

The World Health Organization Legal Regimes and the Shaping of Nigeria's Health Law and Policy

Os regimes jurídicos da Organização Mundial da Saúde e a formulação de leis e políticas de saúde na Nigéria

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ABSTRACT

Global health governance concerns the collective responses needed within the public health community to effectively tackle the shared challenges arising in an increasingly connected world. It is a truism that promoting a robust health infrastructure is critical to the attainment of good health and wellbeing. Yet the legal infrastructure – the laws and policies that empower and obligate as well as limit government and private action concerning health, has been neglected in the mainstream literature. This is because health infrastructure has focused more on physical structures of public health agencies such as clinics, hospitals and the human resources that operate them. The purpose of the study was to explore the extent to which the World Health Organization legal regimes such as the Framework Convention on Tobacco Control (2003) and the Revised International Health Regulations, have impacted on health law and policy in Nigeria. It posits that the various conventions and regulations adopted, which were subsequently ratified and declared applicable to Nigeria, had been domesticated. However, the lack of respect for the rule of law has stymied the maximisation of the expected benefits from such legal regimes. It concludes that the World Health Organization should develop a programme for public health law capacity-building and policy surveillance to ensure continuous and organised efforts to assist member states including Nigeria to strengthen their legal infrastructure.

Keywords: Health; Human Rights; Nigeria; World Health Organization.

RESUMO

A governança global da saúde diz respeito às respostas coletivas necessárias dentro da comunidade da saúde pública para enfrentar com eficácia os desafios compartilhados que surgem em um mundo cada vez mais conectado. É um truismo que a promoção de uma infraestrutura de saúde robusta seja fundamental para a obtenção de saúde e bem-estar. No entanto, a infraestrutura legal – as leis e políticas que reforçam, obrigam ou limitam as ações governamentais e privadas em relação à saúde – tem sido negligenciada na literatura dominante. Isso ocorre porque a infraestrutura de saúde tem se concentrado mais nas estruturas físicas dos órgãos de saúde pública, como clínicas, hospitais, e nos recursos humanos que os operam. O objetivo deste estudo foi explorar até que ponto marcos legais da Organização Mundial da Saúde, como a Convenção-Quadro para o Controle do Tabaco (2003) e o Regulamento Sanitário Internacional revisado, impactaram as leis e políticas de saúde na Nigéria. O artigo postula que as várias convenções e regulamentos adotados, que foram posteriormente ratificados e declarados aplicáveis a Nigéria, foram internalizados no país, porém, o desrespeito ao estado de direito tem impedido a maximização dos benefícios esperados de tais marcos legais. Concluiu-se que a Organização Mundial da Saúde deve desenvolver um programa de capacitação em legislação e políticas de saúde pública e vigilância em saúde para garantir esforços contínuos e organizados, a fim de contribuir para que os Estados-Membros, incluindo a Nigéria, possam fortalecer sua infraestrutura legal.

Palavras-Chave: Saúde; Direitos Humanos; Nigéria; Organização Mundial da Saúde.

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Introduction

The World Health Organization (WHO) depends on international law through the structure and processes created and supported by its Constitution (WHO, [1946]). Although the WHO Constitution made provisions for the organisation to use innovative and fairly radical legal mechanisms (treaties, regulations, soft laws) those mechanisms have largely remained on the margins of the WHO international health work in over six decades of its history. Since its establishment in 1948, the WHO is known to have adopted only two legally binding normative instruments: the International Health Regulations and Framework Convention on Tobacco Control. This is an indication that the organisation has historically neglected international law in its work by underutilizing its enormous constitutional powers. The common argument used to explain the WHO antipathy to international law is that the WHO has been dominated by medical and public health experts. As Fidler aptly noted:

WHO was isolated from general developments concerning international law in the post-1945 period. This isolation was not accidental but reflected a particular outlook on the formulation and implementation of international health policy. WHO operated as if it were not subject to the normal dynamics of the anarchical society; rather, it acted as if it were at the centre of a transnational Hippocratic society made up of physicians, medical scientists, and public health experts. The nature of this transnational Hippocratic society led WHO to approach international public health without a legal strategy (FIDLER, 1999).

Taylor also observed that:

WHO's traditional reluctance to utilize law and legal institutions to facilitate its health strategies is largely attributable to the internal dynamics and politics of the organisation itself. In particular, this unwillingness stems, in large part, from the organisational culture established by the conservative medical professional community that dominates the institution (TAYLOR, 1992).

Other reasons for the historical neglect of international law by the WHO include the fact that the Organisation came into existence at the beginning of a revolutionary period for biomedical tools such as antibiotics and vaccines, and activities were focused on delivering these, for which legal initiatives were not needed. Besides, the WHO's limited experience with regulatory regimes is fraught with controversy and conflict.

The WHO's neglect of international law nonetheless produces a distorted image of the role of international law in the area of public health. The protection of human health is an objective that states, intergovernmental organisations, and non-governmental organisations have embedded in many areas of international law (FIDLER, 1999). A significant proportion of international law exists for example to protect human health. Yet none of this international law was developed within the WHO. Other areas of international law that contain rules and institutions that protect human health include international trade law, international human rights law, international humanitarian law, international law on arms control, international law on narcotic drugs and international Labour law.

Nevertheless, as a multilateral institution, the WHO has the mandate and opportunity to establish or influence laws, legislations, and guidelines that set the foundation for international and national health law or policy. In international law, states are regarded as the most important actors. It is obvious that if an international agreement is to become applicable there is a need to implement the outcome of such negotiations at the national level. States must translate an international agreement or treaty into national laws or policies and develop enforcement mechanisms. International treaties

provide blueprints for action, but it is not until the lawmakers put decisions into practice at home that they become functional.

Nigeria became a full member of the WHO in 1960. Since then, it has worked in close collaboration with the Nigerian government. Besides, Nigeria had been a party to the WHO legal regimes even before its full membership of the WHO. These are manifested in several public health laws, policies and institutional arrangements. Building upon existing literature on Nigeria's health diplomacy, this is the first study to look comprehensively at the interplay between global health law and Nigeria's health law. This article aims to explore the extent to which the WHO, through its legal instruments, has influenced national health law in Nigeria. Indicative questions this article will answer include: what are the implications of international law adopted under the auspices of the WHO in the promotion of domestic health status? How can member states strengthen their legal infrastructure and what role has the WHO played in this?

The article utilizes the primary and secondary method of data collection. The primary data were obtained from oral interviews and daily newspaper reports. It further draws upon materials from the WHO Archives in Geneva and National Archives, Ibadan. Secondary data were sourced from books, journal articles, government publications and the internet. The data generated were analysed using descriptive and content analysis.

I Understanding the Legal Instruments of the WHO

The Constitution of the WHO provides for three types of legal instruments namely, conventions and agreements, regulations and recommendations. Article 2 (k) of the Constitution authorizes the WHO to:

Propose conventions, agreements, and regulations and make recommendations with respect to international health matters and to perform such duties as may be assigned by thereby to the Organisation and are consistent with its objective (WHO, [1946]).

The WHO's powers to adopt conventions and agreements concerning any matter within the competence of the organisation is covered by Article 19 of its Constitution that provides as follows:

The Health Assembly shall have authority to adopt conventions or agreements concerning any matter within the competence of the organisation. A two-thirds vote of the Health Assembly shall be required for the adoption of such conventions or agreements, which shall come into force for each member when accepted by it in accordance with its constitutional process (WHO, [1946]).

It has been argued by scholars that Article 19 provides the WHO with limitless treaty-making power that surpasses any treaty powers possessed by its precursors such as the Pan American Sanitary Bureau, the International Office of Public Health, and the Health Organisation of the League of Nations. Article 21 of the WHO Constitution empowered the World Health Assembly (WHA) to adopt legally binding regulations in several fields such as:

- (a) sanitary and quarantine requirements and other procedures designed to prevent the international spread of disease;
- (b) nomenclatures with respect to diseases, causes of death and public health practices;
- (c) standards with respect to diagnostic procedures for international use;
- (d) standards with respect to the safety, purity and potency of biological, pharmaceutical and similar products moving in international commerce;

(e) advertising and labelling of biological, pharmaceutical and similar products moving in international commerce (WHO, [1946]).

Article 21 gives the WHA the authority to adopt regulations that could become legally binding without the positive act of consent by states as symbolised in the age-old treaty-making conventional practice of signature and subsequent ratification in international law. For regulations adopted under Article 21, there is a contracting out procedure in Article 22.

Article 22 provides that:

Regulations adopted pursuant to Article 21 shall come into force for all members after due notice has been given of their adoption by the Health Assembly except for such members as may notify the Director-General of rejection or reservations within the period stated in the notice (WHO, [1946]).

Article 21 and 22 of the WHO Constitution have been described as creating a quasi-legislative procedure that represents a radical departure from the conventional international treaty-making practice in the late 1940s when the WHO was established (SHARPE, 1947).

Article 23 of the WHO Constitution (1948) stipulates that “the Health Assembly shall have authority to make recommendations to members concerning any matter within the competence of the organisation” (WHO, [1946]). Although soft laws instruments, like recommendations and declarations, are not automatically legally binding, international legal scholars agree that they have nonetheless catalysed the evolution of rules of international law. In the modern state system, therefore, the relevance of international law in controlling the international spread of infectious and non-communicable diseases within the mandate of the WHO falls within the three categories of conventional treaty-making authority (Articles 19 and 20); regulatory authority (Articles 21 and 22); and non-binding soft law authority (Article 23) (WHO, [1946]).

These explicit legal powers exist alongside the general authority to engage in assistance activities to improve health services and support informed public opinion on health matters in the Member States (MARKS-SULTAN *et al.*, 2016). The WHO's legal mandate extends to addressing a lack of transparency in national public health laws. Article 63 of the WHO Constitution obliges Member States to communicate to the WHO their important laws, regulations, official reports and statistics on health (WHO, [1946]). This obligation clearly reflects the importance of national laws on the WHO's mission. Transparency of national laws and access to legal information is critical to effective international coordination in health and to the supportive role of the WHO in providing needed expertise and guidance (MARKS-SULTAN *et al.*, 2016). The authority to collect these legal texts places the WHO in a unique position to support better access to member states' national health laws for research, emerging response, public information and technical assistance. However, the challenge has always been to get compliance with the mandate and then to manage the inflow of legal texts.

II The WHO Framework Convention on Tobacco Control and Tobacco Law in Nigeria

It is on record that the WHO did not adopt any convention from its inception to 2003. However, the WHO had been granted before then several supervisory and advisory functions under several conventions adopted under the auspices of the United Nations and the International Atomic Energy Agency (IAEA). The WHO inherited the supervisory role of the League of Nations regarding the 1931 convention for limiting the manufacture and regulating the distribution of Narcotic drugs (Resolution WHA 7.7) (WHO, 1954).

It was also granted a similar function under the provisions of the 1971 Convention on psychotropic substance (Resolution WHA 24.57) (WHO, 1971).

The origin of the work of the WHO with tobacco as a health issue began with the resolution of the Executive Board at its 55th Session in 1970. From 1970-1995, the WHA adopted several resolutions in favour of tobacco control measures. The most significant WHA resolution relating to tobacco smoking was 'Tobacco or Health' adopted by 39th WHA in 1986. Section 1 (1) of the resolution affirms: "that tobacco smoking and the use of tobacco in all its forms are incompatible with the attainment of health for all the year 2000" (WHO, 1986). The move towards the negotiation of the WHO Framework Convention on Tobacco Control started in 1996 when the WHA adopted the resolution for the development of a WHO framework convention on tobacco and related protocols. As a follow-up, the WHA adopted a resolution in 1999 – Resolution WHA 52.18 – which established an intergovernmental negotiating body to draft and negotiate a proposed WHO Framework Convention (WHO, 1999).

The WHO Framework Convention on Tobacco Control (FCTC) was adopted by the 56th WHA in May 2003 and entered into force in 2005 (WHO, 2003). This was the first treaty adopted by the WHO. It was adopted against the backdrop of the increasing use of tobacco globally. It was generally agreed that tobacco use is one of the major public health disasters. There are about 1.3 billion smokers in the world (BAPTISTE, 2008). Tobacco smoking is also the second major cause of death of one in ten adults in the world. It was predicted that if the smoking patterns continue, they will cause about 10 million deaths each year by 2025.

In Africa, available data shows a rising consumption trend in the WHO African Region. For instance, the total cigarette consumption in Africa rose from 131,181 million sticks in 1995 to 212,788 million in 2000 an increase of 38.4 per cent (WHO [s.d.]). The Africa Tobacco Situation Analysis report on Nigeria showed that the prevalence rates for cigarette use are greater than 15 per cent. About 93 million sticks are produced yearly in Nigeria and all these cigarettes are consumed in the country. The adoption of FCTC is significant because it represents the first international legal instrument designed to promote multilateral cooperation and national action to reduce the growth and global use of tobacco. Derek Yach has described it as "a cornerstone of policy development aimed at reducing the burden of disease attributable to tobacco" (YACH, 2014, p. 1771). The policy has been remarkably successful given its wide acceptance by the WHO member states. The provisions of the FTCT include measures to encourage state parties to impose bans or restrictions on tobacco advertising, sponsorship, and promotion, establish new packaging and labelling of tobacco products, establish indoor air controls, and strengthen legislation to combat tobacco smuggling (WHO, 2003).

Specifically, the treaty mandated the state parties to undertake a comprehensive ban on tobacco advertising, promotion, and sponsorship as far as their constitutions permit. The treaty also obliges state parties to adopt and implement large clear visible legible and rotating health warnings and messages on tobacco products and its outside packaging occupying at least 30% of the principal display areas. The treaty urged the state parties to adopt and implement or promote effective measures providing for protection from the exposure of tobacco smoke in indoor workplaces, public transport, indoor public places, and all other public places.

National tobacco control is the foundation for public protection against tobacco. It is an incontrovertible fact that Nigeria's health laws or policies, especially tobacco control law and policies, had been influenced by various WHO resolutions. Before the adoption of the WHO FTCT in 2003, Nigeria had promulgated laws regulating tobacco smoking. One such law was the Tobacco Smoking (Control) Act of 1990 (NIGERIA, 1990). This Act was promulgated during General Babangida's regime and was championed by

the former Minister of Health, Olikoye Ransom Kutu. The Tobacco Smoking (Control) Act of 1990 (NIGERIA, 1990) provided for the control of smoking in certain places and advertisement of tobacco in Nigeria. It was introduced as part of the general strategy towards the attainment of Health for All by the year 2000 as well as a faithful commitment to various WHO resolutions, especially the WHA resolution "Tobacco and Health" in 1986 (WHO, 1986). Other policies influenced by the WHO were the Code of Advertising Practice (APCON) 1993 and APCON resolution at its 89th meeting held on July 11, 2001. The Advertising Practitioners Council of Nigeria (APCON) gave a directive that banned all sorts of advertisement sponsorship, promotion, testimonial and brand stretching of tobacco products across the country (THE HEALTH...).

Apparently, these measures were adopted in the absence of a comprehensive law to regulate the manufacturing, distribution, and consumption of tobacco products in Nigeria. The treaty was not domesticated in the country until 2015, ten years after the FCTC entered into force. Nigeria was one of the signatories of the treaty having signed and ratified the treaty in 2004 and 2005 respectively. As a party, Nigeria is obligated to domesticate the treaty, and this has come in the form of the Nigerian Tobacco Bill. Nigeria used the Convention as an umbrella to fashion the new Tobacco Bill to bring them into line with the treaty. The Bill was passed by the Senate and the House of Representatives in 2011 but unfortunately was not signed into law by the President. In April 2014, the Bill was repacked by the Federal Ministry of Health and submitted to the Federal Executive Council, which gave its nod to it. The Tobacco Control Act 2015 (NIGERIA, 2015) was finally signed into law by President Goodluck Jonathan on May 27, 2015. The Tobacco Control Act regulates the manufacturing, advertising, and distribution of tobacco products in Nigeria. The major provisions include the prohibition of smoking in public places to include bars and restaurants; no smoking on public transportation, in schools and hospitals, among others; a ban on all forms of direct and indirect advertising; prohibition of sales of cigarettes within a 1,000-meter radius of areas designated as non-smoking; mass awareness about the danger of smoking and the formation of a committee that will guide the government on the issue of tobacco control in the country. Prior to 2015, several states had enacted laws prohibiting smoking in public places. They include Osun, Cross River, and the Federal Capital Territory. It is not surprising that the delay in the passage of the bill suits the tobacco industry, which supports weak legislation or no legislation at all.

In observance of the FCTC, the Federal Government instituted an anti-smoking campaign that was featured in the media. Today, cigarette packs in Nigeria contain text-only warnings: "The Federal Ministry of Health warns that smokers are liable to die young," which covers approximately thirty per cent of the front and forty per cent of the back. This is in line with the belief that domestication of Article 11 of the FCTC (WHO, 2003) regarding pictorial warning labels may result in a reduced prevalence of youth smoking in Nigeria. Pictorial warnings, when used appropriately, evoke negative emotive feelings of fear and disgust, and are readily understood by a diverse audience regardless of age or secular education. Another strategy used for tobacco control is cigarette pricing. In fact, the price of the lowest-priced twenty cigarette pack in Nigeria is N50 while premium cigarettes were sold for about N200. Increasing retail cigarette prices in Nigeria is likely to decrease smoking-related disease particularly among youths who are price sensitive. There is clear evidence that among currently known interventions, excise tax increases above inflation have the greatest simple impact on youth smoking, particularly because youth are more price-sensitive and less addicted than adults (YACH, 2002). Bans on all forms of promotion and advertisement and marketing benefit both youth and adults. Despite all these measures, the tobacco companies continued to explore areas not covered by the APCON directive or existing laws to advertise the products. Those areas include delivery vans, point of sale, traffic signs, and umbrellas. It also continued

to associate tobacco with arts, music, and fashion, among others. They also color-coded all their brands in Nigeria.

British American Tobacco Company (BATN) has always argued against increased taxes on tobacco products, a recommendation which the FCTC puts forward as a key to cutting back on the number of people who buy cigarettes. It has been argued by critics that these measures against the tobacco companies were a breach of the memorandum of understanding between the Federal Government and the tobacco companies, particularly the British American Tobacco Company (CORRUPT..., 2007). They opined that the BATN, for example, contributed to the economic development of the country through sustainable agricultural development projects, sustainable water projects, sustainable environmental projects, and poverty reduction and economic empowerment.

Nevertheless, several studies have examined the potential economic impact of the complete elimination of tobacco use and production (ECONOMIC...). The evidence shows that the elimination of tobacco will not affect the economy because tobacco use has many externalized costs not paid for by smokers or tobacco manufacturers. This involves healthcare costs incurred by the government while taking care of smoking-related diseases. When people no longer spend their money on tobacco, they will spend their money on other things (THE FISCAL..., 2003). This alternative spending will stimulate other sectors of the economy. Conversely, if the money is saved rather than spent, the increased savings will have stimulatory macroeconomic effects. The World Bank's review of the economics of tobacco use also debunked many of the myths about job and revenue losses that effective tobacco ban was purported to cause (WORLD BANK, 1999). The World Bank demonstrated that policies reducing tobacco demand, such as the increase in tobacco taxes, will neither cause long term job losses nor will it reduce tax revenues. Rather, it will bring unprecedented health benefits without harming economies.

In Nigeria, progress in tobacco control has been slow for two fundamental reasons: weak human and institutional capacity in legislation economics, and advocacy and lack of political will (ANAEMENE, 2016). Although it took Nigeria ten years to domesticate the treaty, it is only a comprehensive legal framework like the Tobacco Control Act that can address the issue of tobacco smoking in Nigeria. Effective implementation of the Tobacco Law is the way to go, and this depends on public support. For this reason, media advocacy and communications that frame the tobacco debate in public health terms and encourage vigorous public debate about tobacco control options are essential.

III The WHO Revised International Health Regulations and Public Health Laws in Nigeria

Since the establishment of the WHO, only two regulations had been adopted by the Assembly under Article 21 (a) and (b). The first Regulation was adopted in 1948. The first Assembly adopted WHO Regulation No.1 regarding the unification of the statistical classification of morbidity and mortality primarily for comparability (WHO, 1948). The Regulations were revised several times. These Regulations had historical importance. First, they provided a guide to member states in compiling mortality and morbidity statistics by cause, age and sex and for various areas of the national territory. Second, the regulations constituted a departure in international law by laying obligation on state without signature ratification of a formal treaty.

The second WHO Regulation was adopted by the Fourth WHA in 1951 (WHO, 1951). They were replaced in 1969 by the International Health Regulations (WHO, 1969), which entered into force in 1971. The International Health Regulations represented a revised version of the previous international sanitary conventions including the 1903, 1912 and 1926 International Sanitary Conventions. The International Health Regulations is significant because it ensures maximum security against the international spread of

diseases with minimum interference with world traffic. They contain rules on notification and epidemiological information, national health organisations imports and airports, health measures on transport, cargo, goods, baggage, and mail. Also, the Regulations contain specific rules on each of the diseases subject to the Regulations health documents and charges. In 1973, the WHA amended the Regulations, particularly as regards the provisions for cholera. The 34th WHA in 1981 amended those Regulations to exclude smallpox, given its global evaluation.

In a similar development, the World Assembly Health requested the Director-General in 1995 to prepare a revision of the International Health Regulation. In this regard, an informal consultation was held in December 1995. It concluded that the Regulations have adequately served and would continue to serve the principles on which they were conceived. The 52nd WHA in 1999 considered a report by the WHO Secretariat on the progress of the revision and updating process of the International Health Regulations (WHO, 2005).

Finally, in 2005 the International Health Regulations (IHR) was revised (WHO, 2005). The Revised Regulations represented an international legal instrument binding on virtually all states of the international community. As Professor Lawrence Gostin rightly pointed out, the WHO's normative powers are impressive and far-reaching "as states can be bound by health regulations without the requirement to affirmatively sign and ratify" (GOSTIN, 2008, p. 242).

One of the most important innovations introduced by the revised regulations is their application to a wide spectrum of infectious diseases that require continuous epidemiologic surveillance and compulsory notification to the WHO when unusual and unforeseen events of international relevance occur. As pointed out by David Fidler in his early commentaries on the draft Regulations,

this innovative approach – which provides for an 'open category' encompassing any disease that may seriously and generally put public health at risk- represents the real revolutionary element characterising the IHR 2005, since they allow a more flexible application with better management of new health hazards (FIDLER, 2002, p. 3).

Specifically, Nigeria had been a party to all the previous regulations even before its full membership of the World Health Organisation in 1960. These are manifested in several public health laws, policies, and institutional arrangements. Article 3, paragraph 4 of the revised IHR emphasises the sovereign right of State to legislate in pursuance of their health policies but the discretion must be exercised within the boundary of the IHR 2005 (WHO, 2005). Two sources of legal mechanisms authorise the Federal government to adopt precautionary and subdual actions based on either speculation about or during emergencies. One source of authority is the Nigerian Constitution. The Constitution permits the President to announce a public health emergency as well as restrict certain individual rights, including the right to personal liberty and property. The President is also authorised by law to declare a state of emergency either unilaterally or at the behest of a state governor in the event of any of the following:

[...] c) there is critical breakdown of public order and public safety in the federation or any part thereof as to require extraordinary measures to restore peace and security; d) there is a clear and present danger of an actual breakdown of public order and public safety in the federation or any part thereof requiring extraordinary measures to avert such danger; e) there is the occurrence or imminent danger, or the occurrence of any disaster or natural calamity, affecting the community or a section of the community in the federation; f) there is any other public danger which clearly constitutes a threat to the existence of the federation (NIGERIA, 1999).

In 2014, the then Nigerian President, Goodluck Jonathan, exercised his authority, as enshrined in the Constitution. He announced a national emergency following the outbreak of the Ebola disease in the country (EBOLA..., 2014). He also directed all relevant government agencies both at the federal and state levels to work in tandem towards the containment of the disease. A Special Intervention Plan and a Special Intervention Fund of NGN1.9 billion were also released to combat the virus. Similarly, President Muhammadu Buhari exercised the same powers when he signed the COVID-19 Regulations 2020, which declared COVID-19 a dangerous infectious disease.

Another legal mechanism is the statutory (legal) regime. The Revised Quarantine Act 2004 remains the only extant law governing matters related to public health crisis in the country (NIGERIA, 2004a). The Act provides for and regulates the imposition of quarantine and to make other provisions for preventing the introduction into and the spread in Nigeria and the transmission from Nigeria of infectious diseases in line with the International Health Regulations. The Act regulates the imposition of quarantine and to make other provisions for preventing the introduction into and spread in Nigeria, and the transmission from Nigeria, of dangerous infectious diseases. The Quarantine Act requires the President to declare any contagious disease as a deadly infectious disease. This authority was used in the past to categorise sleeping sickness as a harmful infection. Likewise, the President is empowered by the Act to declare any location within or outside the country an infected local area. The Nigerian Public Health Bill is currently being considered at the Nigerian legislative chambers. The Bill is intended to replace the extant Quarantine Act.

A major requirement of the IHR 2005 (WHO, 2005) is the building of core capacities at the various points of entry – airports, ports and land borders. This is imperative to facilitate timely response to events of public health emergency of international concern. It further stipulates the role of competent authorities at the various designated points of entry. To manage this effort, the Port Health Services was established as a unit in the Public Health Department of the Federal Ministry of Health. It is noteworthy that the Port Health Services was established in 1925 in response to the plague epidemic (ADEMUSON, 2011). The Port Health Services is saddled with the responsibility of implementing the IHR at the designated points of entry. There are five designated international airports, where such services existed. Besides, there are five designated seaports. There are land borders in 22 of the 36 states of the country.

The Nigerian Centre for Disease Control (NCDC) is another institution established in response to the requirement of the IHR. The NCDC was established primarily to identify, assess and communicate current and emerging threats to human health posed by infectious disease. NCDC partners with other national health agencies in Africa in the discharge of its responsibilities of developing and strengthening disease surveillance and early warning systems. The agency is also involved in providing scientific information and training.

Another way in which the WHO Regulations has influenced public policy in Nigeria is in the field of integrated disease surveillance and response. Article 5.1 of the IHR 2005 requires State Parties to adopt or strengthen their infrastructure for public health surveillance and responses (WHO, 2005). Nigeria introduced the disease surveillance system in 1988. The establishment was informed by the outbreak of yellow fever in 1986/87, which affected 10 out of the then 19 existing states of the Federation. The extent of the outbreak was ascribed to weak or rather of absence disease surveillance and notification mechanisms in most states (NIGERIA, 2005a). Sequel to this, the Federal Ministry of Health set up a committee to review the disease surveillance and notification mechanisms in the country. A Disease Surveillance and Notification System (DSNS) was subsequently developed in 1988/89. The DSNS

identified and designated forty diseases of public health importance that require routine monthly notification.

Although significant strides were made in the implementation of the disease surveillance system in the late 1980s and early 1990s, it did not produce the expected outcome - the information required for immediate response. This is attributable to the vertical surveillance systems adopted by some disease control programmes. Besides, the involvement of laboratories was unsatisfactory. This disappointing situation was not peculiar to Nigeria; other countries in the WHO African Region faced a similar challenge. As a corollary, the WHO Regional Committee for Africa in her 48th Session in September 1988 in Harare, Zimbabwe pushed for a total revision of the existing surveillance system by member states. The Committee further promoted the adoption of an integrated disease surveillance system by countries in the region. The Integrated Disease Surveillance and Response (IDSR) that emerged from this development was endorsed by countries in the WHO African region including Nigeria.

As part of the initial step in the implementation process of the IDSR in Nigeria, an orientation workshop was organised in June 2000 primarily to sensitize the major stakeholders. Furthermore, a Steering Committee was set up in January 2001 to midwife the implementation process. The Committee undertook a thorough assessment of the existing surveillance system. It found that one of the shortcomings of the previous system was the use of vertical surveillance by certain disease programmes. Other flaws include the proliferation of reporting forms and format which resulted in incomplete and untimely reporting; the dearth of pre-positioned medicines and vaccines; lack of communication tools; absence of case management protocols, insufficient laboratory equipment; high rate of communicable diseases e.g., malaria, diarrhoea, pneumonia, measles, tuberculosis, and HIV/AIDS; and poor funding (NIGERIA, 2005a). The Committee came up with three major recommendations. First, it suggested the establishment of national standard case definitions and management protocols for priority diseases. Second, it proposed requisite training for IDSR and thirdly the provision of a budget line for IDSR (NIGERIA, 2005a). Therefore, the National Policy on Integrated Disease Surveillance and Response was formulated in 2005. The Policy provided a comprehensive national guideline for IDSR with details of sectoral responsibilities. It also defined the roles for the tiers of Nigeria's health system as well as the private sector.

IV The WHO International Code of Marketing of Breastmilk Substitutes and Health Law in Nigeria

In line with the responsibility bestowed on the WHO by Article 23 of its Constitution, a recommendation known as the International Code of Marketing of Breast-milk Substitutes was adopted by the 34th WHA in 1981 (WHO, 1981). The Code was formulated in 1981 in response to the realisation that poor infant feeding practices were negatively affecting the growth, health, and development of children. It was also seen as a major cause of mortality in infants and young children. Also, poor infant feeding practices were a serious obstacle to social and economic development.

The process for the adoption of the Code involved an intensive consultation and negotiation between the concerned parties. The major stakeholders were the WHO, representatives of governments, intergovernmental organisations, non-governmental organisations, industry or experts in the fields of concern to the issues. The process also took the form of debates between religious, consumer-activist, and local action groups on the one hand and industry on the other.

In January 1981, the WHO Executive Board endorsed the fourth draft of the Code and gave its unanimous support to a resolution to the WHA that it should adopt the

code as a recommendation rather than a regulation. The Code was finally adopted in May 1981 by the 34th WHA by 118 votes; one member state, the United States, voted against the Code and three member states, Argentina, Japan and the Republic of Korea, abstained. The United States had opposed the WHO Code from the beginning stating that its provisions were unrealistic, unworkable, that they operated against child health, served as an attack on the free market, and violated the right for free speech.

Despite these criticisms, it has been argued that the efforts of the WHO to protect the child through an International Code of Marketing of Breastmilk Substitutes provided an example of an attempt at an infant's right to food. It also served to create public awareness of the causes of infant malnutrition in the world, especially in developing countries. The Code sets out detailed provisions concerning information and education on infant feeding; promotion of breast-milk substitutes and related products to the public and mothers; promotion of breast-milk substitutes and related products to health workers and in health care settings; and labelling and quality breast-milk; and the implementation and monitoring of the Code (WHO, 1981).

It is pertinent to state that there is one version of the Code. However, there have been several WHA resolutions adopted since 1981 that referred to the marketing and distribution of breast-milk substitutes. Noteworthy is also the fact that the WHO has continued to promote infant and young child nutrition including technical support to national governments for implementing the Code. For this purpose, the Innocenti Declaration was adopted which set operational targets for the Code's implementation within member states (UNICEF, 2005). WHO and UNICEF jointly organised the Baby-Friendly Initiative (BFI), which focused on the role of health services in the promotion of safe motherhood, child survival, and primary health care. The initiative stated several criteria that hospitals need to obtain baby friendly status (BABY-FRIENDLY...). Among the criteria is the non-distribution of free or low-cost supplies of breast-milk substitutes. In 2002, WHO member states endorsed a Global Strategy for Infant and Young Child Feeding (GLOBAL..., 2002).

Nigeria domesticated the Code in 1986 and backed it legally with Marketing (Breastmilk Substitutes) Act No. 41 of 1990 as amended by Act No. 22 of 1999 (NIGERIA, 2004b). (Federal Republic of Nigeria, 2004). According to the UNICEF report, Nigeria is grouped among the countries that have enacted legislation or other legal measures encompassing many of the provisions of the international code (UNICEF, 2011). In May 1999, the Federal Government reviewed and amended the code of marketing of breast-milk substitutes. This gave birth to the National Agency for Drug Administration and Control (NAFDAC) -Marketing of Infant and Young Child Foods and other Designated Products Regulations 2005 (NIGERIA, 2006), which was gazetted, launched and disseminated to stakeholders including infant food manufacturers in 2006. This amendment introduced stiffer fines and a clearer definition of breast-milk substitute. One major challenge is the monitoring and enforcement of the Code. To address this problem, the government embarked on the development of a system for monitoring the marketing of breast-milk substitutes undertaken by the NAFDAC National Committee on Food and Nutrition (NCFN) and UNICEF. Some policy outcomes include the Nigerian National Breastfeeding Policy adopted in 1998.

In accordance with the Innocenti Declaration (UNICEF, 2005), which set operational targets for the implementation of the Code of marketing of breast milk substitutes and recommended that all governments should develop national breastfeeding policies, a Nigerian National Breastfeeding Policy was adopted in 1998. The policy recommended exclusive breastfeeding for the first six months. A national breastfeeding coordinator was appointed. The coordinator provided an effective focal point. However, after two years, the office of the National Coordinator for Breastfeeding became non-functional. This was due to the persistent deployment of personnel in the Ministry

of Health, which rendered that office redundant. Besides, inadequate funding also undermined the effectiveness of the coordinator. The BFHI has encouraged hospitals and facilities providing maternity care to follow the ten steps. It was recommended that hospitals and maternity facilities that need to purchase breast milk substitutes should do so at full price through normal procurement channels, accepting no fee or low-cost supplies.

According to the WHO Assessment Report in 2008, 1,052 of 21,562 hospitals and facilities offering maternity services were designated baby-friendly (WHO, 2008). Furthermore, the result of an evaluation of BFHI in 2000 revealed favourable changes in lactating mothers' knowledge and practices of breastfeeding. The evaluation showed an exclusive breastfeeding rate of 62% at four months and 59% at six months in a sample of babies born in BFHI hospitals (WHO, 2008). However, it has been argued that should a similar survey be carried out today, it was unlikely that figures like these would be obtained. This is because the initiative lost its initial momentum. It was no longer pursued by the same vigour, as was the case when it was initially introduced. This is evidenced by only 39% of six-month-old children being exclusively breastfed in 2012 (ANUFORO, 2013).

In 2005, Nigeria adopted a comprehensive National Policy on Infant and Young Child Feeding (NIGERIA, 2005b). The provisions of WHO recommendations such as the International Code of Marketing of Breastmilk Substitutes and other initiatives such as the Innocenti Declaration on the protection, promotion and support of breastfeeding and the BFHI were recognised in the articulation of this policy. The policy was adopted to fill the revealed gaps in policy provisions on infant and young child feeding in the available national policies on nutrition and maternal-child health. A comprehensive national policy in Nigeria became imperative because of the HIV/AIDS pandemic and the possibility of transmission of HIV through inappropriate feeding options.

The policy also recognises that there are children in special circumstances who need further attention and extra support to meet their nutritional requirements. Also, there are situations under which breast milk substitutes or other artificial feedings may be necessary. These groups include infants and young children of HIV mothers; sick infants and young children, particularly those with persistent diarrhoea and those living with HIV/AIDS; low birth weight infants; motherless/adopted infants and young children; infants and young children in emergencies; and infants with cleft palate.

Other policies included the National Plan of Action on Food and Nutrition in Nigeria 2005, which was aimed at improving the nutritional status of all Nigerians with particular emphasis on the most vulnerable groups such as children, women and the elderly. The National Policy on Food and Nutrition in Nigeria 2002 also emphasised the need to promote, encourage and support exclusive breastfeeding for the first six months, and promote the continuation of breastfeeding well into the second year of life. It is important to note that despite legislative provisions, effective implementation of the Code has been poor. Nestlé and other companies have continued to promote infant foods through other means. Under the guise of its Nestlé Nutrition Services, Nestlé continues to sponsor doctors' meetings and many strategies are being used to push the company's products in Nigeria. Besides, an attempt has been made by these companies to circumvent the strong condemnation they receive from the global health community. To this end, many companies have formed partnerships with United Nations agencies to combat malnutrition. They have succeeded in linking their brand with the humanitarian image of the UN agencies to benefit from the aid funds pouring into these agencies from donor governments. For instance, Global Alliance for Improved Nutrition (GAIN)'s global health partnership opens its website with the message, "Improving nutrition can also seriously benefit your business by creating growth in new and existing markets" (GLOBAL..., 2008).

Another major setback is the fact that civil society groups have not monitored compliance with the Marketing (Breast Milk) Substitutes Act. In India for instance, two civil society groups, the Breastfeeding Promotion Network of India (BPNI) and Association for Consumer Action on Safety and Health (ACASH), have been instrumental in exposing the unlawful practices of baby food manufacturing companies. In 1994 and 1995, the Government of India issued a notification in the Gazette of India to authorise BPNI and ACASH and two other national semi-government organisations to monitor compliance and they empowered them to initiate legal action (GLOBAL..., 2008). The situation in Nigeria is completely different. The non-involvement of the civil society groups in Nigeria could be seen as an oversight of how sustained advocacy and action by such groups can influence public opinion and decision-making. Other factors have militated against the successful implementation of the Code in Nigeria. These include the problem associated with public policy implementation in the country. It has been observed that despite the availability of public policies that seek to improve the life of the average Nigerian, the State lacks the political will to realise such policy objectives. The argument is that even if the set objectives stand to benefit the public, some groups of people, usually the influential ones in government will jeopardise or frustrate the implementation of such public policies. Another problem is that the Nigerian state downplays the crucial issues of implementation design of public policies. This trend translates to the advent of public policies without clear-cut modalities or mechanisms for implementation. In most cases, the government formulates national policies without adequate enlightenment and education. Corruption is also a major issue in the politics of public policy implementation in Nigeria. In fact, when corruption penetrates the implementation process, public policies become mutated, and the desired goals may not be achieved. Most public policies are formulated but corruption ruins them and makes the implementation process impossible. Another problem may arise when the target beneficiaries are not involved in the formulation of policies that affect their lives. Also, the failure of policymakers to take into consideration the social, political, economic and administrative variables when analysing for policy formulation could mar the implementation process. Instructively, some government agencies and institutions lack the requisite manpower and financial resources to implement these policies. High-level poverty and low literacy, as well as socio-cultural practices, have also constituted a serious albatross to the effective implementation of the Code in the country.

V The WHO and Right to Health in Nigeria

Health is a fundamental human right, indispensable for the exercise of many other human rights, and necessary for living a life in dignity. It would be recalled that the right to the highest attainable standard of health as a normative standard was first enunciated in 1948 in the Constitution of the WHO and has since been reiterated in several WHO Declarations such as the 1978 Alma-Ata Declaration on Primary Health Care (WHO, 1978) and the 1998 World Health Declaration (WHO, 1988). Understanding health as a human right creates a legal obligation on States to ensure access to timely, acceptable, and affordable health care of appropriate quality as well as to provide for the underlying determinants of health, such as safe and potable water, sanitation, food, housing, health-related information and education, and gender equality (RIEDEL, 2014). The right to health necessitates that the Nigerian government and judiciary take positive action to ensure the right to health for Nigerians. The right to health is guaranteed by section 17 (c) & (d) of the Nigerian Constitution (as amended) which states: The States shall direct its policy towards ensuring that: "(c) the health, safety, and welfare of all persons in employment are safeguarded and not endangered or abused;(d) there are adequate medical and health facilities for all persons" (NIGERIA, 1999).

Furthermore, the National Council on Health is under an obligation to "ensure that children between the ages of zero and five years and pregnant women are

immunized with vaccines against infectious diseases". Under the National Programme on Immunization Act, there is no limitation with respect to age as the government is required to effectively control, through immunization and the provision of vaccines the occurrence of certain deadly diseases such as tuberculosis, poliomyelitis, diphtheria, whooping cough, tetanus, neonatal tetanus, measles, disease of women of childbearing age among others. The National Council on Health shall ensure the delivery of basic health services to the people of Nigeria and prioritize other health services that may be prescribed from time to time by the Minister of Health after consultation with the National Council on Health.

The National Health Act (NHA) 2014 is also one of the legislations that uphold the human right to health (NIGERIA, 2014). The Act provides a legal framework for the regulation, development and management and set standards for rendering health services in Nigeria and for related matters. The NHA consists of seven parts including: Responsibility for health and eligibility for health services and establishment of National Health System, Health Establishments and Technologies, Rights and Obligations of Users and Healthcare Personnel, National Health Research and Information System, Human Resources for Health, Control of Use of Blood, Blood Products, Tissue and Gametes in Humans, and Regulations and Miscellaneous Provisions. The Act has not been fully operationalized due to several challenges including poor knowledge of the Act by health professionals and members of the public; and poor political commitment by government to the implementation of the Act (ENABULELE, 2017). However, the Act has the potential to significantly redefine Nigeria's health system and protect the right of Nigerian people to health.

Other legislations for the protection of the right of the Nigerian people to health include the National HIV/AIDS Agency Act, National Agency for Food and Drug Administration and Control Act, Food and Drug Act, Dangerous Drug Act, Counterfeit and Fake Drugs and Unwholesome Processed Foods (Miscellaneous Provisions Act and Quarantine Act). The National Environmental Standards and Regulations Enforcement Agency (Establishment) Act and other environmental protection legislation and regulations have also protected the right to health.

Conclusion

The Nigerian experience demonstrates the relationship between domestic actions and implementation of international health law. Nigeria has made remarkable progress in terms of governance of health issues manifested in legal responses, institutional arrangements and policy initiatives. These are clear indications of the influence of WHO legal regimes on national public health laws in Nigeria through its legal instruments. It is axiomatic that national law is an intervention tool. It impacts positively on the health of the population. It could also be an obstacle to action. Major public health achievements in the past three decades depended on legal interventions. For instance, legal responses have been utilised to reduce the consumption of tobacco, manage public health emergencies and lifestyle-related chronic diseases. In virtually every case involving public health problems, States including Nigeria must incorporate the international legal obligations into national law and policy. This is imperative as a breakdown of the incorporation process could jeopardise the entire international regime. Once enacted, health law can be a powerful tool for changing unhealthy behaviours and environments and for coordinating the work of health systems. However, one of the weaknesses of Nigeria concerning its national legal systems generally and domestic public health law specifically is the lack of respect for the rule of law. It is no gainsaying that multiplying international legal regimes does little to address the incorporation of international legal norms into domestic law and policy if states do not simultaneously improve the rule of law. To validate the view that law is an effective tool

for health protection and promotion, the citizens must be mobilised and empowered to secure the enforcement of their right to health.

Improvements are needed in the health law of nations. Modern public health cannot be effective without laws, the WHO cannot achieve its goals unless it can help all Member States including Nigeria to develop and implement all the legal and regulatory tools they need. The WHO must demonstrate strong committed leadership in this area. The Organisation should focus on improving among its member states national legal compliance, transparency and accountability to ensure seamless attainment of sustainable development. To this end, the WHO should develop a programme for public health law capacity building and policy surveillance to ensure continuous and organised efforts to help the Member States to strengthen their legal infrastructure.

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