 95, art. 2.


\textsuperscript{100} Id.


\textsuperscript{102} Id. art. 1 (stating that the objective of the Convention is “to protect human health and the environment from persistent organic pollutants.”).

\textsuperscript{103} See von Schirnding, Onzivu & Adede, supra note 94, at 970–72.
required regional entities to craft law on matters contained in the
treaty, provided that the regional agreement is compatible with
obligations of the parties under the global agreement. In this
and other ways, regional economic integration organizations have
the potential to support the implementation of global public health
norms. Furthermore, global agreements have directly facilitated
the development and implementation of regional legal regimes
and vice versa as is the case with the environment.

B. THE ROLE OF THE WHO: CONTRIBUTING TO EVIDENCE-BASED
INTERNATIONAL HEALTH LAW

Regional integration organizations' efforts to incorporate
health protection within their trade integration agenda should not
be pursued in isolation from existing global health law. When reg-
ional provisions are crafted without considering the existing body
of international health law, the proliferation of conflicting global
and regional standards can undermine international health
policy. The effect of the conflicting standards is an incoherent
body of health law and a waste of scarce financial and technical
public health resources. Existing international health law has
since the creation of the UN, benefited from UN health expertise.

104. GATT SECRETARIAT, THE RESULTS OF THE URUGUAY ROUND OF
105. See also United Nations Environment Programme, Regional Seas Strategic
http://www.unep.org/regionalseas/Publications/sdirections.doc. The UNEP Regional
Seas Programme covers 18 regions of the world, making it one of the most globally
comprehensive initiatives for the protection of marine and coastal environments -
the Antarctic, Arctic, Baltic, Black Sea, Caspian, Eastern Africa, East Asian Seas,
Mediterranean, North-East Atlantic, North-East Pacific, North-West Pacific, South
Pacific, Red Sea and the Gulf of Aden, South Asian Seas, South-East Pacific, the
Western and Central Africa, and the Wider Caribbean. United Nations Environment
Programmes/default.asp (last visited Oct. 31, 2005). "[The Regional Seas Programme] provides regional platforms for both implementation of the principles of
sustainable development and for regional implementation of programmes and
activities related to global conventions and Multilateral Environmental Agreements
(MEAs)." United Nations Environment Programme, Global Conventions and MEAs,
http://www.unep.org/regionalseas/Partners/MEAs/default.asp (last visited Oct. 31,
2005). These include Basel, PICs, POPs, Climate Change Conventions, the
Convention on Biological Diversity, Convention on Migratory Species and the United
Learned in Global Environmental Governance, 18 B.C. ENVTL. AFF. L. REV. 213,
106. See generally Bethany Lukitsch Hicks, Treaty Congestion in International
Environmental Law: The Need for Greater International Coordination, 32 U. RICH.
The WHO is the international community's most prominent global public health agency. The Charter of the UN enshrines the WHO with a mandate to promote and protect health within the UN system.\(^{107}\) The constitution of the WHO enumerates significant treaty-making powers, but to date these powers remain largely unused.\(^{108}\) At the creation of the WHO in 1948, it was envisaged that international law would play an important role in global health policy.\(^{109}\) The WHO constitution provides the Organization with the authority to promote and adopt conventions, regulations, and recommendations that address any matter within its competence.\(^{110}\) Complementing the authority of the WHO, the World Health Assembly (WHA) has the authority to adopt regulations on sanitation and quarantine issues, nomenclatures of diseases, causes of death, public health practices, and standards for international diagnostic procedures.\(^{111}\) The WHA also has the authority to promulgate standards "for the safety, purity and potency of biological, pharmaceutical, and similar products moving in international commerce, and regulations governing the advertising and labeling of biological, pharmaceutical and similar products moving in international commerce."\(^{112}\) The legal authority granted to the WHO to adopt health standards has resulted in the development of the International Health Regulations\(^{113}\) and the WHO Nomenclature Regulations.\(^{114}\) Presently, WHA resolutions constitute a body of soft law that persuasively guides WHO member states. The WHO encourages compliance through its international reporting procedure. Under the WHA resolutions, each member is required to report annually to the Organization on the "action taken and progress achieved in improving the health of its people."\(^{115}\) Moreover, the WHO

\(^{107}\) U.N. Charter art. 57.


\(^{110}\) WHO, BASIC DOCUMENTS, supra note 108, art. 19.

\(^{111}\) Id. art. 21.

\(^{112}\) Id.


\(^{115}\) WHO, BASIC DOCUMENTS, supra note 108, art. 61. See also id. arts. 62–65 (discussing other reporting requirements for member states).
constitutions affirms health as a human right.\textsuperscript{116} As such, the constitution provides a sound legal basis for the widespread recognition of health as a human right. Furthermore, under Article 18 of the International Covenant on Economic, Social and Cultural Rights, the WHO is obligated to report to the Economic and Social Council on the progress it has made towards satisfying the relevant provisions of the covenant.\textsuperscript{117} Unfortunately, the WHO has not effectively utilized its law-making powers to promote public health.

The law-making powers of the WHO reflect the international dimension of public health. Moreover, the WHO's definition of health, a state of complete physical, mental, and social well being, and not merely the absence of disease or infirmity,\textsuperscript{118} gives the Organization an expansive legal basis upon which to develop international public health law. The WHO is a specialized agency of the UN and collaborates fully with the entire UN on matters relating to public health.\textsuperscript{119} Furthermore, the WHO constitution empowers the organization to collaborate with other competent intergovernmental organizations, including a number of regional organizations in the southern hemisphere.\textsuperscript{120} The WHO has a regional operational structure by which its regional offices collaborate with the regional integration organizations within each region.\textsuperscript{121} The WHO has been criticized for relying too much on

\textsuperscript{116} Id. prmb. ("[E]njoyment 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 or social condition.").


Pursuant to its responsibilities under the Charter of the United Nations in the field of human rights and fundamental freedoms, the Economic and Social Council may make arrangements with the specialized agencies in respect of their reporting to it on the progress made in achieving the observance of the provisions of the present Covenant falling within the scope of their activities. These reports may include particulars of decisions and recommendations on such implementation adopted by their competent organs.

\textit{Id.}

\textsuperscript{118} WHO, BASIC DOCUMENTS, \textit{supra} note 108, prmb.

\textsuperscript{119} \textit{Id.} art. 69.

\textsuperscript{120} \textit{Id.} art. 70 ("The Organization shall establish effective relations and cooperate closely with such other inter-governmental organizations as may be desirable. Any formal agreement entered into with such organizations shall be subject to approval by a two-thirds vote of the Health Assembly.").

\textsuperscript{121} \textit{Id.} arts. 44–55 (providing a regional structure for the WHO). "Each regional organization shall be an integral part of the Organization in accordance with this Constitution." \textit{Id.} art. 45.
the medical model of health and ignoring the importance of law and other social variables affecting health.122 Recent developments at the WHO and increased calls for the WHO to enhance the role of international law in public health protection have led to major WHO contributions to the development of modern international health law. First, the WHO has developed two major international legal instruments designed to protect public health. Currently, the WHO is facilitating the development and implementation of the WHO Framework Convention on Tobacco Control (FCTC).123 The FCTC entered into force on February 27, 2005 and has attained seventy-six contracting parties as of July 2005.124 The number of contracting parties continues to increase.125 The FCTC requires its contracting parties to address issues as diverse as tobacco advertising, promotion, sponsorship, packaging, and labelling. The FCTC also requires parties to improve regulation of the domestic tobacco industry, specifically requiring disclosure of the contents of tobacco products and tobacco smoke.126 Additionally, the FCTC requires contracting parties to address illicit trade in tobacco products, price and tax measures, sales of tobacco to and by young persons, government support for tobacco manufacturing, treatment of tobacco dependence, passive smoking and smoke-free environments, surveillance, research and exchange of information, and scientific, technical, and legal cooperation.127 The Treaty allows regional and sub-regional entities to enter into agreements relevant to the FCTC provided such agreements are compatible with the Convention and such agreements are communicated to the Secretariat.128

The WHO’s FCTC has invigorated international health law

122. See Fiona Godlee, WHO in Retreat: Is it Losing its Influence?, 309 BRIT. MED. J. 1491 (1994) (decrying the WHO’s attachment to the medical model since its inception). See also Lynn Eaton, WHO Lacks Teeth on International Health Issues, Says Professor, 327 BRIT. MED. J. 1070 (2003).


125. Id.

126. FCTC, supra note 123, arts. 9–10.

127. Id., arts. 8, 11–22.

128. Id. art. 2.
for a number of reasons. The FCTC adopts a demand control approach which utilizes tax and price measures in an attempt to control the demand of tobacco, thereby lowering the prevalence of tobacco use and exposure to tobacco smoke.\textsuperscript{129} The FCTC's approach departs from the common supply control approach, which has been predominantly followed by the existing conventions on drugs and other psychotropic substances, especially the UN's Single Convention on Narcotic Drugs, 1961,\textsuperscript{130} Convention on Psychotropic Substances, 1971,\textsuperscript{131} and the Convention against the Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988.\textsuperscript{132} Furthermore, the FCTC emphasizes the need for parties to undertake comprehensive, multi-sectoral tobacco control measures at global, regional, and local levels.\textsuperscript{133} The FCTC also contains provisions that permit the implementation of the FCTC without reliance exclusively on subsequent specific protocols.\textsuperscript{134} The FCTC takes into account obligations of the parties in other relevant legal instruments

\begin{itemize}
  \item \textsuperscript{129} \textit{Id.} arts. 4–16.
  \item \textsuperscript{131} UN Convention on Psychotropic Substances, February 21, 1971, 10 I.L.M. 261 (1971).
  \item \textsuperscript{132} UN Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, December 20, 1988, 28 I.L.M. 493 (1989).
  \item \textsuperscript{133} FCTC, \textit{supra} note 123, arts. 5, 20, 22.
  \item \textsuperscript{134} Part II of the FCTC contains the objective guiding principles and general obligations of the Convention. \textit{Id.} arts. 3–5. The Convention contains two types of usual provisions found in treaties: general obligations and guiding principles. These are commonly found in typical "Framework Conventions" in the environmental field; their implementation relies exclusively upon subsequent specific protocols. For example, the implementation of the 1979 Long-Range Transboundary Air Pollution (LRTP) relied on the adoption of eight protocols which include: the 1999 Protocol to Abate Acidification, Eutrophication and Ground-level Ozone, the 1998 Protocol on Persistent Organic Pollutants (POPs), the 1998 Protocol on Heavy Metals, the 1994 Protocol on Further Reduction of Sulphur Emissions, the 1991 Protocol Concerning the Control of Emissions of Volatile Organic Compounds or Their Transboundary Fluxes, the 1988 Protocol Concerning the Control of Nitrogen Oxides or Their Transboundary Fluxes, the 1985 Protocol on the Reduction of Sulphur Emissions or Their Transboundary Fluxes By At Least 30 Percent, and the 1984 Protocol on Long-Term Financing of the Cooperative Program for Monitoring and Evaluation of the Long-Range Transmission of Air Pollutants in Europe. See Convention on Long-Range Transboundary Air Pollution, Protocols to the Convention, http://www.unece.org/env/lrtap/status/lrtap_s.htm (last visited Oct. 22, 2005) (providing hyperlinks to the eight protocols). However, the FCTC also contains sufficient detailed provisions on measures relating to demands for tobacco, on measures relating to the reduction of the supply of tobacco, and on scientific and technical cooperation and communication of information. These permit the implementation of the FCTC without reliance exclusively upon subsequent specific protocols. See FCTC, \textit{supra} note 123, arts. 6-22.
\end{itemize}
(national or international) applicable to aspects of tobacco control, while recognizing the parties' commitment to give priority to their right to protect public health.\textsuperscript{135} The FCTC also contains a provision on questions of liability in relation to the treaty which has never been addressed by any of the framework conventions.\textsuperscript{136} Finally, the treaty is a multilateral treaty in which the potential saboteurs of its implementation (the tobacco industry) are specifically identified, and an appropriate provision to warn the parties is included.\textsuperscript{137}

Another important and recent WHO-sponsored instrument was the revision of the International Health Regulations (IHR).\textsuperscript{138} The IHR were adopted by the 58th WHO World Health Assembly in May 2005. The objective of the IHR is to "prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with... contemporary public health risks, and which avoid unnecessary interference with international traffic and trade."\textsuperscript{139} Under the IHR, countries have broad obligations in capacity building,\textsuperscript{140} such as the development of institutions and the provision of financial and technical support to undertake routine measures to detect and respond to public health measures of international concern at ports, airports, land borders, and other transportation hubs.\textsuperscript{141} The list of diseases whose discovery requires immediate party notification has also

\textsuperscript{135} FCTC, \textit{supra} note 123, arts. 2, 13, 16, & prmb.
\textsuperscript{136} \textit{Id.} art. 19.
\textsuperscript{137} \textit{Id.} art. 5 ("In setting and implementing their public health policies with respect to tobacco control, Parties shall act to protect these policies from commercial and other vested interests of the tobacco industry in accordance with national law.").
\textsuperscript{139} \textit{Id.} art. 2.
\textsuperscript{140} See WHO, Building Blocks for Tobacco Control, A Handbook, xxiv (2004), \textit{available at} http://www.who.int/entity/tobacco/resources/publications/general/HANDBOOK\%20Lowres\%20with\%20cover.pdf (defining capacity building as development of human resources and organization engineering. It includes ability to perform functions, solve problems, and achieve objectives at three levels: individual, institutional, and societal). See also SAKIKO FUKUDA-PARR ET AL., \textit{CAPACITY FOR DEVELOPMENT: NEW SOLUTIONS TO OLD PROBLEMS} (2002).
\textsuperscript{141} WHO, Building Blocks, \textit{supra} note 140. The regulations also include a framework for countries to decide whether other incidents constitute public health events of international concern. Consideration is made of whether an outbreak is serious, unusual or unexpected, whether there is a significant risk of international spread, and whether there is a significant risk of international travel or trade restrictions. The rules also provide a code of conduct for how to notify and respond to public health events of international concern. They highlight areas where strengthening is required, including within the WHO.
been expanded.
In addition, the WHO has shown a renewed interest in the monitoring of international legal developments that have a significant impact on the state of public health and regional mechanisms. The WHO works with a number of global and regional actors organized to improve international public health. Finally, the institutional structure of the WHO, with its strong scientific and technical base, is uniquely qualified to establish minimum legal standards for public health. Minimum standards promulgated under the auspices of the WHO act as useful reference points for regional organizations’ efforts to promote public health within their respective spheres of jurisdiction.

C. INTERNATIONAL TRADE LAW: THE WORLD TRADE ORGANIZATION AND HEALTH POLICY

A discussion on health policy and regionalism inevitably requires insight into international trade law, primarily the effects of WTO law on public health. A number of regional integration organizations have established the liberalization of trade as their primary goal. While the objective of international trade law is primarily the promotion of trade, its impact on public health in developing countries should not be diminished. The WTO legal regime has great potential to function as a tool to protect public health in developing countries. Under the WTO’s legal regime, the protection of human, animal, and plant life, as well as health, is one of the few general exceptions that allows WTO member states to violate GATT provisions. Despite its positive attributes, international trade law has had negative effects on the promotion of public health in developing countries. For example, global and regional trade agreements enable some countries to liberalize trade in tobacco products, reduce tobacco tariffs, and ultimately lead to cheap tobacco products that produce neg-

142. There are numerous memoranda of understanding (MOUs) between the WHO and various global and regional organizations. See, e.g., WHO & ASEAN, Mid-Term Review of the ASEAN-WHO Memorandum of Understanding: Summary Report (Dec. 6-7, 1999), available at http://w3.who.int/LinkFiles/DRD_coord-2_rev_1.pdf.
143. GATT SECRETARIAT, supra note 104.
144. See Bloche & Jungman, supra note 7, at 530–31 (discussing the potential of the WTO to protect public health).
145. GATT SECRETARIAT, supra note 104, at 519.
146. See JHA & CHALOUPKA, TOBACCO CONTROL IN DEVELOPING COUNTRIES, supra note 58, at 25–29.
ative health consequences for consumers. The negative impact of trade liberalization on public health in developing countries has already been addressed in the context of the tobacco trade.

Relevant WTO agreements that address the protection of health include the Agreement on Trade in Goods, the General Agreement on Trade in Services (GATS), the Agreement on the Application of Sanitary and Phytosanitary Measures, the Agreement on Technical Barriers to Trade (TBT), the Agreement on Agriculture, the Agreement on Import Licensing Procedures, the Agreement on Trade Related Aspects of Intellectual Property (TRIPS), and the Agreement on Import Licensing procedures. The following sections discuss these agreements as they relate to public health. Importantly, these agreements describe conditions under which WTO members may subordinate trade considerations to other legitimate policy objectives such as the protection of public health. This recognition of the promotion of public health as a valid exception to WTO trade obligations provides insight into the degree to which trade liberalization schemes in developing countries will respond to the current public health threats facing their member states. It is important to note that legal regimes of regional integration organizations mirror those of the WTO and any shift in health policy by the WTO is viewed with much interest by states, as well as trade and health advocates and practitioners.

1. The Jurisprudence of Article XX (b) of GATT

GATT/WTO jurisprudence has addressed issues relating to the protection of public health under GATT's Article XX (b). Article XX provides inter alia that:

[S]ubject to the requirement that such measures are not applied in a

150. These agreements can be found in WORLD TRADE ORGANIZATION, THE RESULTS OF THE URUGUAY ROUND OF MULTILATERAL TRADE NEGOTIATIONS: THE LEGAL TEXTS (1994).
manner which would constitute a means of arbitrary or unjustifiable
discrimination between countries where the same conditions prevail,
or a disguised restriction on international trade, nothing in this Agree-
ment shall be construed to prevent the adoption or enforcement by any
contracting party of measures: ... (b) necessary to protect human,
animal or plant life or health; ... (g) relating to the conservation of
exhaustible natural resources if such measures are made effective in
conjunction with restrictions on domestic production or con-
sumption.151

The WTO legal regime recognizes that free trade is not the
only important international policy goal. Thus, WTO law includes
exceptions that allow members to work towards other policy goals
such as national security, sustainable development, improved
public health, environment quality, and fair labor standards.152
The numerous exceptions provide a legal basis for dealing with
the control of the vast array of emerging communicable and non-
communicable diseases in the third world.

The Asbestos Dispute Case is an important illustration of
how domestic health concerns relate to international trade ag-
reements.153 At issue was a French Decree prohibiting the man-
ufacture, sale, export, and import of asbestos fibers and pro-
ducts containing asbestos fibers.154 The French Decree was chal-
lenged by Canada as a violation of GATT.155 The issue before
the Appellate Body was whether imported asbestos fibers and
French domestic alternatives were like products.156 The Panel
listed several criteria for determining like products: the physical
properties of the products, their end uses, consumer tastes and
habits, and tariff classification.157 The Appellate Body added
that the health risk inherent in a product is another criterion to
be applied as the health risk could influence the physical char-

151. GATT 1994, supra note 4, art. XX.
152. Id. arts. XX, XXI. The WTO Working Group on the Environment has met
regularly, since 1991. Its task is to examine, upon request, specific matters relevant
to trade policy aspects of measures to control pollution and protect the human
environment. See WTO, Decision on Trade and the Environment, (Apr. 15, 1994),
available at http://www.wto.org/english/docs_e/legal_e/56-dtenv_e.htm; see also
Donald McRae, Trade and the Environment: Competition, Cooperation or
Confusion?, 41 ALBERTA L. REV. 745 (2003) (discussing ways in which conflicts
between trade and the environment are reconciled or left unresolved, the problems
that have to be faced in any further reconciliation, and other neglected and
underlying issues relating to the trade and environment debate).
153. Appellate Body Report, European Communities — Measures Affecting
Asbestos and Asbestos-Containing Products, WT/DS135/AB/R (March 12, 2001).
154. Id. ¶ 1.
155. Id. ¶ 3.
156. Id. ¶ 109.
157. Id. ¶ 101.
acteristics of a product and consumer tastes. The Appellate Body determined that Canada had failed to prove a French breach of the WTO national treatment principle which requires WTO members to protect foreign products the same way it protects domestic products. Under the logic of the WTO Appellate Body, the French Decree was necessary to protect human health within the meaning of Article XX (b) of GATT.

The Appellate Body went on to state that WTO members "have the right to determine the level of protection of health that they consider appropriate." The determination of whether a measure was necessary involves a balancing of factors including the importance of the common interests or values protected by the measure, the efficacy of such measures in pursuing desired policies, and the accompanying impact of the law or regulation on imports and exports.

The Appellate Body held that the more vital the common interests and values pursued, the more easily it could accept the measure designed to achieve those aims as necessary. In this regard, human health was vital and important in the highest degree. The Asbestos Dispute Case provides a way for developing countries to take action to protect public health within the existing WTO framework. The decision marked the first time the WTO Dispute Settlement Body interpreted Article XX (b) flexibly, permitting member countries to enact public health measures that potentially conflict with WTO obligations.

2. TRIPS and the Drug Wars: Prospects for Public Health Protection in Developing Countries

An important WTO agreement that has major implications for the future of public health protection in developing countries is the Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS). The TRIPS Agreement provides minimum standards governing the international use of intellectual property,
including use for the development of medical technologies and pharmaceuticals. The Agreement also guarantees patent protection for intellectual property. The TRIPS Agreement, in contrast to other WTO trade agreements, contains a greater public health exception. The Agreement provides that “[m]embers may, in formulating or amending their laws and regulations, adopt measures necessary to protect public health and nutrition and to promote the public interest in sectors of vital importance to their socio-economic and technological development, provided that such measures are consistent with the provisions of this Agreement.” The Agreement also allows members to disregard existing intellectual property patents when necessary to prevent abusive commercial exploitation of the invention or to protect public order, morality, and human life or health. In order to disregard patent protections, developing countries need to first prove that their actions are necessary to protect public health. After doing so, a country may opt to produce and sell the drug through a non-commercial body. WTO members are permitted to determine the basis for granting compulsory licenses and must limit any compulsory license issued by restricting it to the purpose for which it was granted, mandating that the license is non-exclusive and cannot be assigned. A number of developing countries have argued that compulsory licenses should be granted whenever essential drugs are required and that public health should take precedence over the potential economic damages to companies.

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166. Id. art. 1, 27(3)(a).
167. Id. art. 8(1). While the interpretation of the TRIPS for public health protection has been further achieved by the adoption of the Doha Declaration on the TRIPS Agreement and Public Health, the health exceptions in Article XX(b) of the General Agreement on Tariffs and Trade or the General Agreement on Trade in Services have not been as much the focus of scrutiny by developing countries on matters of public health.
168. Id.
169. TRIPS, supra note 165, art. 27 (“Members may exclude from patentability inventions, the prevention within their territory of the commercial exploitation of which is necessary to protect [human life and health] . . . [and] to avoid serious prejudice to the environment.”).
170. Id.
171. Id. art. 31(b).
172. Id. art. 31. While the term compulsory licensing does not appear in the TRIPS Agreement, the practice falls under article 31 of the Agreement.
173. See also Frederick M. Abbott, The WTO Medicines Decision: World Pharmaceutical Trade and the Protection of Public Health, 99 AM. J. INT'L. L., 317, 323–324 (2005) (“[D]eveloping countries on the whole have shared interests in assuring that there will be alternative production of medicines not under the control
Moreover, TRIPS provides that the least developed nations are not bound by its provisions until 2006, and even this time-frame may be extended if necessary. Developing countries also argue that the TRIPS Agreement permits the production or importation of generic drugs to avert the public health disaster arising from the HIV/AIDS epidemic. This is so despite the argument by pharmaceutical companies and others that compulsory licensing policies are a disincentive to research development for future drugs.

In Pharmaceutical Manufacturers Association and 41 Others v. President of South Africa and 9 Others, the South African High Court endorsed the production and importation of cheap generic drugs for HIV/AIDS treatment under their interpretation of the TRIPS Agreement. This court victory has ener-

of patent holders and that they will have access to newer products, wherever produced.

174. TRIPS, supra note 165, arts. 65, 66.
175. A number of developing countries such as Brazil, Thailand, and South Africa have taken measures in this direction to manufacture or import cheap generic drugs. For example, South Africa authorized the Minister of Health to "prescribe conditions" for the supply of more affordable medicines so as to protect the health of the public. See Medicine and Related Substances Control Amendment Act 90 of 1997, available at http://www.info.gov.za/gazette/acts/1997/a90-97.pdf. In particular, section 15C of the Act permits the Minister to grant compulsory licenses and allow measures such as parallel importing. See id. at sec. 15C. The Brazilian Presidential Decree on Compulsory Licensing established the legal requirements for granting compulsory licenses in cases of national emergency and public interest, including situations of public health crisis, as provided for under article 71 of the Industrial Property Law No. 9.279. Through these legal frameworks, Brazil has been able to produce generic AIDS drugs. See Presidential Decree No. 3,201 of Oct. 6, 1999 (Brazil), available at http://www.cptech.org/ip/health/d/brazil/PresDecree.html; see also Law No. 9,279, May 14, 1996 (Brazil).


177. Pharmaceutical Mfrs. Ass'n v. Pres. Of the Rep. of S. Africa, Case no. 4183/98, High Court of South Africa (Transvaal Provincial Division), available at http://www.tac.org.za/Documents/MTCTPrevention/ pharmace.doc. It is unfortunate that a number of pharmaceutical companies preferred a protracted court challenge in the South African Courts. This court challenge delayed the importation of life-saving generic drugs into South Africa. This is in contrast to developments in Canada and the United States relating to anthrax drugs. In the face of public health threats relating to anthrax, the Canadian government announced that it was suspending the patent on anthrax drugs to allow production of a generic version by local companies; pressure from patent holder Bayer forced the Canadian government to reinstate the patent. See Colleen Chien, Cheap Drugs at What Price to Innovation: Does the Compulsory Licensing of Pharmaceuticals Hurt Innovation?, 18 BERKELEY TECH. L. J. 853, 868 (2003) ("[I]n the 1960s and 1970s, the U.S. government made and used tetracycline and meprobamate for the military without permission from patent holders."); James Thuo Gathii, Balancing Patent Rights and Affordability of Prescription Drugs in
gized campaigns for access to cheap generic drugs in Africa and other parts of the developing world. In South America, Brazil's pharmaceutical companies have produced generic drugs and helped prevent a full-blown AIDS crisis in that country. As a result, HIV/AIDS mortality in Brazil has plummeted and HIV-positive Brazilians have experienced a significant improvement in quality of life.

Unfortunately, many developing nations are unable to pursue the expensive litigious route to enforce the TRIPS health exceptions for the provision of affordable AIDS drugs for their people. The South African litigation shows the relationship between international trade law and health promotion in a developing country context. The softening stance of developed nations has resulted in an attitude shift over TRIPS. During the WTO ministerial conference in Doha, member states passed the Doha Declaration on the TRIPS Agreement and Public Health. This Declaration recognized the gravity of the public health problems afflicting many developing and least developed countries, especially public health problems resulting from HIV/AIDS, tuberculosis, malaria, and other epidemics.

It "stress[es] the need for TRIPS to become part of the wider national, and international solution to address these health problems." The Declaration also stated that "the TRIPS agreement does not and should not prevent members from taking measures to protect public

Addressing Bio-Terrorism: An Analysis of In Re Ciprofloxacin Hydrochloride Antitrust Litigation, 13 ALB. L.J. SCI. & TECH. 651 (2003). Similarly, in the fall of 2001, the threat of a compulsory license was used to drive down the price of the patented drug Ciproflaxin by almost 80%. Id. at 657. In the United States, owing to the high price of Ciproflaxin, there were calls within the United States for the production of a generic version of the drug. Id. at 653. The anthrax scare heightened the developed countries' appreciation of the need for affordable drugs for all. See id. at 661-62.

180. Pharmaceutical Mfrs. Ass'n, Case no. 4183/98 (showing the challenges involved in a TRIPS litigation related to access to drugs). Another South African case, Treatment Action Campaign v. Minister of Health 2001 (4) BCLR 356 (T) (S. Afr.), did not deal directly with TRIPS issues but rather sought to compel the South African government to increase its budget for the treatment and care of HIV/AIDS patients.
182. Id. at ¶ 1.
183. Id. at ¶ 2.
health.\textsuperscript{184} Still further, it affirmed that TRIPS “can and should be interpreted and implemented in a manner supportive of WTO Members’ right to protect public health, and particularly, to promote access to medicines for all.”\textsuperscript{185} It affirmed the right of WTO members to fully utilize the provisions in the TRIPS Agreement, which provide flexibility to promote public health. It further provides that “each member has the right to grant compulsory licences and the freedom to determine the grounds upon which such licences are granted.”\textsuperscript{186} Furthermore, “each member has the right to determine what constitutes a national emergency or other circumstances of extreme urgency, it being understood that public health crises including those relating to... epidemics, can represent a national emergency or other circumstances of extreme urgency.”\textsuperscript{187} It also states that the least developed countries shall not be required to implement or apply Sections 5 and 7 of Part II of TRIPS as it applies to pharmaceutical products until January 1, 2016, without prejudice to the right of these countries to seek other extensions of the transition periods as provided for in Article 66.1 of the TRIPS Agreement.\textsuperscript{188} The Council for TRIPS was instructed to give effect to this provision “pursuant to Article 66.1 of the TRIPS Agreement.”\textsuperscript{189}

While in many ways this Declaration represents a triumph for public health protection in developing countries, the exceptions of Articles 8 and 27 of TRIPS, allowing parties to manufacture generic patented drugs to treat AIDS, are still subject to the national treatment and most favored nation principles of GATT.\textsuperscript{190} The national treatment provision of the TRIPS Agreement requires a WTO member to accord other WTO members’ nationals treatment no less favorable than that accorded to its own nationals in the area of intellectual property protection.\textsuperscript{191} As long as the measure in question does not discriminate between nationals and non-nationals, it will meet the requirements of Article I of TRIPS. Production of generic drugs for markets in some developing countries that actually need it more than other countries could be considered discriminatory.

A Declaration of this nature is soft law until clear practice

\textsuperscript{184.} \textit{Id.} at ¶ 4.
\textsuperscript{185.} \textit{Id.} at ¶ 4.
\textsuperscript{186.} \textit{Id.} at ¶ 5(b).
\textsuperscript{187.} \textit{Id.} at ¶ 5(c).
\textsuperscript{188.} \textit{Id.} at ¶ 7.
\textsuperscript{189.} \textit{Id.}
\textsuperscript{190.} \textit{Id.} at ¶ 5(d).
\textsuperscript{191.} TRIPS, \textit{supra} note 165, art. 3–4.
emerges in conformance with the agreed upon norm; until then the Declaration will not displace the legal principles governing patent protection embedded in the TRIPS agreement. Moreover, developing country members are encouraged to apply TRIPS for public health purposes in full compliance with the objectives of the Agreement as a whole. The main objective of TRIPS has not adequately reflected public health protection.

One major shortcoming of the Declaration is that it only provides for the local manufacture of generic drugs and does not provide for importation of generic drugs manufactured by another country. Manufacture of a generic drug presupposes the existence of the necessary technology and other infrastructure within developing countries to reproduce such drugs. Unsurprisingly, in many developing countries the requisite technology is lacking. As such, developing countries are not able to manufacture cheap generic drugs to combat the AIDS epidemic, and thus cannot fully avail themselves of the Declaration's benefits. Although the Declaration confirms the liberty of WTO members to utilize parallel imports as an alternative source of low-cost branded drugs, it leaves open the sourcing issues for poor countries unable to produce drugs efficiently through domestic manufacturers due to inadequate or ineffective manufacturing capacity. For poor countries, local production is impossible and importation from exporters limited because under TRIPS, countries are required to produce generic drugs primarily for domestic use. Thus, paragraph six of the Doha Declaration required a resolution to the production for export dilemma by 2002. The impasse was

192. See Ignaz Seidl-Hohenveldern, On International Economic “Soft Law,” in 163 RECUEIL DES COURS (HAGUE RECUEIL) 164 (1979). The author states that the main role of soft law in international economic law is as a device to overcome a deadlock in relations between states pursuing conflicting ideological and economic aims. The Doha TRIPS Declaration creates only an illusory expectation that it is binding. Doha TRIPS Declaration, supra note 181.

193. Doha TRIPS Declaration, supra note 181, at ¶ 5(a).

194. See id. at ¶ 6. Paragraph six only emphasizes the need to find ways to strengthen local manufacturing capacity. The Declaration is silent on the importation or exportation of generic drugs.

195. See TRIPS, supra note 165, art. 31(f) (requiring that uses of patents which are not authorized by the patent holder shall be used predominantly to supply the domestic market of the member making use of the patent).

196. See Doha TRIPS Declaration, supra note 181.

We recognize that WTO members with insufficient or no manufacturing capacities in the pharmaceutical sector could face difficulties in making effective use of compulsory licensing under the TRIPS Agreement. We instruct the Council for TRIPS to find an expeditious solution to this problem and to report to the General Council before the end of 2002.
resolved by the Decision of August 2003 on the Implementation of Paragraph Six of the Doha Declaration on the TRIPS Agreement and Public Health.197 Unfortunately, immense challenges must be resolved before the Decision is implemented, particularly in view of disagreement over the legal status of the Chairperson's statement on the August 2003 Decision.198 Hopefully, the Doha Declaration and the Paragraph Six Decision will translate into positive benefits for public health by stemming the disease pandemics harming developing countries. The Declaration could help to attract financial resources and facilitate the transfer of technology from richer countries to developing countries in order to establish infrastructures to manufacture generic drugs. However, it is also important to note that the controversy over the Doha Agreement and Implementation of the Doha Decision illustrates the potential rewards and difficulties faced by states and other health actors seeking to utilize international trade law, especially WTO law and policy, to promote public health.

3. Remarks on the WTO Legal Regime, Regionalism, and Public Health

While health protection is an important consideration of WTO law, health protection measures must restrict trade as little as possible. One option has been to develop new international legal instruments establishing multilateral compromises in the policy areas that have a bearing on international trade, such as the environment and public health.199 New legal and normative frameworks may give developing countries the opportunity to develop, participate in, and apply legal initiatives promoting public health

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199. See WTO, Decision on Trade and the Environment, supra note 152.
at the multilateral and regional levels. International trade law and regionalism have combined to offer a vehicle for health promotion in various parts of the developing world. The legal regimes of regional trade organizations have replicated the laws and policies of the WTO. While the legal regimes of both the WTO and regional trade organizations aim to accentuate trade liberalization, a number of regional integration organizations are paying increasing attention to social and economic development, particularly concerns regarding health and disease.

200. Compare Agreement On The Common Effective Preferential Tariff (CEPT) Scheme For The ASEAN Free Trade Area art. 5A, January 28, 1992, 31 I.L.M. 513 (1992) [hereinafter CEPT for ASEAN] with GATT 1994, supra note 4, at art XI. ASEAN Member States must “eliminate all quantitative restrictions in respect of products under the CEPT Scheme upon enjoyment of the concessions applicable to those products.” CEPT for ASEAN, art. 5A. They are also required “to eliminate other non-tariff barriers on a gradual basis within a period of five years after the enjoyment of concessions applicable to those products.” Id. Article XI of GATT 1994 requires that contracting parties must not place any prohibitions or restrictions on importation, exportation or sale of any product within and between territories of contracting parties with exceptions such as duties, taxes, or other charges. GATT 1994, supra note 4, art. XI. Similarly, article 8 of the Revised Treaty of Chaguaramas Establishing the Caribbean Community Including the CARICOM Single Market and Economy requires each member state, “with respect to any rights covered by this Treaty, accord to another Member State treatment no less favourable than that accorded to: (a) a third Member State; or (b) third States.” Revised Treaty of Chaguaramas Establishing the Caribbean Community Including the CARICOM Single Market and Economy art. 8, Jul. 4, 1973, available at http://www.caricom.org/jsp/community/revised_treaty-text.pdf. This reflects the spirit of article I of the General Agreement on Tariffs and Trade. GATT 1994, supra note 4, art. I. Furthermore, article 35(1)(c) of the Treaty Establishing the African Economic Community provides that a member state, after notifying the secretariats and other member states, “may impose or continue to impose restrictions or prohibitions affecting: ... the protection of human, animal or plant health or life or the protection of public morality.” Treaty Establishing the African Economic Community art. 35, June 3, 1991, 30 I.L.M. 1241. This is very similar to article XX(a)-(b) of GATT authorizing a contracting party to adopt or enforce measures necessary to protect human, animal, or plant life or health, provided such measures do not amount to arbitrary or unjustifiable discrimination between countries where same conditions prevail, or do not amount to disguised restriction on international trade. GATT 1994, supra note 4, art. XX.
III. CASE STUDIES ON REGIONAL ORGANIZATIONS' PROMOTION OF PUBLIC HEALTH IN DEVELOPING COUNTRIES

A. GENERAL

Regionalism is best defined as addressing transnational issues through joint regional action, in contrast to global action. Regionalism is a focus of both empirical and normative inquiry because it identifies emerging trends and structures and clarifies distinct arrays of prescriptions and strategies for addressing transnational problems. Scholars and practitioners have emphasized the importance of regionalism. Firstly, regionalism may embody mechanisms that perpetrate negative effects of globalization. For example, the largely unaccountable global power and influence exerted by multinational corporations, transnational banks, and their financial affiliates has contributed to environmental degradation and the development of negative health threats. In the context of a regional trade agreement, environmental regulations such as packaging laws or green taxes imposed by an importing country may be viewed in the realm of regional trade agreements as non-tariff barriers; such barriers are

201. See Winfried Lang, New Regionalism in a Changing World Order, in INTERNATIONAL LAW: THEORY AND PRACTICE 45 (Karel Wellens ed., 1998). Lang defines regionalism in a number of ways. Neo-functionalist theory defines "regionalism as the incremental creation of regional institutions." Id. Based on the expectation that these institutions could supersede national institutions, they were supposed to gain the loyalty of economic actors. Id. The federalist theory supposed that distributing power among two or more levels, as is in a federal state, "could be of some help in relations between nation-states." Id. Referred to as constructivism, it focuses on the communal identity in regional integration. Constructivism focuses more on collective security than economic need for the integration in question. While the objectives of regionalism in developing countries today is economic, neo-functionalist regionalism must meet new threats, such as environmental risks, drug-trafficking, and global terrorism. Id.


generally prohibited with some defined exceptions.\textsuperscript{205} Regionalism aims to undo trade barriers and liberalize trade. Within interpretation of regional trade agreements, environmental regulations can be interpreted as disguised trade barriers, a characterization which can undermine environmental protection. The nexus between free trade and the environment was recognized in the important 1991 Restrictions on Import of Tuna GATT\textsuperscript{206} dispute settlement panel ruling which found unlawful a U.S. trade ban aimed at preventing the incidental killing of marine mammals by commercial fishermen.\textsuperscript{207} Global actors focus on consumerism, with development ethos inclined towards returns on capital by maximizing growth.\textsuperscript{208} Paradoxically, regionalism can reinforce consumerism and erode the role of regional mechanisms as a buffer against negative globalization due to the expanding regional liberalization regimes such as NAFTA and ASEAN.\textsuperscript{209} Secondly, regionalism has proven capable of meeting the challenges posed by breakdowns of law, order, and governance.\textsuperscript{210} Regional cooperation was effec-
tive in Liberia and in East Asia during the recent SARs outbreak. Regional cooperation also proved effective following the tsunami in Southeast Asia. Regionalism positively complements UN or other global action. Thirdly, developing countries' new reliance on regionalism promotes a progressive and aspirational regional governance structure for the promotion of sustainable development, human rights, environmental protection, public health, and labor rights. Finally, regionalism can make positive independent contributions and also is an important constituent structure in global governance.

Therefore, regionalism in developing countries offers a platform for mitigating the adverse effects of globalization, such as public health threats, by establishing frameworks and mechanisms, in addition to coordinating response measures. In the face of stagnating or dwindling international assistance for protecting public health, regional integration can provide efficient and cost effective means for health training, capacity


211. For example, the ECOWAS and the African Union have worked to establish and maintain the often fragile peace in Liberia and continue alongside the international community to promote reconstruction and return to democratic governance. See African Union, Report of the Chairperson of the Commission on the Situation in Liberia (July 25, 2005), available at http://www.africa-union.org/psc/35th/Report%20_Eng.pdf.

212. See, e.g., ASEAN, Joint Declaration of the Special ASEAN Leaders Meeting on Severe Acute Respiratory Syndrome (SARS) (Apr. 29, 2003), available at http://www.aseansec.org/sars2.htm [hereinafter ASEAN SARS].


214. Id.


216. See CHARLES OMAN, DEVELOPMENT CENTRE OF THE ORGANIZATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT, GLOBALIZATION AND REGIONALISATION: THE CHALLENGE FOR DEVELOPING COUNTRIES 1–30 (1994) (arguing that the main challenge for regionalism is whether it can be a vehicle for international harmonization of national policies in areas such as labor, environment, etc. and whether nations can constitute the building blocks for enhancing multilateral cooperation in the vast areas of human endeavor, from trade to other matters of social cooperation).
building, or implementing evidence-based health-related guidelines, as well as sharing epidemiological studies and best practices within a given region or sub-region.

Regionalism has contributed tremendously to harmonizing transnational values between member states of regional and subregional organizations in the Asia-Pacific, Latin America, Africa, and the Middle East. The international community has now come to accept regionalism as an important and inevitable forum for addressing global and regional policy issues. The most notable uses of regionalism have been in the areas of human rights protection, trade, conflict resolution, environmental protection, and development of institutions of governance.

While public health is not regarded with the importance it deserves in the governance and legal structures of regional organizations in the global south, regionalism within Europe has demonstrated that it is possible to ensure health protection while meeting competing trade objectives. The EU has led the way in the development of a body of health law through the promulgation of a number of health directives. To start, EU treaties empower the European Community to develop public health legislation. Pursuant to the Treaty Establishing the European Community, the Community is also required to ensure a high level of human health protection whenever it defines or implements its policies. Members are encouraged to maintain a

217. Id.
218. See U.N. Charter, art. 52, ¶ 1 (providing for conflict resolution by regional organizations); GATT, supra note 4, art. 24, ¶¶ 3–4 (allowing regional trade agreements); Cotonou Partnership Agreement, European Union-African Caribbean and Pacific Group of States, June 23, 2000, 2000 O.J. (L 317) 3 [hereinafter Cotonou Agreement].
219. See generally OMAN, supra note 216, at 1–30.
222. EC Treaty, supra note 220.
223. Id. art. 129, ¶ 1.
high level of health protection in community policies by “improving public health, preventing human illness and diseases, and obviating sources of danger to human health,” to include “the fight against the major health scourges, promoting research into their causes, their transmission and prevention, health information, education,” and reducing drug related damage.\textsuperscript{224} The EU has been at the forefront of harmonizing public health norms in areas such as tobacco control and occupational health.\textsuperscript{225} The EU has also provided financial and technical resources for public health promotion in developing countries.\textsuperscript{226}

Likewise, an increasing number of regional and sub-regional organizations in the global south do recognize the improvement of public health as a legitimate goal. For example, the Treaty establishing the Common Market for Eastern and Southern Africa has provisions on health protection and promotion.\textsuperscript{227} Likewise, the East African Community Treaty has similar provisions on the promotion and protection of health.\textsuperscript{228} These initiatives, however, still

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\textsuperscript{226} See Cotonou Agreement, supra note 218, art. 25 (committing the EU to cooperation with ACP countries in development of basic infrastructure including healthcare).

\textsuperscript{227} See Treaty Establishing the Common Market for Eastern and Southern Africa, art. 50(c), 110, Nov. 5, 1993, 33 I.L.M. 1067 [hereinafter COMESA Treaty]. Article 50(c) allows member states to take individual action for health protection. Under Article 110, member states agree to cooperate to protect and improve health.

\textsuperscript{228} East African Community Treaty, Kenya-Uganda-Tanz., Nov. 30, 1999, available at http://www.eac.int/documents/EAC%20Treaty.pdf. Article 117 provides that “[i]n order to promote the achievement of the objectives of the Community . . ., the Partner States undertake to co-operate” in health activities. Id. art. 117. Article 118 states that:

[w]ith respect to co-operation in health activities, the Partner States undertake to take joint action towards the prevention and control of communicable and non-communicable diseases and to control pandemics and epidemics of communicable and vector-borne diseases such as HIV/AIDS, cholera, malaria, hepatitis and yellow fever that might endanger the health and welfare of residents of the Partner States, and co-operate in facilitating mass immunization and other public health community campaigns.
need strong legal, political, and technical thrusts. Because developing countries' major public health problems have international implications, initiatives undertaken by geopolitical groups will inevitably require the incorporation of global health laws, policies, and norms that are based on scientific and other sound evidence. As such, the mobilization of political will and the strengthening of institutional public health structures are crucial. The improvement of public health has not been a priority of most regional organizations in the south. Instead, the priorities of these organizations have focused on trade, poverty reduction, conflict resolution, and in some cases, human rights. Despite the existence of legal and governance mechanisms that could be applied to promote health, these mechanisms have not in practice permeated the varying legal regimes of regional organizations. However, in the face of mounting disease epidemics in the developing world, emerging trends do point to a greater interest in health within regional organizations. For the most part, members of regional organizations are also members of the WHO and other UN agencies involved in the generation and promotion of global health policies and programs. The following study of selected regional organizations reveals the variety and complexity of different regional approaches to dealing with public health threats.

It is important to note that the constitutive and subsequent legal instruments of these organizations do make provisions for health protection. However, to determine whether the different regional organizations offer a solid and sustainable regional legal regime for the promotion of public health, the following is required. First, it is important to establish the body of hard and soft law promulgated by the regional organizations and analyze the texts of the relevant agreements relating to health. Second, it is important to consider the corresponding governance, implementation, and enforcement mechanisms of these organizations and how they influence public health in reality. Third, it is also necessary to explore the compatibility of these agreements with the existing body of international health law. For the purposes of this article, I have considered four regional integration regimes in developing countries: the African Union (AU), the Economic Com-

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229. A number of regional integrations such as the European Community and the African Union participated in the negotiations of the WHO Framework Convention on Tobacco Control. See FCTC, supra note 123.

230. See supra note 89 and accompanying text.
munity of West African States (ECOWAS), the Association of South East Asian Nations (ASEAN), and the Caribbean Community.

B. THE AFRICAN UNION

Nowhere else in the world are disease pandemics imposing such a disproportionately heavy health, social, and economic burden than in Africa. Diseases currently ravaging the African population include HIV/AIDS, malaria, and tuberculosis. Additionally, Africa is currently experiencing an increasing emergence of non-communicable diseases including tobacco-related diseases. Since its founding, the Organization of African Unity (OAU) and now its successor, the African Union, have developed multiple legal and policy instruments designed to address public health problems in the region. These instruments show promise for an effective and coherent legal health protection regime in Africa. Unfortunately, these provisions have not yet been clarified or translated into effective tools to reduce the burden of disease on the continent.

The Constitutive Act of the African Union was adopted by the member states of the Organization of African Unity in Lome, Togo, on July 11, 2000. The Act replaced the Charter of the Organization of African Unity. The Act, which is more comprehensive and dynamic than the OAU Charter, has various positive provisions. Article 2 establishes the African Union. Indeed, one of the stated objectives of the Union is to work with relevant international partners in the eradication of preventable diseases and the promotion of good health on the continent. Pursuant to Article 10, an Executive Council composed of foreign affairs ministers, or such other ministers or authorities as are designated by the governments of member states, was created and entrusted

232. See Onzivu, supra note 22, at 243 (discussing how the legal instruments of the African Union have not kept pace to respond to action to counter disease pandemics in Africa).
234. Id. art. 33.
with the responsibility to coordinate policies of common interest to member states.\textsuperscript{236} Not surprisingly, health is one such area.\textsuperscript{237} However, the AU's Executive Council consists predominantly of foreign affairs ministers, even though member governments may designate other ministers or authorities. Accordingly, it is questionable how effectively the group can dispose of the health issues before them. The constitution also establishes a Specialized Technical Committee on Health, Labour and Social Affairs which reports to the Executive Council.\textsuperscript{238} The role of this committee is to ensure the coordination, follow up, evaluation, and harmonization of health programs in Africa.\textsuperscript{239} In addition to the Specialized Technical Committee, the constitution also establishes an Economic, Social, and Cultural Council that will address health matters.\textsuperscript{240} This commission could enhance health promotion work to counter disease pandemics in the region. The structure of the AU makes its potential for improving public health great. The African Union mechanisms have the capability to become significant tools for counteracting the underlying causes of public health threats in addition to directly advancing public health through the provision of financial and technical assistance to its member states. Unfortunately, this potential is largely unrealized. Presently, the African Union lacks the technical capacity possessed by the WHO and other regional health agencies.\textsuperscript{241}

It is yet to be seen if the new Constitutive Act of the African Union will provide a practical framework for addressing public health concerns in Africa. Like its predecessor the OAU, the AU also faces financial problems.\textsuperscript{242} The annual operating budget of

\begin{itemize}
\item \textsuperscript{236} Constitutive Act of the African Union, supra note 233, arts. 10, 11.
\item \textsuperscript{237} Id. art. 13.
\item \textsuperscript{238} Id. art. 14.
\item \textsuperscript{239} Id. art. 15.
\item \textsuperscript{240} Id. art. 22.
\item \textsuperscript{241} See id. art. 23 (providing for the imposition of sanctions on any Member State that defaults in the payment of its contributions to the budget of the Union). However, the Act does not make an explicit provision on how it will finance the expanded activities and programs assigned to the renewed Organization. Id. In the African Union, the Committee on Health, Labor and Social Affairs and the Economic, Social & Cultural Council are organs that possess competence on health matters. Despite the fact that a Secretariat staff handles health matters, the staff may not adequately possess the required technical and financial resources for public health work. In contrast, the WHO is a specialized health agency with many years of health expertise.
the AU in 2004 was a low 43 million U.S. dollars, even though the AU has set an ambitious targeted budget of 297 million U.S. dollars annually.\(^{243}\) With member contributions in arrears, operations are difficult to execute. The persistent poverty and balance of payments problems among African nations make it difficult for member states to contribute financially to the AU.\(^{244}\) The creation of new mechanisms at the AU,\(^{245}\) and the burden of conflict-prevention operations, such as those in Darfur, have necessitated the convening of a donor conference to mobilize external funding.\(^{246}\)

As a result, public health concerns have been marginalized.

The AU has already undertaken AIDS and malaria control initiatives but has yet to add non-communicable diseases to this list.\(^{247}\) Recently, the AU has become more involved in the fight against AIDS and malaria in the region, but only on an ad hoc basis. Also, in 2003 the African Union Assembly made a Declaration on Malaria, HIV/AIDS, Tuberculosis and Other Infectious Diseases.\(^{248}\) The Declaration urged the international community to provide more funding to governments and institutions in Africa, requested governments and international agencies to enhance partnerships with African nations, and


\(^{245}\) See Constitutive Act of the African Union, supra note 233, art. 5. Whereas the Charter of the OAU established the Assembly of Heads of State and Government, the Council of Ministers and the General Secretariat and the Commission of Mediation, Conciliation and Arbitration, the Constitutive Act of the African Union has created new institutions: the Assembly of the Union, the Executive Council, the Pan-African Parliament, the Court of Justice, the Commission, the Permanent Representatives Committee, the Specialized Technical Committees, and the Economic, Social and Cultural Council and the Financial Institutions. Id.

\(^{246}\) Press Release, supra note 242.

\(^{247}\) The AU has adopted a number of Declarations on infectious diseases but none yet, for example, on tobacco control. See, e.g., Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases, A.U. Doc. Assembly/ AU/Decl.6(II) (Apr. 27, 2001), available at http://www.un.org/ga/aids/pdf/abuja_declaration.pdf [hereinafter Abuja Declaration].

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encouraged other nations to help African nations build the
capacity to manufacture affordable drugs at local and regional
levels. The Commission, in collaboration with UNAIDS and
other international agencies, was requested to monitor the
implementation of the Declaration and regularly report to the
Assembly. In April 2001 in Abuja, the heads of state of the AU
member states adopted the Abuja Declaration on HIV/AIDS,
Tuberculosis and other Related Infectious Diseases, pledging to
make fighting against HIV/AIDS their highest priority in respect
to national development plans. They also pledged to adopt a
multisectoral strategy to control HIV/AIDS, tuberculosis, and
other infectious diseases, called for international resources and
collaboration, and resolved to enact appropriate legislation and
international trade regulations to ensure the availability of drugs
at affordable prices. The Declaration requested the Secretary
General, in collaboration with the WHO, UNAIDS, and other UN
and regional organizations, to monitor the implementation of the
outcome of the summit.

In 2000, the OAU, now AU, adopted the Lome Declaration. The
Lome Declaration affirmed the 1987 Declaration on Health as
a foundation of socioeconomic development. The Lome Decla-
ration also affirmed the Tunis and Dakar Declarations on AIDS in
Africa as important instruments to fight AIDS. Further, member
states committed themselves to undertake preventive measures to
tackle the growing AIDS problem, requesting the Secretary
General of the OAU to work closely with the WHO and UNAIDS
in this regard. Other instruments executed by the AU include
the Decision on Polio Eradication in Africa, which urged for a
final push and commitment of member states to fully eradicate
polio from the African continent, and the Decision on the World

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249. Id.
250. See id. at ¶ 3–7.
251. See Abuja Declaration, supra note 247.
252. Lome Declaration, O.A.U. Doc. AHG/Decl.2 (XXXVI) (July 12, 2000),
253. Declaration of Health as a Foundation For Development, O.A.U Doc.
AHG/DECL.1 (XXIII) (July 29, 1987), available at http://www.africa-
255. Assembly of Heads of State and Government, Decision on Polio Eradication
in Africa, A.U. Doc. EX/C1/Dec.64(III) (July 8, 2003), available at http://www.africa-
union.org/Official_documents/council%20of%20minsters%20meetings/Maputo/EX_C
L_Dec%2064.pdf.
Report on Violence and Health. The AU health ministers have convened within its framework to discuss health issues in Africa, and the AU has also celebrated the Africa malaria control day, an organized campaign to focus political attention and raise public awareness concerning malaria. Political commitments of this nature show the importance the African countries are attaching to health cooperation in the face of disease pandemics.

However, the AU's actions to date do little to create a strong and binding legal instrument designed to combat Africa's growing public health threats such as the AIDS epidemic. There is also no evidence of AU efforts to develop a binding legal framework to strengthen health policies instead of the ad hoc measures such as the health-related Declarations adopted by the Organization. Of course, optimists argue that soft law will evolve over time. However, the practical effect of the AU's Declarations will depend on the political will of member states and the resources they actually commit to implementing these declarations. Moreover, the AU's sole focus on infectious diseases ignores the rising burden of non-communicable diseases caused by tobacco usage.

The AU is also responsible for implementing the Treaty Establishing the African Economic Community. Article 73 of the Treaty provides that member states agree to promote and increase cooperation among themselves in the field of health. To this end, member states have agreed to cooperate in developing primary healthcare programs. Member countries can also introduce or prohibit restrictions on, or prohibitions of, certain goods negatively affecting public health. Unfortunately, improving Africa's dire state of public health is not one of the Treaty's objectives, listed in Article 4 of the Treaty. One would expect the health concerns referenced in Article 73 to be mentioned explicitly in the Treaty's list of objectives. The supreme organ of the African Economic Community is the Assembly of Heads of State and Government. The Assembly is

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258. Id. art. 73.
259. Id.
260. Treaty Establishing the African Economic Community, supra note 200, art. 35. Similar provisions exist under the Treaty Establishing the Economic Community of West African States, supra note 257, art. 43.
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responsible for supervising and implementing the Community's stated objectives.\textsuperscript{261} The Economic and Social Commission, which addresses health matters specifically, is not endowed with any decision-making powers. It can communicate policy recommendations directly to the Assembly but only through the mechanism of the Council, which may lead to unnecessary bureaucratic red tape.\textsuperscript{262} Despite the looming and current public health epidemics in Africa, including AIDS, malaria, and TB, health seems to be an ancilliary consideration of the Treaty. However, the African Union Conference of Trade Ministers did recognize the importance of public health protection in Africa by adopting the AU Ministerial Declaration on EPA Negotiations, a declaration that included a section on intellectual property rights and public health. The relevant text states:

\begin{quote}
We note that the African Group (at the WTO) initiated the discussion on the clarification of flexibilities in TRIPs, particularly in relation to patents and public health as well as biodiversity. We call on African countries to take appropriate measures at the national level to make full use of these flexibilities in line with the outcome of the African Union Commission workshop held in March 2005 in Addis Ababa. We call on the EU not to introduce in the EPA negotiations any TRIPs plus proposals (which go beyond existing TRIPs obligations) which would compromise these flexibilities. If such proposals are advanced, they should be rejected.\textsuperscript{263}
\end{quote}

The AU Ministerial Declaration is significant because it is a strong statement by trade ministers, not health ministers, urging other WTO members to refrain from obstructing the full implementation of the Doha Declaration on TRIPs and Public Health. While declarations have questionable legal value, they do apply important political pressure. It remains to be seen if the AU Ministerial Declaration does signify a commitment, on behalf of regional trade ministers, to make the promotion of public health a higher policy priority.

The African Charter on Human and Peoples Rights proclaims that all individuals have the right to enjoy the best attainable

\textsuperscript{261} Treaty Establishing the African Economic Community, \textit{supra} note 200, art. 8.


state of physical and mental health. 264 State Parties to the Charter are called upon to take the necessary measures to protect the health of their people. 265 While some commentators view the Charter as devoid of any practical method to enforce economic and social rights, 266 the African human rights system does help gauge member nations’ public health priorities. Moreover, the Charter affirms the human rights basis of the WHO constitution and in this way contributes to a legal regime of health protection in Africa. 267 Similarly, the African Charter on the Rights and Welfare of the Child provides for the right of every child to enjoy the best attainable state of physical, mental, and spiritual health. 268 Under the Charter, state parties are required to take action to reduce the infant and child mortality rate, to ensure the provision of necessary medical assistance and health care, to facilitate the development of primary healthcare, and to combat disease and malnutrition including preventive health care, family life education, and provision of service. 269 States are also called upon to integrate basic health service programs in national development plans and to mobilize resources for the development of primary healthcare for children. 270


264. African Charter on Human and Peoples Rights art. 16, June 27, 1981, 21 I.L.M. 58 (entered into force Oct. 21, 1986). The states are required to ensure that their people receive medical attention when they are sick.
265. Id.
266. See, e.g., Martin Scheinin, Economic and Social Rights as Legal Rights, in ECONOMIC, SOCIAL AND CULTURAL RIGHTS: A TEXTBOOK 41 (Asborn Eide, Catarina Krause & Allan Rosas eds., 1995).
267. See WHO Constitution, July 22, 1946, 62 Stat. 2679. The Preamble of the WHO Constitution declares that "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 condition."
269. Id.
270. Id.
major international human rights instruments eliminating discrimination and those upholding the dignity of women. On matters of women's health, parties are required to ensure respect for and promotion of women's health, including securing sexual and reproductive rights.272 The Protocol specifically cites a woman's right to protection against sexually transmitted diseases including HIV/AIDS.273 The Protocol provides for national judicial protection and attempts to ensure state party compliance through a periodic reporting requirement.274 The Protocol is one of the first international legal instruments that explicitly claims the right to protection from HIV. These instruments form a sound basis for the promotion of health in the AU and support the notion that health deserves more attention from the AU's Member States.

Unfortunately, the implementation of African regional human rights instruments has been problematic.275 For example, under Article 59 of the Banjul Charter, human rights measures taken by state parties are confidential until decided otherwise by the heads of state. However, this confidentiality only serves to undermine the accountability, transparency, and access to information for States, NGOs, and individuals, which are vital to international human rights law. The mandate of the Commission is limited. After investigating a reported violation of human rights, the Commission can only report to the Assembly of Heads of State.276 Although the AU seems recently energized to champion the lofty ideals of unity, cooperation, economic development, and fundamental human rights in the region, it has previously failed to work seriously towards the realization of these objectives.277 In this regard, the African regional legal system is still unprepared to deal with major public health pandemics on the continent.

272. Id. art. 14.
273. Id. art. 14(1)(d-e).
274. Id. arts. 25, 26.
275. For further discussion on this, see Obijiofor Aginam, Legitimate Governance Under the African Charter of Human and Peoples Rights, in Legitimate Governance in Africa: International and Domestic Legal Perspectives 345, 367, 374 (Edward Kofi Quashigah & Obiora Chinedu Okafor eds., 1999).

The Protocol on the Establishment of an African Court on Human and Peoples Rights promises a potential forum for parties seeking redress on public health issues.\(^{278}\) The Protocol entered into force in January 2004. The Protocol vests the African court with a broad jurisdictional mandate that provides automatic jurisdiction over all cases and disputes submitted to the court concerning the interpretation and application of the Charter, the Protocol establishing the court, or any other relevant human rights instrument ratified by the states concerned.\(^{279}\) The Commission, state parties, and African Intergovernmental Organizations are covered by this rule. Accordingly, member states or organizations, such as the East African Community, can bring claims to the court to enforce health-related rights. The court has jurisdiction to adjudicate disputes brought against a state party to the Protocol\(^{280}\) in which it is alleged that the state has violated the African Charter on Human and Peoples Rights\(^{281}\) or any other human rights instrument that the states have ratified.\(^{282}\) Such claims may be filed directly with the court by the complaining party or indirectly with the African Commission on Human and Peoples Rights.\(^{283}\) The Commission, a state party that has lodged a complaint with the Commission, a state party against whom a complaint is lodged, and other specified actors have access to the court.\(^{284}\) For these actors, access to the court is automatic.\(^{285}\)

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279. Id. at art 3 ("The jurisdiction of the Court shall extend to all cases and disputes submitted to it concerning the interpretation and application of the Charter, this Protocol and any other relevant Human Rights instrument ratified by the States concerned. In the event of a dispute as to whether the Court has jurisdiction, the Court shall decide.").

280. Id. art. 3.

281. Id. art. 5.

282. Id. art. 7.

283. Id. art. 5.

284. Protocol on the Establishment of an African Court on Human and Peoples Rights, supra note 278. Under this article, the following are entitled to submit cases to the African Court Human and Peoples' Rights: the Commission; the State Party, which had lodged a complaint to the Commission; the state party against which the complaint has been lodged at the Commission; the state party whose citizen is a victim of human rights violation; and African Intergovernmental Organizations. When a state party has an interest in a case, it may submit a request to the Court to
Unfortunately, the court has no jurisdiction to entertain cases directly from individuals and NGOs.\footnote{See id.} The court has discretion to grant jurisdiction to NGOs with observer status before the Commission in a possible claim involving a state if that state had lodged a declaration accepting claims from NGOs.\footnote{Id. art. 34 ("At the time of the ratification of this Protocol or any time thereafter, the State shall make a declaration accepting the competence of the Court to receive cases under article 5(3) of this Protocol. The Court shall not receive any petition under article 5(3) involving a State Party which has not made such a declaration.").} The court also has discretion to grant or deny individual and NGO access at will. Moreover, for a willing court to hear a case filed by an individual or NGO, the State being charged with the violation must have expressly accepted the court’s jurisdiction over such cases. Additionally, the court has advisory jurisdiction to provide a legal opinion on any matter relating to the Charter or any other relevant human rights instruments ratified by the states.\footnote{Id. art. 4.} Advisory opinions can be requested by a member state of the OAU, any of its organs, or any African organization recognized by the African Union.\footnote{Id.} The court is also empowered to craft remedies for victims of human rights violations and has the authority to seek enforcement of its judgments against states.\footnote{Id. art. 27.}

The breadth of the court’s jurisdiction permits claims made in relation to health rights. By extending the court’s jurisdiction to all cases and disputes submitted to it concerning the interpretation and application of the Charter, the Protocol, and any relevant human rights instrument ratified by states, the Protocol has aided the enforcement of global and regional public health standards in human rights treaties. However, the Protocol’s provisions for direct access to the court are limited and mark a serious shortcoming of the court’s jurisdictional provision. This is a great drawback in view of the fact that African NGOs have been active in advocating for health rights. If effectively used, the court could provide an important forum for promoting public health on the African continent.
2. The Court of Justice of the African Union

The Protocol of the Court of Justice of the African Union was adopted in 2003 but has not yet entered into force. Under the Protocol, eligibility to submit cases is not only accorded to state parties but also to organs of the African Union and to third parties under conditions to be determined by the Assembly and with the consent of the state party concerned. Like the African Court of Human and Peoples Rights, the court has jurisdiction to hand down advisory opinions on any legal question at the request of the organs of the Union, financial institutions, and a regional economic community. Even at a time when the continent's disease burden requires urgent intervention, it is yet to be seen if the court will enforce the health-related obligations of AU Member States. The provision has not gone far enough to entertain advisory opinion requests from other competent international organizations or civil society. The Protocol has endowed the court with wide jurisdiction, covering interpretation and application of the Constitutive Act, all principal and subsidiary legal instruments within the framework of the Union, any question of international law, and all other instruments and agreements involving the member states and/or the Union. Parties are required to comply with judgments of the court under the Protocol, and non-compliance will trigger sanctions from the Assembly of Heads of State and Government of the Union. The court's wide jurisdictional net will certainly encompass enforcement of health obligations derived from regional instruments and the existing body of global health law. In this way, the Court of Justice of the African Union, alongside the Human and Peoples Rights Court, could become a major instrument promoting public health in Africa.

292. Id. art. 18.
293. Id. art 44. A regional economic community is not defined in the Protocol but it could refer also to sub-regional integration organizations such as the Economic Community of West African States, the East African Community, etc.
294. Id. art. 19.
295. Id. arts. 51, 52.
3. The Pan African Parliament

National parliaments play a key institutional role in the promotion of public health because they have the unique responsibility of enacting regional public health legislation. Likewise, the Pan African Parliament could play a regional legislative role in matters of health. The Protocol establishing the African Parliament is now fully operational and could play a pivotal role in supporting the development of health law in Africa. The Parliament is composed of five members from each member state of the Union. The Parliament's main objective is to facilitate the implementation of the policies and objectives of the African Union, the protection of human rights, and cooperation among Regional Economic Communities and their parliaments. The Parliament is endowed with law-making powers. However, the law-making powers of the Parliament have to be defined by the Assembly of the Union. The Parliament will also work to harmonize and coordinate the domestic laws of member states. While public health issues do not specifically appear in the Protocol establishing the Pan African Parliament, the Parliament will inevitably face matters of health law and policy-making. Since its formation, the Parliament has been predominately preoccupied with settling conflicts and addressing African poverty. But even these problems have health implications and it is likely that the Parliament will be a future player on matters of African health policy.

Despite the many problems the AU faces, it is important that the organization incorporates public health concerns into its mainstream activities. With the prevailing public health crisis and recognized link between health and development, AU health policy cannot continue to be ad hoc and sporadic. Instead, an enduring legal framework is needed to make the improvement of public health a long-term priority.

C. THE ECONOMIC COMMUNITY OF WEST AFRICAN STATES

The Economic Community of West African States

297. Id. art. 3.
298. Id. art. 11.
299. Id.
(ECOWAS)\textsuperscript{300} was created in 1975 to promote broad cooperation among West African nations. The organization is composed of Benin, Burkina Faso, Cape Verde, Cote d’Ivoire, Gambia, Ghana, Guinea, Guinea Bissau, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, and Togo. The goal of the organization is to promote co-operation and development in all fields of economic activity, particularly in the fields of industry, transport, tele-communications, energy, agriculture, natural resources, commerce, monetary and financial questions and in social and cultural matters. The purpose of the cooperation between nations is to raise the standard of living of their people, increase and maintain economic stability, foster closer relations among its members, and contribute to the progress and development of the African continent.\textsuperscript{301}

The ECOWAS’ institutional structure is divided into the Conference of Heads of State and Government, Council of Ministers, Community Parliament, Economic and Social Council, Community Court of Justice, Executive Secretariat, Specialized Commissions, the Fund for Cooperation, Compensation and Development, and the West African Monetary Agency. Since 1990, ECOWAS has taken gradual steps to create its own free trade area.

1. *The ECOWAS Protocol on the Establishment of the West African Health Organization*

The ECOWAS Protocol on the Establishment of a West African Health Organization was adopted in 1987 but did not enter into force until January 2001. The Protocol created the West African Health Organization (WAHO), a merger of two pre-existing health agencies, the anglophone West African Health Community and the Francophone Organization de Coordination et de Cooperation pour la Lutte contre les Grandes Endemies (OCCGE). WAHO is a specialized Institution of the Economic Community of West African States.

The preamble to the Protocol recognizes health as an important aspect of socioeconomic development, stating that the unequal national development in the promotion of health and control of disease poses a major problem common to the entire West African region. It also states that the Organization is

\textsuperscript{300} Treaty of the Economic Community of West African States, May 28, 1975, 14 I.L.M. 1200.

\textsuperscript{301} Treaty Establishing the African Economic Community, *supra* note 200.
created as a means to effectively mobilize all available human, material, and financial resources within the sub-region.

The objective of the WAHO is "the attainment of the highest possible standard and protection of health of the peoples in the sub-region through the harmonization of the policies of Member States, pooling of resources, cooperation with one another and with others for a collective and strategic combat against the health problems of the sub-region." The responsibilities of the organization include, inter alia, the promotion of research on the major endemic diseases ravaging the sub-region, undertaking activities aimed at eradicating or controlling the diseases, and serving as a forum for collecting and disseminating technical, epidemiological, research, training, and other health information among member states. The organization is also charged with the duty to promote and harmonize the production of vaccines, the manufacture of drugs, the establishment of quality control laboratories, and the exchange of manpower and health technology among member states. It also has a duty to assist member states in strengthening regional health services and infrastructure and promoting cooperation among scientific and professional groups that contribute to the advancement of public health. The WAHO also has a role in advising member states on the public health implications of development projects, and it is required to collaborate with international, regional, and sub-regional organizations to solve health problems in the sub-region. Finally, it has a law-making power to propose conventions, agreements, and regulations with respect to sub-regional health matters.

The supreme organ of WAHO is the Assembly of Ministers of Health of ECOWAS member states. The functions of the Assembly include: to determine the general policies of WAHO, to approve the Health Organization's program of work, to establish technical committees to undertake the work of the Health Organization, and to consider the directives or recommendations bearing on health made by the authority. The Assembly then reports the steps taken by the Health Organization to give effect to such directives or recommendations. The Assembly of Ministers also makes recommendations to

302. Id. art. 3.
303. Id. art. 2.
304. Id.
305. Id.
306. Id.
member states with respect to any matter within the competence of the Health Organization. WAHO is an integral part of ECOWAS and the WAHO protocol is an integral part of the ECOWAS treaty. Its legal powers enable it to collaborate with a number of regional international and bilateral institutions.

WAHO's integral role and inclusion in ECOWAS is a unique instance in which a regional trade organization has created a legal mechanism through which it can promote public health. Because the Protocol only entered into force in 2000, its effectiveness in promoting public health in the region is still undetermined. Like other developing geopolities, ECOWAS is beset with a lack of public health resources. It is estimated that ECOWAS members are currently thirty million U.S. dollars in arrears. The number is highly significant, considering that ECOWAS' annual operating budget is estimated at ten million U.S. dollars. Additionally, peacekeeping in Liberia and Sierra Leone and involvement in Ivory Coast have diverted enormous resources from social activities such as those relating to public health. 307 ECOWAS' actions are strongly tied to UN direction. For example, peacekeeping by ECOWAS, partly based on the UN Charter, gained momentum after the Security Council called upon the group to support regional peacekeeping efforts. 308 Similarly, the recent UN Security Council resolution to combat HIV/AIDS may stimulate ECOWAS action to promote public health. 309 The ECOWAS' marginalization of public health is due in part to the increased priority of regional trade liberalization, in addition to peacekeeping efforts in a number of its member states. In such circumstances, a WAHO legal

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307. ECOWAS has undertaken or supported peacekeeping missions in Liberia, Sierra Leone, and Guinea. See Binaifer Nowrojee, Joining Forces: The United Nations and Regional Peacekeeping-Lessons from Liberia, 8 HARV. HUM. RTS. J. 129, 130 (1995) (discussing ECOWAS's regional peacekeeping efforts in Liberia in an attempt to end the bloody civil war in that area).

308. Chapter VIII of the UN Charter envisions a role for regional organizations. See U.N. Charter ch. VIII. Article 52(1) provides:

Nothing in the present Charter precludes the existence of regional arrangements or agencies for dealing with such matters relating to the maintenance of international peace and security as are appropriate for regional action provided that such arrangements or agencies and their activities are consistent with the Purposes and Principles of the United Nations.

Id. art. 52, ¶ 1. Article 53(1) provides that "[t]he Security Council shall, where appropriate, utilize such regional arrangements or agencies for enforcement action under its authority." Id. art. 53.

strategy giving greater visibility to the region's public health problems and the need to generate resources to solve those problems could make the WAHO Protocol an important tool for promoting and protecting public health in the ECOWAS region. Of course, its success will hinge, in large part, on the degree of international cooperation the region can generate. The ECOWAS treaty provides that member states shall encourage and strengthen cooperation amongst themselves in health matters. AIDS, malaria, and other diseases are taking their toll on West Africa, a fact that should spur regional cooperation on public health issues amongst ECOWAS member states.

2. Court of Justice of the Community

Article 15 of the Treaty of ECOWAS established the ECOWAS Court of Justice of the Community. Article 15 also provided for the adoption of a Protocol to define the status, composition, powers, and procedure of the court. It required the ECOWAS Court of Justice to carry out the functions assigned to it with judicial independence that must be upheld by member states and the institutions of the Community. Judgments of the court are binding on ECOWAS member states, the institutions of the community, its individuals, and corporate bodies. The ECOWAS Treaty establishes the Authority of Heads of State and Government of member states which is the supreme institution of the Community and is composed of Heads of State and/or Government of member states. The Authority "is responsible for the general direction and control of the community and shall take all measures to ensure its progressive development and the realization of its objectives." In this connection, member states or the Authority may refer any dispute on the application of the treaty and its protocols to the court of the community. The court's decision is final and is not subject to appeal. The treaty provides for the possible imposition of sanctions on a member state if a state fails to fulfill its obligations to the community. Potential sanctions include the suspension of community loans and assistance, exclusion from presenting candidates for work of the

311. See id. art. 15.
312. Id.
313. Id. art. 7.
314. Id. art. 76.
organization, suspension of organizational voting rights, and suspension from participation in the activities of the organization. Pursuant to Article 15 of the treaty, the Rules of the Court of Justice were adopted and became effective in 2002. While the Rules of Procedure paved the way for the procedural organization and operation of the court, the rules made the court open only to member states that bring action on behalf of their citizens. Accordingly, individuals are not able to bring actions to compel their governments to fulfill health-related obligations under the ECOWAS Treaty.

Unfortunately, the effectiveness of the court is difficult to gauge. To date, the court has not handed down rulings relating to health protection. Further weakening the power of the court is the fact that the imposition of sanctions can be waived. Despite this weakness of the court, the ECOWAS treaty and its protocols do explicitly provide for the protection and promotion of human rights, a regional approach that offers real promise for promoting public health rights in the sub-region. Moreover, in August 2004, the ECOWAS Protocol was amended to allow individual ECOWAS citizens direct access to the court. The Supplementary Protocol was drafted in Accra in January 2005 and should enhance access to justice in ECOWAS. The Supplementary Protocol will enable NGOs direct access to the court to advocate for and promote health-related obligations enshrined in the ECOWAS legal regime. The court has the potential to become a pivotal tool for health protection in West Africa. For its potential to be realized, however, member states will need to quickly ratify this supplementary protocol, increase the court’s budget, and respect the judicial independence of the court. The court and other institutions of the community, if reinforced to deal with health violations, could transform themselves into powerful vehicles of public health protection in West Africa.

D. THE ASSOCIATION OF SOUTH EAST ASIAN NATIONS

The Foreign Ministers of Southeast Asian countries created the Association of South East Asian Nations (ASEAN) with the

318. Id.
Globalism, Regionalism, or Both

Bangkok Declaration in August 1967. However, the Organization was initially unable to define its precise goals or its future role. Today, the ASEAN is a major regional trade organization in Asia composed of Brunei Darussalam, Indonesia, Malaysia, Philippines, Singapore, Thailand, Lao PDR, Myanmar, and Vietnam. The initial purpose of ASEAN was to develop a prosperous and peaceful community of Southeast Asian nations to enhance the group's regional identity. The founders of ASEAN envisioned facilitating regional cooperation to promote solidarity to steer economic progress in the ASEAN region. At the 1976 Bali summit, ASEAN adopted its first major treaty, the Treaty of Amity of Cooperation in Southeast Asia. The treaty established general principles relating to ASEAN countries, strengthening economic cooperation, development, and assistance in the region. The ASEAN group has also adopted other important regional legal instruments. These include the Agreement on the Common Effective Preferential Tariff Scheme for the ASEAN Free Trade Area of 1992, the ASEAN Framework Agreement on the Facilitation of Goods in Transit of 1998, and the ASEAN Framework Agreement on Intellectual Property Cooperation. Despite the

319. The ASEAN Declaration (Bangkok Declaration), Aug. 8, 1967, 6 I.L.M. 1233.
321. See PAUL DAVIDSON, TRADING ARRANGEMENTS IN THE PACIFIC RIM, 26–28 (2005) (discussing some of the broader challenges to the ASEAN legal and governance mechanisms such as the lack of supra-national bodies and community law comparable to the European Community, among others).
324. Article 2(2) of the ASEAN Framework Agreement on Intellectual Property Cooperation provides that ASEAN member states shall implement intra-ASEAN intellectual property arrangements in a manner in line with the objectives, principles, and norms set out in relevant conventions and the Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS). See ASEAN Framework Agreement on Intellectual Property Cooperation, Dec. 15, 1995, 35 I.L.M. 1073, 1074, available at http://www.aseansec.org/6414.htm [hereinafter Framework Agreement]. In doing so, member states must account for the international conventions on intellectual property rights to which they are parties, and the international obligations assumed under the provisions of the Agreement on TRIPS. Id. Article 2(4) further provides the following:
fact that there are no specific provisions imposing direct public health obligations in the core treaties, the ASEAN has adopted a number of declarations that can promote public health. These declarations are soft law but do provide a regional platform of health cooperation and enhance the region's political commitment to health protection. The important ASEAN declarations include the Declaration of ASEAN Concord, the Declaration of the 5th ASEAN Health Ministers Meeting on Healthy ASEAN 2020, the ASEAN vision 2020, the Bangkok Summit Declaration of 1995, the Hanoi Declaration of 1998 and Plan of Action, and the 7th ASEAN Summit Declaration on HIV/AIDS.

The founders of ASEAN aimed at accelerating social progress and promoting active collaboration and mutual assis-

Memorandum States shall recognize and respect the protection and enforcement of intellectual property rights in each Member State and the adoption of measures necessary for the protection of public health and nutrition and the promotion of public interest in sectors of vital importance to the Member State's socio-economic development... consistent with their international obligations.

Id.

325. Scholars have argued that the concept of soft law is useful in international relations:

While it may be paradoxical and confusing to call something "law" when it is not law, the concept is nonetheless useful to describe instruments that clearly have an impact on international relations and that may later harden into custom or become the basis of a treaty... 'Recommendations may not make law, but you would hesitate to advise a government that it may therefore, ignore them, even in a legal argument...' The main value of international "soft law," which is very important in the field of international economic law, is as a device 'to overcome a deadlock in relations between states pursuing conflicting ideological and/or economic aims.'

D.J. HARRIS, CASES AND MATERIALS ON INTERNATIONAL LAW 65 (5th ed., Sweet & Maxwell 1998) (internal citation omitted).


tance in social matters. While the ASEAN goal was rather ambivalent, the promotion of public health was still an aspect of social progress they envisaged working towards.\footnote{332} The Bangkok Declaration was clarified by the ASEAN heads of state in 1976 when they declared that one of the primary concerns of ASEAN cooperation would be the elimination of disease.\footnote{333} The clarification was important even though its social plan of action failed to mention public health cooperation.\footnote{334} Emerging trends suggest that ASEAN is expanding its scope of cooperative activities beyond economic and political matters to encompass public health issues. The increasing public health threat of AIDS, the persistence of malaria, and the rising burden of lifestyle diseases, such as tobacco-related diseases will inevitably make the promotion of public health an important issue for the ASEAN to address. In 1992, the ASEAN member states signed agreements that created important legal frameworks for health activities undertaken by ASEAN members. For instance, the Agreement on the Common Effective Preferential Tariff Scheme for the ASEAN Free Trade Area has rules on health protection, sanitation, and phytosanitary measures.\footnote{335} The Agreement authorizes a member state to take action and adopt measures which it considers necessary for the protection of human health.\footnote{336} Similarly, the Framework Agreement on Enhancing ASEAN Economic Cooperation authorizes any member state to take action and adopt measures which it considers necessary for the protection of human health.\footnote{337} Products that fall under this

\footnote{332. See Treaty of Amity and Cooperation in Southeast Asia art. 4, (Feb. 27, 1976), available at http://www.aseansec.org/1217.htm ("The High Contracting Parties shall promote active cooperation in the economic, social, technical, scientific and administrative fields as well as in matters of common ideals and aspirations of international peace and stability in the region and all other matters of common interest.").}

\footnote{333. The Preamble to the Declaration of ASEAN Concord listed eight primary objectives and principles to enhance Asian cooperation in economic, social, cultural and political fields, which included the elimination of disease, poverty and hunger. Unfortunately, the body of the Declaration did not elaborate on these objectives. See Declaration of ASEAN Concord, supra note 326.}

\footnote{334. Id.}

\footnote{335. Agreement on CEPT, supra note 322.}

\footnote{336. Id. art. 9.}

\footnote{337. The Framework Agreement on Enhancing ASEAN Economic Cooperation provides a legal framework for cooperation among ASEAN member states in, among other areas, trade, industry, minerals and energy, finance and banking, food, agriculture and forestry, and transportation and communications. See Framework Agreement on Enhancing ASEAN Economic Cooperation art. 12, Jan. 28, 1992, 31
classification are placed in the general exception list and are not subject to the ASEAN tariff reduction scheme. This list includes products like guns, ammunitions, and narcotic drugs. The exception list has been extended to restrict some food products as well. Unfortunately, ASEAN has not included harmful trade goods like tobacco products on the exception list. Still, and importantly, almost all ASEAN member states with the exception of Thailand, Philippines, and Myanmar have placed alcoholic beverages on the exception list, and accordingly, alcohol is not the subject of the ASEAN tariff reduction and free trade scheme. The exclusion of alcohol from the ASEAN tariff reduction scheme by some member states can help to reduce alcohol consumption and promote good health in those countries.

In the 1992 Singapore Declaration, ASEAN agreed that it would make a coordinated effort to curb the spread of AIDS by exchanging information on AIDS, in addition to formulating and implementing policies and programs designed to address the problem. This was indeed an early display of political commitment on the part of ASEAN to fight AIDS. The Bangkok Summit Declaration of 1995 calls on ASEAN members to raise functional cooperation to a higher plane. The Declaration specifically calls on members to engage in economic cooperative activities, initiate new areas of cooperation, and promote closer cooperation in the international fields. ASEAN agreed to enhance functional regional cooperation to strengthen the collective regional response to the problems and challenges posed by HIV/AIDS, including the mobilization of resources to support pooling of their own resources, and sharing of human, financial, and technical resources among themselves.

I.L.M. 506, 512. Health is not included as an area for cooperation in the Framework Agreement, but rather as a general exception. Id. Thus, Article 12 of the agreement, which reflects the language of Article XX(b) of GATT, states that "[n]othing in this Agreement shall prevent any Member State from taking action and adopting measures which it considers necessary for the protection of... human, animal or plant life and health." Id; see also GATT, supra note 4, art. XX(b).

338. The list of products that each country has leeway to exclude from the tariff reduction scheme is available on the website of the US-ASEAN Business Council, available at http://www.us-asean.org/aftatariffs.asp (last visited Sept. 26, 2005).


341. Bangkok Declaration, supra note 329, at 1067.

342. Id. at 1068.
implementation of important public health activities. The ASEAN member states also agreed to enhance regional cooperation on initiatives promoting the survival, protection, and development of children.

1. ASEAN Dispute Settlement Mechanisms and Public Health

The ASEAN Protocol on Enhanced Dispute Settlement Mechanism was adopted by the ASEAN heads of state on November 29, 2004 in Vientiane, LAO PDR. The Protocol entered into force upon the receipt of ratification instruments from all ASEAN member states. The Protocol creates an enforcement mechanism to promote health within the ASEAN region. Any dispute with health implications between ASEAN member states could potentially be brought within the ambit of the protocol's dispute settlement mechanism. The Protocol establishes panels that deliberate and make recommendations on all disputes to the group of Senior Economic Officials. The ASEAN Economic Ministers (AEM) hear and dispose of appeals.

a. Jurisdiction

The Protocol establishes subjects that will be covered by its rules and also designates the parties that can invoke the dispute settlement process pursuant to the Protocol. The Protocol's rules of procedure apply to disputes brought pursuant to the consultation and dispute settlement provisions of various ASEAN agreements. Under the Protocol, member states are required to "accord adequate opportunity for consultations regarding any representations made by other member states with

343. Id. at 1071.
344. Id.
346. Id. art. 1(3).
347. Id. art. 12(1).
348. Specifically, Article 1 of the ASEAN Protocol discusses its coverage and application. It provides that "[t]he rules and procedures of this Protocol shall apply to disputes brought pursuant to the consultation and dispute settlement provisions of the Agreement as well as the agreements listed in Appendix I and future ASEAN economic agreements (the 'covered agreements')." Appendix I of the ASEAN Protocol lists a total of 46 covered agreements. See ASEAN Protocol, supra note 345, art. 1.
respect to any matter affecting the implementation, interpretation, or application of the Agreement or any covered agreement. When member states believe direct or indirect benefits they are entitled to under regional agreements are being nullified or impaired because of another member state's actions or inaction, that member state may seek redress from the other member state involved.

The protocol's jurisdictional provision is broad enough to allow member states to bring health-related disputes under the agreement. This could mean that any health-related disputes relating to agreements listed in Annex I of the Protocol can be pursued under the Protocol. In regards to who has standing to institute a claim under the dispute settlement process, only member states are entitled to invoke the settlement body's jurisdiction. NGOs and individual citizens cannot directly lodge a claim under the protocol. The only provision that permits some degree of participation for non-members is Article 8(4), which provides that a dispute settlement panel “shall have the right to seek information and technical advice from any individual or body which it deems appropriate.” Accordingly, the WHO and other organizations or health-related NGOs could provide advice in disputes involving the protection and promotion of health. Unfortunately, the Panel retains a high level of discretion over whether or not to solicit the aid of such bodies. Furthermore, member states may resort to other forums to resolve disputes with other member states, but only before the Senior Economic Officials meeting has made a ruling on the Panel report.

b. Procedures

Before members may invoke the dispute resolution mechanism, the protocol provides for a period of consultation between member states that includes good offices, conciliation, or

349. Id. art. 3(1).
350. Id. art. 3(2).
351. Id. art. 1.
352. Id. art. 8(4).
353. Id. art. 1(3).
354. See e.g., B.G. Ramcharan, The Good Offices of the United Nations Secretary-General in the Field of Human Rights, 76 AM. J. INT'L L. 130, 132 (1982) (suggesting that as a method for furthering peaceful solutions to international disputes, the good offices of the Secretary-General have been defined as “the informal contacts and friendly suggestions made as far as circumstances allow by the Secretary-General, which are designed to facilitate the settlement of a dispute between two or several of the Organization's Member States.”).
mediation. If consultations fail to settle a dispute sixty days after the receipt of the request for consultations, the dispute is then handled by the Senior Economic Officials Meeting (SEOM). The SEOM is required to establish a panel and address agreements cited by parties to the dispute. The panel then makes its findings and reports to the SEOM. After receiving the report, the SEOM considers the panel's report and makes a ruling. Member states who are parties to the dispute may appeal the SEOM ruling to the ASEAN Economic Ministers within thirty days of the decision.

There are several procedural and substantive issues that may arise concerning health-related disputes. First, health-related disputes will be conclusively settled by the SEOM. While health protection may not always be in harmony with ASEAN economic interests, health promotion has become a key issue for ASEAN, especially in light of the emerging and re-emerging infectious disease pandemics in the region. In the future, it will be beneficial if health experts provide direct input into SEOM dispute settlement deliberations. Requesting amicus curiae briefs from health experts is an issue that ASEAN may need to consider in its efforts to integrate public health within the ASEAN regime. Second, ASEAN's proceedings are strictly confidential and non-transparent in health-dispute cases. This undermines access to information and public participation in the Dispute Settlement Mechanism. Positively, the new 2004 Dispute Settlement Mechanism (DSM) may curb some of the non-transparency and confidentiality issues of the old system by enabling NGOs and international organizations to submit amicus curiae briefs to the dispute settlement panels at the panel's discretion.

Other challenges relating to the DSM include determining whether the new system has jurisdiction over potential health-related disputes between a party to an ASEAN agreement and a non-party member state of ASEAN. Does the DSM have jurisdiction over disputes arising within the ASEAN context but involving non-member dialogue partners such as Japan and China? Moreover, how will the presence of an ASEAN DSM influence the way in which member states utilize other mech-

355. ASEAN Protocol, supra note 345, art. 4(1).
356. Id. art. 5(2), 6(2).
357. Id. art. 5(2), 9(1).
358. Id. art. 13(2).
359. Id. art. 8(4).
anisms on matters of health, such as the WTO dispute settlement mechanism?

c. Remedies

ASEAN member states are obligated to comply promptly with decisions of the SEOM or ASEAN Economic Ministers. Member states are also required to provide the SEOM or the AEM with a status report detailing their progress in implementing the ruling or decision. If a member fails to comply with the SEOM's or AEM's decisions within a reasonable time, member states must enter into negotiations in the interest of agreeing on acceptable compensation. If no satisfactory compensation is agreed upon, then any party can request the AEM to suspend the member state's application of concessions or other obligations under the Agreement. The ASEAN process for granting remedies is detailed and lengthy. Enormous harm can be done to a member state if the process for granting a remedy is lengthy. Such remedies will apply to disputes concerning health matters. The ASEAN Secretariat provides panels with secretariat support. The ASEAN Secretariat has the responsibility of monitoring the implementation of the SEOM's ruling and AEM's decision. The Secretariat also facilitates conciliation or mediation with a view to assisting member states to settle a dispute.

2. Other Health Policy Initiatives

In Kuala Lumpur in 1997, the ASEAN Vision 2000 was adopted by ASEAN Heads of State. Importantly, the Vision advanced its notion of caring societies, focusing on eradicating poverty, hunger, malnutrition, ensuring environmental protection, and addressing drug trafficking and other transnational

360. Article 15 provides the following for parties to the dispute:

... shall comply with the findings and recommendations of panel reports adopted by the SEOM within sixty (60) days from the SEOM's adoption of the same, or in the event of an appeal sixty (60) days from the SEOM's adoption of the findings and recommendations of the Appellate Body reports, unless the parties to the dispute agree on a longer time period.

Id. art. 15(1).

361. Id. art. 16(1).

362. See e.g., id. art. 8–11.

363. Id. art. 15(6).
GLOBALISM, REGIONALISM, OR BOTH

Unfortunately, health cooperation within ASEAN was not mentioned. Also in 1997, ASEAN signed a five-year agreement to collaborate with the WHO on the control and prevention of many of the key global public health threats. A number of major diseases were highlighted for action by WHO and ASEAN.365

In Hanoi in 1998, the ASEAN heads of state adopted the Hanoi Declaration of 1998.366 In the Declaration, ASEAN member states agreed to provide their peoples with medical care and access to essential medicines.367 The heads of state agreed to increase cooperation regarding the control and prevention of communicable diseases, including AIDS. The Hanoi Declaration is an important commitment on behalf of the ASEAN. Furthermore, in passing the Hanoi Plan of Action, ASEAN agreed to implement an ASEAN Plan of Action for Children,368 providing a framework designed to ensure the survival, protection, and development of children. Additionally, the Plan of Action will be designed to strengthen the ASEAN Regional AIDS Information and Reference Network.

In April 2000 at Yogyakarta in Indonesia, the ASEAN Health Ministers’ Declaration on the Healthy ASEAN 2020 encouraged wide ranging health cooperation among ASEAN member nations.369 The Declaration recalled the ASEAN Vision 2020 and the Hanoi Declaration, recognizing the rise of communicable diseases, noncommunicable diseases, and the need to prepare the ASEAN health sector to meet the challenges and take advantage of the opportunities arising from globalization and trade liberalization. The Declaration also declared that the advancement of public health shall be at the center of development in ASEAN by 2020.370 The Declaration also emphasized health as a fundamental right of peoples and that ASEAN health policy shall strive to achieve justice and equity in health development with a strategic focus on health promotion and disease prevention. Its mission is to strengthen and intensify ASEAN cooperation over public health issues and to ensure that public health concerns are factored into ASEAN development.

364. ASEAN Vision, supra note 328.
365. WHO & ASEAN, supra note 142.
366. Bangkok Declaration, supra note 329.
367. Id. ¶ 24.
369. Health Minister Meeting, supra note 327.
370. Id. ¶ 9.
efforts and the larger scheme of regional cooperation. The Declaration's plan of action included an agreement to take steps to institute tobacco control, disease surveillance, activities for malaria control, and the ASEAN program on HIV/AIDS prevention. The plan also addressed the impact of trade liberalization on the ASEAN health sector, especially the impact relating to international trade agreements such as TRIPS. The Declaration also established a health unit at ASEAN and pledged to strengthen cooperation with WHO, UNAIDS, UNDP, NGOs, and the private sector. Finally, a framework for progress relating to AIDS prevention was established.

On November 5, 2001 in Bandar Seri Begawan, Brunei Darussalam, the ASEAN heads of state adopted the ASEAN Summit Declaration on HIV/AIDS. The Summit Declaration recalled the UN Declaration of Commitment on HIV/AIDS that secured a global commitment to enhance coordination and intensification of national, regional, and international efforts to combat HIV/AIDS. The Declaration stated that 1.6 million people are living with HIV/AIDS in the ASEAN region, a number rising due to high-risk behavior exacerbated by economic, social, political, financial, legal, and cultural obstacles.

The Agreement also urged the ASEAN heads of state to lead and guide the regional response to the HIV/AIDS epidemic, making the advancement of public health a national priority and integrating HIV/AIDS prevention, care, and treatment in the mainstream development planning, including poverty eradication strategies, of ASEAN nations. The Agreement also called for the creation of a positive environment to confront stigma,

371. A key program of action was to address the impact of globalization and trade liberalization on the health sector. Id. The program sought to harmonize product registration requirements and standards for health products, work toward gradual harmonization of standards and regulations for health services, and to develop strategies to strengthen ASEAN's capacity and competitiveness on health-related products and health services. Id. It also included strengthening collaboration on health research and development with a focus on pharmaceuticals, including traditional medicines, biomedical products and vaccines, formulating an ASEAN Food Safety Policy and an ASEAN Framework on Food Safety, collaborating more closely with policy makers in the trade sector, and intensifying the development of human resources for health in the area of globalization and trade liberalization. Id. ¶ 4.


373. Id. ¶ 5.
eliminate discrimination, support vulnerable groups, and to strengthen health, educational, and legal capacities to tackle AIDS. It called for multisectoral collaboration to confront the regional AIDS problem. Still further, the Agreement called for joint regional collaboration in activities that support national programs for prevention, care, and treatment of HIV/AIDS including resources to support joint regional activities.

Finally, the ASEAN heads of state urged ASEAN dialogue partners, the UN system organizations, donor agencies, and other international organizations to take greater action towards the advancement of public health. The Declaration also urged full international participation in the development and implementation of the actions contained in the Declaration. The group agreed to support the establishment of the Global HIV/AIDS and health fund to ensure that countries in the region would have equal access to the fund. This Declaration was replicated in the 2004 7th ASEAN Health Ministers meeting on Health Without Frontiers, in Penang, Malaysia. The 2004 Declaration stressed the need to accelerate work assessing the public health impact of globalization and international trade agreements such as the GATS and TRIPS. The ASEAN Framework Agreement on Intellectual Property Cooperation was signed in Bangkok on December 15, 1995.374

The Penang Declaration also noted that because diseases now spread across borders, any serious efforts to improve the state of public health must involve regional cooperation. The ASEAN heads of state agreed to enhance collaboration with the WHO and the wider UN in achieving the Millennium Development Goals and strengthening national infrastructure to counter

374. Framework Agreement, supra note 324, at 1074. The Framework Agreement provides:

Member States shall recognise and respect the protection and enforcement of intellectual property rights in each Member State and the adoption of measures necessary for the protection of public health and nutrition and the promotion of the public interests in sectors of vital importance to the Member State's socio economic and technological development, which are consistent with their international obligations.

Id. Like the Agreement on TRIPS, the ASEAN intellectual property regime provides for an exception to the implementation of intellectual property rules in cases of public health emergencies. With the adoption of the Doha Declaration on the TRIPS and Public Health by the WTO, which has strengthened public health exception measures under the TRIPS, ASEAN Member States such as Malaysia have supported the general developing country position of the importance of implementing fully the flexibilities concerning patents and public health protection enshrined in the Declaration on HIV/AIDS.
disease pandemics such as HIV, SARS, tuberculosis, malaria, and dengue fever.

The rapid outbreak of SARS prompted the ASEAN region to cooperate on public health issues more than ever before. With the outbreak of avian flu in South East Asia, ASEAN has initiated cooperation to control the flu. The ASEAN Secretariat, with the assistance of the WHO, prepared a five-year plan on healthy ASEAN lifestyles adopted by the Health Ministers. An ASEAN workshop in Myanmar focused on the development of a regional protocol and epidemiological assessment of the needs and resources of elderly people. It also focused on the development of regional strategies for planning, implementing, monitoring, and evaluating of community based health care services for the elderly. The ASEAN working group on Technical Cooperation in Pharmaceuticals exchanges information on drug safety and medicinal access. ASEAN and WHO have also agreed to extend their Memorandum of Understanding (MOU) five years beyond April 2002.

The numerous ASEAN declarations on public health make clear that ASEAN has broadened its policy scope beyond trade and economic development to health, rural poverty, illiteracy, fighting transnational crime, and environmental protection. Because of ASEAN's widening mandate, Asia's public health crises should trigger the application of ASEAN laws and policies to promote public health. Unfortunately, the impetus of trade liberalization and the quest for trade and economic development

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375. See LINDA LOW, ASEAN ECONOMIC CO-OPERATION AND CHALLENGES 42 (2004). See Jacques deLisle, Atypical Pneumonia and Ambivalent Law and Politics: SARS and Response to SARS in China, 77 TEMP. L. REV. 193 (stating that, as a response to the SARS outbreak, Chinese officials called for increased international cooperation within Asian states and with the WHO during the ASEAN+3 Meeting on SARS and in presentations to APEC's Health Ministers in June 2003); see also Nusa Dua, ASEAN Strengthens Cooperation Against SARS, ASIAN ECONOMIC NEWS, Oct. 14, 2003, available at http://www.findarticles.com/p/articles/mi_m0WDi/is_-2003_Oct_14/ai_108877870/print.

376. See Jane Parry, South East Asia Sets Up Task Force to Tackle Avian Flu, 329 BRIT. MED. J. 876, 876-c (2004) (reporting that the Agricultural Ministers of the ten member states of ASEAN had agreed to set up a task force to fight the spread of avian flu due to the outbreak that killed people in Thailand and Indonesia).

377. See e.g., Shah Ebrahim, South East Asia Confronts Its Rapidly Aging Population, 315 BRIT. MED. J. 1035 (1997) (reporting that Southeast Asia is facing the problems of a rapidly aging population more quickly than other areas of the world. As a result, ASEAN has established a program to tackle the needs of the growing elderly population).

378. See WHO & ASEAN, supra note 142 (providing a list of diseases for action by ASEAN and the WHO).
continues to slow progress for public health promotion within the ASEAN. Despite the common view that human rights are less visible on the agenda of the ASEAN, many ASEAN instruments include a human rights strategy for public health promotion, stating that health is a fundamental right and emphasizing the application of the UN Convention on the Rights of the Child and the UN Convention on the Elimination of Discrimination against Women. Still, it is undeniable that regional security and cooperative measures for promoting trade and economic development have been the overriding goals of ASEAN. “By insisting on a strict separation between human rights policy and trade issues, ASEAN has marginalized human rights.”

The ASEAN institutional framework provides for a regular assembly of health ministers from member countries. The Assembly serves as an important platform to discuss health matters within the region. There is also an ASEAN Subcommittee on Health and Nutrition whose mandate is to enhance public health within ASEAN. Additionally, there have also been calls to establish a permanent health unit within the ASEAN Secretariat. Whether ASEAN’s multiple soft law instruments will increase public health resources and make the advancement of public health a higher priority within ASEAN is yet to be seen. Nevertheless, ASEAN’s health-related declarations show that opportunities for public health promotion exist within the region.

E. THE CARIBBEAN COMMUNITY:

The Caribbean Community (CARICOM) was established by the Treaty of Chaguaramas in 1973. CARICOM was established to foster greater economic integration among Caribbean States, particularly the commonwealth Caribbean. The objectives of CARICOM are to foster sustainable economic development in member states, encourage cooperation in foreign relations, and facilitate functional cooperation in the provision of regional services. To carry out these objectives, CARICOM

379. See e.g., Li-Ann Thio, Implementing Human Rights in the ASEAN Countries: “Promises to Keep and Miles to Go Before I Sleep,” 2 YALE H.R. & DEV. L.J. 1 (1999).
380. Id.
382. Id. at 1.
established a Conference of Heads of Government. While the objectives of CARICOM are economic in nature, social policy goals also fall within the scope of the Treaty. Thus, an objective of the Community is to promote functional cooperation on the advancement of economic and social development and to encourage intensified promotion of public health and education. While the Treaty establishes the Conference of Heads of Government and a Community Council of Ministers as the principal institutional organs of the regional organization, the Treaty also establishes the Council for Human and Social Development which specifically deals with health matters. The Council is empowered to promote a number of social objectives including the improvement of public health, the development and organization of efficient and affordable health care services in the Community, and the promotion of environmental improvement programs. However, the role of this Council is constrained by the decisions of the Conference of Heads of Government. The Treaty also establishes health-related institutions of the Community that include the Caribbean Environmental Health Institute and a Food and Nutrition Institute. While the Treaty has generally focused on trade integration within the region, CARICOM has continually encouraged regional cooperation on matters such as health, education, and foreign policy. CARICOM has also provided a basis for health cooperation directly or under the framework of the Caribbean Environmental Health Institute. The Agreement establishing

383. Id. at 3.
386. Id. at 8.
387. Id. at 12–13.
388. Id. at 14–15.
390. See Agreement Establishing the Caribbean Environmental Health Institute, art. 3 (July 10, 1980), available at http://www.caricom.org/jsp/community/
the Caribbean Environmental Health Institute aims to provide member states with technical assistance, promote quality public health standards within the region, and develop strategies in the area of environmental health. At a direct level, CARICOM has entered into cooperative agreements with the Pan American Health Organization (PAHO), a regional office of the WHO for the Americas. The Agreement recognizes PAHO's role as the region's lead public health organization but also stressed that CARICOM is well placed to support health advocacy, policy formulation, harmonization of laws, and resource mobilization. The Agreement also recognized the need for joint operations between PAHO and CARICOM and a greater exchange of information between both parties on health matters.

The Caribbean Civil Society is another organization that has the potential to shape the development of health policy within CARICOM. The Charter of Civil Society Resolution was adopted by the Conference of Heads of Government of the Caribbean Community in 1997. The Conference of Heads of Government of the Caribbean Community resolved to pay due regard to the principles by which CARICOM member states commit themselves to respect and strengthen the fundamental elements of a civil society. The Charter of Civil Society for the Caribbean Community defined its scope of actors broadly to include the "Government of a State, Associations of Employers, Workers Organizations and such Non-Governmental Organizations as the State may recognize." Under the Charter, CARICOM states are required to do their best to provide a health care system that is sufficient to deal with all potential health challenges including serious and widespread epidemics. States are also required to develop health care systems that are "well administered, adequately equipped and accessible to all without discrimination." Key tenets of the Charter include provisions for the protection of children and women's health,
health rights, and occupational safety.\textsuperscript{398} The civil society has become a key element in shaping global health laws and policies, and a number of Caribbean NGOs have been active in health advocacy.\textsuperscript{399}

Despite these laudable initiatives, it is important to note that CARICOM's institutions have not evolved beyond state control; decisions of the Conference of Heads of Government, the Council, and Ministerial Committees are made on a unanimous basis. Each government is then responsible for implementing those decisions, in keeping with national constitutional, legal, and administrative requirements.\textsuperscript{400} Furthermore, CARICOM's integration has focused primarily on regional organization to promote regional development, largely through trade and investment facilitation by coordinating issues such as transportation matters and migration, concerns recognized as a CARICOM goal in Article 45 of the revised Treaty of Chaguaramas. Moreover, the establishment of the Caribbean Court of Justice is a positive development that, like the European Community Courts, will offer a new opportunity for social progress on policy matters such as health protection within the CARICOM.

\textsuperscript{398} Id. art. XII, XIII.
\textsuperscript{399} For example, NGOs from the CARICOM member states are members of a global alliance of NGOs called the Framework Convention Alliance (FCA). See The Framework Convention Alliance for Tobacco Control, http://www.fctc.org/members/index.php (last visited Sept. 29, 2005). These NGOs include the Heart Foundation of Barbados, Jamaica Coalition for Tobacco Control, St Lucia Cancer Society, Coalition for Tobacco-Free Trinidad and Tobago. Id. The FCA describes itself as a heterogeneous alliance of approximately 200 non-governmental organizations representing about eighty countries around the world who are working jointly and separately to support the development, signing, and ratification of an effective Framework Convention on Tobacco Control (FCTC) and related protocols. Id. The Alliance includes individual NGOs and organizations working at the local or national levels as well as existing coalitions and alliances working at national, regional, and international levels. Id. The FCA was formed out of the need for improved communication among groups already engaged in work around the FCTC process and the need for a more systematic outreach to NGOs not yet engaged in the process, particularly in developing countries that could both benefit from, and contribute to the creation of an effective FCTC. Id.

\textsuperscript{400} Adelle Blackett, Toward Social Regionalism in the Americas, 23 COMP. LAB. L. & POLY J. 901, 934 (2002) (stating that the shared history and broad cultural influences that characterize the inhabitants of the Caribbean Community facilitate this common approach and a common development of social policy initiatives within the regional framework).
1. The Caribbean Court of Justice

The Caribbean Court of Justice, based in Port of Spain, Trinidad and Tobago, was inaugurated in April 2005 and has the potential to contribute to the codification and progressive development of international health law. The design and jurisdiction of the court make it unique. The court is endowed with both original and appellate jurisdiction. In the exercise of the court's broad original jurisdiction, the court is authorized to hear and deliver judgments on disputes between parties to the Agreement, between parties to the Agreement and the Community, referrals from national courts or tribunals of contracting parties, advisory opinions requested by parties to the Agreement of the Community, and even applications by nationals concerning the interpretation and application of the Treaty. Therefore, the court is an international court that will apply rules of international law on matters of health. One innovative provision in the Agreement grants locus standi in the court to private entities upon special leave of the court. In this way, like the European Court of Justice, this court will not merely be commercial in nature, but will also dispense decisions with far ranging social implications. Additionally, it is likely that health-related Agreements of the Community will be interpreted by the Caribbean Court of Justice.

As a sui generis entity, the court is endowed with appellate jurisdiction, as a superior court of record, with rights of appeal in civil proceedings in disputes of value of over EC$ 25,000. Final proceedings in any civil or other proceedings which involve a question as to the interpretation of the constitution of the contracting party, including redress for breach of fundamental rights conferred in those constitutions, and such other cases as may be prescribed by any law of the contracting party. In this way, the court is the court of final resort and has effectively replaced the Judicial Committee of Her Majesty's Privy Council in England. By applying constitutional, statutory, and common law, among other forms of law, the tribunal will almost certainly be interpreting matters involving the

401. Agreement Establishing the Caribbean Court of Justice at 12 (2001), available at http://www.caricom.org/jsp/archives/agreement-ccj.pdf (Article XVII(1) provides that the Court, in exercising its original jurisdiction, "shall apply such rules of international law as may be applicable.").
402. Id. art. III.
403. Id. art. IX.
404. Id. art. XXV.
advancement of public health. Moreover, a number of the constitutions of Caribbean states expressly provide for the protection of health. Finally, by permitting the appearance of natural and legal persons before the court, under its original and appellate jurisdictions, the court has the potential to provide broad access to the Caribbean civil society. Individuals and NGOs alike could make health-related claims against governments and public or private entities in order to enforce and implement health obligations derived from municipal and international law applicable to the contracting parties.

CONCLUSION

Developing countries need to prioritize public health programs if the current tide of disease epidemics is going to be reversed. One way forward is for developing countries to fully participate in international cooperative efforts to promote public health. The development of public health laws at the global, regional, and national levels is crucial if the burden of disease epidemics in the developing world is to be counteracted. It is important that developing countries actively participate in international law and policy making to promote the public health of their people. However, the way forward for developing countries is to work to ensure that the new regionalism in which they participate fully meets the health goals of member states.

It will be important for governments, as the principal actors in regional integration, to initiate, support, and promote public health and ensure an evidence-based health policy framework in any activities of those organizations. Secondly, the regional legal and governance mechanisms, as well as institutional units of the regional integration organizations, will need to enhance their capacity on matters of health policy. The regional parliaments, the courts, the commissions, and assemblies of health ministers will need to undertake capacity-building activities to further promote scientific evidence-based health policy within the regional frame-

405. See, e.g., Republic of Suriname 1987 Constitution with Reforms of 1992 art. 36, available at http://www.georgetown.edu/pdba/Constitutions/Suriname/english.html (Article 36 provides that “[e]veryone shall have a right to health” and “[t]he State shall promote the general health care by systematic improvement of living and working conditions and shall give information on the protection of health.”).

works. Regional institutions need to enhance their decision making processes, clarify health policy objectives, be able to reconcile national, regional and international scientific evidence-based health policies, and strengthen secretariat viewpoints. The importance of collaboration with the World Health Organization and other global and regional health actors is also crucial to accessing skills, knowledge, and expertise in order to promote health policy within regional legal and governance mechanisms. Additionally, non-state actors committed to the causes of health should be encouraged to participate within the regional mechanisms by being granted access to the courts and the right to advocate before the regional bodies in order to promote health.

Finally, the political commitment of member states and the mobilization of internal financial and technical resources are key aspects of any meaningful contribution to health promotion in the developing world. Despite the existing challenges within regional integration organizations, the potential for the enhancement of technical and financial cooperation, for an increased exchange of information, and for the development of regional health jurisprudence responsive to health needs of developing countries, makes the newfound reliance on regional institutions to promote public health promising. Importantly, the improvement of public health within developing countries will only be realized if the new regionalism in developing countries fully integrates health and other social issues within their core economic integration agendas. Law is an instrument of social change. Accordingly, the increasing global public health threats facing the developing world and lack of clarity on health policy should spur the continued evolution of regional legal regimes to promote public health in the 21st century.

408. Id. at 173.