International Public Health Law: From Collaborative Service Delivery Initiatives to a Rights Discourse

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1. Introduction

In public health the shift from national to global governance began in the mid-19th century, when international health diplomacy emerged because of concern about infectious diseases. During the next 100 years this facet of diplomacy expanded as states, international organizations, and non-state actors tackled global threats to public health through international law and institutions.

This article provides an overview of the beginning and development of international initiatives on health service delivery and its gradual development as a rights discourse. It examines the historical origins of the field and the factors contributing to its contemporary evolution. In addition, this article briefly reviews the nature and the significance of international law on health as an aspect of 'service' *vis a vis* 'rights' and the contribution of international organizations to the gradual codification of international law on health rights. This article argues that international collaboration and concern for health, which began as service delivery initiatives by member states, ultimately led to establishing a rights discourse under the United Nations regime.

2. The Beginning of International Health Diplomacy

International Health diplomacy began in 1851, when European states gathered in Paris for the first International Sanitary Conference[1] to discuss cooperation on cholera, plague and yellow fever.[2] Four quasi-international bodies were already in existence at the time of the Paris Conference of 1851. These were the *Conseil sanitaire de* Teheran, the *Conseil sanitaire maritime et quarantenaire d'Egypte*[3] and

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1 Attended by diplomatic and medical representatives of twelve countries.

2 See, Howard-Jones N., *The Scientific Background of the Sanitary Conferences, 1851-1938*, Geneva, WHO, 1975.

3 The *Conseil sanitaire maritime et quarantenaire d'Egypte*, usually known as the Egyptian Quarantine Board, was the most important of these four bodies. It acted as

the *Conseil superieur de Sante de* Constantinople. Although they differed individually in certain important respects, they were on the whole similar in origin and development. All had originally been set up as local health boards, on the initiative of the rulers of Morocco, Persia, Egypt and Turkey respectively.[4] States had previously dealt with transboundary disease transmission through national quarantine policies. The development of railways and the construction of faster ships were among the technological advances that increased pressure on national quarantine systems.[5] National policies not only failed to prevent the spread of disease but also created discontent among merchants, who bore the brunt of quarantine measures and urged their governments to take international action.[6] Thus, disease control became a subject of diplomatic discussion as a result of cholera epidemics that swept through Europe in the first half of 19th century.

The cholera epidemics of 1853, 1854 and 1865 led to other conferences, in Paris in 1859, Constantinople in 1866 and Vienna in 1874. At these and subsequent conferences (Washington, 1881; Rome, 1885) the necessity for a common understanding based upon recently acquired knowledge became more evident; but it was not until 1892, at the International Sanitary Conference in Venice, that a formal International Sanitary Convention was first drawn up, resulting from the general desire to prevent the introduction of cholera into Europe from the East by way of the Suez Canal. Further international sanitary conferences followed: at Dresden in 1893, Paris in 1894 and Venice in 1897.[7] Because of high-level disagreement over what measures were needed and acceptable, the conventions and regulations that emerged from the majority of these conferences were never successfully ratified by participating governments, until the eleventh conference in Paris (1903) produced

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the regional bureau of the Office International d'Hygine Publique for epidemiological intelligence from countries of the Near East, and continued to function until it was formally abolished by the Convention of 31 October 1938, which transferred its duties to the Egyptian Government. See, WHO, "Report of the Interim Commission to the First World Health Assembly", *Official Records of the World Health Organization*, Part I, Activities, No 9, June 1948, p.19.

4 For details see, WHO, "Report of the Interim Commission to the First World Health Assembly", *Official Records of the World Health Organization*, Part I, Activities, No 9, June 1948, p.19.

5 See, generally Goodman N. M., *International Health Organisations and their Work*, Churchill Livingstone, London, 1971.

6 WHO, Filder, D. P., "The Globalization of Public Health: The First 100 Years of International Health Diplomacy", *Bulletin of the World Health Organization*, 79(9), 2001, p. 843.

7 See, WHO, Report of the Interim Commission to the First World Health Assembly, "*Official Records of the World Health Organization*", Part I, Activities, No 9, June 1948, p.19.

what Goodman describes as 'the first effective convention'.[8] The International Sanitary Convention of 1903 was in effect the consolidation of four earlier conventions[9] i.e.,: Convention on Sanitary Measures to Regulate Westbound Shipping through Suez Canal, 1892; Convention on Notification of Epidemic Disease, 1893; Convention on Hygiene Measures for Pilgrim Ships, 1894; and Convention on Obligatory Notification of Plague, 1897.

3. Early Organizations on Health Cooperation (prior to the League of Nations)

International health cooperation which began with the first International Sanitary Conference in Paris in 1851, ultimately led to establishing two separate organizations one located in America and the other in Europe. These are: the Pan American (originally international) Sanitary Bureau and the Office International d'Hygine Publique. The paragraphs below, briefly documents these early initiatives prior to coming into existence of the Health Organization of the League of Nations which is considered to be the first global organization to take control and be concerned with the issue of health.[10]

3.1 Pan American (originally international)[11] Sanitary Bureau

The first health agency to function over a wide area and on behalf of many governments was the Pan American Sanitary Bureau established in 1902. The Bureau was formally organized by the first Pan American Sanitary Conference, Washington, 1902, following a decision of the second International Conference of American States, Mexico City, 1902. The Bureau acted as the executive organ of the Pan American Sanitary Conferences. The Pan American Sanitary Bureau undertook the collection and dissemination of epidemiological information soon after its establishment, and in 1927 it became a "regional bureau" of the Office International d'Hygiene Publique under the provisions of the International Sanitary Convention of 1926.

With its headquarters in Washington, the Bureau formed the central coordinating sanitary agency and collected and distributed epidemiological information for all countries adhering to it. In addition to epidemiological information, some of the

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8 Goodman, N. M., *International health Organizations and Their Work* (2nd edition), Churchill Livingston, Edinburgh, 1971, p. 23.

9 The Constitution of an international Committee to consolidate the existing four Conventions was unanimously agreed in the 1897 Conference.

10 See generally, Fielder, D.P., "From International Sanitary Conventions to Global Health Security: The New International Health regulations", *Chinese Journal of International Law*, 2005, pp.4-9.

11 The Bureau was originally known as 'International' instead of Pan American'. The names were changed as a result of establishment of the Office International d'Hygine Publique in 1907.

principal duties of the Bureau were the prevention of the introduction of infectious diseases into the American republics, and from one republic to another, the restriction of quarantine measures to the minimum compatible with the prevention of disease, improvement of national health-administrations, and the promotion of liaison between the different national health-services. It has also acted as a convenient agency to which the American republics could turn for advice or assistance in combating epidemics, in reorganizing public-health services, in formulating sanitary codes, and in many other fields of hygiene and sanitation.

3.2 Office International d'Hygine Publique

Proposals for the establishment of a permanent international health office had been discussed at earlier sanitary conferences, but it was not until 1903 at the international sanitary conference in Paris that a resolution for the creation of it was passed. The proposal took definite shape at the Rome Conference of 1907 and the Office International d'Hygine Publique (OIPH) was formally established by the Rome Agreement of 9 December 1907.[12]

At its inception, the OIPH was predominantly European, the United States of America being only exception among twelve signatories at Rome. Ultimately, however, nearly sixty countries including British India joined, to give the Office a more truly international character. Its principle object as laid down by article 4 of its statute was: "to collect and bring to the knowledge of participating states facts and documents of a general character which relate to public health, especially as regards infectious diseases, notably cholera, plague, yellow fever, small pox and epidemic typhus, as well as the measures taken to combat them". Article 10 among others, provided for the publication of a monthly bulletin to contain: (a) laws and general or local regulations promulgated in the various countries respecting transmissible diseases (b) information concerning the spread of infectious diseases (c) information concerning works executed or measures undertaken for improving the health localities and (d) statistics dealing with public health.

The main concern of OIHP was the enforcement and periodical revision of the international sanitary conventions. Two principal conventions were administered, the Sanitary Convention of 1926 and the International Sanitary Convention for Navigation of 1933. The first required adhering governments to notify the appearances within their territories of the pestilential diseases - plague, cholera, smallpox, yellow fever and typhus - and dealt with the quarantine and other

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[12] See, WHO, "Report of the Interim Commission to the First World Health Assembly", *Official Records of the World Health Organization*, Part I, Activities, No 9, June 1948, p.20.

provisions to be observed, so far as land and sea transport was concerned, on their appearance and the measures to be adopted to prevent their spread.

4. The League of Nations and its Endeavour on Health

The League of Nations was established in the aftermath of First World war. The Covenant of the League of Nations contained in it, the charter of a Health Organization under it, as article 23 provided that State Members of the League "will endeavour to take steps in matters of international concern for prevention and control of disease".[13] During the first World War, many of the functions of OIHP were in abeyance. It possessed neither the machinery, the staff nor the funds to permit rapid action required by an emergency. Thus, the immediate post-war years saw an attempt to establish an international health organization with greater resources and wider scope.

The danger of epidemic typhus, which was raging in Russia and threatening to spread across Poland to the rest of Europe, stimulated immediate action. To meet the emergency, the Council of the League on 19 May 1920, authorized the establishment of a temporary Epidemic Commission. The object was to secure, if possible, a single health agency, dependent upon the League of Nations. An international conference of experts convened by the Council of the League of Nations in London in April 1920, prepared a draft constitution of a public-health agency, which was accepted with some modifications by the first Assembly of the League in December 1920. It would have placed OIHP under the direction of the League, and made all health activities dependent on a general assembly consisting of technical delegates nominated officially by their respective governments; but to become effective, it required the assent of all the governments parties to the Rome Agreement of 1907, and this unanimous assent could not be obtained, the United States in particular not being a member of the League. A Compromise was reached at a "Mixed Commission" in Paris in May 1923, composed of members of the provisional Health Committee of the League and of the *Comite* permanent of OIHP. The two organizations henceforward were to work in close co-operation, each maintaining its individuality.[14]

The Health Organization of the League of Nations showed for the first time the full value of international collaboration in medicine and public health, and much of its scientific work has been recognized as being of the highest standard. But the existence of two independent health organizations entailed, in spite of the efforts to

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13 See, the Covenant of the League of Nations.

14 See, WHO, "Report of the Interim Commission to the First World Health Assembly", *Official Records of the World Health Organization*, Part I, Activities, No 9, June 1948, p.21.

perfect collaboration, a certain amount of overlapping, and the resulting friction undoubtedly limited the development of international health work. All the international health organizations in existence in 1939, the Pan American Sanitary Organization, OIHP, and the Health Organization of the League of Nations, were bodies with advisory but without executive power, authorized only to collect and distribute technical information and statistical data, and to act as liaison organs between national health-administrations.

One may ask why it was considered necessary to set up a separate health organization as part of the League of Nations in addition to the already existing OIHP. Once again, the menace of epidemic was a cogent factor. Further, the scale and urgency of post-war health problems seemed to loom far larger than the modest resources of the OIHP.

5. Establishment of the United Nations and its Commitment on Health and Health Rights

After the end of the Second World War the United Nations (U.N.) was set up in 1945 by the Charter of the United Nations. One of the features of the UN Charter which distinguishes it from the Covenant of the League of Nations, is its concern for human rights and fundamental freedoms. There are seven specific reference in the charter of human rights and freedoms but nowhere does it catalogue or define them.[15] During the initial drafting of the U.N. Charter, however, states did not mention health, either as a goal of the organization or as a human right. In fact, original drafts do not include any mention of health. But for the belated efforts of the Brazilian and Chinese delegations to the 1945 U.N. San Francisco Conference on International Organization— jointly proposing the word "health" as a matter of study for the General Assembly,[16] finding international health cooperation to be among the purposes of ECOSOC,[17] and advocating for the establishment of an international health organization[18] — health would have received no mention in the creation of the United Nations. The Charter only commits the United Nations to promote solutions to health problems; the Charter does not declare a right to health for individuals. Nonetheless, the inclusion of the reference to seeking solutions to "international . . . health . . . problems" in the basic document of the United Nations, indicates the fundamental, deeply rooted nature of this right.

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[15] Khan, B. U., *Fifty Years of the Universal Declaration of Human Rights*, Dhaka, 1998, p.23.

[16] See, Article 13 of the United Nations Charter.

[17] See, Article 55 of the United Nations Charter.

[18] See, Article 57 of the United Nations Charter.

Notwithstanding this promise of international health cooperation in the U.N. Charter, it fell to the subsequent human rights treaties to codify a human right to health in international law. In doing so, the U.N. proclaimed its Universal Declaration of Human Rights (UDHR) on December 10, 1948, enacting through it "a common standard of achievement for all peoples and all nations". Defining a collective set of interrelated social welfare rights, the emerging U.N. framed a right to health in the UDHR by which:[19]

> Everyone has the right to *a standard of living adequate for the health and well-being*[20] of himself and of his family, including food, clothing, housing and *medical care*[21] and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

In preparing this right to a standard of living adequate for health, there was widespread agreement that a human right to health included both the fulfilment of necessary medical care and the realization of underlying determinants of health—explicitly including within it public health obligations for food and nutrition, clothing and housing, and social services. Although health as a stand-alone right was not fully developed in the declaration, it was deemed important enough to include as a specific item of the right to an adequate standard of living for every person.

6. Health in International Law and the World Health Organization

The Constitution of the World Health organization (WHO) was adopted on July 22, 1946 and entered into force on April 7, 1948 as the first specialized agency created by the United Nations. The Preamble defines health positively, as "complete physical, mental and social well-being, not merely negatively as the absence of disease or infirmity". The Preamble goes on to analyse the obligation of the nations to contribute to the health of their people. This obligation in not imposed from outside, but follows form the fundamental right of every human being, and therefore of humanity as a whole. From the fundamental right to health of every human being, the Preamble moves to the health for all peoples, observing that this is fundamental to their attainment of peace and security, and depends on the fullest cooperation of individual and states.

The Preamble of the WHO Constitution further requires the acceptance of its principles by the member states. It asserts that this is needed for cooperation among countries to promote and protect the health of not only their own people but of all peoples. The Preamble also implies WHO's obligation to advance intergovernmental cooperation and international initiatives for health of all the people whose

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19 Article 25 of the Universal Declaration of Human Rights.

20 Italics added for emphasis.

21 Italics added for emphasis.

fundamental human right and a worldwide social goal". Though this tells us little about what the right to health means, it does represent the flowering of the rights-based approach to achieving health. Although WHO has increasingly taken a rights based approach in its study, and advocacy of health projects, the great bulk of information generated by WHO and the great bulk of its pronouncements on world health reflect not so much a rights perspective as a functional, institutional approach. Consequently, WHO's pronouncements do not give much direct guidance as to the content of the right to health.

7. Health as a Rights Discourse under the United Nations Regime

The most explicit statement of the right to health is in Article 12 of the Covenant on Economic, Social and Cultural Rights, 1966. Article 12 of the Convention on Economic, Social & Cultural Rights provides in full as follows:

> 1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
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> 2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
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>   (a) the provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
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>   (b) the improvement of all aspects of environmental and industrial hygiene;
>
>   (c) the prevention, treatment and control of epidemic, endemic, occupational and other diseases;
>
>   (d) the creation of conditions which would assure to all medical service and medical attention in the event of sickness.

A textual analysis of Article 12 reveals a number of important aspects of the right to health as recognized in this, the key document, for the right to health as a human right. The first paragraph of Article 12 recites the content of the right as "the enjoyment of the highest attainable standard of physical and mental health." Aside from the nod to both physical and mental health, the term "health" is not further defined. Whatever health means, the right to it is to encompass both physical and mental attributes. The right is not to physical perfection and not to flawless mental attitudes and processes; rather it is to the "highest attainable standard" of both. This language implies several things. First, there is a standard or a range of standards which can be identified or defined. That is, there is some set of attributes which can be defined as health and one can identify and articulate that standard. Second, the standard referred to is not an ideal one; it is a practical one. We are not concerned with a Platonic ideal of health, but with an Aristotelian concept grounded in reality. This is the meaning of the term "attainable." Third, the standard to be attained is not

a minimal standard, but the "highest attainable." That is, the right encompasses not merely a right to some base, minimal level of health, which in turn encompasses a number of physical conditions conducive to health, but a right to a higher standard.

The term "attainable" must be understood in light of the general approach of the Covenant on Economic, Social and Cultural Rights ("ESC") which obligates States Parties to progressive realization of the full right to health.[28] Under Article 2 of the ESC each state agrees to "take steps . . . to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means . . .".[29] The implication is that what is to be done to comply with the duty in the United States would be different comply with the duty in the United States would be different from that in Bangladesh or Brazil because of the differences in economic and other available resources.

The second paragraph of Article 12 is unusual, but not completely unique, in the human rights treaties insofar as it specifies not the content of the right, not the general scope of the right, and not only educational steps to be taken but rather it identifies relatively specific fields of endeavour in which steps are to be taken to achieve health. The phrasing of the paragraph warrants close examination. It identifies "steps to be taken . . . to achieve the full realization of this right . . ." The use of the term "full realization" is consonant with the conception of the right as one which exists, but which cannot be immediately fully realized and as one for which the specific standard of to be achieved will change over time. The implication of the verb "to achieve" is the same.

The list which follows the introductory clause is not the right to health itself, rather it lists some of the fields in which efforts are to be made to ensure enjoyment of the right. The treaty itself makes this distinction between the rights and the intermediate "steps" to be taken to achieve the right. However, in practical application the distinction is not so clear. The right proper is to "the enjoyment of the highest attainable standard of physical and mental health." Several of the intermediate steps themselves are more in the nature of ends, reduction in stillbirth rate and improvement of the environment, while others are more direct, e.g., prevention and control of endemic diseases. The distinction is one between a status (healthy) and a process (steps to enhance ability to achieve the desired status).

Despite this distinction between the right proper and the means (list of steps), the list helps identify the obligations of the duty-holder, i.e., the state, toward the right holder, i.e., the individual. An individual cannot properly claim, "I have a right to health so make me healthy;" but that person can assert: "I have a right to health so

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[28] The International Covenant on Economic, Social and Cultural Rights, 1966, Article 2.

[29] Id.

do the things necessary to enable me to have health." Viewed from the obligation perspective, the idea is that a state cannot guarantee or provide health directly; it can only provide conditions conducive to the attainment of health.

The Covenant on Civil and Political Rights, 1966 does not include a right to health, but it does include provisions which affect the right to health such as the right to life,[30] to freedom from torture[31] to liberty and the security of the person,[32] to humane treatment of prisoners,[33] to freedom of thought, conscience and religion,[34] and to freedom "to seek, receive and impart information."[35]

The Convention on the Elimination of All Forms of Racial Discrimination, 1965, reinforces the non-discrimination principle and right of equality found in both the Convention on Economic, Social and Cultural Rights and the Convention on Civil and Political Rights. Article 5 of the Racial Discrimination convention catalogues rights in which discrimination cannot be allowed. Economic, social and cultural rights are included with a specific listing of "[t]he right to public health, medical care, social security and social services . . .".[36] Unlike in the Convention on Economic, Social and Cultural Rights, the references to the right to health in the Racial Discrimination Convention are cast in terms of services and actions rather than in terms of a right to health as such. Since the focus of the treaty is non-discrimination on the basis of race, the focus on actions related to creating health rather than the condition of health makes sense.

In addition to requiring equality, the Convention on the Elimination of All Forms of Discrimination against Women, 1979 recognizes "the right to protection of health and to safety in working conditions, including the safeguarding of the function of reproduction."[37] The convention uses a new phrase, "protection of health," instead of using the more established phrases of a "right to health" or a "right to enjoyment of health." The use of the word "protection" implies the taking of steps to create the conditions conducive to good health, or at least to avoid conditions antithetical to health. Unlike the racial discrimination treaty, this convention does not enumerate the various aspects of the right to health other than as quoted above.

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30 See, The International Covenant on Civil and Political Rights, Article 6.

31 *Id.* at Article, 7.

32 *Id.* at Article, 9.

33 *Id.* at Article, 10.

34 *Id.* at Article, 18.

35 *Id.* at Article, 19.

36 *Id.* at Article, 5.

37 The Convention on the Elimination of All Forms of Discrimination against Women, 1979, Article, 11.

This convention also reaffirms that the treatment of women may be different in some settings because of maternity.[38] This treaty makes explicit that maternity, and reproduction in general, are treated as aspects of the right to health. The treaty also provides explicitly for pregnancy and maternity care in relation to enabling women to work.[39] These provisions add some specificity to the idea of a right to health for women.[40]

The convention also adds specific content to the right of health in the guise of preventing discrimination against women in the "field of health care" by insuring not only equal access to health care services in general, but also specifically noting that family planning health care services are included in the term "health care services".[41] The second paragraph of Article 12 makes plain that parties undertake to "ensure to women appropriate services in connexion with pregnancy, confinement and post-natal period, granting free services where necessary as well as adequate nutrition during pregnancy and lactation."

8. Health Rights in Regional Human Rights Treaties

Examination of the documentary sources of the international human right of health would not be complete without reviewing the three primary regional human rights conventions: the African Charter on Human and Peoples' Rights, 1981 (Banjul Charter);[42] the American Convention on Human Rights, 1969;[43] and the two European instruments, the European Convention for the Protection of Human Rights and Fundamental Freedoms, 1950[44] and the European Social Charter, 1961.[45]

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38 Note that the Convention on Economic, Social and Cultural Rights provides specifically for prenatal, maternal and childhood health care as fields to which states should take steps to enhance health. Article, 12, 2(a).

39 The Convention on the Elimination of All Forms of Discrimination against Women, 1979, Article, 11.

40 This article does not consider the special aspects of the right to health with respect to women beyond the short summary in these paragraphs. That important refinement is left for another time.

41 The Convention on the Elimination of All Forms of Discrimination against Women, 1979, Article, 12.

42 Entered into force October 21, 1986.

43 Entered into force July 18, 1978.

44 Entered into force September,3, 1953.

45 Adopted by the Committee of Ministers of the Council of Europe on July 6, 1961.

The European Convention and its Protocols are easiest to consider they do not conclude affirmative rights,[46] such as the right to health. However, the European Social Charter does contain a "right to the protection of health".[47] The European Social Charter provides that "the High Contracting Parties undertake . . . to take appropriate measures designed inter alia . . ." to promote health through education and advice, to encourage "individual responsibility in matters of health, . . . to prevent as far as possible" epidemics and other illnesses, and "to remove as far as possible the cause of ill-health".[48] The European Charter adopted a restrictive approach of not protecting a right to health as such. Instead, it only requires the taking of "appropriate measures" for the "protection of health." The charter does not even contain a definition of health such as is found in the Covenant on Economic, Social and Cultural Rights and or in the World Health Organization. References to more than the mere absence of disease and to including both mental and physical health were explicitly rejected.[49] Nonetheless, the European Social Charter does reinforce the notion that the right to health is more than a right to medical care and includes in the fields which it touches the whole range of causes of ill health. This charter also reinforces the focus on preventive measures and education as opposed to merely responding to medical or other health problems.

In Contrast to the cautious, narrow European approach, the African Charter provides that "[e]very individual shall have the right to enjoy the best attainable state of physical and mental health".[50] This now-familiar formula deviates from the Convention on Economic, Social and Cultural Rights only in minor ways. However, the paragraph articulating steps to be taken is quite different insofar as it both establishes a more general obligation on States Parties to "take the necessary measures to protect the health of their people" and establishes a specific duty on states "to ensure that they [the state's people] receive medical attention when they are sick".[51] the African Charter thus emphasizes the centrality of medical attention

46 The single exception is the right to education in Protocol No. 1 art. 2. In addition, the European court of Human Rights has imposed affirmative duties on member states under Article 11, the freedom of association, and Article 8, the right to privacy.

47 See, the European Social Charter, Article 11. The development of this article is traced in Roscam Abbing, *International Organizations in Europe and the Right to Health Care,* 1979, pp. 77-83.

48 See, Roscam Abbing, *International Organizations in Europe and the Right to Health Care*, 1979, p.82.

49 See, The European Social Charter, Article.11.

50 The African Charter on Human and Peoples' Rights (Banjul Charter), 1981, Article, 16(1).

51 *Id.* Article, 16(2).

without limiting the duty to take steps to further the right to enjoyment of health to any specific categories.

The American Convention on Human Rights does not provide economic, social and cultural rights directly. It does provide that the "State Parties undertake to adopt measures . . . with a view to achieving progressively, by legislation or other appropriate means, the full realization of the rights implicit in the economic, social, educational, scientific, and cultural standards set forth in the Charter of the Organization of American States (OAS) as amended by the Protocol of Buenos Aires".[52] The OAS Charter does not specifically identify enjoyment of health as a human right. It does articulate a "right to material well-being", and healthy working conditions.[53] One could infer from these rights and the other social, economic and cultural rights, a general right to health as being implicit, and thus subject to the duty to take steps to achieve it progressively.

In contrast, the Additional Protocol of the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (Protocol of San Salvador) specifically provides for the right to health in Article 10. It uses language similar to that of the World Health Organization ("WHO") preamble: "Everyone shall have the right to health, understood to mean the enjoyment of the highest level of physical, mental and social well-being". Similar language in the 1948 American Declaration of the Rights and Duties of Man further reinforce the existence and importance of the right to health. Article XI of the American Declaration provides that "every person has the right to the preservation of his health through sanitary and social measures relating to food, clothing, housing and medical care, to the extent permitted by public and community resources".

9. Conclusion

The first definite movements towards international co-operation in public health date from the earlier half of the nineteenth century, a period when a series of epidemics of cholera and plague from the East swept across Europe. Every country dreaded these scourges, and each attempted to protect itself by the methods which its officials judged to be possible and effective. The inconveniences of such unilateral action to rapidly expanding communications and commerce became so great that several attempts were made to arrange a meeting of representatives from the different interested nations. But nothing came of these until 1851, when an

[52] The American Convention on Human Rights, 1969, Article, 26.

[53] The Charter of the Organization of American States, 1948, Article, 3 (a) & (b).

international conference was held in Paris to try to reach some mutual understanding on the sanitary requirements of shipping in the Mediterranean. The immediate results of the conference were negligible, but the first official contact had been made in international collaboration in the prevention of disease.

Thus, the beginning of international health co-operation as we know it today i.e., co-operation between two and more states, is located in the series of international sanitary conferences that took place between 1851 and 1903. The establishment of the OHIP in 1909 marked the point of transition, from the era of international conference to permanent international health organisations, of which Pan American Sanitary Bureau (PASB) was the first established in 1902. The development singled by the emergence of the first international health organisations was part of a broader movement towards international co-operation, which had been growing in range and complexity throughout the nineteenth century.

Thus, the series of International Sanitary Conferences that began in 1851 and continued for almost a century, together with other diplomatic efforts produced many treaties on infectious disease control. Also important to the development of international legal regimes on infectious diseases was the creation of international health organizations with mandate to facilitate cooperation on infectious diseases. Four such organisations emerged during the first 100 years period: the Pan American Sanitary Bureau in 1902, Office International d'Hygine Publique in 1907, the Health Organisation of the League of Nations in 1923 and the World Health Organization (WHO) in 1948.

Unlike the League of Nations, whose task in relation to health was to "endeavour to take steps in matters of international concern for prevention and control of disease", the establishment of the United Nations in the aftermath of Second World War, brought a paradigm shift in global health governance. Right to health was implicit in the UN Charter but nevertheless it laid the foundation of it and as a result, among other rights, 'health' found its place in the Universal Declaration of Human Rights, 1948, followed by various United Nations covenants and conventions as detailed earlier. The analysis of all these conventions provides significant insight into the right to health and the duty of the States Parties with respect to it. Thus, the international collaboration and concern for health, which began as service delivery initiatives by member states, ultimately led to establishing a rights discourse under the United Nations regime.

Globalization has limited the capacity of governments to protect health within their sovereign borders through unilateral action alone and national and international health are increasingly recognized as intertwined and inseparable. In addition, the

idea that governments have human rights responsibilities to protect and promote public health and can and should be held accountable domestically and internationally for their actions is gaining widespread acceptance. In this new era of global health governance, international law has an important role to play in promoting and coordinating international cooperation and national action. Through the codification of binding global health law standards that regulate interstate behaviour and national conduct as well as the creation of other global norms that influence state actions, international health rights law has expanding significance in national public health law and policy.