PART 3

INTERNATIONAL REGULATION OF HEALTH CHALLENGES
10. Communicable disease control

Stefania Negri

1. INTRODUCTION: COMMUNICABLE DISEASES AS A MAJOR GLOBAL PUBLIC HEALTH THREAT

Communicable diseases are infectious diseases caused by microbial agents (viruses, bacteria and parasites) that are potentially transferable from reservoirs to susceptible hosts.¹ There are several possible classifications of communicable diseases, including based on the nature and characteristics of the pathogen (microbiological classification), their main clinical manifestations (clinical classification), or the mode and dynamics of transmission (epidemiological classification). According to the latter, which is better understandable also to non-medical professionals, communicable diseases may be subdivided into contagious, vehicle-borne and vector-borne diseases. This classification is particularly relevant to the public health discourse because it provides the medical rationale to determine the most appropriate measures of prevention and control (see Table 10.1).

Due to their epidemic and pandemic potential,² communicable diseases have represented a major public health threat since the dawn of humanity.³ A century ago, infectious diseases were by far the leading cause of

¹ The reservoir of an infectious agent is the habitat in which the agent normally lives, grows, and multiplies. Reservoirs include humans, animals, and the environment. The susceptible host is a person who can be infected due to lack of any natural or acquired (for example through vaccination) defence against the infectious agent. Not all infectious diseases are communicable: examples of non-communicable diseases are those caused by toxins from food poisoning or infections caused by toxins in the environment, such as tetanus.

² The term epidemic refers to situations where the increase in the number of cases is above the expected rate in a particular area and in a specific time interval, while the accepted definition of pandemic is ‘an epidemic occurring worldwide, or over a very wide area, crossing international boundaries and usually affecting a large number of people’ (John Last (ed.), A Dictionary of Epidemiology (4th edn, OUP 2001)).

³ On the history of pandemics, an overview of traditional and emerging ones and the relevant causative factors, see Jean Salmon, ‘Rapport introductif’ in
death throughout the world, and still today, despite an overall decrease in their global incidence, the related mortality rate remains impressive. Suffice it to mention that the top ten causes of death reported during the last 15 years include communicable diseases such as lower respiratory infections, diarrhoeal diseases, tuberculosis and HIV/AIDS.4

Table 10.1 Epidemiological classification of communicable diseases and relevant public health measures of prevention and control

<table>
<thead>
<tr>
<th>Classification</th>
<th>Transmission</th>
<th>Diseases</th>
<th>Prevention</th>
<th>Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contagious diseases</td>
<td>direct (host to host)</td>
<td>e.g. HIV-AIDS, SARS, Ebola, meningitis</td>
<td>e.g. prophylaxis and immunization</td>
<td>isolation and quarantine*</td>
</tr>
<tr>
<td></td>
<td>physical contact, close proximity</td>
<td>e.g. tuberculosis, measles, pertussis, influenza, cold</td>
<td>e.g. prophylaxis, immunization, hygiene, face masks</td>
<td>isolation, distance measures, ventilation, environmental control</td>
</tr>
<tr>
<td>Vehicle-borne</td>
<td>indirect (through an inanimate intermediary)</td>
<td>e.g. tuberculosis, measles, pertussis, influenza, cold</td>
<td>e.g. prophylaxis, immunization, hygiene, face masks</td>
<td>isolation, food recall, food seizure, closure of food premises, decontamination, good hygiene</td>
</tr>
<tr>
<td>A. Airborne</td>
<td>respiratory droplets, dust (between humans)</td>
<td>e.g. tuberculosis, measles, pertussis, influenza, cold</td>
<td>e.g. prophylaxis, immunization, hygiene, face masks</td>
<td>isolation, food recall, food seizure, closure of food premises, decontamination, good hygiene</td>
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<tr>
<td>B. Foodborne</td>
<td>contaminated food (between humans) (from animals to humans: zoonoses*)</td>
<td>e.g. hepatitis, botulism, E. coli infection, salmonellosis, brucellosis, bovine spongiform encephalopathy</td>
<td>e.g. prophylaxis, immunization, food safety, hygiene, separation of raw and cooked food, thorough cooking, storage at safe temperatures</td>
<td>e.g. isolation, food recall, food seizure, closure of food premises, decontamination, good hygiene</td>
</tr>
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### Classification Transmission Diseases Prevention Control

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<tr>
<td>C. Waterborne</td>
<td>non-treated drinking water or contaminated bathing waters (between humans) (from animals to humans: zoonoses)</td>
<td>e.g. cholera, typhoid, E. coli infection, legionellosis, leptospirosis, Guinea worm disease</td>
<td>e.g. prophylaxis, immunization, hygiene and sanitation, disinfection, drinking bottled water, treatment of waters, proper waste management</td>
<td>e.g. isolation and quarantine, sanitation, disinfection</td>
</tr>
<tr>
<td>Vector-borne diseases</td>
<td>indirect (through a living intermediary) e.g. mosquitoes, ticks, flies, bugs (between humans) (from animals to humans: zoonoses)</td>
<td>e.g. malaria, yellow fever, Dengue fever, Rift Valley fever, West Nile fever, Chagas disease, Zika</td>
<td>e.g. prophylaxis, immunization, insecticidal nets, outdoor/aerial and indoor spraying, proper waste management</td>
<td>e.g. isolation and quarantine, habitat and environmental control, biological control, chemical control</td>
</tr>
</tbody>
</table>

**Notes:**

- Isolation and quarantine help protect the public by preventing exposure to people who have or may have a contagious disease. The difference between these two measures is that isolation normally applies to those known to be ill, while quarantine applies to those who have been exposed.
- Zoonotic diseases are infectious diseases of animals that can cause disease when transmitted to humans. Any disease or infection that is naturally transmissible from vertebrate animals to humans and vice versa is classified as a zoonosis.

Globalisation of travel and trade, population movements, unplanned urbanisation and environmental challenges, such as climate change, have had a significant impact on the transmission of these diseases, which now cross borders at an unprecedented rate and multiply exposure and mutual vulnerability of people around the globe. Moreover, public health crises caused by the outbreak of emerging and newly identified communicable diseases, that were unknown only a generation ago (such as the severe

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*On the concept of mutual vulnerability, see especially Obijiofor Aginam, *Global Health Governance. International Law and Public Health in a Divided World* (University of Toronto Press 2005).*

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acute respiratory syndrome, avian and swine flu and bovine spongiform encephalopathy), as well as the violent re-emergence of known ones (like Ebola), have lit the spotlight on the limits of the available tools and procedures for risk prevention and management, thus calling for a more robust response from the global health community.

Today, a paradigm shift in infectious disease control, axed on a stronger and more coordinated collective action, enables international institutions, governments and other relevant stakeholders to tackle global health risks and protect public health worldwide. The watershed in disease surveillance and response was marked by the adoption by the World Health Organization (WHO) of the International Health Regulations 2005 (IHR 2005), the only global binding instrument governing the reporting of disease outbreaks and the prevention of their international spread.

In light of the foregoing, the present chapter will specifically focus on the role of the IHR (2005) in global disease control—thus leaving aside other sources of global health law that may be relevant to communicable diseases— with the aim of critically assessing strengths and weaknesses that emerged during their first decade of implementation. To this end, the chapter will first describe the evolution of international law in the field of public health and infectious disease control and the circumstances that led to the adoption of the IHR (2005); then it will explain the innovations introduced by the Regulations, focusing on the features that make it unique in the present scenario of global health law and governance. Against this background, the application of the IHR (2005) in times of public health emergencies of international concern will be assessed through the lens of the health and human rights and the health-security paradigms, given the prominent and ever increasing interconnection

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6 According to Suerie Moon’s view, both ‘voluntary formal norms endorsed by an authoritative governing body’ and ‘binding formal norms negotiated by authoritative stakeholders (i.e. governments)’ qualify as ‘global health law’ (see her chapter ‘Global health law and global governance for health: concepts, tools, actors, power and functions’, in this volume). Following her approach, relevant global health law sources in the field of communicable diseases should include not only the WHO International Health Regulations, but also the WHO Pandemic Influenza Preparedness Framework, the Codex Alimentarius Commission’s technical norms and standards concerning food safety, the WHO Guidelines for Safe Recreational Water Environments and the WHO Guidelines for Drinking-Water Quality, just to mention a few.
between public health, human rights protection and international security. In this latter respect, the chapter will finally conclude by advancing some proposals for possible improvements in the implementation of the Regulations in order to overcome major human rights and security concerns raised by non-compliance with IHR obligations.

2. THE EVOLUTION OF INTERNATIONAL LAW IN RESPONSE TO COMMUNICABLE DISEASES

Infectious disease control is at the very root of the development of international law in the field of public health. In fact, the origins of international health law can be traced back to the middle of the nineteenth century, when the first sanitary conferences were convened in Europe with the aim of negotiating agreements and regulations to combat the cholera epidemics, protect States from disease importation and reduce the burden of quarantines on international trade. Since then, international cooperation in the field of public health has steadily increased in response to the ‘great scourges of humanity’ and international law has consequently evolved under the push of compelling health security needs.

The evolution of this international framework has been largely characterised by the progressive shift from domestic jurisdiction and exclusive sovereignty over health issues to inter-state cooperation, and from such multilateral cooperation to institutionalisation, and later to global governance. Scholars identify these different phases with well-defined historical periods. According to Makane Moïse Mbengue, the first era of international cooperation (moving from quarantine measures to international sanitary conventions) runs from mid-nineteenth century to the beginning of the twentieth; the second era (from surveillance to institutionalization) covers the first half of the twentieth century; the third era starts in 1945 and mainly coincides with the leading role of the WHO in meeting the challenges of universalization in the management of public health risks, and, more recently, of global health governance. See also Fidler (n 8); Obijifor Aginam, ‘International Law and Communicable Diseases’
the transition from national regulations of unilateral quarantine measures to international harmonisation through bilateral and multilateral sanitary conventions, and finally to the emergence of international health law.10

Until the end of the Second World War and the establishment of the United Nations (UN), the outcomes of this century-long process of intense health diplomacy were both normative and institutional: on the one hand, they led to the negotiation and conclusion of a plethora of sanitary agreements, and, on the other hand, they culminated in the institution of four international health organizations, conceived as permanent fora enhancing a stronger intergovernmental collaboration.11

The establishment of the WHO, which immediately took the lead in the fight against infectious diseases, represented a landmark step in this evolving process. The Organization took upon itself the responsibility for the management of the international regime of disease control and soon engaged in an onerous work of revision and consolidation of the existing sanitary conventions. This led to the adoption of the International Sanitary Regulations of 1951,12 the first universal and coherent legal regime of surveillance and control of ‘quarantinable diseases’ (plague, cholera, yellow fever, smallpox, typhus and relapsing fever) binding on all WHO Member States.13 In replacing all the conventions adopted

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12 WHO, Resolution WHA4.75 of 25 May 1951.

13 The Regulations are an international legal instrument binding on nearly all States of the international community. Articles 21 and 22 of the WHO Constitution confer upon the World Health Assembly the authority to adopt regulations on a broad range of topics, including ‘sanitary and quarantine requirements and other procedures designed to prevent the international spread of disease’, which produce compulsory effects for all Member States that do not expressly ‘opt out’ or make reservations to them within a limited deadline. These provisions empower the Assembly with extraordinary and far-reaching normative
between 1903 and 1944, the 1951 Regulations succeeded in remedying some of the most apparent shortcomings of the then existing conventional regime: geographical gaps, overlapping of treaties, inconsistencies due to the succession of treaties, obsolescence and the inadequacy of these conventions to adapt to the developments of scientific knowledge and the increase in rate and speed of international traffic and trade. Nonetheless, they soon called for further updating and improvements, until a major revision was accomplished in 1969, when a consolidated version of the text was adopted under the name of International Health Regulations (IHR).

The IHR (1969) initially covered the six ‘quarantinable diseases’ mentioned above, but they were later amended to reduce the number of these diseases to three (yellow fever, plague and cholera) and to mark the global eradication of smallpox. The Regulations sought to guarantee powers, or quasi-legislative powers, inasmuch as ‘states can be bound by health regulations without the requirement to affirmatively sign and ratify’ them. See Michel Bélanger, *Droit international de la santé* (Economica 1983) 96; Gian Luca Burci and Claude-Henri Vignes, *World Health Organization* (Kluwer 2004) Chapter II, 124–55; quotation from Lawrence O. Gostin, *Public Health Law: Power, Duty, Restraint* (UCP 2008) 242.


See Burci and Vignes (n 13) 135.

Additional amending Regulations were adopted on 26 May 1955 and 23 May 1956.


maximum health security with minimum interference with world traffic. On the one hand, in order to shield States from the risk of importing infectious diseases, they established a global surveillance system based on notification duties, general and disease-specific provisions, and specific health-related capabilities at ports and airports. On the other hand, they contained provisions authorizing maximum restrictive measures applicable to international movements of persons and goods, and limited government interference with regard to diseases not subject to the Regulations.

Unfortunately, over time the IHR (1969) increasingly failed to achieve their core purposes due to a complex series of causes. These were mainly related to their narrow scope (suffice it to mention that HIV/AIDS could not be addressed by the Regulations), the dependence on official country notifications and the lack of a formal internationally coordinated mechanism to contain international disease spread. Therefore, a combination of major problematic factors determined the Regulations’ failure, prominent among them the obsolescence of the maximum restrictive measures approach, the adoption of over-restrictive public health measures contrary to the minimum interference objective, the breakdown of the surveillance system due to a regular failure to notify outbreaks, and the WHO’s lack of enforcement powers.19 These factors, together with the growing concern about emerging and re-emerging diseases and the Regulations’ clear inadequacy to address them, triggered a further revision process which was launched in May 1995.20 A few years later, the occurrence of the first global public health emergencies of the twenty-first century—the 2003 outbreak of SARS and the 2004 pandemic of avian influenza A/H5N121—posed an even stronger demand for global health security and served as major catalyst for prioritizing a thorough rethinking of the IHR.

19 Fidler (n 8) 61–68.
21 See David P. Fidler, SARS, Governance and the Globalisation of Diseases (Palgrave Macmillan 2004); Gian Luca Burci, ‘La gestion d’une crise sanitaire internationale: le cas du SRAS’ in Mehdi and Maljean-Dubois (n 3) 135; Jean-Luc Angot, ‘La gestion d’une crise sanitaire internationale: le cas de l’influenza aviaire’, in ibid., 143.
3. THE INTERNATIONAL HEALTH REGULATIONS (2005) AS THE PILLAR OF GLOBAL HEALTH LAW IN THE FIELD OF COMMUNICABLE DISEASE CONTROL

The World Health Assembly (WHA) adopted the revised International Health Regulations in May 2005. These Regulations embody a radically new strategy of global health governance inspired by the principles of timeliness, effectiveness, flexibility and universality. Timeliness and effectiveness underpin the new rules and procedures on surveillance, alert and reaction. Flexibility is guaranteed by the adaptability of these rules and procedures to the different transmission dynamics of new or emerging diseases (human-to-human, animal-to-human, and transmission via food or water), to the advances in the fields of epidemiology, biotechnology, information technology and data sharing, and, most interestingly, to events concerning accidental or intentional release of biological, chemical and radionuclear agents. Universality is achieved not only through universal application and bindingness on all WHO Member States, but also through the implementation of a multilateral co-operative system of notification, advice and support in the event of an international public health emergency.

States, but also through the possible involvement of non-State actors and the opportunity afforded to non-Member States to accede to the Regulations.

While the purpose of the revised Regulations has remained substantially unaltered—‘to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade’—their approach and scope have radically changed.

The IHR (2005) aim at striking a fair balance between sovereign rights, human rights, freedom of traffic and trade, and a shared commitment to protect global health. They define specific rights and impose proactive conducts and obligations not only in the field of international cooperation among States and with the WHO, but also at domestic level, requiring States Parties to strengthen their national health systems in terms of preparedness and response to large-scale public health emergencies. In essence, the IHR (2005) introduce a range of core innovations including a very broad scope of application; obligations for States Parties to develop certain minimum public health capacities not limited to disease control at points of entry; procedures for the determination of a ‘public health emergency of international concern’ (PHEIC) and for the issuance of relevant recommendations; obligations to notify the WHO of events that may constitute a PHEIC; provisions authorising the WHO to rely on non-governmental sources of information and early

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23 The IHR (2005) are binding on 196 States, including all WHO Members, of which only two (India and the United States of America) submitted reservations under Article 62 of the Regulations. For this reason they have come to be considered as the ‘most important global health treaty of the twenty-first century’ (Gostin (n 22) 178).

24 Mondielli (n 22) 63, 68–70.

25 Article 2 of the IHR (2005). Contrary to their predecessors, the revised Regulations have added the definition of ‘international traffic’ in Article 1: ‘the movement of persons, baggage, cargo, containers, conveyances, goods or postal parcels across an international border, including international trade’.

26 See Article 13 of the IHR (2005). Annex 1 stipulates the minimum core capacity requirements for surveillance and response to communicable diseases at the local community level, at the intermediate level, and also at the national level. They call upon Member States to develop and enhance their capacities for surveillance, reporting, notification, verification, response, and collaboration, and their activities concerning designated airports, ports and ground crossings.

27 Articles 12, 15 and 49 of the IHR (2005).

28 Article 6 of the IHR (2005).
warnings by third parties, taking into consideration unofficial reports of public health events and asking States for verification;\textsuperscript{29} protection and full respect for dignity, human rights and fundamental freedoms of persons and travellers; and the creation of National IHR Focal Points and WHO IHR Contact Points for urgent communications between States Parties and the WHO.\textsuperscript{30} Some of these innovations stand out for their relevance to the successful implementation of the Regulations and thus deserve a closer analysis.

First of all, concerning the IHR’s scope, it is remarkable that the revised Regulations encompass a significantly broader spectrum of infectious diseases and also extend to the natural, accidental or deliberate release of biological, chemical or radionuclear materials. In fact, the IHR (2005) confer on the WHO the jurisdiction to address any ‘public health risk’,\textsuperscript{31} be it caused by ‘traditional’ communicable diseases (for example smallpox, cholera, pneumonic plague, yellow fever, meningitis), new and emerging diseases (such as SARS, human influenza caused by new virus subtypes, wild poliomyelitis, viral haemorrhagic fevers, like Ebola), or any other disease which may spread internationally and represent a serious risk to global public health. Therefore, in line with an ‘all hazards approach’, they apply to any ‘illness or medical condition, irrespective of origin or source, that presents or could present significant harm to humans’.\textsuperscript{32} As stressed by David Fidler in his early commentaries, the provision of this ‘open category of disease’, encompassing any illness that may seriously and widely put public health at risk, irrespective of origin and source, represents the real revolutionary feature of the revised text, since it allows both the WHO and Member States to manage new health hazards through a more flexible and effective application of the Regulations.\textsuperscript{33}

\textsuperscript{29} Articles 9 and 10 of the IHR (2005).
\textsuperscript{30} See in particular Articles 2 to 12 of the IHR (2005).
\textsuperscript{31} Article 1 of the IHR (2005) defines a ‘public health risk’ as ‘a likelihood of an event that may affect adversely the health of human populations, with an emphasis on one which may spread internationally or may present a serious and direct danger’.
\textsuperscript{32} Ibid.
Secondly, the Regulations set up an integrated global alert and response system (GAR) relying on a number of surveillance and emergency networks, which provides the necessary technical tools to comply with the obligation to promptly notify (within 24 hours) events detected by national surveillance systems in accordance with the ‘algorithm’ contained in Annex 2. This ‘decision instrument’ makes a distinction between: a) mandatory notification of events concerning a restricted number of diseases (smallpox, wild poliomyelitis, human influenza due to new viral subtypes, SARS), which appear unusual and unexpected and pose a serious risk of adverse impact on public health, and b) mandatory notification of other events meeting at least two out of the four conditions laid down in Annex 2 (seriousness of the public health impact of the event; unusual or unexpected nature of the event; potential risk of international spread and potential interference with international travel or trade). Mandatory notification is thus required for any event of potential international public health concern, including those of unknown causes or sources, and for events involving a given list of diseases (cholera, pneumonic plague, meningitis, yellow fever, viral hemorrhagic and other infectious fevers) whose dangerousness and epidemic potential are already known.

Thirdly, the concept of ‘public health emergency of international concern’ (PHEIC), which is prominent in the dynamics of Annex 2, is one of the core innovations in the IHR (2005). Article 1 defines a PHEIC as ‘an extraordinary event which is determined to constitute a public health risk to other States through the international spread of disease and to potentially require a coordinated international response’. This definition implies the occurrence of a serious, sudden, unusual or unexpected situation, carrying implications for public health beyond the affected State’s national borders and requiring immediate international action.

34 The networks that operate under the general umbrella of the IHR include the Global Outbreak Alert and Response Network (GOARN), a global network launched in 2000 to combat the international spread of disease, the International Food Safety Authorities Network (INFOSAN), a joint WHO-FAO network launched in 2004 to promote the exchange of food safety information and to improve collaboration among food safety authorities at national and international levels; the Global Early Warning System for Major Animal Diseases, including Zoonoses (GLEWS), a WHO-FAO-OIE joint early warning system launched in 2006 to detect, analyse and assess each event for its potential international importance according to the risk assessment criteria set forth in the IHR (2005).

35 Annex 2 to the IHR (2005): ‘Decision instrument for the assessment and notification of events that may constitute a public health emergency of international concern.’
Under the terms of the Regulations, the responsibility of determining whether a public health event is within this category lies with the WHO’s Director-General, who may seek the views of the IHR Emergency Committee. This Committee is composed of international experts in disease control, virology, vaccine development, infectious disease epidemiology, public health and so on. It provides technical advice and views on whether an event constitutes a PHEIC, on the temporary recommendations that should be applied by the country experiencing such an emergency and by third countries, and on the termination of a PHEIC. Once the Director-General has declared a public health emergency of international concern, and temporary recommendations have been issued, these are communicated to the States Parties, together with information on any health measure adopted by the States concerned. Such recommendations concern the appropriate health measures regarding persons, baggage, cargo, containers, conveyances, goods and postal parcels, which should be applied by States Parties in order to prevent or reduce the international spread of disease and avoid unnecessary interference with international traffic.

A similar procedure is adopted when the Director-General deems that a specific ‘public health risk’ calls for standing recommendations to be applied periodically or routinely. In this case, technical advice on the adoption, modification and withdrawal of standing recommendations is provided by a Review Committee (a body composed of experts serving on the IHR Expert Roster and, when appropriate, other expert advisory panels of the Organization) also on the basis of relevant information

36 Articles 12 and 49 of the IHR (2005).
37 Article 48 of the IHR (2005).
38 Articles 15 and 49 of the IHR (2005). The Regulations intend to balance health needs with traffic and trade interests: article 12 provides that the risk of interference with international traffic has to be taken into consideration in determining whether a PHEIC occurs; article 28 prohibits refusal of access to ships or aircrafts at any point of entry unless that point is not equipped for applying health measures; article 33 states that goods, other than live animals, in transit without transhipment shall not be subject to health measures under the Regulations or detained for public health purposes; article 43 allows States Parties to adopt additional health measures, provided that a) they are not more restrictive of international traffic than reasonably available alternatives that would achieve the appropriate level of health protection, b) States adopting additional measures provide the WHO with the public health rationale and scientific information on them.
obtained from any State Party, intergovernmental organization or non-
governmental organization in official relations with the WHO.39

In light of the foregoing, the IHR (2005) can be indeed considered a
landmark innovative instrument in infectious disease control. They devise
a global health governance framework engaging different actors and
stakeholders and placing the interaction between national and inter-
national health authorities at the heart of decision-making and operational
activities, with a view to sharing responsibilities and fulfilling the duty to
cooperate to avoid major public health emergencies. Within this frame-
work, the Regulations also set up a challenging interplay between public
health goals and other collective interests such as human rights protec-
tion, freedom of trade, environmental safety and international security.40
Prominent among these concurring objectives are human rights and
security concerns, and it is precisely in this connection that the sections
that follow will explore the implementation of the IHR (2005) through
the lens of both the health and human rights and the health and security
paradigms.

THROUGH THE LENS OF THE HEALTH AND
HUMAN RIGHTS PARADIGM

4.1 Public Health Responses to Declared PHEICs

As noted before, one of the major innovations characterizing the IHR
(2005) is inclusion of human rights concerns. The Regulations emphasize
respect for the dignity, human rights and fundamental freedoms of
persons and travellers and uphold it as one of the core principles
underpinning their implementation.41 Furthermore, they attach prominent

39 Articles 16, 50 and 53 of the IHR (2005).
40 David Fidler lays special stress on these aspects: ‘the new IHR create a
strategy and framework for integrated, flexible and forward-looking governance
for addressing serious threats to public health. The new IHR engage State and
non-State actors, address numerous public health threats and draw together
objectives found in multiple international legal regimes – specifically those
concerning infectious disease control, human rights, trade, environmental protec-
tion and security – and configure them in a way that has no precedent in
international law on public health.’ (Fidler (n 22) 326).
41 See especially articles 3 and 32 of the IHR (2005). Other relevant
provisions focus on travellers and refer to their rights when subject to health
importance to scientific principles and evidence—including epidemiological data demonstrating the dynamics of disease transmission and the ability of a given pathogen to cause community-level outbreaks—as the appropriate basis for medical justification of public health measures adopted under the Regulations’ relevant provisions. Human rights and scientific principles thus set the legal and medical standards which, taken together, serve as benchmarks to assess the legitimacy and legality of public health responses to disease outbreaks.

This is a crucial starting point to discuss the appropriateness of public health measures adopted in response to epidemic or pandemic events. In fact, such measures have often been the object of debate and controversy with regard to the required fair balance between public health needs and individual rights. This has especially been the case for governmental responses to major outbreaks occurred before the entry into force of the revised Regulations (especially SARS and avian influenza), although the same can equally apply to measures adopted in response to public health crises declared as PHEICs under the terms of the IHR (2005) (swine influenza, poliomyelitis, Ebola haemorrhagic fever and Zika virus disease outbreaks).

To set the scene for a more detailed discussion of the compatibility of public health measures with human rights, it is necessary to briefly overview the reactions of both affected and third States to the major international public health events that have occurred so far.

The first outbreak to be qualified as a PHEIC was the swine flu pandemic caused by the A/H1N1 virus (declared in April 2009 and measures or public health observation. See, for example, articles 23 (prior informed consent), 32 (respectful treatment of travellers), 42 (non-discrimination) and 45 (confidentiality of health information). For an exhaustive discussion, see Andraž Zidar, ‘WHO International Health Regulations and Human Rights: From Allusions to Inclusion’ (2015) 19 The International Journal of Human Rights 505.

42 Articles 12, 17 and 43 of the IHR 2005.
44 In this respect, it has to be noted that six Emergency Committees have been convened since 2007, but in two cases, the Yellow Fever and the Middle East respiratory syndrome outbreaks, the Director-General did not declare any PHEIC.
terminated in August 2010). The IHR Emergency Committee issued temporary recommendations excluding the closure of borders and restrictions to international travel or trade. It recommended, as a matter of prudence, that people who were ill would better delay international travel and that people developing symptoms following travel should seek medical attention. Early in the pandemic, however, a few countries instituted travel and trade restrictions (especially against Mexico, which was the first affected country), and almost half of the countries recommended avoiding travel to areas affected by the pandemic. Although the WHO did not receive any formal complaints, there were media reports of travellers being quarantined and detained as a consequence.

A second major outbreak due to poliovirus was declared a PHEIC in May 2014 (and still remains such as of May 2018). Also in this case, the IHR Emergency Committee issued temporary recommendations excluding national lockdowns and bans on international travel or trade. However, it urged exporting and infected countries to intensify efforts to ensure vaccination of travellers, mobile and cross-border populations, internally displaced persons, refugees and other vulnerable groups. It also recommended that States restrict at all points of departure, irrespective of the means of conveyance (road, air, sea), the international travel of any resident lacking documentation of appropriate polio vaccination.

45 Ninth meeting of the IHR Emergency Committee on Pandemic (H1N1) 2009, Statement by WHO Director-General, 10 August 2010 <www.who.int/csr/disease/swineflu/9th_meeting_ihr/en/>.
46 Second meeting of the IHR Emergency Committee on Pandemic (H1N1) 2009, Statement by WHO Director-General, 27 April 2009. These temporary recommendations were reiterated on the occasion of the following meetings of the Emergency Committee <www.who.int/mediacentre/news/statements/2009/h1n1_20090427/en/>.
The third and most serious emergency was the Ebola outbreak in Western Africa, which was declared a PHEIC in October 2014 (terminated in March 2016). Temporary recommendations were issued for affected states (Liberia, Sierra Leone, Guinea, Nigeria), bordering states, and the international community at large. Recommendations for States with Ebola transmission included restrictions on travel for persons with an illness consistent with Ebola, and restrictions on international travel for Ebola cases or contacts; exit screening of all persons at international airports, seaports and major land crossings, for unexplained febrile illness consistent with potential Ebola infection; isolation of confirmed cases in specific Ebola Treatment Centres; daily monitoring and restricted national travel of contacts; isolation of probable and suspect cases with appropriate restriction on travel. Temporary recommendations addressed to all States confirmed the recommended restrictions for Ebola cases and contacts, but excluded a general ban on international travel or trade. However, the response from both the affected and third countries was much more restrictive and far-reaching than the WHO recommendations. In fact, West African governments invoked extraordinary powers and adopted measures of national lockdown, sanitary cordons, quarantine and general bans on travel which adversely affected the rights of the population at large, and especially the rights of patients and health workers. Some States that were not affected by the outbreak severely restricted the freedom of movement of persons and travellers. The IHR Emergency Committee strongly insisted that there should be no general ban on international travel or trade and stated that flight cancellations and other travel restrictions continued to isolate affected countries, resulting in adverse economic effects, uncontrolled migrations and obstacles to relief and response efforts. The Committee emphasized the importance of normalizing air travel and the movement of ships, including the handling of cargo and goods, to and from the affected areas, to reduce the isolation and economic hardship of the affected countries. It also noted that a

number of States without Ebola transmission had decided or were considering cancelling international meetings and mass gatherings. The Committee expressed concern that more than 40 countries had implemented additional measures going beyond its temporary recommendations, such as quarantine of returning travellers and refusal of entry, cancellation of flights by airlines and border closures. Such measures impeded the recruitment and return of international responders and also had harmful effects on local populations by increasing stigma and isolation, and by disrupting livelihoods and economies. The Committee welcomed the WHO’s monitoring of inappropriate measures and urged States Parties to reverse quickly any such additional measure, reaffirmed the need to avoid unnecessary interference with international travel and transport and to implement only measures commensurate with the current public health risks, and finally declared that excessive or inappropriate travel and transport measures going beyond the temporary recommendations should be terminated by the end of October 2015. In addition, the WHO Director-General reemphasized that there was no public health justification for refusing entry or quarantining travellers simply because they had been in, or were a citizen of, one of the affected countries. She strongly reaffirmed that any measure applied to individual travellers should be based on appropriate public health evidence or information about potential risks posed by them. Other international organizations likewise expressed serious concern for these over-restrictive measures.

measures.\textsuperscript{59} This notwithstanding, in December 2015 it was reported that there were still 34 countries applying such measures.\textsuperscript{60}

The fourth and most recent emergency dates back to 1 February 2016, when, following the Zika virus outbreak, the WHO Director-General declared the cluster of microcephaly cases and other neurological disorders reported in Brazil a PHEIC (terminated in November 2016, despite the IHR Emergency Committee still considering that Zika virus and associated consequences remained a significant enduring public health challenge requiring intense action).\textsuperscript{61} In this case, the Committee declared that there was no need to impose travel bans. In its third meeting, it also addressed the issue of additional risks of international spread possibly stemming from the impending Olympic and Paralympic Games, noting that the individual risks in areas of transmission were the same whether or not a mass gathering was conducted, and could be minimized by good public health measures. It thus concluded that there was a very low risk of further international spread of Zika virus as a result of the Games, considering that they were to be celebrated during the winter season, when the intensity of autochthonous transmission of arboviruses would be minimal, and also noting that Brazil was intensifying vector-control measures in and around the venues for the Games. The Committee therefore reaffirmed its previous advice that there should be no general restrictions on travel and trade with countries, areas and/or territories with Zika virus transmission, and provided additional advice to the Director-General suggesting that countries, communities and organizations that were convening mass gatherings in areas affected by Zika virus outbreaks should undertake a risk assessment prior to the event and

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\textsuperscript{59} In its Resolution 2177 of 18 September 2014, the UN Security Council called on States to lift travel and trade restrictions causing the isolation of affected countries and urged all Member States to implement the WHO’s temporary recommendations (paras 3–5). The Assembly of the African Union equally called for the termination of over-restrictive public health measures in its Decision 553 on Ebola Virus Disease (EVD) Outbreak (Doc. Assembly/AU/3(XXIV), 30–31 January 2015).


63 ‘Brazil warns women not to get pregnant as Zika virus is linked to rare birth defect’ The Guardian (4 December 2015); ‘Ante epidemia de zika, Gobierno recomienda evitar los embarazos en zonas afectadas’ Noticias Colombianas (19 January 2016); ‘Jamaica advises women to delay pregnancy due to Zika virus’ Associated Press (18 January 2016); Gillian Mohney, ‘El Salvador Advises Women to Avoid Pregnancy for 2 Years Due to Zika Outbreak’ ABC News (26 January 2016); ‘Panamá: piden aplazar embarazos en comarca indígena por zika’ Terra Noticias (26 January 2016).


In this respect, it is worth recalling that human rights treaties admit two different regimes of restrictions and limitations, which may be applied whenever public or collective interests need to be balanced with private interests and the full enjoyment of individual rights and freedoms. On the one hand, most human rights conventions include general derogation clauses, which, in exceptional circumstances, allow States to derogate from certain treaty obligations, with the exclusion of those related to the protection of selected non-derogable rights, some of which have become over time jus cogens rights. On the other hand, these conventions also contain limitation clauses appended to specific provisions, which allow States to adopt restrictive measures mainly in the interest of public order, public health and public morals (see Table 10.2).

Both regimes are equally relevant to public health emergencies, although the application of derogation clauses is more controversial. Indeed, whether and when a public health emergency or a PHEIC may represent a ‘public emergency which threatens the life of the nation’ is still an issue of debate, and relevant practice is really scant. As a matter of fact, no practice at all is reported with regard to regional conventions, while only two cases are recorded in relation to derogations from the ICCPR. These cases occurred in 2006 and 2009 and concerned, respectively, the Georgian and Guatemalan notifications to the UN Secretary-General of a declaration of state of emergency following the outbreaks of the H5N1 (bird flu) and the A/H1N1 (swine flu) pandemics. In both cases, however, the emergency decrees adopted by these Governments were almost immediately repealed or declared null and void by the competent national authorities. Later on, notwithstanding the temporary recommendations issued by the IHR Emergency Committees on Ebola.

66 For the ECHR, see Factsheet ‘Derogation in time of emergency’, July 2017.
68 For Georgia, see Presidential Decree No. 173 of 26 February 2006 on ‘State of Emergency in the Khelvachauri district’, approved by the Parliament of Georgia on 28 February 2006, and Presidential Decree No. 199 of 15 March 2006 on ‘Abolishment of the State of Emergency in the Khelvachauri district’, approved by the Parliament of Georgia on 16 March 2006. For Guatemala, see Government Decree No. 7-2009 of 6 May 2009, which was declared for a period of thirty days and limited the rights and freedoms contained in articles 12, 19 and 21 of the ICCPR. On 12 May 2009, by Government Decree No. 8-2009, the President of the Republic repealed Decree No. 7-2009.
Table 10.2 Derogation and limitation clauses in major human rights treaties

<table>
<thead>
<tr>
<th>Classification</th>
<th>Justifying reasons</th>
<th>Rights affected</th>
<th>Legitimacy requirements</th>
<th>Examples*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Derogation clauses</td>
<td>public emergency threatening the life of the nation, armed conflict</td>
<td>all rights except for: right to life, right to a name, right to juridical personality, right to nationality, freedom from torture and inhumane treatment, freedom from slavery, slave-trade and servitude, right to not be imprisoned for contractual debt, respect for the principle of legality in the field of criminal law, freedom of thought, conscience and religion, rights of the child</td>
<td>consistency with obligations under international law, proclamation and notification, strict necessity, limitation in scope and duration, proportionality, non-discrimination, safeguards and judicial control</td>
<td>art. 4 ICCPR, art. 15 ECHR, art. 30 ESC, art. 27 ACHR</td>
</tr>
<tr>
<td>Limitation clauses</td>
<td>national security</td>
<td>freedom of assembly</td>
<td>prescription by law</td>
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<tr>
<td>art. 12, 19, 21, 22 ICCPR</td>
<td></td>
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<tr>
<td>public order</td>
<td>art. 8–11 ECHR</td>
<td>respect for rule of law</td>
<td></td>
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<tr>
<td>public health</td>
<td>art. 2 Additional Protocol No. 4 to ECHR</td>
<td>(democratic) necessity</td>
<td></td>
<td></td>
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<tr>
<td>public safety</td>
<td>arts. 12, 13, 15, 16, 22 ACHR</td>
<td>proportionality</td>
<td></td>
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<tr>
<td>public morals</td>
<td>arts. 5 and 8 Additional Protocol to ACHR</td>
<td>non-arbitrariness</td>
<td></td>
<td></td>
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<tr>
<td>economic well-being of the country</td>
<td>arts. 11–12 ACHPR</td>
<td>non-discrimination</td>
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<tr>
<td>prevention of disorder and crime</td>
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<tr>
<td>respect for the rights and freedoms of others</td>
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</tbody>
</table>


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and poliovirus,\textsuperscript{70} to the effect that affected States should declare a national public health emergency, none of these countries ever notified the UN Secretary-General of any such declaration nor of their intention to apply Article 4 of the Covenant.\textsuperscript{71}

Despite the absence of any significant practice, it cannot in principle be excluded that a disease outbreak with a pandemic potential and a foreseeable serious public health impact may indeed threaten the life of a nation.\textsuperscript{72} However, given that such hypothesis is nowhere expressly mentioned, it is necessary to resort to the interpretive guidance offered by the Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights and the Human Rights Committee’s (HRC) General Comment No. 29 on Article 4 of the Covenant.\textsuperscript{73} The Siracusa Principles state that a threat to the life of the nation is one that: (a) affects the whole of the population and either the whole or part of the territory of the state; and (b) threatens the physical integrity of the population, the political independence or the territorial integrity of the state or the existence or basic functioning of

\textsuperscript{70} WHO Statement on the meeting of the International Health Regulations Emergency Committee concerning the international spread of wild poliovirus, 5 May 2014. The Committee recommended that both infected and exporting States (Pakistan, Cameroon, and the Syrian Arab Republic) and infected but not-exporting States (Afghanistan, Equatorial Guinea, Ethiopia, Iraq, Israel, Somalia and particularly Nigeria) officially declare, at the level of head of state or government, that the interruption of poliovirus transmission was a national public health emergency. This recommendation has been reiterated until the latest Statement of May 2017.


\textsuperscript{72} Gian Luca Burci and Riikka Koskennäki, ‘Human Rights Implications of Governance Responses to Public Health Emergencies: The Case of Major Infectious Diseases Outbreaks’ in Andrew Clapham and Mary Robinson (eds), \textit{Realizing the Right to Health} (Ruffer & Rub 2009) 346, 352; see also Giuseppe Cataldi, ‘Articolo 15’ in Sergio Bartole, Pasquale De Sena, Vladimiro Zagrebelsky (eds), \textit{Commentario breve alla Convenzione Europea per la salvaguardia dei diritti dell’uomo e delle libertà fondamentali} (CEDAM 2012) 555, 557 f.

institutions indispensable to ensure and protect the rights recognized in the Covenant.74

General Comment No. 29 generically states that ‘not every disturbance or catastrophe qualifies as a public emergency which threatens the life of the nation’, and substantially refers to traditional states of emergency, like those deriving from an armed conflict. This notwithstanding, the HRC allows States to invoke their right to derogate from the Covenant also in different contexts, for example in case of a natural catastrophe, a mass demonstration including instances of violence, or a major industrial accident.

In both documents, however, it is provided that the State invoking Article 4 ICCPR must be able to justify the derogatory measures according to the strict necessity principle, that is to say that it must prove that they are needed above and beyond the possibility of simply restricting certain freedoms under the terms of the relevant limitation clauses.75 This test is crucial when it comes to assessing concrete situations in light of these interpretive statements. For example, the Ebola crisis would have fitted into the Siracusa definition of public emergency, given its pandemic proportions and the exceptional and actual threat to the physical integrity of the whole population of the affected States, but it would probably have failed the strict necessity test, especially in light of the recommendations issued by the IHR Emergency Committee and the kind of public health measures suggested.

Turning to limitation clauses, the Siracusa Principles equally provide authoritative guidance on the conditions that limitations on human rights should meet in order to be legitimately applied in the interest of public health protection. The Principles specifically clarify that:

Public health may be invoked as a ground for limiting certain rights in order to allow a state to take measures dealing with a serious threat to the health of the population or individual members of the population. These measures must be specifically aimed at preventing disease or injury or providing care for the sick and injured.76

The Principles also add that in adopting restrictive measures due regard shall be had to the International Health Regulations. Such a reference to the IHR is particularly noteworthy because it stresses that in times of public health emergency national authorities have to comply with both

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74 Siracusa Principles, para. 39.
75 General Comment No. 29, para. 5; Siracusa Principles, para. 54.
76 Siracusa Principles, para. 25.
the Regulations and human rights treaties, and that they are called to ensure consistency and coordination between the obligations stemming therefrom.\footnote{Article 57, para. 1 of the IHR (2005) provides that ‘States Parties recognize that the IHR and other relevant international agreements should be interpreted so as to be compatible’. See Burci and Koskenmiäki (n 72) 352. See also Brigit Toebes, ‘Human Rights and Public Health: Towards A Balanced Relationship’ (2015) 19 The International Journal of Human Rights 488, 496–501; Stefania Negri, ‘Emergenze sanitarie e diritto internazionale: il paradigma salute-diritti umani e la strategia globale di lotta alle pandemie ed al bioterrorismo’ in Scritti in onore di Vincenzo Starace (Editoriale Scientifica 2008) 571, 587 ff.; Negri (n 43) 349–57.}

This means that, in order to comply with both human rights treaties and the IHR (2005), public health measures adopted at national level in response to a health ‘event’ (either defined as a ‘public health risk’ or a PHEIC under the terms of the Regulations) must also satisfy the international standards of legality and legitimacy set by the Siracusa Principles. These include, as a minimum, a clear definition of the legitimate aim or reasons justifying the restrictions; the existence of a legal basis; compliance with the necessity and proportionality tests; non-arbitrariness and non-discrimination; and the existence of an effective remedy against potential human rights violations.

In practice, these international standards and obligations require that public health measures must first of all ‘respond to a pressing public and social need’ and ‘serve the legitimate aim’ of preventing and controlling the spread of communicable diseases. Secondly, they must be strictly necessary and rigorously based on scientific evidence and epidemiological data, and hence medically appropriate in relation to the aim to be achieved, as well as the least invasive and intrusive into the personal sphere. Thirdly, they must be consistent with and possibly not exceeding WHO temporary or standing recommendations, unless additional and more restrictive measures are strictly necessary to achieve a higher level of protection, provided that they are soundly based on scientific information and public health rationale. These requirements apply to all kinds of measures limiting individual rights and freedoms, adopted both under national public health laws and pursuant to the IHR (2005), especially Articles 23 and 31, including medical examination, vaccination, prophylaxis, isolation, quarantine or placing suspects under public health observation.
THROUGH THE LENS OF THE HEALTH-SECURITY PARADIGM

5.1 The Reconceptualization of the Notions of ‘Security’ and of ‘Threat to International Peace and Security’

Along with human rights, the health-security paradigm, encapsulating the concept of securitization of health, is another major issue of discussion in relation to infectious disease control.

Following the pioneering statement contained in the WHO Constitution’s preamble that ‘The health of all peoples is fundamental to the attainment of peace and security’, international institutions and legal scholarship have progressively recognized that health is a key determinant and a component of global security and stability.\(^{78}\)

The emergence of the health-security approach, which has also been explored by the WHO,\(^ {79}\) is closely linked to the reconceptualization of both ‘security’ and ‘threat to international security’. The notion of security has evolved over time and has been reinterpreted as ‘human security’, a concept which moves away from traditional, state-centric conceptions of security focusing primarily on the safety of states from military aggression, to one that concentrates on the security of the individuals, their protection and empowerment.\(^ {80}\) The notion of ‘threat to international peace and security’ has been reinterpreted and actualized by the UN Security Council since the beginning of the 1990s, a time of momentous change for the role of the Council and for the fulfilment of


its primary responsibility for the maintenance of international peace and security.

In a Statement of 31 January 1992, issued at the closure of the first meeting at summit level, the President of the Security Council declared that

the international community … faces new challenges in the search for peace.

… The absence of war and military conflicts among States does not in itself ensure international peace and security. The non-military sources of instability in the economic, social, humanitarian and ecological fields have become threats to peace and security.81

This broadened vision of the notion of ‘threat’ has further expanded, as testified by the practice of the Security Council and its interpretation of Article 39 of the UN Charter in light of current changes and challenges. In recent years, the Council has in fact devoted increasing attention to the evolving nature of threats to international peace and security, holding various separate meetings on a number of issues identified as key new challenges, including public health, the proliferation of small arms and light weapons, transnational organized crime, piracy, drugs, human trafficking and the impact of climate change.82

When it comes to communicable diseases, the Security Council held its first meeting to discuss a health issue as a security threat in January 2000. That meeting was a landmark first step for the subsequent practice of the Council, and the President recognized that they were ‘exploring a brand-new definition of world security’, which would open up the door to seeing ‘security through a new and wider prism and, forever after, think[ing] about it according to a new and more expansive definition’.83


stability and security, focussing particularly on the potential of the
disease to affect UN peacekeeping personnel and requesting the
Secretary-General to strengthen preventative training, while encouraging
Member States to increase cooperation to assist with HIV/AIDS
prevention, voluntary and confidential testing, counselling and treatment
for personnel to be deployed to peacekeeping operations. The resolution
drew the world’s attention to the need for a massive mobilization in the
fight against HIV/AIDS and served as an important counterpart to
parallel efforts on the part of the General Assembly and the Economic
and Social Council to harness the power of the United Nations to
address that threat. After more than a decade of intense commitment to
improving the general situation related to HIV/AIDS, on 7 June 2011,
the Council held a second high-level debate, resulting in the unanimous
adoption of resolution 1983 (2011). In this resolution, the Council
requested the Secretary-General ‘to consider HIV-related needs of
people living with, affected by, and vulnerable to HIV, including women
and girls, in his activities pertinent to the prevention and resolution of
conflict, the maintenance of international peace and security, the
prevention and response to sexual violence related to conflict, and
post-conflict peacebuilding’.

On 23 November 2011 the Council held another meeting devoted to
considering the subject ‘Maintenance of international peace and security:
new challenges to international peace and security and conflict prevention’.
On that occasion the Council was briefed by the Executive
Director of the UN Office on Drugs and Crime on issues of transnational
organized crime, corruption, human trafficking, illicit migration, terrorism, piracy, drug trafficking; by the UN High Commissioner for Refugees on climate migrants; by the WHO Director-General on the risks for peace and security resulting from pandemics and the spread of diseases, such as HIV/AIDS, tuberculosis or malaria, in conflict situations, with a particular focus on their impact on the most vulnerable groups. The UN Secretary-General addressed the Council stating that transnational crime, pandemics, and climate change definitely constituted serious challenges and that although none of the three were new, they were increasingly transnational, increasingly acute, and had ever greater implications for human, State, regional and international security.

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85 UN Security Council, 6668th meeting, S/PV.6668, 23 November 2011, agenda item ‘Maintenance of international peace and security. New challenges to international peace and security and conflict prevention’.
Following the Ebola outbreak, on 18 September 2014 the Security Council held its first emergency meeting on a public health emergency of international concern and unanimously adopted resolution 2177 (2014). In the preamble of the resolution, the Security Council recognized that ‘the peacebuilding and development gains of the most affected countries concerned could be reversed in light of the Ebola outbreak’ and underlined that ‘the outbreak [was] undermining the stability of the most affected countries concerned and, unless contained, [might] lead to further instances of civil unrest, social tensions and a deterioration of the political and security climate’. It therefore determined that ‘the unprecedented extent of the Ebola outbreak in Africa constitute[d] a threat to international peace and security’. The Council, however, did not mention whether it was acting under Chapter VII of the Charter and did not take any enforcement action.86

Relying on the concept of human security, this unprecedented resolution was substantially in line with the UN Secretary-General inclusion of overwhelming outbreaks of ‘deadly infectious disease’ among the threats to peace and security of the twenty-first century.87 It showed that the Council was continuing to push forward the boundaries of what may constitute a threat to international peace and security under international law, and hence that it was broadening the scope of its powers in order to align more closely with a human security framework.

86 Gian Luca Burci, ‘Ebola, the Security Council and the securitization of public health’ (2014) Questions of International Law <http://www.qil-qdi.org/ebola-security-council-securitization-public-health/>. Burci observes that: ‘As a matter of fact, it would have been difficult to imagine what enforcement measures it could have taken in that case in the absence of a political target whose behavior had to be changed through coercion. The use of Article 39 language, therefore, seems to have been designed for a political and symbolic purpose, in particular to generate momentum and additional political, operational and financial commitments by the international community. … The language, if not the use, of Chapter VII is presented as an important symbolism of the need for unprecedented mobilization by the international community.’ See also Gian Luca Burci and Jacob Quirin, ‘Ebola, WHO, and the United Nations: Convergence of Global Public Health and International Peace and Security’ (2014) 18 ASIL Insights <https://www.asil.org/insights/volume/18/issue/25/ebola-who-and-united-nations-convergence-global-public-health-and>; Thérèse Murphy, Health and Human Rights (Hart 2013) 58–71.

87 In Larger Freedom (n 80) paras 78, 105.
5.2 Implications of Attracting Public Health Emergencies and Violations of the IHR (2005) within the UN Security Agenda

The revolutionary extension of the revised Regulations’ scope to events involving the intentional release of biological, chemical and radionuclear agents (for example, the use of biological and chemical weapons and bioterrorism) has conferred on the IHR (2005) an unprecedented significance for the health and security debate.

However, following the Ebola resolution, a broader concept of ‘securitization of health’ has increasingly become the object of a lively and controversial debate imbued with legal and political implications.88 Basically, the health-security paradigm relies on a growing trend towards addressing global health concerns as security threats, which is based on ‘the perception that highly pathogenic infectious diseases spreading internationally may undermine the political, economic and social bases for a state’s stability, plunge it into chaos and possibly … reverberate regionally’.89 Such a trend has proved to have the potential to attract public health emergencies within the Security Council’s broad global security agenda.

In this respect, the Ebola precedent is indicative of the combination of factors that may trigger a possible UN action in response to a global security threat posed by a disease outbreak. Just to mention the most prominent ones, these factors include: widespread violations of the human rights of patients and the population at large; massive cross-border movements of health migrants; civil unrest; adoption of antidemocratic emergency legislation; hardship in living conditions caused by excessively restrictive public health measures or unnecessary interference with trade; and a serious risk of international spread creating regional instability.

In similar scenarios, the Security Council could be called on to ascertain the existence of a threat to international peace and security, attribute clear responsibilities and recommend or decide sanctions against States90 failing to comply with the relevant obligations stemming from international human rights law, the UN Charter and the WHO Regulations.

From the human rights perspective, such violations would include, but would not be limited to, serious breaches of human rights treaties

88 Burci (n 86) para. 6.
89 Ibid., para. 4.
90 Or even against individuals and private entities, following the practice adopted in the case of terrorism.
involving *jus cogens* rights, especially the rights to life and to be free from torture and inhuman treatment; mala fide declarations of public emergencies and suspension of human rights conventions inconsistent with international standards on the legality of derogation regimes; unlawful restrictions on civil rights and fundamental freedoms; and violations of the right to health, as protected by Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), especially by way of non-compliance with the priority obligation to take measures to prevent, treat and control epidemic diseases.\(^{91}\) Besides that, non-compliance with the UN Charter and the IHR (2005) would include violations of the duty to cooperate in good faith with the UN and the WHO; failure or delay in notifying disease outbreaks under Article 6 of the Regulations; refusal to share biological substances and diagnostic specimens (pathogens and related genetic sequence data); failure to implement temporary or standing recommendations issued by the relevant WHO Committees (although they are defined as ‘not-binding advices’ in Article 1); adoption of ineffective and over-restrictive public health measures not justified by medical necessity and sound scientific evidence (an issue which was already addressed in Security Council resolution 2177 (2014)), and so on. If considered individually, these violations hardly amount to a threat to international peace and security, but taken altogether or in combination, as the Ebola lesson teaches, they can indeed contribute to the escalation of a public health emergency to a threat to international security.

Therefore, broadening the scope of UN action, so as to encompass public health emergencies of international concern with the potential to disrupt the stability of a region and/or international security, would enable the Security Council to put pressure on those States that do not cooperate in good faith to global disease control or even worsen the situation by failing to comply with the core obligations imposed by the IHR (2005) and human rights standards.\(^{92}\)

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92 It is noteworthy that the Ebola Interim Assessment Panel ‘request[ed] that the full IHR Review Committee for Ebola examine options for sanctions for inappropriate and unjustified actions under the Regulations … Where Member States behaviour threatens the response to the crisis by, for example, making it impossible for health workers to reach affected countries, there should be a procedure to take this matter to the United Nations Security Council. This should
Action by the Security Council in response to violations of IHR obligations (especially those having significant security implications) would not be ultra vires, but would find its legal justification in the aforementioned Security Council’s and Secretary-General’s broad interpretation of the notion of ‘threat to international security’, as well as in both the preamble of the WHO Constitution (‘The health of all peoples is fundamental to the attainment of peace and security’) and Article 3, paragraph 2, of the IHR (2005) (‘The implementation of these Regulations shall be guided by the Charter of the United Nations and the Constitution of the World Health Organization’). Furthermore, it is useful to recall that cooperation between the WHO and the Security Council is expressly required under the terms of Article 18, alinea (i) of the WHO Constitution, and under Article VII of the Agreement between the United Nations and the World Health Organization,93 which provides that ‘The World Health Organization agrees to co-operate with the Council in furnishing such information and rendering such assistance for the maintenance or restoration of international peace and security as the Security Council may request’.


The adoption of the IHR (2005) was welcomed as a groundbreaking step forward in the progress of international health law in the field of communicable disease control. However, despite the Regulations’ prominent role in global health law and governance, their implementation has not gone without problems and drawbacks.


93 Adopted by the First World Health Assembly on 10 July 1948.
into force) was recently carried out by the IHR Review Committees\textsuperscript{94} and the high-level panels of independent experts appointed by the WHO Director-General and the UN Secretary-General.\textsuperscript{95} These review bodies brought out a number of critical issues and shortcomings adversely impacting on the successful performance of the IHR (2005) and strongly undermining their effectiveness. In particular, they found that the overarching challenges and structural shortcomings consist in poor implementation,\textsuperscript{96} lack of enforceable sanctions,\textsuperscript{97} and the fault of systematic monitoring of human rights violations committed in the implementation of the Regulations, coupled with the lack of any WHO mandate to investigate whether public health measures constitute violations of Article 3, paragraph 1, of the IHR (2005).\textsuperscript{98}

Taking stock of these findings is an important starting point to draw conclusions from the international practice explored so far, with a view to suggesting possible solutions that may improve the implementation of the

\textsuperscript{94} Under article 50 of the IHR (2005), the Director-General establishes a Review Committee entrusted to provide him with technical recommendations regarding amendments to the Regulations; technical advice with respect to standing recommendations, and their modifications or termination; technical advice on any matter regarding the functioning of the Regulations. Members of the Committee are chosen among the persons serving on the IHR Expert Roster and, when appropriate, other expert advisory panels of the Organization. See WHO, Implementation of the International Health Regulations (2005), Report of the Review Committee on the Functioning of the International Health Regulations (2005) in relation to Pandemic (H1N1) 2009, Sixty-Fourth World Health Assembly, A64/10, 5 May 2011; Implementation of the International Health Regulations (2005), Report of the Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response, Sixty-Ninth World Health Assembly, A69/21, 13 May 2016.


\textsuperscript{96} Report 2016 (n 94) 54. The Review Committee stated that such poor implementation is mainly due to resource constraints, conflict and want of political understanding or will. For many countries it results from a severe lack of financial, human and logistical resources. To overcome these problems, the Committee recommended that the WHO Secretariat develop a Global Strategic Plan to improve public health preparedness and urge all stakeholders to provide adequate financial support to strengthen health systems.

\textsuperscript{97} See Report 2011 (n 94) 129.

\textsuperscript{98} Ibid., 81–82.
Regulations and respond to violations of IHR obligations having significant human rights and security implications.

Non-compliance with the Regulations may result, among others, from a deadlock in the progress of States’ core capacities of surveillance, preparedness and response causing a serious hindrance to the timeliness and efficacy of the global response to disease outbreaks, or from the adoption of over-restrictive, unnecessary and disproportionate public health measures combined with human rights violations. To some extent, breaches of the obligations to promptly notify and inform the WHO of events that may pose a serious public health threat may also contribute to the escalation of a public health crisis and its turning into a PHEIC threatening international security. Furthermore, IHR violations consisting in the failure to notify events related to the natural, accidental or deliberate release of biological and chemical agents or radionuclear materials may have even more serious security implications, especially in case of acts of terrorism. Under the Regulations, however, none of these breaches, whatever the seriousness of their effects on global disease control, human rights protection and international security, can be sanctioned though enforcement measures.

When it comes to the practice examined above, it seems that one of the major problems emerged in the implementation of the IHR (2005) concerns the adoption of over-restrictive public health measures affecting traffic and trade and implying unjustified restrictions on human rights, and the corresponding absence of any robust response from the WHO.99

In its report on the Ebola outbreak, for example, the Review Committee addressed the problem of over-restrictive measures that contravene temporary recommendations, harm local populations and disrupt the global response effort. It recalled that implementation of public health measures that are not recommended by the WHO is conditional upon meeting a number of requirements specified in the Regulations, which in fact many States Parties fail to comply with. The Committee urged the States Parties to ‘ensure that the public health response measures they implement comply with the IHR’ and suggested that, when a PHEIC is determined, the WHO Secretariat should: a) strengthen its practice of actively monitoring response measures implemented by States Parties and

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99 In this respect, the Review Committee recommended to reinforce evidence-based decisions on international travel and trade and suggested that the ‘WHO should energetically seek to obtain the public-health rationale and relevant scientific information, share it with other States Parties, and, where appropriate, request reconsideration, as stipulated under Article 43.’ See Report 2011 (n 94) 129–30. Emphasis added.
actions taken by non-State actors, and the impact of such measures and actions on other States Parties; b) review the public health rationales submitted to it under Article 43 by States Parties implementing additional measures, and inform the State Party as to whether or not it considers that the measures are appropriate.\textsuperscript{100}

Indeed, the systematic monitoring of public health measures suggested by the Review Committee appears a very important tool to determine objectively whether such measures meet the requirements of evidence-based scientific justification. However, given that over-reaction to public health emergencies may heavily encroach upon individual rights, and that very rarely do national health measures come under the scrutiny of international human rights bodies, a parallel assessment of their consistency with human rights obligations and standards would be highly desirable.

In this respect, considering that there is no systematic monitoring of human rights violations within the WHO, a possible remedy could consist in introducing a ‘human rights impact assessment’ to be performed on national public health measures communicated under article 43 of the Regulations. This assessment could be done either ex post, by legal experts from the WHO staff contributing to the Secretariat’s monitoring activities, or even ex ante, by the relevant IHR Emergency Committees, which could prospectively offer more detailed guidance to implementing States through targeted and human rights-friendly temporary recommendations. In this latter case, the presence of a human rights expert should be ensured at all times, either as effective member of the Emergency Committee or as additional advisor integrating its composition.\textsuperscript{101}

Turning to the lack of enforcement and sanctioning measures for non-compliance with IHR obligations, the Review Committee advocated for a stronger role of the WHO Secretariat in assessing compliance and

\textsuperscript{100} Report 2016 (n 94) 66. In the Draft Global Implementation Plan, it is proposed that the ‘WHO will establish a standardized process to identify, collate and monitor such additional measures, and to systematically engage with the relevant States Parties to verify the reported measures, understand the basis for their implementation and, if inappropriate, request that they be rescinded’ (Draft global implementation plan for the recommendations of the Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response, paras 21–22, <http://www.euro.who.int/__data/assets/pdf_file/0011/315875/66wd26e_GlobalImplementPlanIHR_160629.pdf>.

\textsuperscript{101} The Director-General may appoint one or more technical experts to advise the Committee, choosing also among persons who are neither members of the IHR Experts Roster nor members of other WHO Expert Advisory Panels.
making this information public, stating that sanctions ‘would be inappropriate and of little value’.\textsuperscript{102} In particular, it considered that the best way to discourage unnecessarily disruptive response measures is to provide for public disclosure, with a view to increasing accountability through greater transparency.\textsuperscript{103} However, it can be seriously questioned whether adopting a ‘naming and shaming’ policy by posting on the WHO Event Information Site news concerning countries implementing public health rationale-insufficient measures would lead very far.\textsuperscript{104} The same can be said about the idea of bringing the question to the attention of the WHO Executive Board and the World Health Assembly, both devoid of any enforcement powers under the WHO Constitution,\textsuperscript{105} unless their involvement is aimed at activating other enforcement mechanisms both within the UN, as discussed above, or within the WHO, as proposed below.

In the present scenario, in fact, a possible alternative solution to a mild ‘naming and shaming’ strategy or a muscular response by the Security Council could consist in the establishment of an ad hoc compliance committee, following the practice adopted in the field of international environmental law.\textsuperscript{106} An IHR Compliance Committee could be established by the Executive Board under Article 38 of the WHO Constitution on a proposal of the Director-General based on technical advice provided by the Review Committee,\textsuperscript{107} or even by the World Health Assembly under Article 18(1) of the WHO Constitution.\textsuperscript{108} Looking forward, the Director-General could be empowered to establish such a Committee by way of amendment of Part IX of the Regulations.

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\textit{Communicable disease control} \hfill 301
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\item \textsuperscript{102} Report 2016 (n 94) 35, 82.
\item \textsuperscript{103} Ibid., 80.
\item \textsuperscript{104} It has to be noted that the WHO proved to be rather reluctant to apply such a remedy, as reproached to Director-General Margaret Chan for failing to post information about the 40 States that adopted over-restrictive measures during the Ebola crisis. See Adam Kamrad-Scott, ‘WHO’s to Blame? The World Health Organization and the 2014 Ebola Outbreak in West Africa’ (2016) 37 Third World Quarterly 401, 411.
\item \textsuperscript{105} Report 2016 (n 94) 66.
\item \textsuperscript{106} One relevant example of environmental agreement involving health-related issues is the UNECE Protocol on Water and Health (London, 17 June 1999). A Compliance Committee was established under Article 15 of the Protocol by the Meeting of the Parties in 2007.
\item \textsuperscript{107} Pursuant to Article 50, para. 1(c), the Review Committee provides technical advice ‘on any matter referred to it by the Director-General regarding the functioning of these Regulations’.
\item \textsuperscript{108} Alinea (1) empowers the WHA ‘to establish such other institutions as it may consider desirable’.
\end{itemize}
The aim of the proposed compliance procedure would be to facilitate, promote and secure compliance with IHR obligations, also with a view to preventing disputes. Following the example of other existing mechanisms, the Compliance Committee should be entrusted with monitoring and reviewing compliance, for example, on the basis of communications filed by other States Parties or non-state actors (mirroring the provision authorizing the WHO to consider also unofficial reports of public health events). The Committee should also be empowered to make recommendations and, if appropriate and necessary, to take sanctions and other measures of a political nature to put pressure on non-complying States (for example the suspension of the State’s right to vote in the WHA, in application of article 7 of the WHO Constitution, which provides for such a sanction in case a Member fails to meet its financial obligations or ‘in other exceptional circumstances’). The compliance review procedure should also interface with and serve as a means to monitor and assess the correct discharging of reporting obligations under Article 54 of the Regulations.

Without necessarily requiring an amendment to the current text, the above proposals for a human rights impact assessment procedure and a compliance procedure would bring strength to the IHR (2005) and enhance their effectiveness, while reaffirming the key role of the WHO in leading and governing their implementation within the UN system.109

109 This aspect is specifically stressed by the Review Committee: see Report 2016 (n 94) 60.