The COVID-19 Pandemic and International Law

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How does the COVID-19 pandemic affect States’ obligations under international law? This is a question of not just academic interest but real importance for people’s lives. After all, whether States abide by international law—and whether international law is fit for purpose—is vitally important for everyone from refugees exposed to the virus in unsanitary detention centers to national leaders fighting disinformation campaigns and safeguarding vaccine supply chains. International law has been central to the world’s response to the pandemic from the start—even if the participants did not always realize it. International law, after all, required States to take certain actions to detect and prevent the spread of the novel coronavirus. Some governments responded quickly and effectively, significantly reducing the impact on their populations, but many others were far less successful. Many have made matters worse by responding to the virus in ways that exacerbated the toll on the most vulnerable populations, violating their international law obligations in the process. Moreover, some States have used the pandemic as an excuse for delaying elections or for failing to provide adequate access to legal aid and information. This Article examines the many ways in which COVID-19 is straining the rules and norms of international law. It considers the five main bodies of international law implicated by the pandemic: international humanitarian law, international human rights law, immigration and refugee law, international cyber law, and the rules and regulations of the World Health Organization. It outlines the obligations each body of law imposes on States, and how those obligations apply during the current pandemic. It concludes with several proposals for reform to the international legal system so that the world can prepare to more effectively address the next inevitable pandemic.

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Introduction

The COVID-19 pandemic, which first emerged in Wuhan, China, in late 2019, has now led to more than 240 million documented infections worldwide and nearly five million documented deaths. Unfortunately, it is far from over. Successive, more transmissible variants have emerged, causing new waves of the disease. Although a number of effective vaccines have been developed and are being distributed, analysts estimate that it will...

take until 2023 before they are accessible worldwide. In the meantime, many more people will die. This tragedy has focused attention on what went wrong: Could the pandemic have been halted in its early stages; what steps could governments have taken to better protect their citizens; and, perhaps most important, how can we prevent something like this from happening again?

There is another question that has received much less attention but is no less important: In their responses to the pandemic, did States abide by or violate their legal obligations to other States and to their own citizens under international law? That question may seem esoteric, of interest only to legal scholars, but, in reality, whether States abide by international law—and whether international law is itself fit for purpose—is vitally important for everyone from refugees exposed to the virus in unsanitary detention centers to national leaders fighting disinformation campaigns and safeguarding vaccine supply chains. International law has been central to the world’s response to the pandemic from the start—even if the participants did not always realize it.

International law, after all, required States to take certain actions to detect and prevent the spread of the novel coronavirus. And yet the virus spread rapidly anyway. After emerging in Wuhan, it quickly jumped to other parts of China as the government silenced doctors and whistleblowers who were calling attention to the virus’s deadly potential. Soon after that, the virus went global. Europe’s first case of COVID-19 may have come as early as December 2019. The first cases were detected in the United States in January 2020. Africa recorded its first case in early February 2020, and a case was confirmed in Latin America some weeks later.

Some governments responded quickly and effectively. The Taiwanese government, for example, closed borders early, increased the domestic pro-

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duction of masks, and relied on big data tools to track the virus’s spread. South Korea was another early success story. As the Atlantic has noted, South Korea based its COVID-19 strategy on fast testing, expansive high-tech tracing, and zero-tolerance isolation. And New Zealand responded so successfully that in the summer of 2020, as the pandemic continued to rage elsewhere, it had no active cases and was able to fully reopen its economy.

Many others, however, were far less successful. In the United States, for example, President Donald Trump refused to take the virus seriously in its early months. As of October, 2021, more than 45 million people in the United States have been infected by the virus, and approximately 740,000 have died, more than in any other country. The United Kingdom’s initial lack of urgency in responding to the virus also led to tens of thousands of excess deaths, disproportionate effects on ethnic minorities, and a staggering death rate proportional to population. A fearsome second wave of COVID-19 ravaged India: The official death toll hit a peak of 4,000 a day in mid-May 2021, and experts have suggested that the true death toll far exceeded official statistics.

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11. Id.


healthcare system” and Prime Minister Narendra Modi’s initial refusal to take the second wave seriously attracted criticism, leading one commentator to term the Indian government’s mismanagement a “crime against humanity.”18 And Brazil, which eased preventive measures too early, also became a global epicenter of the outbreak, with the world’s third worst outbreak after the United States and India.19

Not only have many States failed to prevent or slow the spread of the virus, but many have also responded to the virus in ways that exacerbated the toll on the most vulnerable populations, violating their international law obligations in the process. Greek officials, for example, made headlines by intercepting and turning back boats filled with asylum seekers before those boats could land on Greek soil, sometimes leaving them to drift after disabling their engines.20 Although the country has employed such practices for several years, experts have suggested that “Greece’s behavior during the pandemic has been far more systematic and coordinated.”21 Hong Kong, meanwhile, was celebrated for successfully controlling the spread of the virus.22 But public authorities have also used the virus as justification for repressive restrictions on public demonstrations.23 Numerous governments have also developed technologies, includ-
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Smartphone apps, for contact tracing, but, as one study put it, “there are a number of unresolved questions about the use of smartphone data for health surveillance, including how to protect individual privacy.” Other governments have used the pandemic as an excuse for delaying elections or for denying arrested individuals adequate legal representation. And while the discovery of an effective vaccine has offered hope that the world is at the beginning of the end of the pandemic, human rights organizations have warned that access to the vaccine may be used by governments and rebel groups to advance their political agendas.

As a result of these and similar actions, which are in tension with if not outright violations of States’ international legal obligations, the pandemic is taking a toll not only on individual countries but also on the international legal order. In remarks to the United Nations General Assembly in the midst of the pandemic, French President Emmanuel Macron warned that the U.N. “runs the risk of powerlessness” and that “this crisis, undoubtedly more than any other, requires cooperation, requires the invention of new international solutions.” U.N. officials soon after called on world leaders and non-state actors to recommit to international law. Filippo Grandi, the U.N. High Commissioner for Refugees, warned States not to close “avenues to asylum” or to force “people to return to situations of danger,” arguing that “we all need . . . solidarity and compassion now more than ever before.”


This Article examines the many ways in which COVID-19 is straining the rules and norms of international law. It considers five main bodies of international law implicated by the pandemic. Part I examines international humanitarian law, the rules that govern conduct of belligerents during armed conflict, examining how those obligations are affected by the emergence of a worldwide pandemic. Part II looks at international human rights law—specifically the right to life, the right to health, and civil and political rights—and how States’ responses to the pandemic have put these rights at risk. Part III looks at the implications for immigration and refugee law, specifically the principle of non-refoulement, which prohibits States from returning asylum-seekers to an unsafe foreign territory, and law that governs the treatment of immigration detainees, who are uniquely vulnerable to the pandemic’s spread. Part IV examines whether international cyber law has been violated by recent efforts to hack into the companies developing and distributing COVID-19 vaccines. Part V looks at the rules and regulations of the World Health Organization (WHO), which is the international organization responsible for detecting and responding to global public health threats, and which has been accused of responding slowly and ineffectively to the COVID-19 pandemic. Finally, Part VI makes several proposals for reform so that the world is better prepared to address the next inevitable pandemic.

I. International Humanitarian Law

As the pandemic began to unfold, António Guterres, the U.N. Secretary General, called for warring actors to respect international humanitarian law and appealed for a global ceasefire. But belligerents largely ignored these calls. As a result, States’ conduct risked violating the international humanitarian law (IHL) rules regulating the conduct of States during armed conflict. This Part examines in particular three separate sets of IHL rules: (1) rules governing the conduct of hostilities, which protect medical personnel, hospitals, civilian objects, and infrastructure against attack; (2) rules governing humanitarian access, which allow humanitarian personnel to seek to treat and prevent the spread of a pandemic in war

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30. The COVID-19 pandemic has strained other fields of international law, too. See, e.g., Vincent Power, COVID-19 and Maritime Law: Lives; Laws; and Lessons, 26 J. INT’L MAR. L. 1 (2020). Power points out that most maritime nations around the world “individually adopted laws and practices” in response to the pandemic, rather than attempt “comprehensive co-ordination,” id. at 1, and calls for an international treaty that would govern “the maritime response to pandemics and epidemics generally.” Id. at 2.


zones and areas adjacent to them; (3) and rules governing the treatment of wartime detainees, who are particularly vulnerable to the spreading virus.

A. Conduct of Hostilities

Amidst the COVID-19 pandemic, conflict continues to rage in various parts of the world. In some conflicts, warring parties’ failure to respect IHL rules on the conduct of hostilities long before the pandemic further exacerbated the acute health crisis. In other conflicts, combatants failed to adapt their behavior to the pandemic, leading to violations of IHL—or even sought to exploit the pandemic to gain a military advantage. This includes the violation of rules that protect medical personnel, hospitals, civilian objects, and infrastructure against attack. In Syria, for example, belligerents deliberately or indiscriminately attacked medical personnel and facilities over the course of nearly ten years of conflict, leaving health systems ill-equipped to control the spread of COVID-19. Physicians for Human Rights estimates that more than 900 medical professionals were killed from 2011 through March 2021. The systematic targeting of health care workers and facilities left the country without sufficient numbers of health care workers, which impeded an adequate response to COVID-19 as infection rates among medical professionals rose and the pandemic spiraled wildly out of control.

This section first considers the relevant obligations of participants in “international armed conflicts” (IACs), that is, conflicts between nation states. It then turns to the obligations of belligerents in “non-international armed conflicts” (NIACs), which entail protracted armed violence between governmental authorities and organized armed groups or between such groups themselves. Finally, it closes with an assessment of what these obligations mean in the COVID-19 context.


36. Id.

1. Principles Governing Conduct of Hostilities in IACs During a Pandemic

The International Committee of the Red Cross (ICRC), an “impartial humanitarian body,” in the words of the Geneva Conventions, with a mandate to act as a substitute protecting power for prisoners of war (that is, captured combatants fighting on behalf of a party to the Conventions), contends that, as a matter of customary law, in all conflicts humanitarian relief personnel must be respected and protected. In addition, objects used for humanitarian relief operations must be respected and protected. These rules have generally been accepted by States as customary law.

In addition to customary law, international treaty law governs the conduct of hostilities in IACs, regulating targeting and military operations based on principles of distinction, prohibition on indiscriminate attacks, proportionality, and necessary precautions. The governing conventions—specifically the four Geneva Conventions and Additional Protocol I (API)—protect medical personnel, entities, and equipment from direct attack.

To ensure the care of wounded and sick combatants, the First Geneva Convention (GC I) establishes protections for the belligerent armed forces’

39. See Protecting Powers, Int’l Comm. Red Cross, https://casebook.icrc.org/glossary/protecting-powers#:~:text=the%20absence%20of%20an%20agreement%20or%20system%20has%20been%20used%20in%20recent%20years
[https://perma.cc/AX9V-67Y9].
medical personnel and units, as well as hospital zones, medical transport, and the necessary passage to effect such transport. The Second Geneva Convention (GC II) provides corresponding protections for maritime warfare. In addition, the Fourth Geneva Convention Relative to the Protection of Civilian Persons in Time of War (GC IV) allows parties to a conflict to establish hospital and safety zones, as well as localities and neutralized zones intended to shelter wounded and sick combatants and civilians taking no part in hostilities from the effects of war. It stipulates, moreover, that civilian medical entities and operations, as well as persons engaged in the operation and administration of such civilian hospitals, shall in no circumstances be the object of attack.

For States that are party to it, AP I also extends protections established in GC I and GC II to civilian medical personnel, equipment, and transport, and explicitly prohibits attacks on such entities. AP I recognizes additional protections for medical personnel performing their duties. No one can “be punished for carrying out medical activities compatible with medical ethics” regardless of the benefactor, nor can they be compelled to act (or to refrain from acting) in ways contrary to rules of medical ethics, and force cannot be used to threaten personnel to provide medical information of those who have been or are being treated.

AP I, moreover, prohibits parties to IACs from undertaking indiscriminate attacks that, by their nature, can fail to distinguish between military and civilian objects (including medical facilities and personnel). Belligerents must also assess the proportionality of an attack by weighing the military advantage anticipated against the expected “incidental loss of civilian life, injury to civilians, damage to civilian objects, or a combination thereof.” Belligerents are required to take precautionary steps to minimize incidental harm to civilians and civilian objects in undertaking attacks, and they have a duty to protect civilians and civilian objects under their control from the dangers of conflict. Many of these obligations, moreover, arguably constitute customary law and therefore might be

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44. GC I, supra note 43, arts. 19, 23, 24, 35–37.
47. Id., arts. 18, 20, 21.
49. AP I, supra note 43, arts. 16(1)–(3).
50. Id., art. 51(4).
51. Id., art. 51(3)(b).
52. Id., art. 57.
53. Id., art. 58. Many of these obligations arguably constitute customary law and therefore might be

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considered binding on all States, even those that are not party to AP I. 54

2. **Principles Governing Conduct of Hostilities in NIACs During a Pandemic**

As in IACs, customary international law rules provide for and protect humanitarian relief personnel and objects in NIACs. In addition, Additional Protocol II to the Geneva Conventions (AP II) establishes obligations for States and non-state armed groups that are party to that Protocol, if the conflict takes place in the territory of a state that is party to the Protocol. 55 Belligerents covered by AP II cannot punish medical personnel, who are to be “respected and protected.” 56 Health care workers must not be compelled to undertake tasks contrary to their humanitarian mission or to give priority except on medical grounds. 57 Generally, they should not be punished for adhering to ethical standards on information-sharing and for maintaining confidentiality. 58 Additionally, Common Article 3 of the Geneva Conventions—so called because the text of the article is “common” or shared between all four Geneva Conventions—requires parties to NIACs (whether States or non-state armed groups) to humanely treat individuals not taking part in the conflict, including members of armed forces placed “hors de combat” by sickness or other causes. 59

3. **Conduct of Hostilities in the COVID-19 Context**

The formal rules and obligations governing the conduct of hostilities do not change in the context of a deadly pandemic, but their practical impact may be altered. In particular, certain actions that might be permissible under normal circumstances may be impermissible during a pandemic.

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55. Protocol II Additional to the Geneva Conventions of 12 August 1949 and Relating to the Protection of Victims of Non-International Armed Conflicts, June 8, 1977, 1125 U.N.T.S. 609 [hereinafter AP II]. The United States is also not a party to this Protocol, though the Reagan Administration submitted it to the Senate for approval in 1987 and the Obama administration encouraged the Senate to act on it in 2011 and embraced it as customary law in the process. Press Release, White House, supra note 48.

56. AP II, supra note 55, art. 9.

57. Id.

58. Id., art. 10.

59. GC I, supra note 43, art. 3; GC II, supra note 43, art. 3; GC III, supra note 38, art. 3; GC IV, supra note 43, art. 3.
Some legal obligations incumbent upon parties to a conflict where there is a risk of COVID-19 are fairly straightforward: parties to conflicts are not to target military personnel who are hors de combat because of the virus. Further, belligerents are not to punish medical personnel disseminating personal protective equipment such as masks, carrying out COVID-19 tests, or administering a vaccine, in accordance with their ethical duties, even if such personnel assist enemy forces or civilians allied with those adversaries.

The need for assessing proportionality of attacks and undertaking precautionary measures may also necessitate that parties take into account foreseeable pandemic-related “reverberating effects” of a military operation. Emanuela-Chiara Gillard cites as an example of reverberating harm an attack that results eventually in a disease outbreak, such as an attack that knocks out an electricity generation and distribution system, which might in turn prevent the operation of water purification systems and lead ultimately to an outbreak of waterborne disease. However, as Ellen Nohle and Isabel Robinson explain, “[w]hile there is growing consensus that belligerents in an armed conflict are legally obliged to take into account the reasonably foreseeable reverberating effects of an attack, . . . the precise scope of this obligation remains unclear.” Further, there is not yet a consensus as to what qualifies as a reverberating effect.

Whatever the precise scope of the obligation to account for reverberating effects, the pandemic is likely to magnify foreseeable effects of hostile activities. Second-order impacts from attacks on civilian objects and infrastructure increase the damage of such attacks and thus alter the required proportionality analysis. For example, belligerents may have to assess the risk of attacks that might reduce systemic capacity to respond to COVID-19 (or prevent its spread). A party to a conflict may need to weigh, for example, whether an attack could have the incidental harm of destroying stocks of mechanical ventilators that are in short supply. Likewise, the foreseeable consequences of a temporary interruption to civilian water or medical supply lines might be much greater in a pandemic context than in

60. See GC I, supra note 43, art. 3; GC II, supra note 43, art. 3; GC III, supra note 38, art. 3; GC IV, supra note 43, art. 3.


63. Id. at 19.


65. Id. at 108–09.

66. Id. at 116.
other times, as even temporary lack of access to hygiene or personal protective equipment can significantly affect disease spread.

Additionally, the AP I and AP II obligations to adopt precautionary measures regarding “works and installations containing dangerous forces” might be read to extend special protections to laboratories or medical clinics where biological agents of infectious diseases are kept.67 Such locations might be analogized to those facilities for which these articles provide special protection, namely dams, dykes, and nuclear electrical generating stations. In consequence, if belligerents were to target a vaccine development, distribution, or storage site, they would also have to consider the reverberating effects of such an attack. Given the importance of vaccines to the population’s wellbeing, such an attack would likely be considered disproportionate.

In short, belligerents’ conflict-related duties remain relevant—and abiding by these rules has arguably become even more essential—as COVID-19 has reached populations in conflict-ridden areas. Conversely, violations of such laws and norms, which are all too common, have also taken on greater consequence as conflict-affected societies seek to protect their already vulnerable populations from the added dangers of the current pandemic.

B. Humanitarian Access

As COVID-19 spreads unchecked in war-torn areas around the world, the international humanitarian law principle of humanitarian access has become more urgent than ever. Local health systems, already overburdened by years of war, are poorly equipped to deal with the new challenges posed by COVID-19. In Yemen, for example, both States and non-state armed groups hindered humanitarian access by the U.N. and aid agencies, even as COVID-19 emerged as a threat.68 One report showed that “[e]fforts to prevent the spread of COVID-19 and respond to other urgent health needs in Yemen have been severely hampered by onerous restrictions and obstacles that the Houthis and other authorities have imposed on international aid agencies and humanitarian organizations.”69 The UN warned that as a result, “COVID-19 is ‘likely to spread faster, more widely and with deadlier consequences [in Yemen] than almost anywhere else.”70

This Section first outlines the general IHL principle of humanitarian access. Next, it identifies the specific obligations of belligerents in both

67. AP I, supra note 43, arts. 56–57; AP II, supra note 55, art. 15.
IACs and NIACs. Finally, it assesses the significance of these obligations in the COVID-19 context.

1. Principles Governing Humanitarian Access in IACs in a Pandemic

The ICRC maintains that, as a matter of customary law, in all conflicts, parties must allow and facilitate rapid and unimpeded passage of humanitarian relief for civilians in need. That relief must be impartial in character and conducted without any adverse distinction, subject to the parties’ right of control.71 In addition, “[t]he parties to the conflict must ensure the freedom of movement of authorized humanitarian relief personnel essential to the exercise of their functions.”72 Only in cases of “imperative military necessity may their movements be temporarily restricted.”73 These rules have generally been accepted by States as customary law.

In addition to customary international law, treaty law also governs IACs during pandemics. The Geneva Conventions and AP I establish the right of the ICRC and other aid organizations to provide humanitarian relief.74 Accordingly, while belligerents have the primary obligation to care for the wounded and sick without adverse distinction, if they are unable or unwilling to fulfill their primary responsibility, they may not deny consent to humanitarian agencies that offer assistance.75 As the ICRC’s 2016 Commentary on GC I puts it: “If the humanitarian needs cannot be met otherwise, the refusal of such an offer would be considered arbitrary, and therefore inconsistent with international law.”76 In addition, GC IV—which provides protections to all civilian persons during IACs—requires States to “allow the free passage of all consignments of medical and hospital stores” intended for civilians of another High Contracting Party (i.e., States that are party to the Conventions) and “the free passage of all consignments of essential foodstuffs, clothing and tonics intended for children under fifteen, expectant mothers, and maternity cases.”77

AP I establishes broader obligations for States Parties to that Protocol. It states that “if the civilian population of any territory under the control of a Party to the conflict . . . is not adequately provided with [humanitarian] supplies . . . relief actions which are humanitarian and impartial in character and conducted without any adverse distinction shall be undertaken.”78 Moreover, the parties to the conflict and each High Contracting Party “shall

73. Id.
74. GC I, supra note 43, art. 9; GC II, supra note 43, art. 9; GC III, supra note 38, art. 9; GC IV, supra note 43, art. 10; AP I, supra note 43, art. 71.
75. See GC I, supra note 43, art. 12; GC II, supra note 43, art. 12.
77. GC IV, supra note 43, art. 23.
78. AP I, supra note 43, art. 70.
allow and facilitate rapid and unimpeded passage” of humanitarian assistance, “even if such assistance is destined for the civilian population of the adverse Party.”79 States are not relieved of these obligations during a pandemic. States are, however, entitled to prescribe certain measures to regulate humanitarian activities.80

In short, despite the fact that the provision of humanitarian activities is “subject to the consent of the [p]arties to the conflict concerned,” belligerents arguably have little room to deny consent to humanitarian organizations if they cannot or elect not to meet humanitarian needs themselves.81 The ICRC has also argued that the civilian population has a right to receive humanitarian relief essential for its survival,82 and legal commentators have noted that a State Party’s willful denial of humanitarian access can in certain contexts amount to a war crime.83 Additionally, States that have occupied the territory of other States have primary responsibility in the occupied territory to provide “supplies essential to the survival of the civilian population.”84

2. Principles Governing Humanitarian Access in NIACs in a Pandemic

As in IACs, customary international law rules provide for and protect humanitarian access. In addition, in NIACs, Common Article 3 allows impartial humanitarian bodies to offer their services to the parties to the conflict.85 AP II complements this framework, for States that are party to it. AP II Article 18(2) states that

[i]f the civilian population is suffering undue hardship owing to a lack of the supplies essential to its survival . . . relief actions for the civilian population which are of an exclusively humanitarian and impartial nature and which are conducted without any adverse distinction shall be undertaken subject to the consent of the High Contracting Party concerned.86

AP II speaks only of the consent of the High Contracting Party—that is, the State Party to the conflict.87 However, there is disagreement as to whether State Party consent is always required.88 If a humanitarian relief convoy is

79. Id. art. 70(2).
80. For example, parties to the conflict and each High Contracting Party may articulate “technical arrangements, including search, under which passage is permitted.” Id. art. 70(3). During a virulent pandemic, these “technical arrangements” might validly include measures to contain the spread of disease such as temporary quarantine.
81. See GC I, supra note 43, art. 9; GC II, supra note 43, art. 9; GC III, supra note 38, art. 9; GC IV, supra note 43, art. 10.
82. See 1 JEAN-MARIE HENCKAERTS & LOUISE DOSWALD-BECK, supra note 40, at 199.
84. AP I, supra note 43, art. 69.
85. GC I, supra note 43, art. 3; GC II, supra note 43, art. 3; GC III, supra note 38, art. 3; GC IV, supra note 43, art. 3.
86. AP II, supra note 55, art. 18(2).
87. Id.
traveling to civilians in an area controlled by a non-State actor group and need not traverse territory under the State Party’s control, then does the convoy need State Party consent? The Oxford Guidance on the Law Relating to Humanitarian Relief Operations in Situations of Armed Conflict correctly notes that “as a matter of operational practice, the agreement or acquiescence of all [p]arties to an armed conflict to humanitarian relief operations intended for civilians in territory under their effective control or transiting through such territory will be required” for the safe conduct of operations.89 Yet it also emphasizes that, as with IACs, “consent to humanitarian relief operations may not be arbitrarily withheld.”90

3. Humanitarian Access in the COVID-19 Context

The principles of humanitarian access in IACs and NIACs apply with particular urgency to conflicts during the COVID-19 pandemic. Assistance by aid organizations is essential in places where armed conflict continues to rage and States are ill-equipped to ensure that civilians and captured enemy fighters have access to COVID-19-responsive medical supplies and treatment.

As noted above, humanitarian personnel must be respected and protected, as must objects for humanitarian relief operations.91 If those personnel are transporting COVID-19-related equipment, such as face masks or vaccines, warring parties have a similar duty to respect and protect that equipment. In addition, civilians should not be denied access to essential COVID-19 prevention materials. In cases of occupation, occupying powers have a duty to adopt and apply “prophylactic and preventive measures necessary to combat the spread of contagious diseases and epidemics” such as COVID-19.92 Warring parties in an IAC must treat members of the armed forces and other protected persons who have contracted COVID-19 in light of their obligation to care for the sick and wounded.93

International humanitarian law clearly establishes that aid organizations such as the ICRC have the right to offer aid in both IAC and NIAC contexts. In the current crisis, such aid organizations may be better positioned and equipped than parties to the conflict to provide COVID-19-related aid to civilians and prisoners of war.94 As noted above, while humanitarian activities are subject to the consent of the parties to the conflict, belligerents arguably have little room to deny consent to provide access to aid organizations if they cannot themselves provide the necessary assistance.95 That likely means that aid organizations offering personal

89. Id. at 17–18.
90. Id. at 21.
91. See 1 JEAN-MARIE HENCKAERTS & LOUISE DOSWALD-BECK, supra note 40, at 105–11.
92. GC IV, supra note 43, art. 56.
93. GC I, supra note 43, art. 12.
94. See GC I, supra note 43, art. 9; GC II, supra note 43, art. 9; GC III, supra note 38, art. 9; GC IV, supra note 43, art. 10; AP I, supra note 43, art. 71.
protective equipment (such as masks) and other essential supplies (such as ventilators), medical treatment for COVID-19 patients, and vaccines must be provided access unless the party to the conflict can and does provide for those needs. Warring parties can prescribe technical arrangements for the distribution of COVID-19 supplies and are permitted to supervise the delivery of humanitarian aid. They cannot, however, discriminate against civilians of a rival party to the conflict.

Warring parties around the world have unfortunately violated the obligation to permit humanitarian access. For example, the Syrian regime’s regular targeting of humanitarian relief facilities and vehicles and refusal to grant access and passage to aid workers and aid efforts violate the obligation to protect humanitarian access. This has undoubtedly exacerbated the spread of COVID-19 in the country and, indeed, the region. The same is true in Yemen, where Houthi authorities reportedly blocked international organizations from distributing vaccines in much of the country. Elsewhere, however, warring parties have taken steps to respect the principle of humanitarian access. In Afghanistan, for example, Taliban insurgents offered “secure passage to humanitarian organizations and health workers seeking to provide aid” and provided supplies to those living under Taliban control.

The ICRC has concluded that “arguments based on the necessity to counter the spread of COVID-19 are not valid grounds under IHL to deny consent to humanitarian activities undertaken by impartial humanitarian organizations.” While States might, for example, require all incoming aid personnel to be vaccinated or to quarantine for two weeks under the “technical arrangements” provision of AP I, State Parties cannot entirely refuse access to aid organizations.

96. GC IV, supra note 43, art. 23.
97. The principle of free passage of consignments of medical and hospital stores “applies to all such consignments, when they are intended for the civilian population of another contracting party, whether that party is an enemy, allied, associated or neutral State.” Commentary of 1958: Article 23, Int’l Comm. Red Cross, https://ihl-databases.icrc.org/applic/ihl/ihl.nsf/Comment.xsp?action=OpenDocument&documentId=60CC3CB70E98F1AC12563CD00428693 [https://perma.cc/K33G-VWCM].
102. AP I, supra note 43, art. 7(3). The ICRC study suggests that States even have an affirmative obligation to “ensure the freedom of movement” of aid personnel providing COVID-19 prevention and treatment; see also 1 Jean-Marie Henckaerts & Louise Doswald-Beck, supra note 40, at 201.
Finally, it is worth underscoring the novel coronavirus' virulence. The pandemic does not observe battle lines and does not distinguish between combatants and civilians. Given the virus's potency, States have a responsibility to deliver or allow aid organizations to deliver protective gear and treatment. Failing to allow humanitarian access necessarily increases the exposure of civilians to a virus that has already taken the lives of too many.

C. Treatment of Detainees

In settings of armed conflict, those subject to wartime detention may face circumstances that leave them vulnerable to COVID-19. These include inadequate medical services, overcrowding, lack of adequate ventilation, and pre-existing health conditions lowering their resistance to the disease. South Sudan, where armed conflict has persisted since 2014, illustrates the challenges: The government’s National Security Service (NSS) operates outside of official state structures and has arbitrarily detained alleged political opponents and other civilians in facilities where these individuals have been subject to abuse and substandard conditions. According to Human Rights Watch, these locations lack adequate medical care and are overcrowded and unsanitary. Government efforts to reduce overcrowding in regular prisons in early 2020 did not include the NSS’s detention facilities, putting NSS detainees at even greater risk.

Another example can be found closer to home. At the United States’ military base at Guantánamo Bay, many of the 40 detainees who remained as the pandemic hit were of advanced age and in poor health, leaving them particularly at risk if they were to contract COVID-19. In early 2020, two U.S. service members serving at the base tested positive for the virus, and observers warned that an outbreak among the detainees could be catastrophic.


toward the detainees, despite its longstanding position that military detention operations at the base are compliant with IHL.\textsuperscript{108} The Department of Defense initially planned to offer vaccinations to the detainees in January 2021, but it suspended that plan, apparently due to political pressure, in a move that arguably violated its legal obligations to the detainees.\textsuperscript{109} It was not until April 2021 that the U.S. military finally reported that 32 of the 40 detainees had received at least the first dose of a COVID-19 vaccine.\textsuperscript{110}

This Section examines, first, the obligations of participants in IACs, before turning to those of belligerents in NIACs. The Section closes with an assessment of what these obligations mean in the COVID-19 context.

1. Principles Governing Detention in IACs

The relevant treaty provisions that govern the treatment of detainees in an IAC are mostly contained in GCs III and IV.\textsuperscript{111} Prisoners of war are entitled to both general and specific guarantees of health and hygiene.\textsuperscript{112} In particular, “the Detaining Power is responsible for the treatment” given to prisoners of war; “[p]risoners of war must at all times be humanely treated,” and they must be afforded “every guarantee of hygiene and healthfulness.”\textsuperscript{113} In addition, interned civilians are entitled to “the medical attention required by their state of health.”\textsuperscript{114}

The detaining power also has a duty to implement certain sanitary measures in its POW camps. The detaining power “shall be bound to take all sanitary measures necessary to ensure the cleanliness and healthfulness of camps and to prevent epidemics. Prisoners of war shall have for their use, day and night, conveniences which conform to the rules of hygiene.”\textsuperscript{115} Moreover, “medical inspections of prisoners of war shall be held at least once a month” to “supervise the general state of health, nutri-
tion and cleanliness of prisoners and to detect contagious diseases."\textsuperscript{116} The detaining power has a duty to ensure that the camps meet specified minimum standards for the conditions of detention.\textsuperscript{117}

The detaining power must further ensure that the camp has a suitable physical infrastructure to attend to medical emergencies, including disease outbreaks. Every camp "shall have an adequate infirmary where prisoners of war may have the attention they require"\textsuperscript{118} and "every place of internment shall have an adequate infirmary, under the direction of a qualified doctor" with "isolation wards . . . set aside for cases of contagious or mental diseases."\textsuperscript{119} Camp buildings and quarters also must meet certain hygienic standards. The detaining power "is bound to take all necessary and possible measures to ensure that protected persons shall, from the outset of their internment, be accommodated in buildings or quarters which afford every possible safeguard as regards hygiene and health."\textsuperscript{120}

2. \textit{Principles Governing Detention in NIACs}

IHL provides detainees in a NIAC context both general and specific guarantees of hygiene and health. The Geneva Conventions’ Common Article 3 provides a broad and non-derogable guarantee of proper detainee treatment, stating that “[p]ersons taking no active part in the hostilities . . . shall in all circumstances be treated humanely, without any adverse distinction founded on race, colour, religion or faith, sex, birth or wealth, or any other similar criteria.”\textsuperscript{121} It specifies, moreover, that the “wounded and sick shall be collected and cared for.”\textsuperscript{122}

Similarly, AP II articulates a broad guarantee of proper treatment: The wounded “shall be respected and protected,” shall in all circumstances “be treated humanely,” and shall “receive, to the fullest extent practicable and with the least possible delay, the medical care and attention required by their condition.”\textsuperscript{123} It also contains more specific guarantees of proper detainee treatment: It extends to “persons deprived of their liberty for reasons related to the armed conflict, whether they are interned or detained” the same health and hygiene protections afforded to the “local civilian population.”\textsuperscript{124} Detainee treatment is tied to the standard enjoyed by the local civilian population, but that treatment may not fall below the basic, funda-

\textsuperscript{116}. Id. art. 31.
\textsuperscript{117}. See, e.g., id. art. 25 (quarters); id. arts. 26, 27 (food rations, clothing); GC IV, supra note 43, arts. 89, 90; see also 1 \textsc{Jean-Marie Henckaerts \& Louise Doswald-Beck}, supra note 40, at 428–31.
\textsuperscript{118}. GC III, supra note 38, art. 30.
\textsuperscript{119}. GC IV, supra note 43, art. 91.
\textsuperscript{120}. Id. art. 85.
\textsuperscript{121}. GC I, supra note 43, art. 3; GC II, supra note 43, art. 3; GC III, supra note 38, art. 3; GC IV, supra note 43, art. 3.
\textsuperscript{122}. GC I, supra note 43, art. 3; GC II, supra note 43, art. 3; GC III, supra note 38, art. 3; GC IV, supra note 43, art. 3.
\textsuperscript{123}. AP II, supra note 55, art. 7.
\textsuperscript{124}. Id. art. 5(1)(b); see also 1 \textsc{Jean-Marie Henckaerts \& Louise Doswald-Beck}, supra note 40, at 428–31, 435–37.
mental guarantees of humane treatment under IHL. Moreover, the
detaining authorities shall, “within the limits of their capabilities,” provide
detainees with “the benefit of medical examinations” and ensure that
detainee “physical or mental health and integrity shall not be endangered
by any unjustified act or omission.”

3. Detainee Treatment in the COVID-19 Context

How do these IHL guarantees of proper treatment apply in the context
of COVID-19? The specificity of the answer depends significantly on
whether the conflict is an IAC or a NIAC, but the broad principles are the
same.

The IAC context is tightly regulated: Detainees are to enjoy sanitary
procedures and a basic level of goods and infrastructure in the camps. A
detaining power must take measures to prevent epidemics. In the
COVID-19 context, this would mean providing personal protective equip-
ment such as face masks and building detention facilities that have enough
space for adequate social distancing. Detaining powers are obligated to
conduct regular medical inspections of POWs. Civilian internees who
manifest symptoms of COVID-19 should be quarantined in an isolation
ward and provided with adequate medical treatment; POWs manifesting
symptoms should also be quarantined. Lastly, the ICRC and other aid
organizations can offer humanitarian relief; the detaining power is argua-
bly obligated to consent to humanitarian relief if it cannot meet the health
needs of detainees on its own.

The NIAC context is less tightly regulated, though detainees are still
entitled to “medical examinations,” proper treatment, and to a basic stan-
dard of health and hygiene. If detainees are infected with COVID-19, they
are entitled to the appropriate medical care to the greatest practicable
extent. If feasible, the detaining party should provide the medical facili-
ties at a detention camp with respirators, oxygen tanks, and other equip-
ment commonly used to deal with COVID-19 cases. The detaining power
must also, to the extent practicable, organize medical examinations and
ensure the health of detainees. At the very least, detaining powers should
ensure that detention facilities are large enough to allow for adequate social
distancing and that basic protective equipment, such as masks, is provided.
Lastly, detainees in the NIAC context must be afforded the same COVID-19
protections as the local civilian population, including access to vaccina-
tion. As in IACs, humanitarian bodies can offer their services to the par-
ties to a NIAC, and the detaining party is arguably obligated to consent to
humanitarian relief if it cannot meet the health needs of detainees on its

125. See AP II, supra note 55, art. 7.
126. Id. arts. 5(2)(d)-(e).
127. GC III, supra note 38, art. 29.
128. Id. art. 30; GC IV, supra note 43, art. 91.
129. See id. art. 9.
130. AP II, supra note 55, art. 7.
II. International Human Rights

International human rights law governs the behavior of States towards individuals both within their territory and, to a lesser extent, abroad. Three bodies of human rights law are particularly relevant during the COVID-19 pandemic: the law governing the right to life, the law governing the right to health, and the law governing civil and political rights. This Part examines whether and under what circumstances the failure by many States to effectively respond to the pandemic might have violated the right to life or right to health of those who, as a result, were infected or killed by the virus. It examines, too, whether States that used the pandemic as a basis for suppressing civil or political rights—for example, suspending elections or prohibiting political protests—violated their human rights obligations in the process.

A. Right to Life

Many States have failed to ensure that all individuals under their jurisdiction can live with security and dignity in the face of COVID-19. States’ shortcomings in protecting populations under their care from the threat of COVID-19 may violate a fundamental right in international human rights law: the right to life. This right, included in a number of core human rights treaties, must not be infringed. This Section first outlines the right to life as it is defined in various human rights conventions. It then considers the scope of State obligations related to the right in the context of the COVID-19 pandemic. In light of claims that countries are culpable for the virus’s impact on other States when they have failed to prevent COVID-19’s spread beyond their borders, this Section also evaluates the extraterritorial reach of the right to life and its application to the current pandemic.

1. The Right to Life, as Defined and Protected by International Law

The right to life is a fundamental, foundational principle of international human rights law under both customary international law and treaty law. The non-binding Universal Declaration of Human Rights

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The Universal Declaration of Human Rights (UDHR) states that “everyone has the right to life, liberty, and security of person.”\textsuperscript{135} The International Covenant on Civil and Political Rights (ICCPR), which has 173 parties, provides that “every human being has the inherent right to life,” which is to be “protected by law,” and that “no one shall be arbitrarily deprived of his life.”\textsuperscript{136} Further, the Convention on the Rights of the Child (CRC), which has 196 parties, states that “States Parties recognize that every child has the inherent right to life.”\textsuperscript{137}

Regional human rights treaties also entrench the right to life. The American Convention on Human Rights (ACHR) affirms that “[e]very person has the right to have his life respected.”\textsuperscript{138} The European Convention on Human Rights (ECHR) similarly states that “everyone’s right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.”\textsuperscript{139} The African Charter on Human and Peoples’ Rights states that “human beings are inviolable.”\textsuperscript{140} “Every human being shall be entitled to respect for his life and the integrity of his person. No one may be arbitrarily deprived of this right.”\textsuperscript{141}

As a non-derogable right in the ICCPR, the right to life cannot be suspended even in a state of emergency.\textsuperscript{142} The African Commission on Human and Peoples’ Rights has similarly held the right to life to be non-derogable.\textsuperscript{143} However, the right to life is not an unbounded right, as provisions of human rights conventions provide leeway for authorities to use deadly force in their pursuit of justice or security. Article 2(2) of the ECHR, for example, provides that “[d]eprivation of life shall not be regarded as inflicted in contravention of this Article when it results from the use of force which is no more than absolutely necessary.”\textsuperscript{144}

\begin{footnotes}
\footnotetext[137]{Convention on the Rights of the Child art. 6(1), Nov. 20, 1989, 1577 U.N.T.S. 3 [hereinafter CRC].}
\footnotetext[139]{Convention for the Protection of Human Rights and Fundamental Freedoms art. 2(1), Nov. 4, 1950, 213 U.N.T.S. 221 [hereinafter ECHR].}
\footnotetext[141]{Id.}
\footnotetext[142]{ICCPR, supra note 136, art. 4(2).}
\footnotetext[144]{ECHR, supra note 139, art. 2(2); see also ICCPR, supra note 136, art. 6(2).}
\end{footnotes}
2. The Right to Life During a Pandemic

The U.N. Human Rights Committee, the body of independent experts established to monitor implementation of the ICCPR, has stressed that the right to life, as expressed in the ICCPR, should not be “interpreted narrowly;” accordingly, individuals are entitled “to be free from acts and omissions that are intended or may be expected to cause their unnatural or premature death, as well as to enjoy a life with dignity.” 145 Critically, the Committee suggests States Parties “should take appropriate measures to address the general conditions in society that may give rise to direct threats to life or prevent individuals from enjoying their right to life with dignity,” conditions that may include “the prevalence of life-threatening diseases.” 146 It also notes that “[t]he duty to protect the life of all detained individuals includes providing them with the necessary medical care and appropriate regular monitoring of their health.” 147 In *Toussaint v. Canada*, the Committee specifically held that Canada’s exclusion of undocumented immigrants from a federal health care program violated the right to life, among other rights; the Committee found that the duty to respect the right to life “extends to reasonably foreseeable threats and life-threatening situations that can result in loss of life.” 148

Parties to adjudication in the European Court of Human Rights (ECtHR) have invoked the right to life across a range of issues, including in the health care context. In *Powell v. United Kingdom*, the ECtHR wrote, “[I]t cannot be excluded that the acts and omissions of . . . [state] authorities in the field of health care policy may in certain circumstances engage their responsibility under the positive limb of Article 2.” 149 And, in *Cyprus v. Turkey*, the ECtHR observed that “an issue may arise under Article 2 of the Convention where it is shown that the authorities of a Contracting State put an individual’s life at risk through the denial of health care which they have undertaken to make available to the population generally.” 150 A State authority is obligated, the Court continued, to take “appropriate steps to safeguard the lives of those within its jurisdiction.” 151 Further, in *Stoyanov v. Bulgaria*, the ECtHR broadly interpreted the Convention’s right to life provision as sometimes requiring the authorities to take preventive

146. Id. ¶ 26.
147. Id. ¶ 25.
151. Id.

3. Application in the Context of COVID-19

States have at least minimal obligations to protect the lives of their inhabitants through taking steps to address clear health threats to the population, such as the deadly COVID-19 virus. For instance, as noted above, the U.N. Human Rights Committee states that the right to life obligates ICCPR States Parties to “address . . . life-threatening diseases.”\footnote{153. General Comment No. 36, supra note 145, ¶ 3.} Further, as Alessandra Spadaro points out, the Committee articulates a “due diligence obligation” for States to “undertake reasonable positive measures . . . in response to reasonably foreseeable threats to life originating from private persons and entities.”\footnote{154. Alessandra Spadaro, COVID-19: Testing the Limits of Human Rights, EUR. J. RISK. REG. 1-9 (2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7211800/#fn7 [https://perma.cc/2LZ2-QSRE].} While this due diligence obligation is presented in the context of physical threats by armed groups or criminals, Spadaro suggests the duty could also entail “protecting individuals from threats to life posed by others carrying an infectious and deadly disease, such as COVID-19.”\footnote{155. Id.} These readings of the ICCPR’s right to life provision square neatly with other authoritative bodies’ interpretation of the right to life as it appears in other instruments. For instance, as Elizabeth Stubbins Bates has explained, the ECtHR’s Stoyanovi decision and other opinions of that court suggest that States Parties to the ECtHR may have a positive duty to plan for pandemic response so that lives can be saved once public health emergencies arise.\footnote{156. Elizabeth Stubbins Bates, COVID-19 Symposium: Article 2 ECHR’s Positive Obligations–How Can Human Rights Law Inform the Protection of Health Care Personnel and Vulnerable Patients in the COVID-19 Pandemic? OPINIOJURIS (Apr. 1, 2020), https://opiniojuris.org/2020/04/01/covid-19-symposium-article-2-echrs-positive-obligations-how-can-human-rights-law-inform-the-protection-of-health-care-personnel-and-vulnerable-patients-in-the-covid-19-pandemic/ [https://perma.cc/THM3-MH69].}

The failure of a State to take at least minimal steps to protect its population from the spread of COVID-19 arguably violates the right to life of those who become infected and die. The precise scope of this positive obligation is not clear, but it likely does not mean that States are required to establish lockdown measures or mandatory masking policies. On the other hand, it likely does mean that States at least have a duty to not knowingly contribute to the spread of the virus. For instance, States should ensure first responders and health care workers have access to necessary personal protective equipment (especially masks) to protect themselves and those they serve. Moreover, the right to life might be violated by denying access to health care essential to treating those at risk of losing their lives to the pandemic. The right to life does not guarantee universal access to...
health care, of course. But the ICCPR arguably does require States to provide a minimal access to health care in order to fulfill the right to life.157  

There is also clarity on some minimum State obligations: U.N. human rights experts have specified that any lifesaving COVID-19 interventions must not discriminate among social groups.158 For instance, access to the vaccine must be provided without invidious discrimination. States also have a heightened responsibility to protect the right to life of those they detain. As noted above, the Human Rights Committee has concluded that the duty to protect the life of detained individuals includes providing necessary medical care and monitoring of their health.159 In the United States, for example, incarcerated people have been infected by COVID-19 at rates five times that of the general population, and the death rate of those incarcerated is higher than the national death rate.160 Given this greater level of vulnerability of incarcerated populations, and the difficulty they have protecting themselves from infection (they obviously cannot self-quarantine), States have heightened obligations to protect them. This means that incarcerated or detained persons should be provided essential protective equipment (masks) and that social distancing and other measures should be instituted to limit the spread of the virus. Those who are infected should be quarantined away from the rest of the population of those detained and should be provided adequate medical care. The detained should not be denied access to the vaccine, and there may be an obligation to at least ensure access equivalent to that available to the general population. As noted in Part III, these obligations extend, as well, to detention facilities for immigrants.

4. States’ Obligations Outside their Territories

There have been accusations that some governments’ inadequate responses to COVID-19 have allowed the virus to spread transnationally and harm populations abroad.161 It is therefore worth considering whether States’ right to life obligations apply outside their own borders—that is, extraterritorially.

157. General Comment No. 36, supra note 145.
159. General Comment No. 36, supra note 145, ¶ 25.
There is significant disagreement over the scope of extraterritorial obligations under the primary treaty that establishes the right to life—the ICCPR. Article 2(1) requires a State Party to respect the rights of individuals “within its territory and subject to its jurisdiction.” Some States, including the United States, have taken the view that the ICCPR does not apply extraterritorially. The Human Rights Committee, however, has concluded that the obligations under the treaty extend to “those within the power or effective control of the forces of the State Party acting outside its territory, regardless of the circumstances in which such power or effective control was obtained.” The Committee has also specified that States have an obligation to “ensure that all activities taking place in whole or in part within their territory and in other places subject to their jurisdiction, but having a direct and reasonably foreseeable impact on the right to life of individuals outside their territory . . . are consistent with” ICCPR Article 6.

The ICJ recognized in its advisory opinion *Legal Consequences of the Construction of a Wall in the Occupied Palestinian Territories* that State obligations under a number of human rights conventions—including the ICCPR, CRC, and Convention against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment (CAT)—apply “in respect of acts done by a State in the exercise of its jurisdiction outside its own territory.” Regional courts and conventions take varying approaches to the question of extraterritoriality. The ECtHR clarified in *Al-Skeini v. United Kingdom* that the ECHR obliges States Parties exercising “effective control” in foreign territory to secure the rights and freedoms identified in the Convention for individuals subject to that control. In *Coard et al. v. United States*, the Inter-American Commission on Human Rights similarly recognized that “jurisdiction” may “refer to conduct with an extraterritorial locus where the person concerned is present in the territory of one State, but subject to the control of another State.”

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162. ICCPR, supra note 136, Art. 2(1).
164. General Comment No. 31 on the ICCPR, U.N. Hum. Rts. Comm., ¶ 10 (Mar. 29, 2004), docstore.ohchr.org/RepLeafletsFilesHandler.ashx?enc=6QkG1d%2FPPRiCAqBKB7ysyoCwCMkoRk2QVAVeRQmTmJnRO%2Bud3cPvrcM9YxW6fxaxxpmZ9kUtFpW0q%2FbWV%2FtpKizpZnbEjw%2FFgeZRAjDfunJQRnbjEahb31WQPL2mLFDe6ZSwMmQVMGVA%3D%3D [https://perma.cc/4XZG/L94P].
165. General Comment No. 36, supra note 145, ¶ 22.
Charter on Human and People’s Rights does not have a provision explicitly tying duties to State jurisdiction, which some scholars have pointed out suggests that the Charter’s duties may apply extraterritorially.

As a result of the limited extraterritorial effect of human rights obligations described above, States have a limited duty to protect the lives of foreign nationals abroad from the COVID-19 threat and to refrain from “acts and omissions” that leave other populations susceptible to the virus. A State Party to the ICCPR exerting effective control of or asserting authority over foreign territory or persons would, under most readings of the ICCPR, be expected to ensure that State policies do not knowingly contribute to “unnatural or premature” deaths during a pandemic. Thus, administering powers of non-self-governing territories, such as the Falkland Islands, American Samoa, and French Polynesia, would likely be obliged to protect the right to life of individuals in those territories by containing the spread of COVID-19 and providing minimum adequate care to infected individuals. The same is likely true of the U.S. military base and detention center located at Guantánamo Bay, Cuba.

B. Right to Health

Nearly all States have found it difficult to protect their populations from COVID-19 and prevent its transmission within and beyond their borders. Some States, however, have displayed particularly abysmal responses, leading to widespread infection and deaths. In Brazil, for example, President Jair Bolsonaro’s deliberate efforts to publicly deny the magnitude of the COVID-19 threat to the domestic population undermined public understanding of the disease’s severity. That denialism contributed to a population-adjusted COVID-19 mortality rate that is one of the highest in the world. According to one estimate, more than 400,000 additional deaths...
Brazilians died as a result of the disastrous response.¹⁷⁵ The Indian government’s response, too, has been so terrible that Arundhati Roy has called it a “crime against humanity.”¹⁷⁶ This Section examines whether such policy failures might implicate States’ obligations to protect the international right to health. It first summarizes how human rights conventions define the right to health. It then considers States’ obligations to protect this right in the context of the ongoing pandemic. It also considers whether and how this right extends extraterritorially.

1. The Right to Health, as Defined and Protected by International Law

Numerous international declarations and conventions articulate a human right to health. The non-binding UDHR specifies that “everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services.”¹⁷⁷ The right to health is most thoroughly conceptualized in the International Covenant on Economic, Social, and Cultural Rights (ICESCR), which has 171 parties. It stipulates that States Parties “recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”¹⁷⁸ and shall take the steps necessary to progressively “achieve the full realization of this right.”¹⁷⁹ The WHO Constitution, to which more than 190 States are party, declares that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.”¹⁸⁰

A number of other treaties also provide protections for health to ensure health care interventions are inclusive, equitable, and non-discriminatory. The CRC and the Convention on the Rights of Persons with Disabilities (CRPD) provide respectively that children and people with disabilities should enjoy the “highest attainable standard of health” without discrimination.¹⁸¹ The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) specifies States Parties are to take “appropriate measures to eliminate discrimination against women in the field of health care in order to ensure . . . access to health care ser-

¹⁷⁶. See Roy, supra note 18. It likely does not, in fact, meet the legal standard for a “crime against humanity.”
¹⁷⁷. UDHR, supra note 135, art. 25.
¹⁸¹. See CRC, supra note 137, art. 24(1); see also Convention on the Rights of Persons with Disabilities art. 25, Dec. 13, 2006, 2515 U.N.T.S. 3 [hereinafter CRPD].
Further, the International Convention on the Elimination of All Forms of Racial Discrimination (CERD) creates a duty on States Parties to ensure equality in the enjoyment of “the right to public health, medical care, social security and social services.”

Regional human rights conventions also inform the conception of the right to health and its scope in international law. The American Declaration of the Rights and Duties of Man notes in Article XI that “every person has the right to the preservation of his health through sanitary and social measures relating to food, clothing, housing and medical care, to the extent permitted by public and community resources.” Additionally, the African Charter on Human and Peoples’ Rights stipulates in Article 16 that “[e]very individual shall have the right to enjoy the best attainable state of physical and mental health.” While the ECHR does not explicitly articulate a right to health, it has served as the basis for health-related claims before the ECtHR. ECtHR case law has generally established that agents of contracting States must “refrain from acts or omissions of a life-threatening nature, or which place the health of individuals at grave risk,” and “refrain from treatment which damages a person’s physical health.”

2. The Right to Health During a Pandemic

The ICESCR requires States Parties to take steps necessary for “the prevention, treatment, and control of epidemic, endemic, occupational, and other diseases.” The Committee on Economic, Social and Cultural Rights has clarified that the right to treatment entails “the creation of a system of urgent medical care in cases of accidents, epidemics and similar health hazards.” While the obligation to prevent, treat, and control epidemics is not among the obligations the General Comment identifies as “core” and non-derogable, the Committee has said it is of “comparable priority.” States that have signed but not yet ratified the ICESCR (the United States, Cuba, Palau, and the Comoros) must not take actions contrary to the

185. African Charter, supra note 140, art. 16.
“object and purpose” of the treaty. More broadly, the Committee also advanced four fundamental elements of the right to health: availability of health care facilities, goods and services in sufficient quantity; accessibility, in terms of non-discrimination, physical access, affordability, and access to information; acceptability, such that health care is ethical and culturally respectful; and the provision of health care of appropriate quality. These elements remain pertinent in all contexts of health provision, including pandemic response.

Regional human rights bodies have affirmed that corresponding conventions establish positive obligations related to the right to health that apply during a pandemic. For instance, the ECtHR held in Asiye Genc v. Turkey that Turkey had not taken “sufficient care” to ensure its health system functioned appropriately. The Inter-American Court of Human Rights (IACtHR) also found in Poblete Vilches and Others v. Chile that the right to health is a right found within the economic, social, cultural, and environmental rights guaranteed by Article 26 of the American Convention on Human Rights, and it faulted the Chilean government for inadequate health care in its public hospitals that resulted in a tragic death.

In addition to the positive obligation under the ICESCR, “there is a strong presumption that retrogressive measures taken in relation to the right to health are not permissible” and States Parties should refrain from “interfering directly or indirectly with the enjoyment of the right to health.” International courts have referred to this negative duty of

191. General Comment No. 14, supra note 188, at ¶ 12.
196. General Comment No. 14, supra note 188, ¶¶ 32-33.
States to not infringe on the ability to access health care. The ICJ determined in the Israeli Wall advisory opinion that Israel’s erection of a separation barrier between the West Bank and Israel restricts access to health services, and thus violates the ICESCR’s right to health.197 Some regional bodies’ jurisprudence also underscores States’ duties to refrain from negatively interfering with their citizens’ health, as those obligations are formulated in corresponding regional human rights conventions. In Social & Economic Rights Action Center (SERAC) and Center for Economic and Social Rights (CESR) v. Nigeria, for example, the African Commission on Human and Peoples’ Rights addressed the legal ramifications of environmental degradation stemming from the Nigerian government’s involvement in oil production.198 The Commission found that the government violated the African Charter’s right to health by failing to take appropriate precautions and share information on health risks with the public.199 In doing so, it emphasized that States Parties are “obliged to desist from directly threatening the health and environment of their citizens” in addition to taking affirmative measures to protect public health.200

3. Application in the Context of COVID-19

States Parties to the ICESCR have obligations to affirmatively protect the right to health of their populations during the COVID-19 pandemic. In an April 2020 statement, the ESCR Committee reiterated its guidance that States Parties establish urgent medical care systems in pandemics. The Committee called on States Parties to “make all efforts to mobilize the necessary resources to combat COVID-19 in the most equitable manner.”201 In so doing, it outlined several recommendations for States Parties in addressing the current pandemic. It suggested, for example, that States mobilize health care resources and ensure “a comprehensive, coordinated health-care response to the crisis.”202 It encouraged particular attention to marginalized and vulnerable groups, who are likely to suffer disproportionate negative effects of the pandemic. It further stated that workers should be protected from risks of contagion at work, measures should be adopted to address profiteering, and accessible information about the pandemic should be disseminated. These various steps to address COVID-19 would broadly embody the four elements of the right to health the Committee (and regional courts such as the IACtHR) had previously advanced.

197. Israeli Wall Advisory Opinion, supra note 166, at ¶ 134.
199. Id. ¶ 64.
200. Id. ¶ 52.
202. Id. ¶ 13.
At a minimum, States have negative obligations under the ICESCR to not jeopardize people’s health during COVID-19 by diverting essential funds or medical supplies (including vaccines) toward illegitimate purposes. Further, providing or knowingly assisting in the distribution of faulty medical supplies or unsafe vaccines would likely violate the right to health; such actions would be similar to those the Nigerian government undertook that, according to the African Commission on Human and Peoples’ Rights, directly threatened citizens’ health.203 The right to health may also prohibit State actions during the pandemic that have a more indirect impact on individuals’ health. For example, States should not disseminate misinformation about the virus that facilitates COVID-19’s spread and endangers public health. While the extent of ICESCR signatory States’ duties not to defeat the object and purpose of the treaty is less clear, it is reasonable to infer that governments of such States should at a minimum not undermine or counteract efforts to prevent, treat, or control COVID-19. Furthermore, States Parties to more specialized international human rights conventions, such as the CRC, CEDAW, CERD, and CRPD, also have obligations to ensure that health care responses to the virus are broad-based and do not deny treatment to certain ethnic or racial groups or on the basis of sex or disability, for instance. As the Office of the High Commissioner for Human Rights has clarified, “treatment [for COVID-19] should be available to everyone without discrimination, including the most vulnerable or marginalized.”204

Governments may also have obligations to work toward an adequate COVID-19 response arising out of regional human rights treaty obligations. Regional bodies have sought to clarify State duties in light of COVID-19. As the pandemic emerged, the Inter-American Commission on Human Rights stated that the right to health requires States Parties to the American Convention to “provide timely, appropriate health care and treatment” during the current pandemic.205 In issuing this clarification, it extended the logic of the IACtHR’s Poblete Vilches decision, in which the Court faulted a State for not providing health services in accordance with the right to health elements of availability, accessibility, acceptability and quality.


4. States’ Obligations Outside their Territories

The scope of the extraterritorial reach of the right to health is highly contested, and there is little relevant case law that offers clarity. The ICESCR generally requires that States Parties “take steps individually and through international assistance and co-operation . . . with a view to achieving progressively the full realization” of the rights the Covenant identifies.206 As Todd Howland notes, “the ‘jurisdiction’ limitation that exists in the European Convention, the ICCPR and the American Convention on Human Rights is conspicuously absent in the International Covenant on Economic, Social and Cultural Rights.”207 Scholars have argued that the lack of a clear restriction of jurisdiction in the ICESCR suggests it was intended to have extraterritorial scope.208 Regarding extraterritorial duties in the context of a pandemic, the ESCR Committee has found collective responsibility for the control of transmissible diseases, implying wide extraterritorial application of the right: “[G]iven that some diseases are easily transmissible beyond the frontiers of a State, the international community has a collective responsibility to address this problem.”209 Though it is not clear the ESCR Committee intended to establish a formal transboundary obligation on States Parties to assist other States in responding to pandemics, this statement underscored the value of such cooperation.210

A group of international experts articulated a set of narrower, negative extraterritorial obligations related to economic, social, and cultural rights (including the right to health) in the non-binding 2011 Maastricht Principles on Extraterritorial Obligations of States in the Area of Economic, Social and Cultural Rights.211 According to these principles, which draw on existing international law, all States have an obligation to respect such rights “of persons within their territories and extraterritorially”; to “refrain from conduct which nullifies or impairs the enjoyment and exercise of economic, social and cultural rights of persons outside their territories”; and to “refrain from any conduct which impairs the ability of another State . . . to comply with that state’s . . . obligations as regards economic, social and

206. See ICESCR, supra note 178, art. 2(1).
209. General Comment No. 14, supra note 188, ¶ 40.
cultural rights.” Applying these principles to the COVID-19 pandemic, States Parties likely have a duty to work cooperatively with other nations to contain the COVID-19 threat.

In the April 2020 communication referenced above, moreover, the ESCR Committee outlined a number of obligations that States Parties to the ICESCR have in combatting COVID-19 not only within their own territory but extraterritorially as well. These include avoiding the obstruction of access to essential equipment, ensuring free flow of necessary goods, and alleviating financial burdens on developing countries. States Parties to the ICESCR likely also have obligations to avoid impinging upon foreign populations’ right to health. Consequently, States Parties are likely obligated to take reasonable steps to prevent infectious diseases from spreading beyond the State’s territory, to not disseminate pernicious misinformation about the virus that can mislead and endanger foreign populations, and to refrain from deliberately weakening other governments’ capacity to provide essential care to their populations, including through economic sanctions.

C. Civil and Political Rights

In response to COVID-19, many States have curtailed civil and political rights, including by limiting public gatherings, constraining freedom of movement, and requiring the disclosure of private medical information and location histories and close contacts. Though many of the constraints and disclosure requirements States have put in place are necessary to combat the pandemic, some governments have exploited the crisis to begin or continue assaults on civil and political rights. This Section identifies some of the specific civil and political rights protected by the ICCPR that are under assault as governments respond to COVID-19. It focuses on four general categories: (1) restrictions on speech and assembly; (2) intrusions on privacy; (3) modifications to or delays in electoral processes; and (4) denials of justice and fair trial. While not exhaustive, these areas represent the most prevalent transgressions that are collectively producing a civil and political rights crisis amid a public health crisis.

Although this Section focuses on the ICCPR, other treaties also protect civil and political rights. While not legally binding, the UDHR broadly outlines fundamental civil and political rights. The CERD and CEDAW both prohibit discrimination with respect to a number of rights, including those related to judicial processes and political participation. And an array of regional treaties also provide significant protections for civil and

212. See id. ¶ 19–21.
213. See Statement on the Coronavirus Disease (COVID-19), supra note 201.
215. UDHR, supra note 135.
216. See CERD, supra note 183; see also CEDAW, supra note 182.
political rights. This Section, therefore, is meant as merely a starting point in assessing the ways in which civil and political rights are affected by the pandemic.

1. Right of Speech and Peaceful Assembly

ICCPR Article 21 requires that the “right of peaceful assembly” be recognized and allows restrictions on the exercise of this right only to the extent they are necessary “in the interests of national security or public safety, public order, the protection of public health or morals or the protection of the rights and freedoms of others.” As the Human Rights Committee has indicated, States Parties are not to derogate from this provision to restrict peaceful assembly “if they can attain their objectives by imposing restrictions in terms of Article 21.” Further, there must be a fair means for legally contesting official decisions to limit assembly. Separately, ICCPR Article 19 enshrines the rights to hold opinions without interference and to freedom of expression, though restrictions can be imposed for the protection of public health, among other aims. The Human Rights Committee has made clear that individuals should be permitted to express and receive opinions regarding, among other subjects, political discourse and commentary on public affairs.

Despite these clear stipulations, governments of States Parties have taken advantage of the need to prevent the spread of COVID-19 to also constrict political activity that poses a threat to the status quo. In Hong Kong (where the ICCPR applies), for instance, authorities denied demonstrators permission to organize a pro-democracy march on the grounds that such protests could further spread COVID-19. Protest leaders alleged that these were false pretenses, pointing out the city’s decision to open a local theme park. The official claim that restrictions were needed to protect public health created new barriers to demonstrations

217. See, e.g., ACHR, supra note 138, arts. 3-16; African Charter, supra note 140, arts. 2-13; ECHR, supra note 139, arts. 1-14.
218. See ICCPR, supra note 136, art. 21.
220. Id. ¶ 72.
221. ICCPR, supra note 136, art. 19.
against China’s National Security Law and the Hong Kong government’s acquiescence thereto.

Governments have also imposed disproportionate restrictions on journalists reporting on the virus under the guise of limiting misinformation. In Sri Lanka, the government made public criticism of or disagreements with official policy an offense meriting arrest and took into custody at least a handful of individuals who allegedly posted false or misleading information about the pandemic or the government’s response to it.225 In India, journalists critical of the government’s public health response were arrested and charged with a variety of offenses.226 The government must “tackle the spread of pessimism, negativity and rumour,” Prime Minister Modi told a group of top editors in July 2020.227 In total, as of October 2021, fifty-eight States have issued measures that affect expression and 153 have issued measures that affect assembly.228

Governments must judiciously balance efforts to contain COVID-19 with safeguarding liberties to speak and assemble and must not use the pandemic as a pretext for suppressing political opposition. As the Human Rights Committee reaffirmed, governments seeking to protect public health can restrict the rights to expression and peaceful assembly to protect individuals from COVID-19.229 However, these restrictions must be necessary for that purpose and must be in conformity with the law. As the Special Rapporteur on the promotion and protection of the right to freedom of opinion and expression has noted, criminal penalization of disinformation related to the pandemic may be disproportionate and unlawful, and can be counterproductive in any regard.230 The Human Rights Committee also underscores that “freedom of expression . . . and a civic space where a public debate can be held” are not only inherently critical rights to be protected as States respond to COVID-19, but are also instrumentally important for ensuring States Parties are adhering to their other human rights


227. Id.


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obligations. Governments seeking to balance competing interests in protecting public health and civic space might look toward the ICCPR-compliant approach of Latvia, whose government formally derogated from Article 21 in prohibiting all public gatherings in March 2020, published a month-long extension of its derogation, and subsequently withdrew its derogation and eased restrictions in May 2020.

2. Right to Privacy

ICCPR Article 17 prohibits States Parties from arbitrarily or unlawfully interfering with a person’s “privacy, family, home or correspondence” and establishes a right to protection of the law against such interference. The Human Rights Committee has also clarified that “‘arbitrary interference’ can also extend to interference provided for under the law,” and calls for technically lawful interference to comport with the aims of the Covenant. In this comment, the Committee recommends regulation of the collection and storage of individuals’ personal information (whether done by government authorities or private entities) and calls on States to ensure such data is not used for purposes contrary to the Covenant.

As of October 2021, sixty-one States have issued measures in response to the pandemic that affect privacy. Some governments’ contact tracing, symptom tracking, and quarantine enforcement programs may not fully comport with the letter or spirit of Article 17 or the corresponding comment. For example, the government of Bahrain established an app-based system that facilitates real-time collection of information on users’ locations, which can be easily linked back to individuals. Quarantined individuals must use the app and wear a Bluetooth-enabled bracelet that collects location and diagnostic data and can face legal penalties for not complying. Amnesty International notes such a program is “unlikely to be [a] necessary and proportionate” response to COVID-19. In light of substantial political repression in Bahrain, there is a risk that such tools may be used to further limit free expression and participation in public life.


233. ICCPR, supra note 136, art. 17.


235. Id. ¶ 10.

236. COVID-19 Civic Freedom Tracker, supra note 228.

contrary to the intent of the ICCPR.\textsuperscript{238} While States are justified in collecting data to stop the spread of the virus, they need to be attentive to privacy concerns. The WHO’s International Health Regulations (IHR) offer guidance on State regulations in response to a public health emergency. They establish stipulations on the collection and use of personal data, noting that it should be processed both “anonymously” and “fairly and lawfully” and that it should not be “kept longer than necessary.”\textsuperscript{239} As 194 States are member States of the WHO, the IHR should also inform governments’ approach to contact tracing and similar pandemic-related information gathering.

3. Right to Participate in the Electoral Process

ICCPR Article 25 specifies “every citizen shall have the right and opportunity . . . to take part in the conduct of public affairs” and “to vote and to be elected at genuine periodic elections.”\textsuperscript{240} Regardless, States Parties have had to balance this obligation with efforts to prevent COVID-19’s spread, raising concerns that modification, postponing, or suspension of elections are undertaken for opportunist reasons. In Bolivia, unelected interim President Jeanine Áñez and the country’s Supreme Electoral Tribunal justified postponing presidential elections, first in May 2020 and once again in September 2020, based on the COVID-19 health emergency.\textsuperscript{241} Prior to the eventual election, which was successfully held in October 2020, the delays exacerbated political tensions arising from Áñez’s controversial assumption of the presidency in November 2019.\textsuperscript{242} Further, even as they encouraged other States to refrain from delaying electoral processes, some Western governments, such as New Zealand’s, also opted to delay elections as a means of preventing the pandemic’s spread.\textsuperscript{243}

\textsuperscript{240} ICCPR, supra note 136, art. 25.
Governments preparing for and conducting elections have to balance public health and electoral rights. States Parties to the ICCPR do have some flexibility, as the Covenant permits derogation of Article 25 provided certain conditions are met.\(^{244}\) In some cases, modifications to electoral processes (including delays) may be necessary not only to prevent COVID-19’s transmission, but to ensure the public feels safe voting. Some governments have successfully balanced public health concerns with the need to proceed with elections and ensure their integrity. For instance, ahead of and during its National Assembly elections in April 2020, South Korea adopted measures to ensure both safety and broad participation. It put in place measures to prevent transmission (including disinfecting polling places and disseminating a voter code of conduct regarding hygiene and quarantine practices), while also making arrangements to allow quarantined individuals to vote and observers to remotely watch vote tallying.\(^{245}\) Similarly, in recognition of the risks of in-person gatherings, state governments across the United States passed and implemented laws allowing residents to vote early or use mail-in and absentee ballots during the 2020 election cycle.\(^{246}\) These modifications offered the public protection from COVID-19 and are believed to have contributed to record levels of voter turnout.\(^{247}\)

4. **Right to Justice and Fair Trials**

ICCPR Article 9 protects individuals from being “subjected to arbitrary arrest or detention” and prohibits deprivations of liberty “except on such grounds and in accordance with such procedures as are established by law.”\(^{248}\) Importantly, Article 9(3) notes that “anyone arrested or detained on a criminal charge . . . shall be entitled to trial within a reasonable time or to release,” and Article 9(4) explicitly provides detainees with the opportunity to bring proceedings before a court that can order release if detention is unlawful.\(^{249}\) These obligations, while intrinsically critical, also help ensure a State Party’s compliance with Article 2(3), which provides for effective remedies to those whose rights or freedoms (including civil and political rights) have been violated by persons acting in an official role.

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\(^{244}\) ICCPR, supra note 136, art. 4.


\(^{247}\) See id. (“Nearly 160 million people voted, more than in any other election in the past 120 years, and a staggering 101 million of those ballots were cast early or absentee”); *Election Policy Briefing: By-Mail Voting Survives 2020*, OSET INSTITUTE (Dec. 31, 2020), https://trustthevote.org/wp-content/uploads/2020/12/31Dec20_VoteByMail-2020AndBeyond.pdf (“The expansion of by-mail voting in this election was clearly a contributing factor to record-breaking participation.”) [https://perma.cc/2ZUW-DUZR].

\(^{248}\) ICCPR, supra note 136, art. 9.

\(^{249}\) Id.
capacity.\textsuperscript{250}

Some governments have used the pandemic as an excuse to arbitrarily arrest and detain opponents or for curtailing their access to justice. In India, for example, demonstrators and activists protesting the government of Prime Minister Modi and its Hindu nationalist policies were arbitrarily arrested, and Human Rights Watch reports that subsequent to arrest, detainees had limited access to legal counsel and lawyers have found it difficult to view court records.\textsuperscript{251} Long-lasting court closures have also impeded bail filings, contributing to activists’ continued detention.\textsuperscript{252} Further, authorities have sometimes been able to keep individuals in custody after they have been granted bail by filing additional charges against activists, potentially prolonging their exposure to the virus in prisons.\textsuperscript{253}

UN agencies recommend that as governments impose safety measures on courts that may delay legal processes, they prioritize critical legal cases that implicate non-derogable rights (in addition to considering arrangements for remote proceedings, where possible).\textsuperscript{254} As an example, the Spanish government’s “state of alarm” initiated in March 2020 embodied this concept: As the organization Fair Trials highlights, Spanish measures to adjourn judicial proceedings did not apply to “habeas corpus proceedings, duty courts, proceedings in which the suspect is arrested or currently in pretrial detention, protection orders, and urgent matters related to inmates and violence against women or minors.”\textsuperscript{255}

5. Derogation under the ICCPR

As noted, some States have opted to formally derogate from particular ICCPR obligations in response to COVID-19.\textsuperscript{256} ICCPR Article 4 sets out requirements for States Parties to the Covenant seeking to derogate from their obligations “in time of public emergency which threatens the life of the nation and the existence of which is officially proclaimed.”\textsuperscript{257} These States may only undertake such measures “to the extent strictly required

\textsuperscript{250} ICCPR, supra note 136, art. 2.

\textsuperscript{251} India: End Violence in Prosecuting Delhi Violence, HUM. RTS. WATCH (June 15, 2020), https://www.hrw.org/news/2020/06/15/india-end-bias-prosecuting-delhi-vio-


\textsuperscript{253} HUM. RTS. WATCH, supra note 251.


\textsuperscript{256} PEACEFUL ASSEMBLY WORLDWIDE, supra note 232.

\textsuperscript{257} ICCPR, supra note 136, art. 4.
by the exigencies of the situation.” The measures must not be inconsistent with other international law obligations or be applied in a discriminatory manner, and any derogations must be temporary. In cases of derogation, the State Party “shall immediately inform the other States Parties . . . through the intermediary of the Secretary-General of the United Nations, of the provisions from which it has derogated” and why it has elected to do so. Importantly, Article 4(2) prohibits derogation from ICCPR provisions that, among others, enshrine the right to life; prohibit torture and cruel, inhuman or degrading treatment or punishment; prohibit slavery; provide the right to recognition as a person before the law; and protect freedom of thought, conscience, and religion. The Human Rights Committee has further clarified that derogations from Covenant provisions during public emergency must be of “an exceptional and temporary nature.”

Despite these duties, most States Parties that have declared states of emergency in response to COVID-19 have failed to notify the Human Rights Committee of their derogations from ICCPR provisions: The Centre for Civil and Political Rights documents that, as of October 2021, just twenty-four States that had declared states of emergency had notified the United Nations of this development, while more than forty-eight had yet to do so. This is to say nothing of States that may have derogated from fundamental obligations without officially initiating states of emergency.

III. Immigration and Refugee Law

The threat posed by COVID-19 has been used by governments around the world to roll back key protections guaranteed under immigration and refugee law. This Part examines whether States’ efforts to restrict immigration during the pandemic ran afoul of their obligations not to return asylum seekers to an unsafe foreign territory, known as “non-refoulement.” It examines, as well, under what conditions States may violate their legal obligations to immigration detainees by failing to adequately protect them from the virus.

A. Non-Refoulement

One of the pillars of international refugee law is the principle of non-refoulement, which prohibits any State conduct “leading to the ‘return in any manner whatsoever’ to an unsafe foreign territory, including rejection

258. Id.
259. Id.
260. Id.
During the pandemic, governments have violated the principle of non-refoulement by closing their borders entirely and halting asylum-processing. The UN High Commissioner for Refugees (UNHCR) estimated in April 2020 that “167 countries have . . . fully or partially closed their borders to contain the spread of the virus” and that 57 of those countries made “no exception for people seeking asylum.” In the United States, for example, the Centers for Disease Control and Prevention (CDC) issued an order in March 2020 that effectively suspended asylum processing for persons traveling from Canada or Mexico. Experts noted that the policy was overbroad and disputed whether there was a credible rationale for categorically barring all asylum seekers, especially since the policy was initiated over the objections of public health authorities.

While governments can take certain protective measures in response to COVID-19, potentially including restrictions on movement, they are not entitled under international law to completely prevent the entry of asylum-seekers—that is, those who are seeking international protection but whose claim has not yet been decided. (Not every asylum-seeker will be recognized as a refugee, but every refugee is initially an asylum-seeker.) This Section first summarizes how human rights conventions and relevant case law conceptualize the principle of non-refoulement, and then reflects on States’ obligations under this principle in the context of the ongoing pandemic. Further, given that some governments have turned back migrants on the high seas or on foreign territory, this Section also considers the extent to which the principle of non-refoulement applies extraterritorially.

1. The Principle of Non-Refoulement

The principle of non-refoulement establishes that those who seek asylum may not be returned to a country in which there are reasonable

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grounds to believe they will be subjected to persecution. The principle is grounded in the 1951 Convention Relating to the Status of Refugees (1951 Refugee Convention) and its 1967 Protocol.\textsuperscript{267} The Protocol extends the Convention’s protections to all refugees irrespective of the location or date of their displacement, and importantly, requires its 146 States Parties to abide by the Convention regardless of whether they are separately party to it.\textsuperscript{268} The principle of non-refoulement is also regarded by UNHCR to be a norm of customary international law.\textsuperscript{269}

The 1951 Refugee Convention defines the prohibition on refoulement in Article 33(1), which states that no “Contracting State shall expel or return (‘refouler’) a refugee in any manner whatsoever to the frontiers of territories where [their] life or freedom would be threatened on account of [their] race, religion, nationality, membership of a particular social group, or political opinion.”\textsuperscript{270} Article 33(2) articulates an exception: The benefit of the present provision may not . . . be claimed by a refugee whom there are reasonable grounds for regarding as a danger to the security of the country in which he [or she] is, or who, having been convicted by a final judgment of a particular serious crime, constitutes a danger to the community of that country.\textsuperscript{271}

Reliance on this exception requires an “individualized showing . . . [and] cannot be applied on a blanket basis to everyone seeking asylum regardless of whether they actually pose a threat.”\textsuperscript{272}

Other international human rights treaties reinforce the principle of non-refoulement in cases where the person returned may face torture or inhuman and degrading treatment. For example, the CAT states that “[n]o State Party shall expel, return (‘refouler’) or extradite a person to another State where there are substantial grounds for believing that he would be in danger of being subjected to torture.”\textsuperscript{273} The Human Rights Committee has also interpreted the ICCPR to encompass the principle of non-refoulement.

\begin{footnotesize}
\textsuperscript{270} 1951 Refugee Convention, supra note 267, art. 33.
\textsuperscript{271} Id.
\end{footnotesize}
The ICCPR affirms that “[n]o one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.” As one legal commentator points out, the “prohibition on refoulement is inferred as a component of the absolute prohibition of torture as well as inhuman and degrading treatment.”

Regional human rights treaties have similarly affirmed and in some cases expanded the prohibition on refoulement. The African Union Convention for the Protection and Assistance of Internally Displaced Persons in Africa (Kampala Convention) obliges States to “[r]espect and ensure the right to seek safety in another part of the State and to be protected against forcible return to or resettlement in any place where their life, safety, liberty and/or health would be at risk.” Such language goes beyond that articulated in the ICCPR and CAT and might apply to the COVID-19 context: Under the Kampala Convention, a refugee arguably cannot be returned to a country that has failed to control COVID-19, as return to such a country would place the refugee’s life and health at risk. The Organization of African Unity (OAU) Convention Governing the Specific Aspects of Refugee Problems in Africa also employs expansive language, stating that “[n]o person shall be subjected by a Member State to measures such as rejection at the frontier, return or expulsion, which would compel him to return to or remain in a territory where his life, physical integrity or liberty would be threatened.” Despite the broad language contained in both the Kampala and OAU Unity Conventions, Rodolfo Marques has noted that neither the African Court on Human and Peoples’ Rights nor the African Commission on Human and Peoples’ Rights has “had the opportunity to determine the dimension of [non-refoulement] within their jurisdiction.”

The American context features similar obligations. The ACHR affirms that a foreign national cannot “be deported or returned to a country, regardless of whether or not it is his country of origin, if in that country his right to life or personal freedom is in danger of being violated because of his race, nationality, religion, social status, or political opinions.”

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275. ICCPR, supra note 136, art. 7.
279. Marques, supra note 276.
280. ACHR, supra note 138, art. 22.
ECHR does not contain an explicit non-refoulement clause, but the ECtHR has effectively read non-refoulement into the Convention’s prohibition on “torture and inhuman or degrading treatment or punishment.” That right, however, is limited to cases where the person expelled faces a reasonable fear that they will be subjected to torture or inhuman or degrading treatment or punishment upon return.

2. The Principle of Non-Refoulement During a Pandemic

Does a public health emergency grant a government the right to derogate from the principle of non-refoulement? Article 33(2) of the Refugee Convention provides that a refugee cannot claim the benefits of the Convention if “there are reasonable grounds for regarding [him or her] as a danger to the security of the country in which he [or she] is.” This may at first glance seem to grant a government-wide discretion. Yet official legal interpretations have cabined a government’s right to turn away asylum seekers. Notably, in its Advisory Opinion on the Extraterritorial Application of Non-Refoulement Obligations Under the 1951 Convention Relating to the Status of Refugees and Its 1967 Protocol, UNHCR stated that the application of Article 33(2) requires an “individualized determination by the country in which the refugee is [located] that he or she comes within one of the two categories provided for” under the Article. Moreover, UNHCR noted that Article 33(2) does not “affect the host State’s non-refoulement obligations under international human rights law, which permit no exceptions.” In other words, a host State must make an individualized determination under Article 33(2) that a refugee poses a danger to the security of the country. If the host State finds the refugee in question poses a danger, then the host State is entitled to refuse admission to that refugee, so long as the State does not violate the non-refoulement obligations contained in other human rights conventions to which it is party.

More broadly, no country can cite a pandemic as an excuse for turning away migrants en masse at the border without assessing asylum claims. Androula Pavli and Helena Maltezou note that while countries can introduce screening protocols at the border, the “results of screening must never be used as a reason or justification for deporting a refugee or a migrant [including an asylum-seeker whose refugee status has yet to be determined] from a country.” Indeed, as various international law experts have noted, States have an affirmative obligation under international law to provide medical care to asylum seekers.

281. Marques, supra note 276.
282. 1951 Refugee Convention, supra note 267, art. 33.
283. UNHCR, supra note 269, ¶ 10.
284. Id. at ¶ 11.
Even if a person does pose a threat (that is, has a serious communicable disease), the principle of non-refoulement under the CAT and ICCPR is non-derogable for States Parties to those conventions (including the United States). The Committee Against Torture—the body that monitors implementation of CAT—affirmed that the principle of non-refoulement is, like the prohibition on torture itself, non-derogable.\textsuperscript{287} Similarly, the U.N. Human Rights Committee—charged with the implementation of the ICCPR—noted that “States [P]arties must not expose individuals to the danger of torture or cruel, inhuman or degrading treatment or punishment upon return to another country by way of their extradition, expulsion, or refoulement.”\textsuperscript{288} A person therefore cannot be returned to a State where there are “substantial grounds for believing that” they would be in danger of being subjected to torture (in the case of the CAT).\textsuperscript{289} The ICCPR has been interpreted to contain a similar prohibition: According to the UNHCR Advisory Opinion on the non-refoulement principle’s extraterritorial application, a person also may not be returned “where there are substantial grounds for believing that there is a real risk of irreparable harm, such as that contemplated by Article 6 [right to life] and 7 [right to be free from torture or other cruel, inhuman or degrading treatment or punishment] of the [ICCPR].”\textsuperscript{290}

In the past, various governments have refused to admit migrants who carried communicable diseases. The United States, for example, provides for exclusion of persons who have a communicable disease of public health significance, but only after individualized medical examination and an opportunity to appeal.\textsuperscript{291} (It was only in 2010 that the United States removed HIV from the list of diseases that could exclude aliens from entry—but even when that ban was in effect, it required an individual determination.\textsuperscript{292}) It is important to emphasize, however, that this is not a basis for denying asylum or for overcoming non-refoulement protections—either under U.S. or international law.

Regional human rights courts have also addressed the principle of non-refoulement. In \textit{Tinco Family v. Bolivia}, the IACtHR articulated procedural safeguards that States Parties to the ACHR must meet before they can


\textsuperscript{287} General Comment No. 4 (2017) on the Implementation of Article 3 of the Convention in the Context of Article 22, Committee against Torture, ¶ 8-9 (Feb. 9, 2018), https://www.refworld.org/docid/5a903dc84.html [https://perma.cc/X6KC-8NUG].


\textsuperscript{289} Convention Against Torture, \textit{supra} note 273, art. 3.

\textsuperscript{290} UNHCR, \textit{supra} note 269, ¶ 19.


expel or deport an asylum seeker. The State must allow an asylum seeker an “adequate and individualized” analysis of their application, must assesses that individual’s “personal circumstances,” and, in the case of an unfavorable decision, must have the right to “review before the competent authority.” Such safeguards represent a procedural minimum; States that are party to the ACHR are clearly obligated to adhere to them even during a pandemic. The following year, the court held in Rights and Guarantees of Children in the Context of Migration that States Parties cannot return

or expel a person—asylum seeker or refugee—to a State where her or his life or liberty may be threatened as a result of persecution . . . or due to generalized violence, foreign aggression, internal conflicts, massive violations of human rights or other circumstances which have seriously disturbed public order.

The “other circumstances” provision is broad in scope and theoretically could prevent a State from turning asylum seekers back to countries that have failed to control a pandemic. An expert roundtable convened by UNHCR cautioned, however, that the “other circumstances” provision is the “least applied by state practice and hence there seems to be the least common understanding regarding its interpretation.”

The ECtHR has found that the principle of non-refoulement applies in situations where a person faces a reasonable fear of being subjected to torture. In Chahal v. United Kingdom, the Court prohibited Mr. Chahal’s expulsion to India, holding that ECHR Article 3, which prohibits torture and “inhuman or degrading treatment or punishment,” implies a prohibition on non-refoulement when individuals face a reasonable fear of being subjected to torture upon return. Such a prohibition is non-derogable and would bind State action even during a pandemic. The ECtHR has also suggested that States’ ability to return asylum seekers to substandard conditions—potentially including conditions of uncontrolled pandemic—is limited by the ECHR. In the recent Case of M.S.S. v. Belgium and Greece, an


294. Id. ¶ 132, 153.


asylum seeker originally from Afghanistan challenged Belgium’s decision to return him to Greece, where he first arrived in the EU. The Court held that Belgium had violated the Convention by returning the applicant to Greece, because “by sending him back to Greece, the Belgian authorities exposed the applicant to detention and living conditions in that State that were in breach of that Article.” Because it is non-derogable, the “non-refoulement” prohibition applies regardless of the pandemic; moreover, “degrading detention and living conditions” may include conditions in countries where a pandemic is uncontrolled.

3. Application in the Context of COVID-19

COVID-19 does not grant States an excuse to derogate from their non-refoulement obligations. In June 2020, international human rights experts laid out 14 Principles of Protection for Migrants, Refugees and Other Displaced Persons, in response to the spread of COVID-19. These principles, while not binding in and of themselves, are derived from “international treaties and . . . customary international law.” Principle 6 cautions that “a State’s pursuit of legitimate health goals must respect the fundamental principle of non-refoulement, including non-return to a real risk of persecution, arbitrary deprivation of life, torture, or other cruel, inhuman, or degrading treatment.”

As noted above, the 1951 Refugee Convention’s non-refoulement obligation does allow an exception for a case where a refugee poses a threat to the host country, but that exception requires an individualized determination. Addressing legal considerations during COVID-19, UNHCR noted that States are “entitled to take measures to ascertain and manage risks to public health” and can implement disease screening protocols as well as impose quarantines in response to COVID-19. Thus, States can take measures to ensure that asylum seekers do not spread COVID-19 to the local host State population. This might include testing and perhaps quarantining for up to two weeks where there is reason to believe that an unvaccinated asylum seeker has been exposed to COVID-19. But they may not return refugees en masse or deny them entry based on generalized concerns about COVID-19.

301. Id.
302. Id.
303. UNHCR, supra note 269, ¶ 10.
4. States’ Obligations Outside their Territories

UNHCR has held that the principle of non-refoulement applies whenever a State exercises effective authority over an asylum seeker. UNHCR has stated that States are “bound . . . not to return any person over whom they exercise jurisdiction to a risk of irreparable harm.”305 The “decisive criterion,” UNHCR continued, “is not whether that person is on the State’s national territory, or within a territory which is de jure under the sovereign control of the State, but rather whether or not he or she is subject to that State’s effective authority and control.”306 A State can exercise such effective authority and control in a wide variety of contexts, including “at the frontier, on the high seas or on the territory of another State.”307

In addition, because the principle of non-refoulement is affirmed in other human rights instruments, including the CAT and the ICCPR, the extraterritorial application of those treaties might similarly constrain a State’s ability to return or expel an asylum seeker.308 For example, the Human Rights Committee, in interpreting legal obligations imposed by the ICCPR, has affirmed that States are required to “respect and ensure the rights laid down in the Covenant to anyone within the power or effective control of that State Party, even if not situated within the territory of the State Party.”309 Such a prohibition applies, according to the Human Rights Committee, wherever the State in question exercises effective control—contexts like a State-run refugee camp, occupied territory, or State-flagged ships and aircraft. (It is important to point out, however, that not all States, among them the United States, accept this interpretation of the ICCPR.)310

Just as the COVID-19 pandemic does not release States from their non-refoulement obligations for those who have reached the border, it also does not release them from their non-refoulement obligations for those who have not yet reached the border. In particular, the “effective authority and control” standard that UNHCR has articulated may constrain State action in a variety of contexts. For example, Greek officials have made headlines by intercepting and turning back boats filled with asylum-seekers before

305. UNHCR, supra note 269, ¶ 35.
306. Id.
307. Id. ¶ 24.
310. The United States has accepted that the CAT—and thus its non-refoulement obligation—applies to its base at Guantánamo Bay and to U.S.-registered ships and aircraft regardless of where they are located. Press Release, White House, Statement by NSC Spokesperson Bernadette Meehan on the U.S. Presentation to the Committee Against Torture (Nov. 12, 2014), https://obamawhitehouse.archives.gov/the-press-office/2014/11/12/statement-nsc-spokesperson-bernadette-meehan-us-presentation-committee-a [https://perma.cc/JM8E-9NQR].
those boats could land on Greek soil.\textsuperscript{311} Greek efforts to divert boats full of asylum seekers away from Greek territory arguably violate the principle of non-refoulement. When Greek officials intercept and interact with the migrant boats, they are arguably exercising “effective authority and control,” even if those boats have not yet reached Greek waters. The European jurisprudence on the ECHR’s extraterritorial application may also bind Greek action. The European Commission held in 


Finally, States may be bound by the extraterritorial application of other human rights instruments to which they are a party. If aliens face the prospect of torture or inhuman or degrading treatment, these non-derogable human rights obligations may impose constraints on their return. COVID-19 does not erase these protections.

B. States’ Obligations to Refugees, Asylum Seekers, and Other Migrants in Detention

For refugees, asylum seekers, and other migrants seeking protection in foreign countries and awaiting regularization of their legal status under the care or custody of national governments, COVID-19 compounds a litany of already-daunting vulnerabilities. Migrants arriving at foreign territory in large-scale influxes and residing in camps or settlements often face conditions that can elevate the risk of infectious transmission. Resources for sanitation, including clean water, soap, and personal protective equipment are sometimes in short supply or not available at all. Limited space and overcrowding may make social distancing infeasible. The disease’s lethality may also be heightened in these environments if medical services are unavailable, inadequate or if residents suffer from other chronic ailments that leave them more susceptible to COVID-19.

These challenges are particularly salient in Greece, for instance, where government authorities have quarantined camps where asylum seekers and migrants are living in substandard conditions after camp residents were found to have contracted COVID-19.\textsuperscript{313} The dire conditions in these sites pre-date the outbreak of pandemic: Before a fire destroyed the Moria camp in September 2020, for example, the site housed at least 8,000 asylum seek-


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ers in a space originally intended to shelter only 3,000 people. Aid organizations seeking to assist residents of camps across the island of Lesbos contend that the Greek government is using the virus as a pretext for detaining migrants while failing to adequately provide for their health in detention. The Asylum Information Database managed by the European Council on Refugees and Exiles concluded in June 2021 that “the detention conditions for third-country nationals, including asylum seekers, do not meet the basic standards in Greece.”

Greece is far from alone in failing to protect refugees and migrants from COVID-19. The United States has subjected asylum seekers (and foreign nationals more broadly) held in detention centers to deplorable conditions. The American Civil Liberties Union has alleged in multiple lawsuits that Immigration and Customs Enforcement (ICE) willfully transferred people between facilities knowing that they were positive for COVID-19, increasing the risk of exposure among detainees. There are reports of inadequate medical monitoring, delayed action in providing medical attention when needed, overcrowding, and inadequate sanitation in these facilities, all of which have contributed to a heightened risk of COVID-19 contraction and transmission. As of March 2021, there were more than 10,400 cases of COVID-19 across 124 ICE facilities.

This Section focuses on how COVID-19 affects States’ obligations toward asylum seekers, refugees, and other migrants under their care in large-scale camps or in custody in smaller facilities, domestically or at points of entry. It first summarizes States’ health-related obligations as they pertain to migrants in State-operated or State-authorized facilities,


including camps, detention facilities, or reception centers at points of entry. It then turns to States’ obligations to immigration detainees during a pandemic. Finally, it considers States’ obligations to immigration detainees in the particular context of COVID-19 and suggests steps States might take to fulfill these obligations.

1. Health-Focused International Law Obligations to Immigration Detainees

Governments have a range of international law duties pertaining to their treatment of refugees, asylum seekers, and other immigrants under their care or custody, whether domestically or at points of entry. As noted above, these obligations are clearly established in the 1951 Refugee Convention and its 1967 Protocol, the core sources of international refugee law. Further, principles of international human rights law enshrined in human rights treaties including the ICCPR, the ICESCR, and the CAT also identify State obligations relevant to State-run or State-authorized facilities for States that are party to those treaties. Many obligations established by these treaties also reflect customary international law binding on all States, though we do not explore that in depth here. Regional human rights treaties and refugee-specific regional instruments (including the Organization of African Unity 1969 Convention and the 1984 Cartagena Declaration) also establish obligations.

The 1951 Refugee Convention specifies core obligations of States Parties to refugees and asylum seekers in the custody or care of governments, regardless of their status or length of stay in the country (including respecting freedom of religious practice and ensuring access to courts and legal assistance, for example). In addition, the various human rights treaties identified above require States Parties to ensure certain minimum conditions of confinement and treatment for those held in State-administered facilities or State-authorized camps and settlements. The right to health, as protected in international human rights law and as explained in Part II, is particularly relevant. ICESCR Article 12 requires States Parties to “recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.” Thus, the Convention’s duty to prevent, treat, and control epidemics would also extend to migrants. As the ESCR Committee has explained, States Parties are required to “respect the right to health” by “refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal immigrants, to preventive, curative and palliative health services.”

323. See 1951 Refugee Convention, supra note 267.
324. ICESCR, supra note 178, art. 12(1) (emphasis added).
325. General Comment No. 14, supra note 188, ¶ 34 (emphasis added).
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States Parties to the ICESCR have core obligations to all individuals under the effective control of the State, regardless of their legal status. As the Committee underscores, “all people under the jurisdiction of the State should enjoy Covenant rights,” including “asylum seekers and refugees, as well as other migrants, even when their situation in the country concerned is irregular.”326 States are expected to take steps to ensure “[t]he prevention, treatment and control of epidemic . . . and other diseases” and to secure access to “medical service and medical attention in the event of sickness.”327 In consequence, if public authorities are unable to provide adequate medical services or supplies to immigrants in State custody or in authorized camps and settlements, they arguably must at least permit independent organizations who can provide such services to do so. These duties as applied to points of entry and reception centers are not solely rooted in obligations toward those individuals in State-operated or -authorized facilities. They are also related to the obligations of States Parties to the WHO Constitution to, as the IHR requires, “ensure . . . that facilities used by travelers at points of entry are maintained in a sanitary condition and are kept free of sources of infection or contamination.”328

Additionally, the Human Rights Committee has specified that States Parties to the ICCPR are obligated to “take special measures of protection towards persons in situation of vulnerability,” a category that includes “displaced persons, asylum seekers, refugees, and stateless persons.”329 Of note, “a heightened duty to protect the right to life also applies to individuals quartered in liberty-restricting State-run facilities, such as . . . refugee camps and camps for internally displaced persons.”330 The State’s obligation to protect the right to life not only extends to facilities and camps within the State’s territory, but also extends to points of entry, international zones, or foreign territory where the State has detained asylum seekers or migrants. As the Human Rights Committee puts it, “States Parties must respect and protect the right to life of all individuals arrested or detained by them, even if held outside their territory.”331

Regional human rights instruments and bodies echo these obligations. In particular, the ECtHR has decided cases related to the health of detainees on numerous occasions. In Yoh-Ekale Mwangie v. Belgium, the Court determined Belgium had violated a Cameroonian national’s right against inhuman and degrading treatment by detaining her in a closed transit center without providing adequate or timely medical care appropriate for her status as an HIV-positive woman.332 By failing to act with due diligence in protecting the woman’s health while she awaited deportation in

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327. ICESCR, supra note 178, art. 12.
328. INTERNATIONAL HEALTH REGULATIONS, supra note 239, art. 22.
329. General Comment No. 36, supra note 145, ¶ 23.
330. Id. ¶ 25.
331. Id. ¶ 63.
State custody, Belgian authorities subjected her to unnecessary suffering. In *Ghavtadze v. Georgia* and related cases, the ECtHR found Georgian authorities had subjected a prisoner suffering from hepatitis C and tuberculosis (both contracted in prison) to inhuman and degrading treatment by failing to provide him adequate or effective medical services.\[333\] Though the case concerned detainees serving penal sentences rather than migrants detained temporarily, the principles the ECtHR conveyed in its ruling demonstrate the Court’s concern with conditions in State-operated detention facilities. The IACtHR has also called on States to protect the health of migrants. In a 2014 Advisory Opinion focused on treatment of children, the Court determined States “must guarantee” medical care while children are in State custody awaiting refugee status determination, including specialized care services tailored to each child’s specific needs.\[334\]

2. *States’ Obligations to Immigration Detainees During a Pandemic*

Governments’ health-related obligations to migrants under their care or within their custody continue during public health emergencies such as pandemics. In fact, States must carefully weigh the risk of infectious disease contraction or transmission within their facilities when deciding whether to detain or confine a migrant in the first instance. States’ abilities to restrict movement of migrants (whether in camps, detention facilities, or ports of entry) are not absolute. The 1951 Refugee Convention prohibits States Parties from imposing restrictions on the movements of refugees and asylum seekers “other than those which are necessary,” and only permits such restrictions while the confined individual’s status in the country is being regularized (or until they obtain admission in another country).\[335\] This obligation applies even if the State views the refugees or asylum seekers as unlawfully present in the State’s territory. While States may initially confine refugees and asylum seekers for a set period in order to undertake health checks “as a preventative measure in the event of specific communicable diseases or epidemics,” refugees and asylum seekers who ultimately apply for protection are entitled to freedom of movement within the foreign State’s territory.\[336\]

A State that has detained migrants or confined them to a camp is restricted in its ability to assess the medical status of detained individuals. The WHO’s IHR specify that when there is evidence of a public health risk, States Parties to the WHO Constitution may undertake, on a case-by-case basis, “the least intrusive and invasive medical examination that would

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\[335\] 1951 Refugee Convention, supra note 267, art. 31(2).

achieve the public health objective of preventing the international spread of disease.”337 Authorities must acquire travelers’ express informed consent (or the consent of their parents or guardians) before subjecting individuals to medical examinations, which must be administered in accordance with established safety guidelines to minimize risk of disease transmission.338 States Parties isolating or quarantining travelers (including refugees and asylum seekers) must arrange for adequate food and water, appropriate accommodation and clothing, medical treatment, and means of communication in a comprehensible language; moreover, such quarantine or isolation measures must be limited in time.339

3. States’ Obligations to Immigration Detainees in the Context of COVID-19

States that detain those seeking to enter their territory have a responsibility to prevent, treat, and control the COVID-19 pandemic within and between their detention facilities to the extent possible. This obligation entails working to ensure the availability of health care services, medical and hygiene supplies (including masks), and adequate sanitation and ventilation in such sites to prevent virus transmission. Medical services and supplies necessary to treat those individuals who have contracted the virus in these facilities and camps are also critical. These duties are among those that hundreds of international experts on refugee and migrant protection have endorsed.340

Human rights bodies have expressly affirmed these obligations. UNHCR has compiled an extensive “toolkit” that outlines a number of treaty obligations that States Parties to various human rights obligations have toward detainees during the COVID-19 pandemic.341 And in May 2020, the IACtHR issued a resolution in the case of Vélez Loor v. Panamá requiring the Panamanian government to take appropriate measures to protect the rights to health, personal integrity, and life of transiting migrants detained at migration reception stations.342 Warning of the potential for a COVID-19 outbreak within the facilities, the Court specifically noted the government’s duties, among others, to conduct health checks for all individuals entering the facilities; adopt appropriate quarantine policies when necessary; provide migrants with free and non-discriminatory access to health care services that have the same standard of care as those available

337. INTERNATIONAL HEALTH REGULATIONS, supra note 239, art. 23(2).
338. Id. art. 23(3)–(4).
339. Id. art. 32.
in the community; ensure ventilation, cleanliness, disinfection, and waste collection; provide free masks, gloves, and other supplies; and promote personal hygiene to prevent disease transmission.

Beyond providing adequate and accessible medical services and supplies, governments should consider means of reducing overcrowding and limiting transfers of detainees that might increase the risk of transmission of COVID-19 within the detainee population. State authorities might allow individuals in their custody or under their care to transition to reside in host communities where they might socially distance more effectively, within the bounds of official processes for determining status. Some States have taken this approach. The Norwegian government has released some migrants from detention in light of the pandemic on a case-by-case basis, allowing selected individuals to seek accommodation with their contacts in the country so long as they regularly report to public authorities.343 Courts in Portugal, France, Japan, Indonesia, and elsewhere have occasionally ordered the release of immigrants in response to COVID-19.344 Portugal has gone further than other countries, offering temporary legal status to migrants and asylum seekers to encourage them to report and seek treatment for suspected COVID-19 cases.345 The Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment underscores this recommendation in advising States Parties to the Optional Protocol to the CAT to "review the use of immigration detention centres and closed refugee camps with a view to reducing their populations to the lowest possible level."346 UNHCR, together with the International Organization for Migration, the WHO, and the Office of the High Commissioner for Human Rights, urged in March 2020 that migrants held in overcrowded and unsanitary conditions "be released without delay" in light of "the lethal consequences a COVID-19 outbreak would have."347 Most States, however, have been reluctant to respond to these calls to release detained migrants, likely fearing that, once released, the

migrants may not return. That reluctance may have had deadly consequences.348

In short, COVID-19 represents a distinct and substantial challenge for States that detain refugees, asylum seekers, and other immigrants. These States have significant international law obligations to protect the especially vulnerable populations under their care in immigration facilities, detention centers, and refugee camps. Meeting these obligations is not only required by international law, but it is also essential to stemming the pandemic.

IV. Cyber Law: Vaccine Theft and Disinformation

In late 2020, cybersecurity researchers reported a suspected state-sponsored attempt to gain access to the accounts of executives and officials at companies and international organizations managing the logistics of COVID-19 vaccine distribution.349 According to IBM, the hackers were apparently seeking information about how the vaccines, some of which have to be kept at extremely low temperatures, will be stored and moved. The motive—whether to simply steal technology or to interfere with the distribution of the vaccine—was unclear.

This is just one in a slew of cyber incidents related to COVID-19, which has proved to be a boon for hackers. Professional life rapidly went digital during the pandemic, making it more vulnerable to cyber criminals. INTERPOL has reported an “alarming” rise in cyber incidents after the pandemic started.350 Much of the crime wave has come from individuals and gangs looking to turn a quick profit, but States have gotten in on the act, too. British, U.S., and Canadian intelligence agencies accused Russia of attempting to steal research from universities and companies working to create a vaccine for COVID-19.351 China apparently attempted to steal vaccine data from the University of North Carolina and other cutting edge research labs.352 Iran tried to break into the personal email accounts of staff at the WHO early in the pandemic.353

States’ adversaries,” according to the *New York Times*, have attempted to pilfer cutting-edge research.354

Data theft is not the only COVID-19-related cyber risk. Russian trolls have for years promoted anti-vaccine content online. Kremlin-linked groups have peddled conspiracy theories about COVID-19, including the idea that it is a U.S.-made biological weapon and half-satirical claims that the Oxford-AstraZeneca vaccine turns patients into monkeys because it is based on a deactivated chimpanzee virus.355 To protect the health of their own citizens and the integrity of international scientific collaboration, States need to respond to State and non-State efforts to spread disinformation.

This Part considers what role international law might play in regulating these cyber incidents. It examines the law governing use of force, the principle of non-intervention, and the proposed “rule” of sovereignty. It finds that international law, at least as currently constituted, does not apply to the known incidents thus far (though if state actors were to interfere with vaccine distribution, that could change). No international legal rule clearly prohibits vaccine espionage or misinformation campaigns. The gaps in the law pose a problem for any response to COVID-19 cyber incidents, but they could also provide States with an opportunity—and an incentive—to clarify the rules that govern cyberspace.356

A. Law Governing the Use of Force

One of the bedrock rules of international law is the prohibition on the use of force, contained in Article 2(4) of the U.N. Charter. Although States have had trouble defining exactly when a cyber operation would constitute a use of force, they have mostly agreed that cyber operations could, in principle, violate the prohibition.357 The bar is high, however.

As one of us put it in a 2012 article: “[T]he best test of when a cyber-attack is properly considered cyber-warfare is whether the attack results in physical destruction—sometimes called a ‘kinetic effect’—comparable to a

354. Barnes and Venutolo-Mantovani, supra note 352.
conventional attack.” That same year, the U.S. State Department put forward a similar view, concluding that a cyber operation would qualify as a use of force if it caused “direct physical injury and property damage” of the kind produced by traditional weapons.

No COVID-19 vaccine hacking or disinformation campaign has met that standard, and it is hard to see how efforts to steal data or spread false information could. It is possible that a cyber operation that destroyed stocks of an approved vaccine, or prevented a country from distributing it, could have a sufficiently close causal link to resulting deaths that it would resemble a traditional attack violating the prohibition on the use of force. But anything short of that is unlikely to meet the legal threshold. Even if a hacking effort significantly delayed the production of a vaccine, rather than merely copying researchers’ data, the link between the operation and subsequent deaths from the lengthened pandemic would probably be too attenuated for the hack to constitute a use of force under current interpretations of international law.

Setting aside the use of force, commentators have made two main arguments for why vaccine hacking and disinformation might break international law. First, they argue that such operations could breach the principle of non-intervention. Second, such attacks might violate a putative rule of State sovereignty. We consider each possibility in turn.

B. The Principle of Non-Intervention

The principle of non-intervention bars a State from coercing another State into acting against its will in an area within its inherent sovereign functions. The definitions of both “coerce” and “sovereign functions” have proven tricky to pin down. Coercion requires more than a mere attempt to influence State policy, such as through diplomacy or propaganda, but exactly how much more has been a point of contention. As for the definition of sovereign functions, the ICJ has concluded that an unlawful intervention must bear “on matters in which each State is permitted . . . to decide freely,” such as “the choice of a political, economic, social and cultural system.” That definition suggests that the principle protects a broad swathe of government policy. As the legal scholars Marko Milanovic and Michael Schmitt have argued, a government’s response to a pandemic...
likely qualifies, since protecting public health is widely regarded as a core function of the State.\footnote{Marko Milanovic & Michael N. Schmitt, Cyber Attacks and Cyber (Mis)information Operations during a Pandemic, 11 J. NAT. SECURITY L. & P’CY 247, 257 (2020).}

State practice backs up these definitions. States have accused the perpetrators of cyber incidents of violating international law, in the words of a recent Chatham House report by Harriet Moynihan, only when the attack has “practical effects” on a State’s ability to exercise its “inherently sovereign powers,” and not when the attack targets individuals and private companies without a broader effect on State policy.\footnote{Moynihan, supra note 360, at 34–35.} Thus in 2018, the United Kingdom accused Russia of a “flagrant violation” of international law for allegedly carrying out a campaign of cyberattacks that disrupted transportation systems in Ukraine.\footnote{Press Release, National Cyber Security Centre, Reckless Campaign of Cyber Attacks by Russian Military Intelligence Service Exposed (Oct. 18, 2018), https://www.ncsc.gov.uk/news/reckless-campaign-cyber-attacks-russian-military-intelligence-service-exposed [https://perma.cc/R4X5-J4BV].} Likewise, in 2020, the United Kingdom accused Russia of violating international law in a 2019 cyberattack on Georgia, which knocked out the national TV station and numerous government websites.\footnote{Press Release, Foreign & Commonwealth Office, UK Condemns Russia’s GRU over Georgia Cyber-Attacks (Feb. 20, 2020), https://www.gov.uk/government/news/uk-condemns-russias-gru-over-georgia-cyber-attacks.}

In contrast, countries have responded in other ways—notably without alleging violations of State sovereignty—to cyber incidents that do not impinge on core State functions. After the 2014 North Korean hack of Sony, U.S. President Barack Obama characterized the incident not as an act of war but as “an act of cyber vandalism.”\footnote{Steve Holland & Doina Chiacu, Obama Says Sony Hack Not an Act of War, REUTERS (Dec. 22, 2014), https://www.reuters.com/article/us-sony-cybersecurity-usa/obama-says-sony-hack-not-an-act-of-war-idUSKBN0JX1MH20141222 [https://perma.cc/8H3N-X8J8].} In 2018, the United States and the United Kingdom declined to accuse Iran of breaking international law by conducting a spear-phishing campaign against private universities and companies, instead treating the incursion as a violation of domestic law.\footnote{Foreign & Commonwealth Office, Foreign Office Minister Condemns Criminal Actors Based in Iran for Cyber-Attacks Against UK Universities (Mar. 18, 2018), https://www.gov.uk/government/news/foreign-office-minister-condemns-criminal-actors-based-in-iran-for-cyber-attacks-against-uk-universities.} The same reticence showed up after the 2017 WannaCry ransomware operation, despite the potentially dangerous effects of the incident. The malware hit the British National Health Service particularly hard, locking patient records and making thousands of medical devices temporarily unusable, leading to the cancellation of doctor’s appointments and surgical procedures. Yet its main aim appeared to be financial gain, not changes to State policy, and the United Kingdom characterized it as “a
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criminal use of cyber space” rather than a violation of international law.369

Thus, attempts to merely steal vaccine research likely do not violate the international law rule against intervention, as simply copying research does not involve coercing the target State or affecting core State policy. It is instead an act of cyber espionage, which is generally not directly regulated by international law (though it is prohibited almost everywhere by domestic law). However, destroying data, disabling vaccine research or production, or disrupting distribution could curtail States’ capacity to respond to the pandemic. Such actions arguably would constitute a prohibited coercive intervention.

As for disinformation, Milanovic and Schmitt persuasively argue that merely seeking to influence the population, even in harmful ways, is not sufficiently coercive to constitute an intervention.370 Yet some acts of misinformation could qualify as prohibited intervention if sufficiently coercive as to remove or significantly limit the State’s capacity to effectively respond to the pandemic. As of this writing, it does not appear that the current vaccine-related operations have crossed, or even come close to, that line.

C. The (Non-)Rule of Sovereignty

Underlying international law is the principle of State sovereignty. Some legal scholars, including Schmitt, the editor of the Tallinn Manual 2.0, have argued that the sovereignty principle creates a stand-alone rule of international law that applies to cyberspace.371 This rule would sweep in many intrusions that fall below the non-intervention threshold. A State violates another State’s sovereignty, the Manual holds, when it exercises State power within the target State’s territory without its consent. Violations can be executed remotely.

A few States, including Finland, France, and the Netherlands, as well as members of the Shanghai Cooperation Organization, have endorsed this view.372 Milanovic and Schmitt, who endorse the principle, argue that


371. TALLINN MANUAL 2.0 ON THE INTERNATIONAL LAW APPLICABLE TO CYBER OPERATIONS r. 4 (Michael M. Schmitt & Liis Vihul eds., 2017).

misinformation campaigns can violate the rule “by causing effects on the territory of” another State “or by interfering with its inherently governmental functions even in the absence of territorial effects.”373 In their view “any negative health outcome would qualify as an ‘effect’” and therefore any cyber-operation that has a negative health outcome violates the sovereignty rule.374 For example, a denial of service attack against a website providing information on virus testing or a ransomware attack that impedes dissemination of information about the pandemic would qualify as a violation as long as there is “some concrete harm.”375

The stand-alone sovereignty argument is not widely accepted, however. The United Kingdom has rejected it outright. In 2018, British Attorney General Jeremy Wright set out his government’s position: “[T]here is no such rule as a matter of current international law.”376 In this view, operations that fall short of the non-intervention rule may be unwelcome—and, depending on the specific facts, illegal under domestic law—but they are not barred by international law.

The U.S. government has expressed sympathy for the British view. In May 2020, Department of Defense General Counsel Paul Ney argued that there was not sufficiently “widespread and consistent State practice . . . to conclude that customary international law generally prohibits such non-consensual cyber operations in another State’s territory,” a position he characterized as sharing “similarities” with the British view.377

Those who reject a rule of cyber sovereignty as an independent rule have, we think, the better of the argument. For one thing, the principle of sovereignty is precisely what underlies the principle of non-intervention. Going beyond non-intervention to bar all cyber operations that infringe on “sovereignty” broadly defined would almost certainly sweep in too much activity. Traditional espionage operations, for example, are not directly regulated by international law.378 The proposed stand-alone rule of sovereignty would risk making most electronic snooping illegal; according to the Chatham House report, “a [S]tate simply sitting on another [S]tate’s server” could violate the victim [S]tate’s sovereignty.379 That would upend intelligence work and would, in any case, be rejected out of hand by the world’s practitioners of cyber espionage (or at least those who are mindful of their international law obligations).

374. Id. at 254–55.
375. Id.
379. Moynihan, supra note 360, at 19.
It is not just States that would find their activities curtailed by a free-standing sovereignty rule prohibiting cross-border cyber operations. Human rights organizations, for example, often seek to influence the politics and law of the countries within which they operate, and these influence campaigns sometimes involve cross-border operations that are resisted by the sovereign State in which they take place. Russia, for instance, has banned foreign non-governmental organizations.380 A broad rule of sovereignty might help legitimate Russia’s actions by substantiating its claim that these organizations and their sponsors are violating Russia’s “sovereignty.” Or consider Voice of America, which aims to provide television and radio programming to populations whose governments do not always welcome it. Does Voice of America’s projection of electronic signals into these countries violate their “sovereignty”?

Some commentators have attempted to save the idea of sovereignty-as-rule by exempting de minimis territorial intrusions,381 but no one seems to agree where to draw the line, and State practice thus far provides no guidance. In the end, as Ney pointed out, the very fact of wide disagreement among States about a potential rule of cyber sovereignty itself forecloses the existence of such a norm—at least at present.

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Without a violable rule of sovereignty, efforts to steal vaccine research likely do not break international law—as long as they do not impede that research. Espionage appears to fall within the zone of intelligence activity.382 Data theft alone does not appear to violate the non-intervention principle, as there is nothing inherently governmental about protecting commercial or scientific information and such theft has not apparently significantly impeded efforts to respond to the virus. (That said, the actions are far from legal: They almost certainly violate U.S. domestic law, including the Economic Espionage Act and the Cyber Fraud and Abuse Act.)

It is no surprise, then, that the United States has largely avoided referring to international law when condemning cyber espionage, instead treating it as a violation of domestic law or aspirational codes of State behavior. In 2015, when China and the United States agreed that neither country would support intellectual property cybertheft—an agreement that proved short-lived—the deal made no mention of international law.383 And in July 2015, when China and the United States agreed that neither country would support intellectual property cybertheft—an agreement that proved short-lived—the deal made no mention of international law.383 And in July

381. See, e.g., Moynihan, supra note 360, at 23 (describing a de minimis threshold as “attractive from a practical and pragmatic point of view”).
2020, when the Department of Justice indicted two Chinese government hackers for attempting to steal vaccine research, it did not accuse China of violating international law, instead simply denouncing it for working to steal the “hard-earned intellectual property” of American companies.384

Even before COVID-19, the international community struggled to define rules of the road for cyberspace and to deter unwelcome State cyber operations. Indicting foreign State hackers can shame wrongdoers and impose unwelcome travel restrictions, but perpetrators of State-backed cyber incidents are unlikely to face criminal prosecution. Diplomatic measures are also frequently insufficient. In July 2020, according to the New York Times, the Trump administration shuttered the Chinese consulate in Houston in part because China was using it for medical research espionage, but it is unclear what effect the move had.385 Bilateral agreements, such as the 2015 U.S.-Chinese deal, can help, but only temporarily. The digital world remains something of a Wild West.386

Perhaps the greatest impact of the cyber incidents during the COVID-19 pandemic has been to reveal how few rules there really are. There have been two UN-sponsored efforts aimed at providing greater clarity about the rules for “responsible behavior in cyberspace.”387 One concluded in March 2021 with little new substantive progress.388 Perhaps the inability of international law to regulate hacking incidents during the pandemic will encourage the international community to begin to take more serious steps to agree on the international rules that govern cyber activities.

V. The WHO’s Pandemic Response and the International Health Regulations

International law has long regulated the management of global public health threats. Ever since 1851, when the first International Sanitary Conference attempted to harmonize quarantine procedures among European States, countries have repeatedly united around the need to prevent the
spread of disease. The latest iteration of the global rules on pandemics, the 2005 International Health Regulations (IHR), set requirements for how States should report outbreaks, manage diseases within their borders, and cooperate to prevent their spread.

The regulations, the first version of which was adopted by the WHO in 1969, are binding on all 194 WHO members. They aim to “prevent, protect against, control, and provide a public health response to the international spread of disease” while minimizing interference with “international traffic and trade” and respecting “the dignity, human rights and fundamental freedoms” of all people. The regulations allow the WHO to coordinate a global disease surveillance network made up of monitoring systems with each state in order to catch outbreaks that risk turning into international health emergencies and report them to the WHO.

Yet during the COVID-19 pandemic, the regulations have too often proven ineffective in shaping the response of States, and even the WHO itself, to the pandemic. Chinese officials reportedly attempted to cover up the initial spread of the disease. The WHO took a full month to declare a public health emergency after learning about the outbreak, leading many to argue it should have moved more quickly. Many States broke with the WHO’s recommendations by imposing strict travel bans, stay-at-home orders, and other repressive measures; although, in retrospect, these moves were likely justified. And, especially early on in the pandemic, competition rather than cooperation ruled the day.

The IHR are binding on WHO members, but they contain no enforcement mechanism. As a result, the WHO has been unable to hold States to their obligations—or discipline those that have failed to meet them. As the disease surges once again in Europe and the United States, it is time for governments to find ways to strengthen the world’s health regulations and return to the principle of cooperation that undergirds them.

A. The Role of the WHO and the International Health Regulations

Although COVID-19 is hardly the first global pandemic, it may be the first to take place despite an international agreement specifically designed to stop it. In 2005, in the wake of China’s failure to report the 2002 SARS outbreak to the WHO for more than two months, the World Health Assem-

389. See International Health Regulations, WORLD HEALTH ORG. [WHO], https://www.who.int/health-topics/international-health-regulations [https://perma.cc/NCJ7-SCHX].
390. See INTERNATIONAL HEALTH REGULATIONS, supra note 239, arts. 2, 3.
bly, made up of the WHO’s members, revamped the IHR to try to address weaknesses in pandemic prevention, detection, and response.394

Before 2005, the regulations had covered just three diseases: cholera, plague, and yellow fever.395 The new regulations covered all potential public health hazards and contained stricter requirements on States to alert the WHO to outbreaks.396 They also gave the Director General of the WHO, acting on the advice of an emergency committee of experts, the power to declare a Public Health Emergency of International Concern (PHEIC), the official international alert. The regulations define such an emergency as an event that “constitute[s] a public health risk to other States through the international spread of disease” and “potentially require[s] a coordinated international response.”397 The WHO has declared six public health emergencies since 2005, most recently on January 30, 2020, in response to the COVID-19 outbreak.398

Apart from giving the WHO the ability to declare an emergency, the revised regulations impose four main requirements on WHO members. First, they must notify the WHO within 24 hours of all public health events inside their territory that might constitute an international public health emergency.399 After States send a notification to the WHO, they must keep the WHO up to date with “timely, accurate and sufficiently detailed” information about the health event.400 Second, States must improve their domestic capacities to prevent, detect, and respond to the spread of diseases that threaten the international community.401 States get to decide how they will fulfill this obligation, but they must “uphold the purpose” of the regulations through their domestic efforts.402 Third, States are limited in how they can respond to disease outbreaks once they occur. The regulations instruct countries to impose only those measures that are supported by scientific evidence, appropriate to the risks involved, and maintain respect for human rights.403 In general, health measures must follow WHO recommendations, although States are allowed to impose additional measures under some circumstances.404 Finally, governments must report to the WHO any public health measures they take that constitute a “significant interference” with international traffic—meaning delaying the entry or departure of travelers or goods for more than 24 hours—along with the rationale for the action and the evidence behind it.405

395. Id. at 266.
396. Id. at 267–68.
397. See INTERNATIONAL HEALTH REGULATIONS, supra note 239, art. 1.
399. INTERNATIONAL HEALTH REGULATIONS, supra note 239, art. 6(1).
400. Id. art. 6(2).
401. Id. art. 5.
402. Id. art. 3.
403. Id. arts. 42, 43.
404. Id. art. 43.
405. INTERNATIONAL HEALTH REGULATIONS, supra note 239, art. 43(3).
B. Potential Breaches of the WHO’s Regulations During the COVID-19 Pandemic

States, and the WHO itself, may have breached the IHR in several ways during the current crisis. First off, China may have violated the requirement to report disease outbreaks to the WHO at the start of the pandemic—although the fault may have been more with local officials in Wuhan than the central government in Beijing.

China first notified the WHO of a cluster of novel coronavirus-like infections on December 31, 2019, but the disease had been circulating in Wuhan for several weeks before that.406 Throughout December, the Wuhan authorities had insisted that the situation was under control.407 Local police had accused several people who posted on social media about the outbreak of spreading “rumors,” and the city’s medical authorities had barred a doctor from speaking publicly about patients suffering from a SARS-like disease.408 Subsequent assessments by the U.S. intelligence community have reportedly concluded that Wuhan authorities played the decisive role in covering up the initial spread of the virus, keeping central party officials in the dark.409

Beijing may have been unaware of the outbreak at the start, but its later delays in releasing information may nevertheless have violated its obligations under the IHR. In January, after reporting the situation in Wuhan to the WHO, Beijing continued to downplay its severity, claiming, for example, that the virus was not spreading from human to human for days after Chinese officials reportedly knew that it was.410 China reportedly sat on other information, too, including the genome of the virus and data from patients.411 By slow walking crucial information, China may

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408. See id.; see also Kynge et al., supra note 391.


have run afoul of the IHR’s requirement that States keep the WHO abreast of “timely” and “accurate” public health information about the outbreak.

Even after China reported the cluster of cases on December 31, the WHO took a full month to declare a PHEIC. That delay reflected, in part, China’s decision to prevent health care workers, scientists, and reporters from speaking publicly about an outbreak of SARS-like illnesses in December and, even after acknowledging the cluster of infections on December 31, to decline for weeks offers from the WHO and the U.S. Centers for Disease Control to send teams of experts to Wuhan.412

In the intervening weeks, more than 8,000 people contracted the disease, 170 of them died, and more than 35 million people in Hubei were placed under lockdown and cut off from the rest of China. Dr. Tedros Adhanom Ghebreyesus, the WHO Director General, convened multiple emergency committee meetings in late January to consider whether a declaration of a PHEIC was warranted. On January 23, the day the Chinese government locked down Wuhan, a meeting of the WHO’s emergency committee did not recommend declaring an emergency.414 Several members concluded that it was “too early,” since there was only “a limited number of cases abroad.”415

The decision not to announce an emergency may have run counter to the IHR. Lawrence Gostin, Roojin Habibi, and Benjamin Mason Meier have argued that the emergency committee members “misapplied” the definition of a health emergency given in the WHO’s own regulations, which requires only the “potential” for international spread and says nothing about the timing of a declaration.416 The rules, however, give the Director General the power to “make the final determination” over declaring a public health emergency.417 That discretion may mean that the ultimate decision not to make the declaration did not violate the regulations, even if the emergency committee got the definition of an emergency wrong.

416. Gostin et al., supra note 398, at 378.
417. INTERNATIONAL HEALTH REGULATIONS, supra note 239, art. 49(5).
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After the WHO finally declared an emergency, many States’ responses arguably bent the rules, as well. The WHO’s regulations require States to generally follow WHO recommendations in responding to disease outbreaks. When States take health measures that go beyond what the WHO recommends, those measures must be as effective as the WHO’s recommendations (or more effective), follow scientific principles and evidence, not intrude more on international travel or be “more invasive or intrusive to persons” than “reasonably available alternatives,” and be implemented with “full respect” for people’s “dignity, human rights and fundamental freedom.”

When the WHO declared a health emergency on January 30, it recommended against “any travel or trade restriction.” While the IHR were designed to prevent border closures that could discourage States from reporting outbreaks, States nonetheless ignored the WHO’s recommendation: The very next day, the U.S. government banned entry for non-citizen travelers who had been in China in the past 14 days. Over subsequent months, governments across the world responded to the pandemic with sweeping international travel bans, flight restrictions, visa cancellations, and quarantine requirements.

Early in the pandemic, some scholars argued that these travel restrictions violated the WHO’s rules. Public health researchers, they noted, had found little evidence that travel restrictions worked in the face of pandemic viruses similar to SARS-CoV-2, and the WHO had advised that such restrictions did more harm than good. The authors of one article in the *Lancet* argued that, since the WHO had provided alternatives, including “risk communication, surveillance, patient management, and screening at ports of entry and exit,” travel bans violated the regulations’ instruction that health measures do not restrict international traffic more than “reasonably available alternatives.”

In retrospect, although flight restrictions and border closures did not work everywhere, according to one study they did play an important role in slowing international transmission. And in countries able to seal them-

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418. Id. art. 43.
selves off entirely or nearly entirely, travel restrictions may have helped significantly. A study of Australia early on in the pandemic concluded that the country’s imposition of a travel ban on February 1 reduced cases by over 80 percent.\footnote{Valentina Costantino, David J. Heslop & C. Raina MacIntyre, The Effectiveness of Full and Partial Travel Bans Against COVID-19 Spread in Australia for Travelers from China During and After the Epidemic Peak in China, 27 J. Travel Medicine 1, 2 (2020).} Those conclusions suggest that at least some governments may have been justified in imposing restrictions despite the WHO’s recommendations to the contrary, as the “reasonably available” alternatives wouldn’t have been as effective.

The WHO also did not advise governments to impose lockdowns early on in the pandemic. Despite an initial burst of enthusiasm for China’s strict approach—“perhaps the most ambitious, agile and aggressive disease containment effort in history,” according to the WHO—the organization recommended only that countries plan to take measures such as suspending large-scale gatherings and closing schools and workplaces, not mass stay-at-home orders and internal travel restrictions.\footnote{See World Health Org. [WHO], Report of the WHO-China Joint Mission on Coronavirus Disease 2019 (COVID-19) 16 (Feb. 28, 2020), https://www.who.int/publications/i/item/report-of-the-who-china-joint-mission-on-coronavirus-disease-2019-covid-19 [https://perma.cc/G8ZS-GXWG].}


To be clear, while the WHO did not recommend lockdowns, it never explicitly opposed them either, and once countries started imposing them, it characterized them more as a last-resort option than as a violation of the rules. In April, the WHO appeared to accept lockdowns as legitimate when it laid out factors for governments to consider before lifting disease control orders.\footnote{U.N. Health Agency Working on Strategies to Gradually Lift COVID-19 Restrictions, U.N. News (Apr. 10, 2020), https://news.un.org/en/story/2020/04/1061532 [https://perma.cc/GBX8-TA2F].} The WHO wanted “as much as anyone” to see restrictions relaxed, Dr. Ghebreyesus said, but easing “too quickly” could lead to a resurgence of the virus.\footnote{Id.} In July 2020, the WHO urged countries to find other ways to manage the virus, saying that lockdowns were not “a long-
term solution."\textsuperscript{429} And in October, Dr. David Nabarro, one of the WHO’s special envoys on COVID-19, said that the WHO did not support lockdowns as “the primary means” of controlling the virus; they could be justified under some circumstances, he said, “but by and large, we’d rather not do it.”\textsuperscript{430} The widespread use of lockdowns to control the virus is thus likely not a violation of the IHR.

Countries may have breached the IHR, however, by failing to work together to combat COVID-19. The regulations require States to “collaborate . . . to the extent possible” by coordinating medical, logistical, financial, and legal responses to public health emergencies. The regulations do not define what this collaboration means in practice, but many States arguably violated it in the early months of the pandemic when governments slammed borders shut, hoarded scarce medical supplies and personal protective equipment, and blamed one another for the spread of the disease.\textsuperscript{431} Even within the European Union, countries ignored rules guaranteeing freedom of movement to impose unilateral border closures.\textsuperscript{432} Yet here, as in other areas, the WHO discovered that in the midst of a crisis, it had little power to convince States to follow the IHR’s provisions.

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The inability to enforce its regulations unfortunately fits into a larger pattern for the WHO. The organization serves an invaluable role as a center of scientific expertise and a champion for global health. Yet it is too often powerless. It is asked to do too much with too little authority or capacity. Those problems, and potential reforms to address them, are addressed in the next Part.

VI. Preparing for the Next Pandemic

COVID-19 has strained the rules and norms of international law, revealing weaknesses in global institutions. If States are to foster a recom-

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mitment to international law that endures beyond the current crisis, they will need to adopt reforms that improve international institutional coordination, streamline communication, shift national governments’ policy incentives, and restore confidence in the international system. A reformed global health infrastructure will help States respond effectively to future global health crises while complying with international law.

Leaders of States, global institutions, and non-governmental organizations should consider three solutions to improve the architecture of the global public health emergency response. First, the U.N. should create a Coordinator strictly responsible for encouraging legal non-health responses to future pandemics in order to complement the work of the WHO and other health-focused institutions. During COVID-19, States have struggled to respond swiftly and effectively to the health crisis while complying with critical humanitarian law, human rights protections, and refugee law principles and norms. A UN Coordinator would ensure that in the future, international law does not get lost in responding to public health crises. Second, structural changes to the WHO’s International Health Regulations and improvements to disease monitoring systems can make future pandemics both less likely and less deadly when they do occur. Third, and perhaps most important, we recommend creating stronger incentives in the form of more funding and privileged access to public health expertise and medical assistance prior to and during disease outbreaks for governments that comply with IHR pandemic preparedness and response standards. This technique would take advantage of innovative “outcasting” techniques for international law enforcement and could help overcome longstanding obstacles to effective reform.433

The COVID-19 pandemic made all too clear the need to strengthen future responses to health emergencies. Momentum for discussions of a new international treaty on pandemics is quickly growing.434 Earlier this year, 194 countries passed a World Health Assembly resolution to host a special session starting on November 29, 2021, in which the Assembly would consider the benefits of an international agreement on pandemic preparedness and response.435 Public health experts have advocated for a potential treaty to feature powerful enforcement mechanisms.436 The steps

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434. WHO Director-General Ghebreyesus and nearly a dozen global leaders have publicly called for an international treaty, while the European Council has adopted a decision to support negotiations for an international treaty. WHO member States will consider a new international treaty on pandemics during the forthcoming November 2021 special session of the World Health Assembly. See An International Treaty on Pandemic Prevention and Preparedness, EUROPEAN COUNCIL (June 15, 2021), https://www.consilium.europa.eu/en/policies/coronavirus/pandemic-treaty [https://perma.cc/5LGC-CKL9].
advocated here could be pursued as stand-alone reforms or included within a future treaty regime.

A. Create a U.N. Coordinator to Focus on Non-Health Responses to a Pandemic

The global response to COVID-19 has required action from a range of governmental, inter-governmental, and non-governmental organizations. This has created a coordination challenge unparalleled in modern memory. It has not gone well. In September 2020, for example, U.N. Secretary General Guterres cast the pandemic as a “clear test of international cooperation—a test we have essentially failed.”

At the United Nations itself, coordination has proven poor—not just in matters necessary to address the global health threat but in encouraging U.N. bodies to consider the implications of the pandemic for their core areas of responsibility. Many of the problems described in Parts I through III might have been alleviated had there been an earlier response from the U.N. bodies responsible for monitoring compliance with the different areas of law—anticipating, for example, the humanitarian and human rights implications of the pandemic and getting ahead of the problem by issuing specific guidance to States as soon as the scale of the pandemic was clear. Instead, U.N. bodies have played catch-up, their advice often arriving only after problems have become widespread. U.N. advice has thus been difficult, if not impossible, to implement effectively.

Given the communication and coordination issues that have bedeviled the international community’s response to COVID-19, future reforms should focus on streamlining and centralizing the global pandemic response. Although there is understandable skepticism about the capacity of the U.N. to serve this role, it is the most universal global organization. With representatives from 197 States, it is the only standing body capable of serving this communication and coordination function. Moreover, its multi-jurisdictional scope—covering a wide range of legal and policy matters—would provide an opportunity for effective, coherent coordination.

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ters—means it is the only organization capable of addressing the range of problems that emerge with a global pandemic.

To allow the UN to effectively play a global coordinating role in the future, the Secretariat should establish a U.N. Coordinator to manage non-health responses to a pandemic. The role of the U.N. Coordinator would be similar to that of Special Envoys appointed by the WHO to coordinate health responses to COVID-19, but the focus would instead be on non-health responses. In February 2020—that is, fairly early on in the pandemic—WHO Director-General Ghebreyesus appointed six Special Envoys on COVID-19, who were meant to collaborate with the “WHO’s Regional Directors and country offices to coordinate the global response to COVID-19.” Among other functions, the Special Envoys were to “engage with regional bodies and national governments,” report to the Director-General on regional and national responses to COVID-19, and engage in “high-level advocacy and political engagement.” Dr. Ghebreyesus appointed a seventh Special Envoy, responsible for coordination in South East Asia, in January 2021.

Each of the Special Envoys has taken an active role by highlighting COVID-19 issues specific to various regions and advocating for heightened global cooperation. Dr. John Nkengasong, for example, one of the Special Envoys and the director of the Africa Centres for Disease Control and Prevention, has called on Canada, the U.S. and European countries to “distribute their excess vaccines equitably to the countries that need it most.” Dr. Nkengasong has specifically called on the Canadian government to make arrangements for vaccine access with the African vaccine acquisition task force. Dr. David Nabarro, another Special Envoy, has proven similarly active in communicating with state governments. In September 2020, Dr. Nabarro spoke with the British Parliament’s Foreign Affairs Committee and specifically called on Britain’s Foreign, Commonwealth, and Development Office to help low-income countries deal with the...
At the very least, these Special Envoys have managed to communicate the WHO’s priorities to state governments, reminding both government officials and the general public of the need for global coordination. Although neither the United Nations nor other organizations has yet conducted a detailed assessment of the Special Envoys’ performance, it is clear that the Special Envoys have served as an important source and conduit of information and attempted to shape a more global response out of national governments’ COVID-19 efforts. In the case of future pandemics, the WHO would do well to resume its practice of appointing Special Envoys to deal with regional pandemic responses.

Despite the good work of the WHO’s Special Envoys, however, the UN’s global response to the pandemic was lacking in several key respects. For one thing, no one was formally tasked with coordinating non-health responses to the pandemic. As COVID-19 has made clear, countries cannot merely rely on public health measures or protocols to deal with long-lasting pandemics. Measures such as quarantine, travel restrictions, and lockdown have imposed sharp consequences on the global economy. There is thus a need for a coordinator or envoy to cooperate closely with institutions such as the World Bank, the International Monetary Fund, and the U.N. Development Program and ensure a well-oiled financial response to future pandemics. This coordinator would work not just with international organizations, but also with national finance ministries and aid organizations as well as with regional bodies such as the Asian Development Bank and the Inter-American Development Bank. The benefits of a well-coordinated global financial policy to a pandemic would include increased macroeconomic stability, decreased damage to global GDP, and more efficient provision of aid to less-developed countries. Last, the U.N. coordinator could also work with U.N. bodies to encourage them to anticipate non-health legal and policy challenges the pandemic might pose for their areas of expertise and to develop quick proactive advice for countries.

A U.N. Coordinator tasked with this portfolio would be able to synthesize the guidance that a number of U.N. institutions and organs provide to States, maximizing the impact of all-too-often disparate lines of effort. Such a Coordinator would amplify and promote the advocacy of, for instance, the Office of the High Commissioner for Human Rights, UNHCR, human rights treaty bodies, and Economic and Social Council programs, funds, commissions, and agencies. In this respect, the U.N. Coordinator would not only augment those institutions’ messaging but could also provide clear guidance on how the various recommendations can practically

445. See id.
inform government policy outside of the health sector when States are grappling with the effects of health crises.

The U.N. Coordinator would also backstop high-level advocacy by the U.N. Secretary-General by addressing the many non-health issues the pandemic implicates. For instance, U.N. Secretary-General Guterres fiercely advocated for a global ceasefire in response to COVID-19’s spread in mid-2020 but was ultimately unsuccessful. While the Security Council’s paralysis was a major reason for this shortcoming, the International Crisis Group notes that a lack of “ceasefire architecture” in various contexts of conflict inhibited agreements; to address this particular gap, the U.N. Coordinator could advocate for policies reflecting IHL principles across conflict zones and promulgate guidance to effect such policies. The Coordinator would have broad pandemic-focused credibility and expertise equivalent to that of the WHO Director-General.

In structuring such an Office, the U.N. would do well to feature the proposed Coordinator as a key member of the U.N. Secretariat rather than as a Special Envoy within an organization such as the WHO. Given the sheer complexity of coordinating the global non-health responses to a pandemic, the Coordinator would benefit from the legitimacy afforded by membership of the U.N. Secretariat and from the consequent ability to act as, in effect, a “coordinator of coordinators.” The U.N. Secretariat, as one of the U.N.’s key organs, is itself composed of various offices and departments. The U.N. has a variety of ways to institutionalize the proposed Coordinator. One option would be to appoint a special advisor, representative, or envoy, similar to the Office of the Special Advisor on Africa or the Office of the Special Representative of the Secretary-General on Sexual Violence in Conflict—both offices contained within the U.N. Secretariat. The U.N. General Assembly might request the Secretary General to create the “Office of the Special Representative of the Secretary General on Comprehensive Responses to Public Health Crises.” Led by a single Coordinator, the Office of the Special Representative would in turn organize itself into divisions that would each focus on particular priorities, including coordinating with U.N. institutions, coordinating with non-U.N. international institutions, and coordinating regional responses. The Special Representative would coordinate and lead the work of these divisions, convening conferences of experts to assist in the development of a legal and political framework to guide future responses to pandemics, and establishing lines of communication to allow rapid coordination in the event of a crisis.

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The U.N. Coordinator role must be a standing position—not merely appointed when a particular pandemic emerges. Regular global health threats are a fact of modern transnational life. In the last decade-and-a-half, there have been three: the current COVID-19 pandemic, the 2014–16 Ebola outbreak, and the 2009–2010 H1N1 flu. Not long before that there was a SARS outbreak in 2002–2004 that was, luckily, contained but could have been much worse. Though none was as deadly as the current pandemic, each of these crises posed serious challenges to the global community. Establishing the U.N. Coordinator as a standing office that develops plans and protocols for significant disease outbreaks and that stands ready to help coordinate non-health responses to health crises would put the international community in a position to respond quickly and proactively when the next crisis inevitably emerges.

B. Reform Global Health Governance

The U.N. is not the only global institution to have fallen short during the pandemic. The WHO has been battered by criticism from national leaders and public health experts for its initially halting and imperfect response. Defenders of the WHO point out that, while it may have been slow to declare COVID-19 an international public health emergency in January, it responded rapidly in other ways, sending a team to Wuhan earlier that month to assess the situation and urging countries to prepare for the likelihood that the disease would spread beyond China. The WHO has had other successes, too. It has worked with social media companies to combat the spread of misinformation about the virus. It has organized large international trials of potential treatments and is playing a major role in COVAX, an initiative to distribute billions of doses of COVID-19 vac-


Criticism of the WHO, moreover, is often a convenient way for governments to distract from their own failures.

Yet the WHO’s shortcomings have been real. The WHO was slow to declare COVID-19 an international emergency and its International Health Regulations were ignored by many States. The organization also found itself unable to coordinate national responses early on in the pandemic, appearing reluctant to criticize its largest members for their inadequate management of the virus. Even before COVID-19, a majority of countries had failed to meet the WHO’s pandemic preparedness standards.

The initial WHO-led investigation into the origins of COVID-19 illustrates some of the organization’s flaws, in particular its reliance on the goodwill of its largest members. While the investigators, who reported their findings in February 2021, provided useful new information about the early spread of the disease in Wuhan, they lacked independent access to crucial data and physical sites and failed to identify exactly how the virus first reached human hosts, whether directly from an infected animal, through an intermediate animal host, or from an accidental laboratory leak. Despite the lack of definitive evidence, the investigators declared that natural transmission from animals was the most likely explanation and a leak from a laboratory was “extremely unlikely.” That conclusion lined up with the Chinese government’s stance, as Beijing has consistently rejected the idea that a lab leak could be responsible. In the aftermath of the investigation, several leading microbiologists and epidemiologists criticized the probe for reaching strong conclusions without clear evidence, and the U.S. government expressed similar reservations. WHO officials acknowledged to the Wall Street Journal that the mission was mandated to “design and recommend scientific studies, not to do an investigation, let


454. Id.


alone a forensic audit of laboratories."\textsuperscript{457}

The WHO is not blind to its problems. In July 2020, it announced an independent review of its response to the pandemic (as well as the responses of individual States).\textsuperscript{458} And in October 2021, it unveiled a new permanent advisory body, the Scientific Advisory Group for the Origins of Novel Pathogens, which will continue to investigate the origins of SARS-CoV-2.\textsuperscript{459} Change is overdue.

1. Reforming the IHR

The WHO’s inability to enforce compliance with the IHR predates the current pandemic. In 2005, the regulations were reformed in response to the 2002–2004 SARS epidemic. The reforms required all States to develop and maintain a set of minimum capabilities to detect and respond to potential international public health emergencies.\textsuperscript{460} States were originally required to comply by 2012, with less developed countries receiving assistance from the WHO to boost their public health capacities. Yet just 22 percent of WHO members met the deadline, and the WHO has repeatedly granted extensions.\textsuperscript{461} In early 2020, 15 years after the regulations were adopted, fewer than half of countries were in compliance.\textsuperscript{462} What’s more, although the standards are set by the WHO, governments monitor and report their own progress, and the WHO has no enforcement mechanism for those that fall short.

Flaws in the IHR may also have played a role in the WHO’s delay in declaring a PHEIC at the start of the COVID-19 pandemic. One of the major changes in 2005 was to give the WHO the ability to use non-governmental sources of information to monitor outbreaks.\textsuperscript{463} That was supposed to address state reluctance to report disease clusters for fear that their neighbors would cut off travel and trade in response.
Yet COVID-19 revealed that the rules still did not work as intended. The WHO still cannot send experts to investigate reports of novel diseases unless the government in question invites them. It took until February 2020, for example, for the WHO’s team to gain access to Wuhan. If the WHO receives information about outbreaks from a non-state source, the regulations require it to verify the reports with the relevant government. Thus even though Taiwan, which is excluded from WHO membership, claims that it warned the organization in late December 2020 that a new virus was circulating and appeared to be transmissible from human to human, the WHO could not act until China confirmed the reports three weeks later. In principle, if a country refuses to work with the WHO in response to a third-party report of an outbreak in its territory, the WHO can make the information public anyway, but the IHR does not specify how much cooperation is necessary, and, in any case, the WHO did not avail itself of this option when it came to COVID-19.

The design of the WHO’s alert system may also have increased the delay in declaring a public health emergency. The regulations create only one level of alert, the PHEIC. Without a more fine-grained series of warnings, the WHO may have wanted to avoid pulling its only fire alarm prematurely.

Observers have suggested several reforms to the IHR in response to the pandemic. The WHO itself has suggested changing its alert system. In the January 23, 2020 statement in which it said that it was too early to declare a public health emergency, the organization suggested that the rules be altered to allow “a more nuanced system” with an “intermediate” alert level. A series of stepped alert levels is a good idea. Such a system would prevent a repeat of the situation in early 2020, when governments may have interpreted the WHO’s decision not to declare an emergency as an indicator that all was well. Stepped alerts would focus attention on the rising danger, not on whether the highest level has been reached. Under a related reform, proposed by former WHO Legal Counsel Gian Luca Burci, the WHO would maintain a database of national responses to public health incidents and ask governments to notify the WHO of any

465. INTERNATIONAL HEALTH REGULATIONS, supra note 239, art. 10.
467. See INTERNATIONAL HEALTH REGULATIONS, supra note 239, art. 10(4).
468. WHO, supra note 414.
such a system would allow the WHO and outside observers to better track global compliance with international law and respond early to any concerning trends.

The emergency WHO committee that declares international public health emergencies should also be given greater political independence. It is possible that the WHO was reluctant to declare COVID an emergency because of the risk of backlash from China. But this is not the first time the WHO has been slow to respond. During the 2014 Ebola outbreak, the WHO was even slower to act. The Director-General did not convene the emergency committee until five months after Guinea and Liberia had notified the WHO of a potential public health emergency. A reformed IHR should create a standing emergency committee that meets regularly—without needing authorization from the Director-General, who may be subject to particular political pressure as the most visible WHO official—to review emerging disease threats. The committee should have the authority to declare health emergencies on its own initiative. And the appointments process should be structured so as to insulate the committee from pressure from major WHO members.

The WHO, moreover, needs more regular mandatory funding so that it is not dependent on voluntary contributions, which currently makes it difficult for the organization to act quickly and autonomously. The underfunding of the WHO is a long-recognized problem. According to the WHO Constitution, the organization should be primarily financed through regularly assessed contributions on member States in proportion to their wealth and population. These contributions are known as “regular budget funds” (RBFs). Yet RBFs do not come anywhere close to covering the WHO’s operating budget, especially during a pandemic, leaving it dependent on voluntary contributions to make up the shortfall. This may have compromised the WHO’s independence. In the early days of the pandemic, the WHO praised China’s response while concealing concessions it had made to the country, likely for fear of alienating Beijing. Although China is not currently a major source of WHO funds, it is a major diplomatic power, and the WHO may well hope that making nice with China will encourage the country to dramatically increase its voluntary contribu-

tions in the future. President Donald Trump blamed China for the pandemic and the WHO for what he suggested was its lackluster response—citing the relationship between the two as one reason for pulling the United States out of the organization (a decision President Joe Biden has since reversed). Greater regular mandatory funding would help eliminate both the perception and reality of any such clientelism.

The COVID-19 crisis also demonstrates that the IHR prohibition on excess travel restrictions may be untenable and even counterproductive. During the COVID-19 crisis, early travel restrictions likely helped reduce the spread of the virus. Indeed, “by the time WHO acknowledged, in late February [2020], that restrictions on travel might have some limited value, the window of opportunity to prevent a pandemic had long been closed.” This experience has fed growing skepticism of the recommendation against travel restrictions: One of the preliminary findings of the “Review Committee on the Functioning of the IHR During the COVID-19 Response,” reported in November 2020, was that “[t]he role of WHO in relation to travel recommendations as well as incentives for States Parties to comply with their obligations related to travel measures need to be further examined.”

Changing the IHR will be difficult. Any changes will require approval from the World Health Assembly, followed by a period during which any member State can opt out of the rules. Although some reforms, such as a more fine-grained alert system, may be largely uncontroversial, opening up the text would kick off a likely years-long negotiating process. Further, once the rules were up for debate, States might take the reforms in unexpected directions. The last time the WHO renegotiated the IHR, after the 2002 SARS outbreak, the process took two years. It took five years for WHO members to finalize the 2011 Pandemic Influenza Preparedness (PIP) Framework. Some proposed reforms, such as giving the WHO greater powers to investigate outbreaks, declare emergencies in the absence of a notification from a member state, and require greater mandatory contributions may be non-starters. Many States are reluctant to agree to hand over such powers to an international body. The next Section offers an idea for helping to overcome this predictable opposition. Even in the absence of

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478. Id. at 289.
fundamental reform to the IHR, however, States and the WHO can improve pandemic detection and preparedness within the current system.

2. National and Global Disease Surveillance

As COVID-19 has shown, speed is paramount in responding to a disease outbreak—and to responding to new variants of an existing pathogen. Rapid responses require accurate real-time information. To that end, one of the WHO’s most important jobs is coordinating disease surveillance systems around the world. The IHR require countries to create and maintain public health monitoring systems that can detect outbreaks quickly. The WHO helps coordinate those efforts and lends technical assistance to countries attempting to build up their monitoring capacities, but there is more that it could do to ensure that the world catches outbreaks early. It should regularly update its interpretations of the IHR requirements to track improving public health standards and continue its work to integrate national systems into a global surveillance network. These steps would allow better global disease monitoring without requiring changes to the IHR.

One potential reform is to create a body to regularly review the implementation and interpretation of the IHR, a step proposed by the Council on Foreign Relations’ 2020 pandemic preparedness task force.479 A group of public health experts would provide the WHO and member States with interpretive guidance on the IHR, allowing the implementation of the IHR’s provisions to track technological progress and current state-of-the-art public health knowledge. Guidance could cover such topics as the latest technical standards for emerging pathogen monitoring systems and what kinds of data—perhaps including genome sequences, pathogen samples, and anonymized patient-level information—States should provide the WHO alongside notifications of emerging outbreaks and new variants.480

States also need new incentives and assistance to comply with the existing IHR requirements for disease surveillance. After the West African Ebola outbreak that began in 2013, experts called for greater efforts to ensure that States complied with the IHR’s requirements for state capacity to detect and respond to disease outbreaks.481 But little was done, and by 2018 still fewer than half of countries were in compliance.482 COVID-19 is an even bigger wakeup call. The delay in reporting the initial outbreak was partly the result of political failures within China, but stronger disease monitoring systems might have made it far more difficult for officials in Wuhan to slow-walk the release of information. A renewed focus by the

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480. See id. at 91.
482. Kandel et al., supra note 462, at 1047.
WHO and member States on boosting national surveillance systems would not require renegotiating the IHR and could be led by a group of the body’s major funders, including the United States.

A further necessary step will be to integrate national surveillance systems into a global disease monitoring network. The WHO already operates the Global Influenza Surveillance and Response System, which uses national influenza centers to monitor trends in influenza around the world. Replicating that system for emerging pathogens would allow the WHO to respond to potential health crises much as it currently does to yearly flu outbreaks. Some initiatives for global emerging pathogen monitoring are already underway. This past summer, a consortium of academic research centers and public health agencies launched Sentinel, a new viral surveillance system based on novel diagnostic tools that can detect hundreds of known and emerging viruses. The system is being deployed in West and Central Africa, but its backers, including the African Center of Excellence for Genomics of Infectious Diseases and Harvard and MIT’s Broad Institute, plan to expand it to other regions. In October, the Africa Centres for Disease Control and Prevention, with funding from the Gates Foundation and the U.S. CDC, among others, launched a program to use cutting-edge genomic sequencing tools to track emerging diseases across the continent. The WHO should build on these efforts, and member States should fund the development and deployment of such systems while providing the WHO with the resources to monitor and maintain them. These steps, like heightened national surveillance efforts, can take place within the existing IHR framework.

C. Develop Proactive Outcasting Tools

The recommendations for reforms to the IHR and national and global disease surveillance are all important steps. But many of these reforms are not new proposals. Some of the most obvious reforms—such as permitting more robust surveillance procedures—have been on the table for decades but resisted by States wary of setting off alarm bells only to find their goods and people barred from entering foreign countries. At the same time, the COVID-19 crisis has reminded us of a longstanding reality: National governments require a broad range of materials and capacity to respond to public health emergencies. Here, we propose creating a treaty

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regime that harnesses these twin realities to encourage States to participate in more effective, and more onerous, regulatory systems in exchange for privileged access to global assistance both prior to and during public health emergencies. This subsection explains the theory behind this approach and then explores possible structural reforms that could create incentives that would more effectively ensure States and global institutions are capable of preventing, containing, and responding to public health emergencies.


International law mechanisms like the WHO’s International Health Regulations face a variety of challenges to effective enforcement. International treaty law is entirely voluntary—no State, for example, is required to be a party to the WHO and its regulations. Therefore, when designing international legal institutions and rules, it is essential to design rules that States are willing to accept. But that creates a significant puzzle: How is it possible to design rules that are effective at changing state behavior (and thus costly to States) that significant numbers of States are willing to accept? This is the fundamental challenge that faces not just international health law but international law as a whole.

There are a number of answers that international law has provided to this question. One too-common answer is to design weak rules and institutions that can gain broad-based support but require little real action from States. As a result, they can be largely ineffective, though they might form the foundation for more stringent and effective measures in the future or offer an organizing tool for domestic reform efforts. International legal institutions are more effective, however, if they utilize a technique one of us has called “outcasting.” Outcasting involves denying the disobedient the benefits of social cooperation and membership. Put simply, the international legal institution creates some benefit to which States want access. That benefit is worth enough to them that they are willing to bear the attendant costs of membership.

A classic example is the World Trade Organization (WTO). Despite

486. To be clear, global institutions must still help countries not in compliance with the IHR grapple with disease outbreaks when they arise. However, facilitating and accelerating access for critical resources to those countries that are compliant and whose policies help prevent disease emergence and spread in the first instance may be a powerful tool for incentivizing national-level buy-in for critical policies.


488. This can be said, for example, of some human rights treaties. See, e.g., Oona A. Hathaway, Do Human Rights Treaties Make a Difference?, 111 Yale L.J. 1935, 2020 (2002).

recent challenges, the WTO is regarded as one of the most effective international legal institutions in the modern era. It requires States to do something costly: admit goods of all other members into the country under mandatory “most favored nation” rules, which provide for lower negotiated tariffs and other trade barriers. Their willingness to do so is monitored, moreover, by a mandatory dispute settlement system with the power to impose penalties. Why are States willing to do this? Because they get the same access to every other member state, enforced by the same dispute settlement process. The system is enforced, moreover, by “outcasting penalties”—in short, States that are found to have broken the rules and refuse to change their behavior to comply are subject to “countermeasures” from the harmed States. Countermeasures are effectively measures that deny wrongdoers the full benefits to which they would usually be entitled as members—state parties that are found to have been harmed by the rule violations of a member will be authorized to break the rules in return, say by raising tariffs on goods coming from the wrongdoing state.

Not every area of international law, however, is as naturally amenable to outcasting tools as trade. Human rights law, environmental law, and international health law face a shared challenge: These are areas where costs of compliance can be high and the benefits of a successful system are, generally speaking, widely distributed. This incentivizes free riding and makes States reluctant to join treaties that impose significant costs. It also makes it extremely difficult to design effective enforcement structures. If the price of membership is too high, no State will participate. The response has often been to design modest rules that States are willing to accept but that are often ineffective at achieving their expressed aims.

There have been creative efforts to find ways around this problem. One example can be found in the Montreal Protocol on Substances That Deplete the Ozone Layer. The designers of the Protocol faced the same problem many environmental treaties face: Solving the problem requires States to take costly steps (eliminate the use of widespread chemicals that deplete the ozone layer within their territory) and produces only dispersed benefits (reducing the thinning of the ozone layer of Earth’s atmosphere). The solution the designers of the Protocol hit on was to create a club good. Parties to the Protocol were required to ban trade in certain designated substances with nonparty States. This created a tangible benefit to membership: access to the trading system. That benefit grew as more States joined the club. The Protocol thus also generated a tool for disciplining States that broke the rules: Their trading rights could be suspended until

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they came back into compliance.\footnote{See Hathaway & Shapiro, supra note 433, at 321–22; see also Oona A. Hathaway \& Scott J. Shapiro, The Internationals 321–22, 371–95 (2017).}

The WHO’s IHR have been hobbled by similar challenges. The benefits of pandemic surveillance are spread globally. But the costs are localized. For example, States that are identified as potential sources of an outbreak may be closed off from international trade and travel as a result. This helps explain why the IHR have been less stringent than might be optimal for pandemic response. It also helps explain the otherwise puzzling regulation that prohibits States from putting in place more stringent travel restrictions than recommended by the WHO. That was an effort to reduce the fear that participation in the surveillance regime could lead to costly travel restrictions. It also helps explain why the WHO’s independent surveillance and investigation powers are limited and regular budget funds inadequate.

More effective institutional design could deploy outcasting tools to enable more effective international health regulations that enjoy better compliance. The next subsection explores three proposals for doing just this.

2. Outcasting Solutions

There are several ways in which the outcasting technique could be used to encourage states to contribute to global collaboration to anticipate, prepare for, and respond to emerging pandemics. The essential insight here is similar to the insight that informed the response to the thinning ozone layer: To overcome States’ reluctance to contribute to solving a collective action problem, create club goods and then condition access to those goods on compliance with the rules of the system. The goal is not to take away from States anything they already have; it is to better align their altruistic impulses and private incentives. States contribute to solving the shared problem of pandemics and, in return, they receive direct access to the benefits they have helped create. There are at least three areas in which this technique could be used: access to vaccines, access to technical expertise, and access to funding for pandemic preparedness.

a. Access to Vaccines

Although companies and governments have already developed a diverse array of COVID-19 vaccines, the international community still has a long way to go in ensuring equitable access. The WHO has set an ambitious target of vaccinating 70% of the global population by the end of 2022.\footnote{Press Release, World Health Org. [WHO], WHO, U.N.Set Out Steps to Meet World COVID Vaccination Targets (Oct. 7, 2021), https://www.who.int/news/item/07-10-2021-who-un-set-out-steps-to-meet-world-covid-vaccination-targets [https://perma.cc/LLG9-5T5M].} Mechanisms providing significant benefits to States combatting COVID-19 are already in place. The Access to COVID-19 Tools (ACT) Accelerator was established in April 2020 specifically to promote the devel-
opment and equitable distribution of tests, treatments, and vaccines for the current emergency.\textsuperscript{494} ACT has an impressive track record: It has procured more than 32 million PCR (polymerase chain reaction) tests and 32 million rapid antigen tests for low- and middle-income countries (LMICs), the creation of a stockpile of dexamethasone for emergency use in severe cases of COVID-19, the procurement of $500 million worth of PPE for LMICs, and the development of 120 million rapid response tests for LMICs.\textsuperscript{495} One pillar of the ACT Accelerator, COVAX, focuses exclusively on the development and fair global distribution of COVID-19 vaccines. States participating in COVAX have access to a diverse selection of COVID-19 vaccines regardless of the States’ wealth or ability to make bilateral deals with vaccine manufacturers. Self-financing participating States are guaranteed doses proportionate to their level of contribution, while funded States will ultimately receive doses sufficient for vaccinating up to 20 percent of their populations.\textsuperscript{496} Other global health funding mechanisms go beyond COVID-19. The private Coalition for Epidemic Preparedness Innovations (CEPI), for example, is a standing organization funding research into vaccines for emerging diseases (and is also currently supporting the ACT Accelerator framework and COVAX).\textsuperscript{497}

To encourage compliance with the IHR, these kinds of mechanisms and certain benefits they offer could be made into long term club goods, available to States contingent on their adherence to the IHR. To foster continued compliance even after the COVID-19 crises dissipates, the existing institutions of the ACT Accelerator (including COVAX) and CEPI should be expanded in scope and duration. Specifically, compliant countries could have access to a standing multilateral mechanism that facilitates production and distribution of vaccines, diagnostics, and therapeutics for emerging and yet-to-emerge infectious diseases. Although CEPI operates on a permanent basis, it is only focused on vaccine production and does not address distribution logistics for future vaccines or the development and manufacturing of components of diagnostics and therapeutics for emerging diseases. As WHO Health Emergencies Programme Executive Director Dr. Michael Ryan has noted, breakdowns in the supply chain and logistics systems for critical products plagued the COVID-19 response, and a comprehensive solution addressing manufacturing, raw materials, distribution, and competition between States is needed to prepare for future global health emergencies.\textsuperscript{498}


\textsuperscript{496} COVAX, supra note 452.


\textsuperscript{498} Nurith Aizenman, ‘Everything Broke’: Global Health Leaders on What Went Wrong in the Pandemic, NAT’L PUB. RADIO (Jan. 25, 2021), https://www.npr.org/sections/goat-
deliveries of vaccines earlier than other States. Similarly, States that are self-financing their production but are participating in the permanent mechanism would also operate within a two-tiered system for vaccine allocation. The tiers could be adjusted to ensure self-financing States still have incentives to participate in the permanent mechanism and that humanitarian concerns do not impede rapid delivery of some portion of total allocations to countries regardless of their compliance with the IHR, when necessary. Alternatively, the WHO and other global institutions could aim to induce private manufacturers of future vaccines to offer doses at slightly reduced prices to those countries that are deemed to be IHR compliant.

Such a standing organization could also be a strong and consistent advocate for the lifting of trade and intellectual property barriers that impede the dissemination of essential health resources. Export controls on medicines and supplies, as well as inflexible protection of intellectual property rights, can inhibit global health cooperation. This has been the case during the current crisis: Once COVID-19 began to spread in China, for instance, the “government not only restricted its PPE exports, it also purchased a substantial portion of the global supply,” disrupting the global supply chain. India similarly paused exports of nationally produced vaccines as infections surged over the course of 2021. National governments’ restrictions on the export of items necessary for preventing or responding to health emergencies can raise costs and limit availability. This danger has become more acute as wealthy nations administer booster doses that divert supplies while priority groups in other countries have yet to access a primary vaccination series. While advocates for vaccine equity have condemned such restrictions and diversions, steady pressure by an organization specifically dedicated to producing and distributing crisis-responsive materials could more effectively diminish barriers.

b. Access to Technical Expertise

To respond to public health emergencies, national governments require both a robust frontline healthcare workforce (including doctors, nurses, public health specialists, and epidemiologists) and qualified ministerial coordinators who can direct dissemination of resources, issue public guidance, and ensure coordination between subnational and nongovern-

502. See Burwell et al., supra note 479.
The WHO should work to ensure all nations, especially developing countries, have the human capital necessary to respond to health emergencies. There is growing recognition of this need: Looking back on the COVID-19 response, the WHO’s Michael Ryan has advocated for a larger health emergency workforce that can be swiftly deployed to countries hit by public health emergencies.507

Eligibility for benefits supporting healthcare and epidemiology personnel in individual countries might be conditioned on their governments’ compliance with the IHR in order to further incentivize the coordination and transparency necessary to prevent public health crises. In short, States that agree to abide by IHR rules (and any reforms to them), gain access to global healthcare expertise organized through the WHO, which will be funded through mandatory contributions of member States.

Decentralized efforts to train frontline healthcare workforces in poorer nations are already ongoing in a decentralized fashion, separate from a strategic global effort. For example, field epidemiology training programs are organized through global networks, the largest of which is TEPHINET (reaching more than 100 countries and comprising 75 of these training programs).508 While the WHO does have some influence in these networks, it has little authority over these independent initiatives. There may be value in centralizing the deployment of such staff under the auspices of a formal, unified global health reserve workforce, overseen by the WHO. The establishment of such a roster was a clear recommendation of the 2011 IHR Review Committee.509 Alternatively, the WHO’s added value may instead lie in facilitating the sharing of expertise among national governments. The WHO might, for example, arrange for high-ranking public officials from governments with a track record of success in public health responses to be temporarily seconded to governments lacking such expertise, both prior to and during public health emergencies.

Similarly, the WHO might push for amendments to the 2010 Global Code of Practice on the International Recruitment of Health Personnel to reinforce the retention of health personnel in low-capacity countries.510 There is evidence that the recruitment of healthcare workers from low- and middle-income countries by the developed world is one factor—along with governance gaps, poor educational systems, and inadequate resources—that can hamper nations’ development of strong health care systems.511

507. Aizenman, supra note 498.
parallel with strengthening codified guardrails against detrimental medical staff migration, the WHO might partner with the World Bank to establish a grant program enabling national governments of low-capacity States to provide financial incentives for health personnel to remain in their home countries.

c. Access to Funding

The ability of individual States to access certain funding mechanisms for public health emergency responses could also be conditioned on IHR compliance. One of the perennial problems faced by the WHO has been inadequate guaranteed funding. States that agree to increase their mandatory contribution levels and comply with enhanced IHR obligations should be granted greater access to funds that can assist them in preparing for, detecting, and responding to a pandemic. Conditioning funding does not require reducing access to existing funding. The system can be structured to limit access to enhanced funding by those that refuse to accept enhanced obligations. Private actors, moreover, could strengthen the incentives by contributing funds as well.

Limiting or delaying noncompliant States’ access to specific facilities may be appropriately conducive to motivating their compliance with the IHR. One such facility for which gate-keeping may be appropriate is the World Bank’s Pandemic Emergency Financing Facility, which supplements financing for low-income countries’ responses to significant cross-border disease outbreaks, in some cases by providing funding directly to governments. While it is important to not punish low-income countries by limiting the application of financial incentives to governments with the most minimal capacity, making it clear prior to public health emergencies that eligible States may be denied or delayed funds from this and other facilities could be a powerful means of promoting compliance with the IHR. A politically feasible approach might be to condition funding for noncompliant States on either demonstrated progress—rather than full compliance—or measurable assurances that they will adhere to the IHR going forward. Agreeing to collaborate with the WHO to conduct a Joint External Evaluation could be one form of assurance. Finally, and regardless of whether these conditions on assistance are in place, funds should be made available to those States that report disease outbreaks early and subsequently suffer economic harm from other States’ travel and trade restrictions. To the extent possible, States should be given incentives to take steps that help protect the entire global community.

Such an incentive structure would have to be carefully crafted. Funds from some mechanisms must remain available to all States, regardless of their internal policy decisions, based on human rights principles. For

example, in the current context, it would be inappropriate to foreclose States from humanitarian assistance funded through the U.N. Global Humanitarian Response Plan for COVID-19. Further, blocking access to some funding facilities could undermine urgent action that can help prevent an infectious disease outbreak from spreading transnationally. One example is the WHO’s Contingency Fund for Emergencies, which “provides funding during the critical gap between the moment the need for an emergency response is identified and the point at which funds from other mechanisms can be released.”

In order to ensure that funds are available for distribution in the first instance, rather than relying on annual contributions to respond to crises, the WHO should establish a permanent emergency fund rather than rely on annual contributions to respond to crises, so that it does not have to fundraise in the middle of future public health emergencies. Further, as the Council on Foreign Relations’ COVID-19 Task Force has suggested, international institutions might look toward nontraditional sources of financing for pandemic response, such as user fees on international economic activity like international travel or financial transactions, to fill funding gaps and create a larger emergency fund that could be distributed to States that participate in effective pandemic preparedness and response.

Conclusion

COVID-19 has exposed longstanding weaknesses in global health institutions. Despite decades of warnings, governments of all levels of capacity have struggled to contain the virus. Millions of people have died and millions more have been infected. While there have been hopeful developments at the global level, such as the establishment of COVAX, the global community has not done enough to effectively respond to the crisis. Moreover, COVID-19 has exacerbated skepticism toward, and neglect of, fundamental principles of international law. States have disregarded or rejected their duties across a number of bodies of law in responding to the pandemic. Balancing commitments to international law against public health is difficult in normal times; during a devastating pandemic, it is even more daunting, when principles such as the right to health may be in tension with other legal obligations, such as protections for refugees or for civil and political rights.

There is an urgent need for creative thinking to encourage and enforce compliance with international law and global health regulations not only


516. Burwell et al., supra note 479, at 81.
during but also ahead of public health emergencies. When the COVID-19 pandemic passes, the impulse may be to move on and put the terrible events behind us. But that would be a mistake. This pandemic has demonstrated that waiting until a crisis hits is a recipe for disaster. Pandemics are a predictable fact of modern life. Though the current crisis is the most severe in a century, it is the third deadly pandemic in a decade-and-a-half. The global community cannot afford to simply wait for the next pandemic to hit but must plan now for the reality that it will come—though we don’t know when. By taking proactive steps to address both health and non-health challenges that have emerged in the current crisis, the global community can reduce the chance that the next pandemic will be as devastating.