

International Expert Consultation On Public Health Law

Co-sponsored by

The International Development Law Organisation (IDLO)
The O'Neill Institute for National and Global Health Law,
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REPORT OF THE RAPPORTEUR

Public Health Law Consultation

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The views expressed in this meeting report are those of the participants in the consultation and do not necessarily represent the decisions or policies of IDLO, the O’Neill Institute, or the World Health Organization.

INTRODUCTION

Law is increasingly being recognized and used as a tool for improving the health of populations at global, national and sub-national levels. As a means of public health improvement, public health law focuses on the power and duties of the state to create the conditions for people to live healthy lives in ways that are consistent with human rights and liberties, and with due regard to other public interests and values that are acknowledged in society.

On 26-28 April 2009, the International Development Law Organisation (IDLO) hosted a consultation on public health law at IDLO headquarters in Rome, Italy. The consultation was co-sponsored by the World Health Organisation (WHO) and by the O'Neill Institute for National and Global Health Law at Georgetown University, Washington D.C. Twenty-two experts in public health law attended the consultation, in their personal capacities. The participants came from a wide range of countries and development agencies including: Australia, Canada, China, Egypt, Kyrgyzstan, Malawi, the Netherlands, South Africa, Uganda, the United Kingdom, the United States, Venezuela, the United Nations University, the Food and Agricultural Organisation (FAO), the World Bank, the United Nations Development Program (UNDP), UNAIDS, together with the sponsors: IDLO, WHO, and the O'Neill Institute.

The objectives of the consultation were to:

1. Propose a conceptual framework for future collaboration on public health law;
2. Identify opportunities for using law to improve health, particularly within developing countries, through action within the international legal arena, and within national legal frameworks;
3. Make recommendations to WHO about its role in the area of health law, in light of WHO's comparative advantage, and to consider proposed objectives for work on public health law at, or sponsored by, WHO;
4. Identify opportunities to strengthen and build networks and capacity to promote health through law; and to
5. Propose a process for future collaboration with emphasis on capacity building and networking to benefit developing countries in the area of public health law.

This report sets out a framework for understanding national health law and international health law, the relationships between them, and the roles of law in health development. Secondly, it draws together key themes from the working groups, which sought to identify priority public health issues and areas where law could have an impact. Following on, it briefly clarifies the role that WHO could play in future partnerships for the development of public health law. Fourthly, it then summarises the consensus that participants reached during the course of the consultation on priorities for future partnerships and work over the next 12 months.

1. A FRAMEWORK FOR UNDERSTANDING NATIONAL AND INTERNATIONAL PUBLIC HEALTH LAW

Whatever legal culture one comes from (civil law, common law, Roman law, Islamic law), the goal of national public health law is to create the conditions in which people can live healthy lives. Governments cannot assure absolute health, but they have a duty to create conditions that give members of the public the best chance of enjoying good health, consistent with the values of social justice. Social justice, in the context of health, includes efforts to reduce health inequalities and to distribute both health services, and the benefits and burdens of public health interventions in a way that is fair. The moral or legal duty of States to protect the health of citizens is the foundation of public health law. This duty is recognized in the Preamble to the Constitution of the World Health Organisation.¹ In most countries, the right to life, and the right to health, are also recognized in national constitutions.

To fulfill their duty, governments need laws that set out their powers to discharge essential public health functions. These include laws relating to surveillance, screening, notification, laws relating to sanitation, safe water, safe and nutritious food, the safety of consumer products, injury prevention, tobacco reduction, and so on. The core public health *functions* include:

- surveillance/monitoring of health status and risks to health;
- public health protection and assurance;
- health promotion (including education, and partnerships to empower individual and community health efforts);
- financing of public health interventions and, in many countries, of health care services;
- training and capacity building; and
- research and evaluation.

Constitutional provisions, such as the right to health, as well as national public health legislation can empower governments to take action in all of these areas. In this way, law also helps governments to discharge their duty to promote and protect the health of their populations. In practice, public health laws tend to focus on surveillance and monitoring of health risks, and on health protection and assurance (across a wide range of issues and topic areas). Importantly, however, the legal powers of government are not unlimited. Whatever the national legal tradition, government powers in public health are constrained by universal human rights norms reflected in, for example, the International Bill of Human Rights and the International Health Regulations.

These three ideas: duty, power, restraint – the duty of government to protect citizens' health; laws empowering governments to discharge this duty and delimiting their roles in this area, and legal constraints to prevent the abuse of power – provide a framework for understanding the goals of national public health law.

There are a variety of specific strategies that law can deploy to protect and promote the health of the population.² These include the legal power of government to:

- **Raise revenue through taxation, and to spend it on public health programs.** For example, taxing harmful products can create incentives for healthy living, and/or revenues to promote a healthy lifestyle;
- **Shape the informational environment:** government has a role in educating the public about risks to health, as well as strategies for healthy living. This may extend to the regulation of hazardous advertising, and labeling requirements on consumer goods. Disease notification laws can also assist in the creation of information assets that inform policy responses, including emergency responses;
- **Protect the natural environment:** the quality of the natural environment impacts directly on health, whether through contaminated air, water or soil, the health consequences of natural disasters (which affect the poor disproportionately), or global warming;
- **Regulate the built environment:** law can subtly shape the built environment in ways that benefit health; for example, by improving access to healthy food, improving safety and security in urban areas, creating safe, well-lit open spaces to facilitate physical activity, or even limiting the ubiquity of fast food;
- **Regulate business:** for example, law can protect health through occupational health and safety standards, emission standards, manufacturing standards, working conditions, and other requirements on businesses and employers;
- **Shape and structure the way in which government discharges its own public health responsibilities:** in order to discharge its public health functions effectively, government can use law to establish agencies, to impose functions and mandates, and to re-structure in innovative ways that permit better coordination, and multisectoral responses to complex health challenges.
- **Indirect regulation through the tort system:** while government is the key actor in public health protection, national constitutions and legal systems may also recognise and permit individuals to vindicate private rights in ways that benefit the health of the public more broadly. The development of a framework for public interest litigation, and for making more effective use of rights set out in national constitutions (for example, the right to health), represents an important avenue for assistance to developing countries.

At the international or global level, public health law covers a spectrum from conventions or treaties, which impose legal obligations under international law, to non-binding, yet normative instruments including declarations, guidelines, and Codes of Practice. The World Health Organisation (WHO) has a remarkably broad mandate to create binding conventions and regulations, and it is not bound to act only on consensus.³ Two of its recent achievements include the Framework Convention on Tobacco Control (FCTC),⁴ and the International Health Regulations (IHRs).⁵ Other normative instruments include the *International Code of Marketing of Breast-Milk Substitutes*,⁶ and the *Global Strategy on Diet, Physical Activity and Health*.⁷ However, these instruments are not comprehensive in addressing current or emerging global health challenges.

There are a variety of other international systems, governed by international law, which impact critically on health and form part of the corpus of international health law. These include the agreements nations must sign in order to gain entry to the World Trade Organisation (the “WTO rules”),⁸ the Codex Alimentarius, which comprises global food standards,⁹ and the International Bill of Human Rights¹⁰ and other instruments recognizing and protecting human rights. The International Covenant on Economic, Social and Cultural Rights includes a right to the enjoyment of the highest attainable standard of physical and mental health, which signatory states are required to take steps to realize in a progressive fashion.¹¹ The Siracusa Principles provide a normative framework for mediating between a State’s powers to protect the health of its people, and the civil and political rights of individuals.¹² There is also a wide range of conventions relating, for example, to the environment, narcotics, radiation, nuclear and chemical weapons, and discrimination against women, that contribute to the protection of public health, even though health protection is not their specific aim.¹³

Global health governance

Beyond international health law lie the broader, regulatory challenges of “global health governance”. What forms of governance, what structures, what kinds of coordination are best suited to progressively improving the health of the world’s population? In addition to WHO, UN agencies, the World Bank, and large-country aid programs, there are a variety of important new stakeholders exercising leadership and significant influence in global health. These include large private funders (e.g. Bill and Melinda Gates Foundation; Bloomberg Philanthropies; Clinton Global Initiative); and public/private partnerships (e.g. the GAVI Alliance – Global Alliance for Vaccines and Immunisation; the Global Fund to Fight AIDS, Tuberculosis and Malaria). Current global initiatives that are critically important to global health include the Millennium Development Goals, and the significant funding boost for tobacco control provided by the Bloomberg Foundation and the Bill and Melinda Gates Foundation.¹⁴ Drawing in and creating effective partnerships between industry partners, large funders, and civil society organizations have become an important priority for global health. Another challenge is to coordinate existing health work more effectively.

Public health law can contribute to the challenge of global health development in several distinct ways. Firstly, multilateral conventions, guidelines and other health law instruments can provide a legal mandate, or a normative framework, for action by countries themselves – whether by implementing global standards through domestic laws and policies (e.g. FCTC), or by otherwise developing their capabilities in ways consistent with international standards (e.g. IHRs).

Secondly, global health stakeholders – including WHO, IDLO, the World Bank and UN agencies – can foster the development of model laws, guidelines and standards that are intended to apply at country level. These can function as resources in the policy dialogue, advocacy and technical assistance provided by a wide range of global organizations (not just legal organizations) in their work at the country level.

The complex environment of global health therefore provides new opportunities to promote the role of public health law at regional and country levels.

2. PRIORITY PUBLIC HEALTH ISSUES AND AREAS WHERE LAW COULD HAVE AN IMPACT

On the first day of the consultation, the working groups were asked to consider priority areas where government has a responsibility to create the conditions for health and to respond to health inequalities, and where “law” could help to discharge these responsibilities.

The working groups understood “health” to mean a healthy population, rather than simply curative, health care services. They also understood law in a broad sense to encompass “hard law” (legislation, statutory instruments, decisions of courts and tribunals), and “soft law” (non-binding, yet normative standards, and regulatory policies that provide the basis for public health practice). The working groups did not confine their discussion only to those issues and areas where it might be feasible for WHO, IDLO and other partners to take the leadership role in future.

Country-level challenges

The working groups confirmed that the relative lack of development of public health law contributes to deficiencies in the protection of population health in many developing countries. Some of the problems identified include:

- ensuring that the international commitments made by governments, as signatories to international agreements, are implemented into domestic laws. It was suggested that model legislation can serve as a model or reference point: encouraging governments to transmit obligations down to the level of policy and practice.
- difficulties in enforcing rights, and discharging obligations, at the country level. In some countries, there is plenty of “soft law” – policies, statements of principle – which have not been followed in practice. There is an important need to improve legal literacy, so that public health advocates can hold governments accountable for the discharge of the legal functions that contribute to health protection.
- difficulties in making effective use of the public health laws that do exist. One participant raised the challenge of creating the conditions where domestic violence laws are treated seriously: implemented and enforced. Again, legal literacy and training (of judges, judicial officers, public health advocates, women’s advocates) could make a contribution here. There was interesting discussion about the synergies that exist between human rights obligations, and health. One participant noted that in the Ukraine, for example, the HIV community was able to use the language of human rights obligations to resist

the purchase of pharmaceuticals that were not pre-approved by WHO, and would have put the HIV community at risk. On the other hand, some countries are not responsive to advocacy that is based upon universal human rights obligations. One participant pointed out that it is important to de-politicise health wherever possible. One way to do this is to keep a technical focus on the basic conditions that contribute to health, rather than focusing on human rights, including the “right to health”. One working group also pointed out that health protection may sometimes require the restriction of human rights. Synergies exist, but not always.

- laws that are too restrictive. One participant suggested, for example, that restrictive abortion laws in Malawi contribute to high maternal mortality rates, due to the high number of non-state sanctioned, unsafe abortions that occur as a result. Law has a role to play in ensuring that the response of the health care system is informed by evidence, and is supportive of human rights. Wherever possible, law should also support responses to disease that are treatment-based, rather than punitive. The incarceration of those with multi-drug resistant TB, and the appalling treatment of the mentally ill in some countries, were cited as examples.

In some countries, there is no effective system of law for the protection of the public’s health, whether it be curative (health care law), or population-focused and preventative (public health law). Ensuring that there is a legal infrastructure for the discharge of a country’s public health functions is an important priority.

Participants pointed out that in some countries, the lack of regulation of health care services also creates risks to public health. Lack of controls over who can prescribe medication, or who can hold themselves out as a medical practitioner, were given as examples. One participant mentioned the lack of regulation of private health care providers in India. In addition, workforce issues – the lack of adequately-trained health professionals in developing countries (especially in Africa), and the “brain drain” to developed countries – are a major challenge for global health governance.

There was debate about whether the lack of a functioning public health infrastructure, or the burden of specific diseases, presents the greater challenge for public health law reform. HIV/AIDS, maternal health and child mortality, tobacco-related diseases, TB, malaria, cardiovascular disease, and mental health were identified as major challenges across many developing countries. In sub-Saharan African, however, it can be difficult to prioritise because all of these diseases are rampant among various parts of the population. Should stakeholders in public health law reform choose from among these disease-specific challenges, or focus more broadly on health infrastructure, and legal aspects of health systems strengthening – including issues such as migration of health care workers, corruption, discrimination and stigma, and the fair allocation of public health resources? Some participants felt that public health laws that assist countries to address their fundamental public health functions, and the core determinants of health, could go a long way towards addressing specific challenges. One important

aspect of this is the need to define the roles and responsibilities of agencies, at domestic, regional and the international level, in order to facilitate monitoring and accountability.

The criteria that could be used to identify where law might make a contribution to public health also attracted discussion. This is important because public health law often needs to balance community interests and individual interests (as in the case of state responses to TB). One working group noted that where health or health care services provision is recognized as a public good, and where market mechanisms will fail to secure it, then the state has an obligation to become involved. This provides a justification not only for communicable diseases regulation, but also for reforms to secure a national health insurance system (regardless of whether services are provided by public, or private entities, or a combination of both). This group made the point that “health systems” extend beyond the mere provision of health insurance products. They include the capabilities required for the effective discharge of public health functions, including human resources, laboratories and response systems. Another working group emphasized that the definition and goals of a public health system need to be very clear, since health can be used as the basis for restricting human rights. For that reason, human rights protections should be built into any laws establishing a public health infrastructure.

Global challenges

While generally focusing on the challenges for public health, and public health law at country level, the working groups also considered ways in which engagement at the global level can contribute to health improvement. One participant noted that, by analogy from the Universal Periodic Review process, which takes place under the auspices of the Human Rights Council,¹⁵ WHO should devote more resources to its “global health reporting function”. For example, it could review the state of water security and quality in different countries.¹⁶ Another pointed out that WHO might begin by mapping legal advisors in Ministries of Health, and Ministries of Finance, in order to identify where the human resources are for public health law. On the other hand, mapping who is doing what in the health field has become a vast challenge. This is one cause of the multiple, uncoordinated initiatives that can limit the ability of countries to absorb aid and assistance effectively. While WHO may not be in a position to comprehensively map health governance initiatives, it may be able to support others with capacity in this area.

Participants also emphasized the importance of creating partnerships with other global health stakeholders and agencies. An example of such a partnership is the jointly sponsored work that WHO and the World Economic Forum have done on workplace-based “wellness” programs.¹⁷ Other possibilities may exist with respect to occupational health and safety and injuries (ILO), trade in food (Codex), and women’s health (the United Nations Development Fund for Women – UNIFEM). The importance of defining a role for health, both formally (within the text of WTO rules) and functionally (within the WTO itself) was emphasized. One working group discussed the possibility of a global health treaty, and pointed out that guidelines

might be a better place to start, since broad model laws can be interpreted in ineffective ways. Guidelines and guidance on the design of a public health system, however, might later lead to a treaty. Guidelines could also function as a valuable resource for conducting audits of public health legislation at the country level.

In summary, the following themes and priorities emerged from the working groups:

- There are serious challenges to the rule of law in the health context, due to the absence or obsolescence of appropriate law, and the lack of implementation and enforcement.
- There are many global health priorities, and each raises many legal issues. On the other hand, in addressing these issues, one size may not fit all. Countries differ in the level of government at which an issue is dealt with, and in the extent to which that governance takes the form of “hard” law, or “soft” law. It follows that the most appropriate legal response to a specific health challenge will vary on a case by case basis.
- Most efforts in public health law have been issue or disease specific. However, one area which is more fundamental is the basic public health infrastructure and basic conditions for health, including the basic roles and capabilities of government in this area. This area has often been overlooked by international agencies.
- There was growing consensus around the value of guidelines and recommendations, together with reporting, as a strategy for prevention. Unlike the broad provisions in a convention, the benefit of guidelines is that they can identify concrete actions and drive the implementation of public health responsibilities more effectively. Guidelines provide a resource for development agencies and other stakeholders to use when they engage with national and regional governments. Guidelines do, however, need to be implementable, and to provide a framework for accountability, as well as comparison between countries.

3. THE ROLE OF WHO IN FUTURE PARTNERSHIPS FOR THE DEVELOPMENT OF PUBLIC HEALTH LAW

The Constitution of the World Health Organisation states that the objective of WHO is “the attainment by all peoples of the highest possible level of health” (Article 1). The Constitution also states that it is the function of WHO to “take all necessary action to attain the objective of the Organisation” (Article 2(v)). However, despite these broad provisions, the extent to which WHO can engage in public health law work is most often determined by resolutions of the World Health Assembly, WHO’s mid-term strategic plan, its available resources, and the priorities of the Director-General.

Internally, within WHO, there is raised awareness of the need for legal literacy in international law, and raised demand from States for guidance. There are significant power imbalances between member States in terms of their knowledge of law, and their capacity to articulate their interests and to promote their interests by using international law in negotiations and multilateral processes.

Although some technical departments within WHO have a strong legal focus (tobacco, IHRs, mental health), few regional offices have staff or units on health law (PAHO has one person; so does the African regional office). Much of the health law capacity of WHO in Geneva is devoted to maintaining the international digest of health legislation.

There was vigorous discussion about what WHO should be doing to build public health law in future. Possibilities include:

- Acting as a hub for the dissemination of good practices, good legislation etc;
- Developing tools, including “how to” manuals on legal topics;
- Monitoring the external arena (the UN system and beyond) in order to identify law-making processes that impact on health and provide opportunities for engagement;
- Responding to requests from member States to provide technical assistance on public health law matters;
- Providing the backbone for a network of partners with expertise in substantive areas of law that impact on health (e.g. environment, trade, IP, international humanitarian law etc).

The constraints that WHO faces in responding to these challenges include lack of resources (including the fact that there are few health lawyers on staff, and little health law expertise); the fact that WHO mostly serves health departments; and lack of appropriate partners for law-related initiatives. On the other hand, the breadth of WHO’s constitutional mandate, and its strong “brand” could make it a valuable partner in initiatives to raise awareness of the value of law as a public health law tool, to identify expertise around priority areas, and to generate demand for assistance in these areas.

While WHO cannot do everything, it is well positioned to play a role as *promoter* of strategic initiatives in the public health law field. This could include identifying strategic entry points for the development of health law expertise, and for the substantive development of national and international health law in support of health objectives.

Beyond this, there are risks in developing a “shopping list” of “things that WHO should do”. A better approach is to ask: how can WHO help to catalyse and to add legitimacy to the actions of appropriate partners so that work can move forward in priority areas?

4. OPPORTUNITIES AND RECOMMENDATIONS FOR BUILDING NETWORKS TO PROMOTE HEALTH THROUGH LAW

On the second day of the consultation, the working groups were asked to focus specifically on opportunities for initiatives in public health law within the next 6-12 months.

The groups considered three questions:

1. What can be done to create a framework for public health law? E.g. guidelines on health and law at the national level?

There was a remarkable level of agreement around this question: the priority should be to create a tool for a legal assessment or audit of existing public health law, and to identify and explain the core constituents of a properly constructed national public health law that would aim to assure the conditions for the public's health.

One participant noted that in his country, passage of public health legislation had been delayed because there was little understanding of the functions of public health or of the State roles and responsibilities that would arise under the legislation. It followed that part of the challenge for future work in this area is to sensitise Ministry of Health officials, public health workers and civil society groups to the meaning of public health, and to clarify the responsibilities of all partners involved in the public health enterprise. Guidelines in this area could provide a tool kit for the World Bank and other agencies engaging at the country level.

Participants recognized the importance of obtaining the imprimatur of high-status stakeholders on any guidelines: WHO, IDLO, and if possible, the World Bank.

One working group discussed the need for a "hook" to catalyse or legitimise public investment in public health law. Some States recognise a constitutional right to health; in other countries, health security language provides a basis for re-visiting the state of a country's public health laws. The cost-effectiveness of public health prevention, and the economic basis for investment in public health infrastructure (including legal infrastructure) may also provide opportunities for advocating the importance of law reform in this area.

Since different countries have different needs and levels of development, a framework for public health law needs to be flexible. One working group advised focusing on minimum standards, and adopting a rights-based approach, with a view towards progressive realization. They considered that a public health framework includes several sub-frameworks. These include the:

- **Legislative framework:** guidelines addressing the legislative framework would include concrete, practical advice to governments about how to go about developing public health legislation, as well as drafting instructions and model

provisions. It is vital that the legislative framework should deal specifically with implementation, compliance and accountability. Many States have legislation, but unless it is implemented and enforced, and unless appropriate agencies are held accountable for the discharge of their functions, the law will have little impact.

More broadly, consideration should be given to law's role in the discharge of the following public health functions: monitoring and surveillance of health risks; public health assurance and protection (includes law as a means of implementing public health policy in priority areas*); public health promotion (empowering individuals and the community to adopt healthy lifestyles); capacity issues (development of the public health workforce); financing (of public health functions, not necessarily the funding of health care services); research and evaluation; advocacy and promotion.

- **Administrative infrastructure:** this includes identifying the specific duties owed by various state agencies in order to deliver on minimum standards for health protection. Inter-Ministerial coordination is an important issue here. Agencies and departments also need to make budgetary space for the discharge of their public health functions. Other issues include identifying responsibility for quality control, monitoring and enforcement.
- **Education and training:** the development of a country's public health infrastructure needs to be supported by a group of public health law-minded people, regardless of whether they work in law, public health, government, or human rights generally. The need to develop capacity in public health law could include formal university training, workshops, student internships etc. Educational initiatives should reach into the medical profession, the judiciary, government and the private sector. In analogous area of international environmental law, global initiatives for education are quite well developed: see the Academy of Environmental Law of the International Union for the Conservation of Nature (IUCN).¹⁸
- **Monitoring and evaluation:** the performance of a public health system needs to be monitored at international and national levels, including through national human rights commissions, which can monitor discrimination in access to health care treatment and public health services. Civil society can also play an important monitoring and evaluating role.

2. What can we do to build capacity for public health law? E.g. Centers of Excellence at regional level

The Working Groups discussed how the participants and the institutional partners (WHO, IDLO, O'Neill) could be a resource for building public health law infrastructure in countries that need support. One working group floated the idea of having several centres of excellence in regions that could provide training and

* In developing a legal framework for public health, core powers and obligations could be identified first, with other components being added later (commensurate with resources, level of functioning of the public health system)

support, in partnership with WHO and others, for countries within that region. The process could begin by identifying lawyers involved in different sectors in developing countries (HIV, food, tobacco), as well as legally-qualified people in government agencies. These networks might be formalized, with the assistance of sponsors (WHO, IDLO, O'Neill), one of whom might provide a secretariat for each network. Alternatively, networks might accrete directly around the work of particular regional centres of excellence, or regional institutions. For example, one of the seven Institutes for Public Health in India might provide a "home" or institutional base for public health law development work in that region.

The working groups confirmed that a good first job is to develop national guidelines and resources about the core functions of public health and the issues to be addressed in any good public health law framework. This would begin with the "basic survival needs" of the population, but could expand outwards to include other laws for the public's health. This approach was distinguished from a "health in all policies" approach. There was discussion about what issues should come first, or follow later.

Other possible priorities for the future include the development of curricula on law and public health, and e-learning tools. The importance of cross-fertilisation across the disciplines was emphasized.

3. How can we identify, strengthen and expand networks on law and health? What type of actors should we include?

There was less enthusiasm for proceeding to develop networks for public health law without a clear understanding of why the network was being developed, and what it would do. The risk is that resources could be expended on developing a network which would peter out unless there was an agenda for work, and at least a minimal secretariat.

4. NEXT STEPS

Participants at the consultation reached broad agreement that the priority area for future work is to work towards the development of a tool kit, or guidelines for law's role in creating and strengthening the basic public health infrastructure. These guidelines will not cover everything, but would prioritise "basic survival needs" of the population, and core public health functions and powers.

The anticipated product of this further collaboration should be focused largely at government. Part of the work of this initiative will be to explain what public health law is and why it is important, and to sell to national governments a framework that they can use to improve their public health systems. To have any credibility at a national level, the guidelines must constitute a practical tool that identifies relevant standards, improves accountability, and helps governments to translate their responsibilities into practice.

Participants at the consultation agreed on the following concrete steps:

The report of the consultation

1. The Report of the Rapporteur will be circulated to all participants in draft form, for comment and amendment.
2. Larry Gostin and Roger Magnusson will work together to distill key themes from the Rapporteur's Report for a journal paper that might be suitable for the *Bulletin of the World Health Organisation*, or another appropriate journal.

Guidelines

3. The participants agree to begin a process of developing guidelines for a national public health law, with a focus on core elements of an effective public health infrastructure. A small drafting team (Larry Gostin, Oscar Cabrera) will prepare a 2-3 page process report or concept note for consideration by WHO, IDLO and the World Bank in the hope that these organizations will buy in to the project and give the guidelines their imprimatur. WHO, IDLO and the O'Neill Institute would continue to play a convening role and to lend legitimacy to the process and its eventual product. Expertise will be drawn from participants in this consultation, and other selected experts.
4. The concept note will provide the basis for the development of drafts of key parts of the guidelines/tool kit, for discussion, elaboration and shaping at future consultations.

Networks

5. Participants agreed to consider the idea of establishing "regional centres of excellence", or perhaps networks that were less formal. The first task towards this would be to identify institutions and organizations working in the regions on public health law that would contribute expertise and capacity to such a network. Centres of excellence might be identified in China, southern Africa, Australasia, the Americas, North Africa, and Europe. In order to be sustainable – or in order to contribute in a coordinated and sustainable fashion to the development of global health law – these centres or networks would need to be: (a) organized around clear goals; and (b) supported by a modest secretariat. An initial step towards the development of networks is a mapping exercise that would aim to identify key individuals and institutions. Participants should share back their work on developing networks, but not in such a way as to interfere with the focus of a subsequent consultation focusing on the development of guidelines.

When completed, the guidelines will represent a public health law tool with significant normative power. Regional networks could play an important part in dissemination and advocacy at that time.

6. In the meantime, IDLO would begin a list serve which could provide the beginnings of a functioning network for the development of guidelines (point 3 above).

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ENDNOTES

¹ Constitution of the World Health Organisation (entered into force 7 April 1948), Preamble.

² See Lawrence Gostin, *Public Health Law: Duty, Power, Restraint*, Berkeley: University of California Press, 2008, pp 28-41.

³ Constitution of the World Health Organisation (entered into force 7 April 1948), Articles 19, 21.

⁴ WHO, *WHO Framework Convention on Tobacco Control*, WHA56.1 (entered into force 27 February 2005).

⁵ WHO, *International Health Regulations (2005)*, WHA58.3; 23 May 2006.

⁶ WHO, *International Code of Marketing of Breast-Milk Substitutes*, WHA34.22 (21 May 1981)

⁷ WHO, *Global Strategy on Diet, Physical Activity and Health*, WHA57.17 (22 May 2004).

⁸ The WTO Rules include the General Agreement on Tariffs and Trade (GATT Agreement); the Agreement on the Application of Sanitary and Phytosanitary Measures (SPS Agreement); the Agreement on Technical Barriers to Trade (TBT Agreement); the General Agreement on Trade in Services (GATS); and the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS).

⁹ http://www.codexalimentarius.net/web/index_en.jsp#

¹⁰ The Bill of Rights comprises the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights (ICCPR) and its two optional protocols, and the International Covenant on Economic, Social and Cultural Rights (ICESCR).

¹¹ ICESCR Article 12; General Comment No. 14 (2000), The Right to the Highest Attainable Standard of Health; 11/08/2000, E/C 12/2000/4.

¹² The Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights, E/CN.4/1985/4, Annex, 28 September 1984.

¹³ A. Taylor, D. Bettcher, S. Fluss, K. DeLand, D. Yach, "International Health Instruments: An Overview", in R. Detels, J. McEwen, R. Beaglehole, H. Tanaka (eds), *Oxford Textbook of Public Health*, 4th ed.; Oxford: Oxford University Press; 2004: 359-386.

¹⁴ Bloomberg Initiative to Reduce Tobacco Use, at: <http://www.tobaccocontrolgrants.org/> ; see also <http://www.who.int/tobacco/communications/highlights/bloomberg/en/index.html>

¹⁵ Universal Periodic Review, at: <http://www.ohchr.org/EN/HRBodies/UPR/Pages/UPRMain.aspx>

¹⁶ See, however, the World Water Assessment Program, at: <http://www.unesco.org/water/wwap/>

¹⁷ World Economic Forum. Working Towards Wellness, at:

<http://www.weforum.org/en/initiatives/Wellness/index.htm> ; PricewaterhouseCoopers, *Working Towards Wellness: Accelerating the Prevention of Chronic Disease*. New York: PricewaterhouseCoopers. Available from: <http://www.weforum.org/pdf/Wellness/report.pdf>

¹⁸ The IUCN Academy of Environmental Law, at: <http://www.iucnael.org/>