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The World Health Organization, International Health Regulations and Human Rights Law

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Abstract

This article examines the influence of human rights law on infectious disease control through the World Health Organization (WHO) *International Health Regulations* (*'IHR'*). The WHO's evolving work to mainstream human rights in global health governance strongly influenced the 2005 revision of the IHR, framing a new balance between health and human rights in public health emergencies. The 2005 IHR make respect for human rights a central principle and integrate human rights standards in explicit and implicit ways. Yet these reforms also fail to reflect economic, social and cultural rights, inadequately connect to the UN human rights system, and leave unresolved significant legal issues with major impacts on human rights. These weaknesses have been exposed by the COVID-19 pandemic, as national pandemic responses have tested WHO's authority under the IHR and disproportionately and unjustifiably restricted a range of human rights. Resolving these gaps will require both normative and institutional reforms that bring together human rights and global health governance, including through broader rights-based partnerships amongst international organizations.

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Keywords

human rights – international law – global health governance – IHR – Siracusa Principles – right to health – economic, social and cultural rights

Introduction

Human rights are essential to providing a public health response to the international spread of disease. Human rights frame legal and institutional responses to infectious disease and provide a path to ensure that public health actions are commensurate with public health risks and avoid unnecessary limitations on individual rights. As the preeminent global health institution, the World Health Organization (WHO) is essential to advancing human rights through the *International Health Regulations* ('IHR'), the principal legal framework governing infectious disease control. The evolution of human rights within WHO governance strongly influenced the 2005 revision of the IHR, which adopted human rights in an unprecedented way, integrating numerous provisions that explicitly and implicitly mirror human rights norms and criteria to govern IHR implementation. Despite these historic reforms, the revised IHR neglect economic, social and cultural rights (especially the right to health), inadequately connect to the UN human rights system, and leave unresolved significant legal issues with major impacts on human rights. These weaknesses have been exposed by the COVID-19 pandemic, as national pandemic responses have tested WHO's authority under the IHR, unjustifiably restricted human rights and illuminated the inadequacies of the IHR in key respects. As states move to reform global health law to address these weaknesses (including through IHR revisions and a new *Pandemic Treaty*), it will be crucial to strengthen both global health law and human rights law in ways that enable more effective responses to infectious disease outbreaks.

This context is the foundation for this article's examination of the strengths and limitations of the IHR in realizing human rights in infectious disease control. Part I reviews the development of human rights law through global health governance, and how the codification of health-related human rights through the UN system influenced evolving WHO efforts to recognize human rights promotion, with WHO seeking to mainstream human rights in global health in the years leading up to the 2005 revision of the IHR. Part II examines the extent to which human rights are addressed in IHR (2005), reflecting contestation and negotiation in the IHR drafting process over the WHO's authority to support states in balancing public health and human rights under global health law.

Part III considers how gaps in these legal and organizational responsibilities have limited human rights safeguards in the COVID-19 response and enabled health and human rights violations. Part IV analyzes the institutional and normative avenues necessary to better align global health law with human rights law in the context of public health emergencies. We conclude that it will be necessary in future global health law reforms regarding public health emergencies to bolster the integration of human rights standards and to build broader rights-based partnerships amongst international organizations to implement human rights in global health.

1 Human Rights Foundations of Global Health Governance

Human rights offer a basis for justice under international law and a crucial normative foundation of global health governance, offering universal legal standards by which to frame responsibilities and facilitate accountability.[1] WHO remains the central institution in the global health governance landscape, with responsibilities to direct and coordinate international action to prevent disease and promote health.[2] Bearing constitutional authority to advance the human right to health, WHO governance increasingly looked to human rights in the decades leading up to the 2005 revision of the IHR.

1.1 *The Evolution of the Right to Health within the UN and the WHO*

The 1945 *Charter of the United Nations* elevated human rights as the normative basis of the post-war international system,[3] with the 1946 *Constitution of the World Health Organization* providing the first international legal conceptualization of a unique human right to health.[4] Establishing an expansive mandate for WHO governance to direct international cooperation for public health, the WHO Constitution declared that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being" and defined health expansively to include "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."[5] The

1 Lawrence O. Gostin and Benjamin Mason Meier, *Foundations of Global Health & Human Rights* (Oxford University Press, Oxford, 2020).

2 Paul Hunt, 'Configuring the UN Human Rights System in the 'Era of Implementation': Mainland and Archipelago' (2017) 39:3 *Human Rights Quarterly* pp. 489–538.

3 *Charter of the United Nations* (San Francisco, 26 June 1945, 3 Bevans 1153, 59 Stat. 1031, T.S. No. 993), art 62.

4 Frank P Grad, 'The Preamble of the Constitution of the World Health Organization' (2002) *Bulletin of the World Health Organization* p. 80.

5 *Constitution of the World Health Organization* (New York, 22 July 1946, 14 U.N.T.S. 185).

WHO Constitution was thus seen to "represent the broadest and most liberal concept of international responsibility for health ever officially promulgated", encompassing international aspirations to heal a world torn apart by war.[6]

The UN General Assembly thereafter proclaimed the 1948 *Universal Declaration of Human Rights* (*'UDHR'*) as "a common standard of achievement for all peoples and all nations", framing within it a set of interrelated civil and political rights and economic, social and cultural rights.[7] Health is recognized in Article 25 as part of everyone's right to a standard of living adequate for health and well-being that includes food, clothing, housing, medical care and necessary social services.[8] This expansive vision of health saw the fulfillment of necessary medical care and underlying determinants of health as a basis for public health systems, with states separately recognizing the need to limit certain rights to protect the general welfare.[9]

Despite the promise that the WHO and UDHR would complement each other, the WHO abandoned its early support for advancing human rights in the 1950s and 1960s. Caught between the Cold War superpowers and their conflicting interpretations of human rights, the WHO Secretariat missed several critical opportunities to advance human rights in public health. First, the WHO did not contest the limited codification of a right to health in the 1966 *International Covenant on Economic, Social and Cultural Rights* ('*ICESCR*'), nor offer observations on early drafts of the ICESCR.[10] Second, the WHO failed to address the relationship between civil and political rights and public health in the development of the 1966 *International Covenant on Civil and Political Rights* (*'ICCPR'*), instead positioning itself as a technical organization whose authority did not extend to human rights.[11] Finally, the World Health Assembly (WHA) failed to address human rights in both the 1951 *International Sanitary Regulations* and 1969 IHR, neglecting human rights protections in the international framework for infectious disease control.[12]

6 Charles Allen, 'World Health and World Politics' (1950) 4 *International Organization* p. 30.

7 United Nations General Assembly (*'UNGA'*), *Universal Declaration of Human Rights* (Res. 217 A (III), preamble, 10 December 1948).

8 UNGA, *supra* note 7, article 25.

9 UNGA, *supra* note 7, article 29.

10 Benjamin Mason Meier, 'Global Health Governance and the Contentious Politics of Human Rights: Mainstreaming the Right to Health for Public Health Advancement' (2010) 46:1 *Stanford Journal of International Law* p. 1.

11 Benjamin Mason Meier and Florian Kastler, 'Development of Human Rights through WHO' in Benjamin M. Meier and Lawrence O. Gostin (eds), *Human Rights in Global Health: Rights Based Governance for a Globalizing World* (Oxford University Press, New York, 2018).

12 *1969 International Health Regulations*. <www.who.int/csr/ihr/ihr1969.pdf>, 7 July 2020.

1.2 *Reconsidering the Balance between Human Rights and Public Health*

However, with WHO noting as early as 1968 that "people are beginning to ask for health, and to regard it as a right", the Organization soon began to engage with international human rights norms and principles as a means to realize improved health systems.[13] WHO drew on human rights under the ICESCR to advance multi-sectoral efforts to address a range of social, economic and political determinants of health.[14] In addressing these determinants of health through "primary health care",[15] there was growing agreement that WHO had the constitutional authority to elaborate state public health obligations to implement the right to health.[16] WHO sought to codify international consensus on the multi-sectoral policies needed to realise the right to health through the 1978 *Declaration on Primary Health Care* (which has come to be known as the *Declaration of Alma-Ata*).[17] The *Declaration of Alma-Ata*, reaffirming the broad definition of the right to health in the WHO Constitution, provided WHO with a renewed foundation for human rights to advance public health, even as this instrument lacked the international legal obligations necessary to uphold primary health care in the face of neoliberal economic constraints.[18]

Focusing on restrictions of civil and political rights to protect public health, with states recognizing in the ICCPR that public health may be invoked as a basis for limiting certain rights, scholars developed the Siracusa Principles in 1984 to clarify that such limitations should occur only in narrowly defined circumstances. In limiting rights in the context of public health, the Siracusa Principles conclude that:

> Public health may be invoked as a ground for limiting certain rights in order to allow a state to take measures dealing with a serious threat to the health of the population or individual members of the population.

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13 WHO, *The Second Ten Years of the World Health Organization* (World Health Organization, Geneva, 1968) p. ix.

14 Benjamin Mason Meier, 'Making Health a Human Right: The World Health Organization and the United Nations Programme on Human Rights and Scientific and Technological Developments' (2013) *The Journal of the Historical Society* pp 218–219; Halfdan Mahler, 'The Meaning of 'Health for All by the Year 2000'' (2016) *American Journal of Public Health*.

15 Henriette Roscam Abbing, *International Organizations in Europe and the Right to Health Care* (Kluwer, Amsterdam, 1979).

16 Claude-Henri Vignes, 'Droit à la santé et coordination' in René-Jean Dupuy (ed), T*he Right to Health as a Human Right: Workshop The Hague, 27–29 July 1978* (Sijthoff and Noordhoff, Leiden, 1979) p. 304.

17 WHO, *Primary Health Care: Report of the International Conference of Primary Health Care,* (Alma-Ata, USSR, 6–12 September 1978).

18 Meier, *supra* note 10.

> These measures must be specifically aimed at preventing disease or injury or providing care for the sick and injured. Due regard shall be had to the international health regulations of the World Health Organization.[19]

The Siracusa Principles recognized that such human rights infringements should be undertaken only when (a) responding to a pressing public need (such as protecting public health), (b) necessary and proportionate to a legitimate aim, (c) prescribed by law and not imposed arbitrarily, and (d) applied as a last resort using the least restrictive means available. Calling for due regard to the IHR when restricting civil and political rights to protect public health, the Siracusa Principles would be applied to assess restrictive measures put in place by governments in response to public health emergencies.[20] Where the IHR had been chiefly concerned with infectious disease surveillance, supported by the Declaration of Alma-Ata in framing health systems, the Siracusa Principles compelled consideration of human rights limitations amid emerging disease threats.

1.3 *HIV/AIDS and UN Mainstreaming Efforts Bolster Human Rights in WHO*

The unfolding HIV/AIDS response would give rise to the modern "health and human rights" movement, making clear the inextricable linkages between individual rights protections and public health outcomes as WHO came to view the rights-based approach to health as instrumental to advancing public health.[21] Although human rights law had recognized that limitations of individual rights are permissible—even necessary—to protect the public's health, WHO found respect for individual rights to be a precondition for public health promotion in the context of HIV prevention and control.[22] With governments restricting the rights of affected populations—through compulsory testing, named reporting, travel restrictions, and coercive isolation or quarantine—these violations of civil and political rights had undermined efforts to engage with marginalized populations.[23] WHO's 1987 *Global Strategy for the*

19 UN Commission on Human Rights, *The Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights* (UN Doc E/CN.4/1985/4, 1984), paras. 25–26.

20 Diego S. Silva and Maxwell J. Smith, 'Limiting Rights and Freedoms in the Context of Ebola and Other Public Health Emergencies: How the Principle of Reciprocity Can Enrich the Application of the Siracusa Principles' (2015) 17 *Health and Human Rights Journal*.

21 Meier and Kastler, *supra* note 11.

22 Jonathan Mann and Manuel Carballo, 'Social, Cultural and Political Aspects: Overview' (1989) 3: 221–223 *AIDS*.

23 Ronald Bayer, 'Public Health Policy and the AIDS Epidemic—An End to HIV Exceptionalism?' (1991) 324 *New England Journal of Medicine* pp. 1500–1504.

Prevention and Control of AIDS advanced new rights-based principles to prevent HIV, focusing on principles of non-discrimination and equitable access to care and stressing the need for public health programs to respect and protect civil and political rights as a means to achieve the individual behavior change necessary to reduce HIV transmission.[24]

The rights-based approach to health would expand beyond the HIV/AIDS response, with human rights becoming a foundation of WHO efforts to advance health in a rapidly globalizing world. Through the application of a range of health-related human rights to an array of health threats, WHO considered a more systematic application of civil, cultural, economic, political, and social rights in global health governance. As human rights advanced with the end of the Cold War, a political space for human rights opened in the 1990's, with the UN looking to human rights as a basis for global governance. The 1993 *Vienna Declaration* sought to end the Cold War division between civil and political rights and economic, social and cultural rights, declaring that all human rights are "universal, indivisible and interdependent and interrelated". This holistic vision of rights was extended to international organizations, with the Vienna Declaration urging "all United Nations organs, bodies and the specialized agencies whose activities deal with human rights to cooperate in order to strengthen, rationalize and streamline their activities."[25]

This led to the 1997 call by the UN Secretary-General for all UN programs, funds and specialized agencies to "mainstream" human rights across their global governance efforts.[26] WHO responded by seeking to implement human rights principles in its global health programming and promote a rights-based approach to infectious disease prevention.[27] WHO enlisted its first human rights advisor in 1999,[28] developed human rights consultations with its staff[29]

24 WHO, *Global Strategy for the Prevention and Control of AIDS* (*1987*).

25 *Vienna Declaration and Programme of Action* (World Conference on Human Rights, 1993) para. 1.

26 UN Secretary-General, *Renewing the United Nations: A Programme for Reform* (1997) (UN doc.A/51/950).

27 Benjamin Mason Meier and William Onzivu, 'The Evolution of Human Rights in World Health Organization Policy and the Future of Human Rights Through Global Health Governance' (2014) 128 *Public Health* p. 179.

28 Daniel Tarantola, 'Building on the synergy between health and human rights: a global perspective' (2000) *François-Xavier Bagnoud Center for Health and Human Rights*, Working Paper 8.

29 Helena Nygren-Krug, 'The right to health: from concept to practice' in Lawrence O. Gostin, Stephen P. Marks, and Jose M. Zuniga (eds) *Advancing the Human Right to Health* (Oxford University Press, New York, 2013) p. 39.

and guidance to increase understanding of human rights,[30] created a Health and Human Rights Team inside the WHO Secretariat and ensured inter-agency collaborations to advance public health through international human rights law.[31]

1.4 *UN Committee on Economic, Social and Cultural Rights (CESCR) General Comment 14 (2000)*

This collaboration between WHO and the UN human rights system led to the adoption by CESCR in 2000 of General Comment 14, which provided an authoritative interpretation of the right to health under the ICESCR.[32] The CESCR sought to strike a new balance between human rights and public heath, recognizing that limitations of rights are "primarily intended to protect the rights of individuals rather than to permit the imposition of limitations by States."[33] General Comment 14 thus gave deference to human rights protections, placing the burden on states to justify that any public health restrictions on rights are "in accordance with the law, including international human rights standards, compatible with the nature of the rights protected by the Covenant [ICESCR], in the interest of legitimate aims pursued, and strictly necessary for the promotion of the general welfare in a democratic society."[34]

General Comment 14 looked to states to address underlying health determinants as a means to realize the right to health—including preventative health services and infectious disease control. However, while the CESCR acknowledged a correlation between the promotion of public health and the realization of the right to health, General Comment 14 concluded that any limitations of human rights to uphold public health must be proportional, time limited, and subject to review.[35] The adoption of General Comment 14 thereby reflected an evolving notion of the right to health amid modern public health crises, laying out an imperative to establish, expand, and strengthen public health systems while protecting interrelated human rights underlying health.[36] General Comment 14, alongside the comments and recommendations adopted by other treaties bodies and the reports of the newly established

30 WHO, '25 Questions and Answers on Health and Human Right' (2002) 1 *Health and Human Rights Publications Series*.

31 Helena Nygren-Krug, 'Health and human rights at the World Health Organization' (2004) 1:7 *Saúde e Direitos Humanos.*

32 CESCR, *General Comment No. 14: The Right to the Highest Attainable Standard of Health* (2000) E/C.12/2000/4.

33 CESCR, *supra* note 32, para. 28.

34 *Ibid.*

35 CESCR, *supra* note 32, para. 29.

36 Benjamin Mason Meier and Larisa M. Mori, 'The Highest Attainable Standard: Advancing a Collective Human Right to Public Health' (2005) *Columbia Human Rights Law Review*.

UN Special Rapporteur on the right to health,[37] established a human rights framework for WHO as it worked with states to implement human rights in public health through a revised IHR.

2 IHR (2005) Incorporates Human Rights Law

Growing attention to human rights at the WHO and increased use of its normative authorities provided a basis in the early 2000s to develop international health law instruments that could promote the right to health. Although the IHR had been previously revised, the 2005 revision of the IHR for the first time provided explicit protection of human rights.

2.1 *Evolving Human Rights at the WHO Extends into the IHR (2005)*

The IHR were first adopted by WHO member states as the *International Sanitary Regulations* (*'ISR'*) in 1951, the first "universal and coherent legal regime of surveillance and control of 'quarantinable diseases.'"[38] These regulations were revised and consolidated in 1969 as the IHR, which were narrow in disease scope, inadequate for state accountability, and inattentive to human rights.[39] In 1995, the WHA formally launched a WHO process to revise the IHR, with a first draft issued in 1998.[40] The revision process progressed slowly until the emergence of Severe Acute Respiratory Syndrome (*'SARS'*), a new infectious disease threat not covered by the IHR, revealed the limitations of the IHR.[41] These limitations were compounded by national responses to SARS—through isolation, quarantine, and surveillance measures—that often unjustifiably restricted individual liberties.[42]

37 Committee on the Elimination of All Forms of Discrimination Against Women, *General Recommendation No. 24: Women and Health* (1999), (A/54/38/Rev.1), chapter I; Committee on the Rights of the Child, *General Comment No. 3: HIV and the Rights of the Child* (2002), (CRC/GC/2003/3); *General Comment No. 4: Adolescent Health and Development in the Context of the Convention Rights of the Child* (2002), (CRC/GC/2003/4).

38 Stefania Negri, 'Communicable Disease Control.' in Gian Luca Burci and Brigit Toebes, *Research Handbook on Global Health Law* (Edward Elgar, Northampton, 2018) p. 269.

39 *Ibid.*

40 *Revision and Updating of the International Health Regulations* (1995) (UN Doc. WHA 48/7).

41 D.P. Fidler, 'Revision of the World Health Organization's International Health Regulations' (2004) *ASIL Insights* 8/8.

42 K.J. Monaghan, 'SARS: Down but Still a Threat,' in S. Knobler, A. Mahmoud, S. Lemon et al (eds) *Learning from SARS: Preparing for the Next Disease Outbreak: Workshop Summary* (Institute of Medicine, Washington, 2004).

The 2005 IHR reform marked a definitive shift from earlier iterations, including through its incorporation of human rights principles and considerations. This novel attention to human rights reflected the evolution at the WHO and the UN described above. It also coincided with the WHO's first use of its constitutional powers in the 2003 *Framework Convention on Tobacco Control* ('*FCTC*'),[43] through which states committed "to give priority to their right to protect public health" and explicitly recognized the right to health in multiple international treaties.[44] This context set the stage for the 2005 IHR reform to frontally address human rights.[45]

2.2 *Engaging with Human Rights throughout the IHR*

The 2005 IHR are ground-breaking in their engagement with human rights, explicitly incorporating human rights norms and criteria in numerous provisions and implicitly reflecting these standards elsewhere. While the IHR's vision of human rights excludes economic, social and cultural rights, civil and political rights are nonetheless made central, with human rights placed as the first principle of the IHR in Article 3.1, which requires that the IHR be implemented with "full respect for the dignity, human rights and fundamental freedoms of persons." This article was absent in the January 2004 Working Draft,[46] but following the first intergovernmental negotiations in November 2004, the Chair's text to be considered at the February 2005 negotiating session Article 2bis proposed "[t]he implementation of these Regulations shall be with full respect for the fundamental human rights and dignity of persons."[47] With the finalization of the IHR, this protection would be expanded under Article 3.1, which holds that implementation of the IHR "shall be with full respect for the dignity, human rights and fundamental freedoms of persons."

Article 3.1 explicitly links the IHR to international human rights law, integrating this regime into the IHR's legal framework and imposing a duty on States Parties to ensure that measures adopted under the IHR are compatible

43 Meier and Kastler, *supra* note 11, p. 120.

44 *WHO Framework Convention on Tobacco Control*, 56th World Health Assembly, Geneva, 19–34 May 2003.

45 David Fidler, 'From international sanitary conventions to global health security: The new International Health Regulations' (2005) 4:2 *Chinese Journal of International Law* pp. 325–392.

46 World Health Organization, *Working Draft of* IHR (January 2004) <www.who.int/csr/resources/publications/IGWG_IHR_WP12_03-en.pdf?ua=1>, 8 July 2020.

47 WHO, *Review and Approval of Proposed Amendments to the International Health Regulations: Proposal by the Chair* (A/IHR/IGWG/2/2, January 24, 2005).

with human rights standards.[48] This linkage with human rights is bolstered in Article 3.2, which requires IHR implementation to be guided by the UN Charter and WHO Constitution. Articles 3.1 and 3.2 underscore the WHO's responsibility to protect human rights by requiring both WHO's recommended measures and states health measures to respect human rights.[49] Yet Article 3.1's failure to delineate the scope of state and institutional obligations to respect human rights renders this more of a guideline and interpretive principle than a legal prescription.[50] This design flaw in the strongest human rights provision of the IHR raises questions about the extent to which this kind of ambiguity is deliberate and intended to undercut the legal authority of the IHR in the realm of human rights.

Beyond this foundational obligation, explicit language related to the protection of human rights appears in several other IHR articles. *First*, Article 32 on the treatment of travelers (originally titled "humane treatment of travelers") requires states, when implementing potentially invasive health measures, to "treat travelers with respect for their dignity, human rights and fundamental freedoms and minimize any discomfort or distress associated with such measures." Such treatment is specified to include treating travelers with courtesy and respect, taking into consideration their gender, sociocultural, ethnic or religious concerns, and providing, amongst other things, adequate food and water, appropriate accommodation and clothing and appropriate medical treatment for travelers subject to quarantine or other public health procedures.[51] Uniquely within IHR (2005), Article 31(c) indirectly acknowledges respecting traveler's economic, social and cultural rights, even as this connection is never made explicit in the drafting process.[52] Moreover, the focus in this provision on the rights of travelers rather than all people within a state underscores the broader design problem in the IHR, and indeed the WHO, that helps the organization pass responsibility for compliance with human rights to member states that may not want to be bound.[53] This narrow focus creates problems for wider human rights arguments for citizens, non-documented travelers and other vulnerable groups.

48 Andraz Zidar, 'WHO International Health Regulations and human rights: from allusions to inclusion' (2015) 19:4 *The International Journal of Human Rights* p. 510.

49 *Ibid.*

50 *Ibid.*

51 World Health Organization, *International Health Regulations*, Art. 32.

52 World Health Organization, *Intergovernmental Working Group on Revision of the International Health Regulations*, p. 10.

53 *See* Eyal Benvenisti, 'The WHO—Destined to fail? political cooperation and the COVID-19 pandemic' (2020) *American Journal of International Law*.

Second, Article 42 stipulates that health measures "taken pursuant to these Regulations shall be initiated and completed without delay, and applied in a transparent and non-discriminatory manner." This requirement was absent in prior debates and revisions of the IHR until introduced in the January 2004 draft, with explanatory notes for the September 2004 draft emphasizing that this article had been "retained in view of the importance of the principles it embodies for the pursuit of the purpose of the Regulations."[54] The Chair's February 2005 draft added the requirement of transparency.[55] A report by the Secretariat in response to the first intergovernmental negotiating session of the IHR expressed that State Parties are all obligated and subject to the same general requirements as laid out in this Article.[56]

Third, Article 45 requires health information collected under the IHR to be "kept confidential and processed anonymously."[57] This provision was largely absent until the January 2005 Chair's text explicitly provided that personal data "shall be kept confidential except to the extent necessary to disclose or transmit it for public health purposes or as required by national legislation."[58] Where the processing of data is essential to assessing and managing a public health threat, the coded data must be processed lawfully, relevant to the health threat, inaccuracies rectified, and not kept longer than necessary.[59] In IHR (2005), these protections were included in Article 45, with an additional protection to individual access to, and ability to correct, data.[60]

In addition to these fairly explicit references to human rights, there are several implicit references to human rights in other IHR provisions. These references extend in particular to the requirements of the *Siracusa Principles* that limitations of rights are only undertaken in response to pressing collective needs like public health, are necessary and proportionate, and are applied as a last resort using the least restrictive means available.[61] For example, Article 17 requires that WHO recommendations for public health emergencies of

54 World Health Organization, *Review and Approval of Proposed Amendments to the International Health Regulations: Explanatory Notes* (A/IHR/IGWG/4, 7 October 2004), p. 11.

55 World Health Organization, *Review and Approval of Proposed Amendments to the International Health Regulations: Proposal by the Chair* (A/IHR/IGWG/2/2, 24 January 2005).

56 World Health Organization, *Reservations to the International Health Regulations: Report by the Secretariat* (A/IHR/IGWG/2/INF.DOC./2, 27 January 2005).

57 World Health Organization, *supra* note 51, Art. 45(1).

58 World Health Organization, *Review and approval of proposed amendments to the International Health Regulations* (A/IHR/IGWG/2/2, 24 January 2005).

59 *Ibid.*

60 World Health Organization, *supra* note 51, art. 45.

61 UN Commission on Human Rights, 1984.

international concern (PHEICs) include health measures that are "not more intrusive to persons than reasonably available alternatives that would achieve the appropriate level of health protection."[62] The language of 'least intrusive measures possible' is repeated in several other IHR provisions,[63] reflecting both human rights protections against non-consensual or invasive medical treatment and the primary injunction of the Siracusa Principles that restrictions of rights be no more restrictive than is required to achieve the purpose of the limitation.[64] For example, Article 31 permits non-consensual health measures in the case of imminent public health risks to the "extent necessary to control such a risk" and as long as they are "the least invasive and intrusive" measures that would achieve the public health objective. The drafting history shows this latter provision shifted from prohibiting non-consensual measures in earlier drafts, with drafters noting that such provisions were more restrictive than existing international human rights law and indicating that measures were subject to IHR provisions mandating humane, non-discriminatory and confidential treatment.

Similar language appears in Article 43, which requires that any additional health measures adopted, beyond those recommended by WHO, "shall not be more restrictive of international traffic and not more invasive or intrusive to persons than reasonably available alternatives that would achieve the appropriate level of health protection."[65] The drafting of this article provoked considerable debate, with earlier drafts far more explicitly constraining governments from imposing "measures exceeding those recommended by WHO under these Regulations." A subsequent draft permitted States to exceed WHO recommended measures when addressing public health emergencies, so long as such measures did not conflict with entitlements under international human rights law.[66] Yet this explicit reference to international human rights law was removed from the final version of Article 43, which instead makes implicit references to human rights criteria of less "invasive" and "intrusive" measures. While Article 43 aims to ensure that additional health measures are backed by scientific justification, informed by WHO guidance, and grounded in human rights, in practice it has emerged as an anchor point for decisions that fall short of each of these criteria.[67] This potential was recognized by scholars

62 World Health Organization, *supra* note 51, art. 17(d).

63 Eg, World Health Organization, *supra* note 51, arts. 23, 31 and 43.

64 *Siracusa Principles*, art. 11.

65 World Health Organization, *supra* note 51, art. 43

66 World Health Organization, *Review and Approval of Proposed Amendments to the International Health Regulations: Draft Revision* (A/IHR/IGWG/3, 30 September 2004).

67 Steven Hoffman et al, 'The Stellenbosch Consensus on Legal National Responses to Public Health Risks: Clarifying Article 43 of the International Health Regulations' (2020) *International Organizations Law Review* pp. 1–30.

and human rights experts, who realized as the IHR were finalized that the lack of strong enforcement mechanisms in the IHR and the significant sovereignty granted to nations could result in national health measures that derogated from human rights principles.[68]

International human rights law is also implied in the imperative in Article 17 for the WHO Director-General to consider "relevant international standards and instruments" in issuing recommendations.[69] When member states asked for clarity during the IHR drafting of what a comparable phrase meant ("applicable international agreements"), this was clarified to "apply to agreements to which the States concerned are Parties in circumstances where both the agreement and the Regulations apply. The purpose of the reference is to enable State action in a manner permitted by those agreements even if not otherwise permitted by the Regulations."[70] Clearly this reference would extend to State Party obligations under human rights law.

2.3 *Analysis of Human Rights in the IHR*

From a human rights perspective, the overriding focus in the 2005 IHR is on ensuring that public health measures do not unjustifiably restrict civil and political rights like privacy, liberty, free movement and non-discrimination. There is explicit incorporation of the Siracusa Principles to the extent that necessity, proportionality, legality and non-discrimination are made legal requirements for many IHR measures that restrict rights. The Siracusa principle of necessity is bolstered in the IHR's emphasis on scientific principles and evidence as the requisite justification for many of the public health measures adopted under the regulations.[71] While some human rights scholars conclude that the IHR are "fully compatible with international human rights standards",[72] others suggest that while the IHR "generally reflect the requirements in international human rights law", it "fell short in terms of protecting human rights with regard to compulsory measures applied in the absence of informed consent."[73] They indicate that the requirement for states to apply least intrusive and restrictive

68 D. Fidler and L.O. Gostin, 'The New International Health Regulations: An Historic Development for International Law and Public Health' (2006) *Journal of Law, Medicine, and Ethics* pp. 85–94.

69 World Health Organization, *supra* note 51, art. 17(e).

70 WHO Intergovernmental Working Group on Revision of the International Health Regulations, *Review and approval of proposed amendments to the International Health Regulations: Explanatory notes* (U.N. Doc. A/IHR/IGWG/G/4, 7 October 2004), para. 16.

71 Negri, *supra* note 37, p. 279.

72 Zidar, *supra* note 47, p. 517.

73 Fidler and Gostin *supra* note 67, p. 87.

measures only applies to medical exams and "not to vaccinations, other prophylaxis, isolation or quarantine (Articles 23.2 and 31.2)"[74] and that the IHR lack due process protections when compulsory measures are applied.[75] Others point out that since the Siracusa Principles explicitly incorporate reference to the IHR when public health is invoked as a ground for limiting rights, this suggests that "in times of public health emergency national authorities have to comply with both the Regulations and human rights treaties, and that they are called to ensure consistency and coordination between the obligations stemming therefrom."[76]

Where the question of restricting civil and political rights rests on resolving some of these technical issues, the most significant gap in the IHR from a human rights perspective is in the almost complete absence of reference to economic, social and cultural rights. The IHR are exclusively focused on civil and political,[77] and do not acknowledge the centrality of the right to health to WHO's mandate nor the extent to which the IHR's fundamental purpose and numerous obligations overlap so significantly with the right to health's imperatives in relation to infectious disease or health systems.[78] Nor is there any recognition of the imperative to apply the Siracusa Principles to the way in which IHR measures may restrict economic, social and cultural rights. This lacuna was made explicit during the drafting process when the Intergovernmental Working Group on Revision of the IHR only considered its implementation in relation to rights protected in the ICCPR.[79]

The only somewhat explicit linkage to economic, social and cultural rights is in Article 32 which specifies that treatment of travellers under quarantine, isolation or who are subjected to medical examinations or other procedures should comport with respect for their dignity, human rights and fundamental freedoms, including through providing "adequate food and water, appropriate accommodation and clothing, protection for baggage and other possessions,

74 *Ibid*, p. 87–88.

75 *Ibid*, p. 88.

76 Negri, *supra* note 37, p. 289–290.

77 WHO Intergovernmental Working Group on Revision of the International Health Regulations, *Review and approval of proposed amendments to the International Health Regulations: Relations with other international instruments*, (U.N. Doc.A/IHR/IGWG/INF. DOC./1), paras. 29–32.

78 Brigit Toebes, Lisa Forman, and Giulio Bartolini, 'Toward Human Rights-Consistent Responses to Health Emergencies: What Is the Overlap between Core Right to Health Obligations and Core International Health Regulation Capacities?' (2020) 22:2 *Health and Human Rights Journal* pp. 99–112.

79 *WHO Intergovernmental Working Group on Revision of the International Health Regulations*, para. 29.

appropriate medical treatment [and] means of necessary communication if possible in a language that they can understand…"[80] Yet there is no acknowledgement of the overlaps between IHR core capacities and ICESCR core obligations under the right to health.[81] Nor is there acknowledgement of the overlap in IHR Article 44 which specifies duties of technical, logistical, financial and legal collaboration and assistance, with the ICESCR's requirement that states provide international assistance and cooperation, especially economic and technical, to the maximum of available resources to progressively realise ICESCR rights.[82] The linkage with this provision is made clearer in earlier drafts of Article 44 which required states to collaborate "within their available resources",[83] a phrase with clear resonance with ICESCR's article 2.1.

3 Weaknesses of the IHR in Safeguarding Rights in the COVID-19 Response

The IHR's textual weaknesses around human rights have been met during COVID-19 by significant implementation failures. The pandemic has exposed the IHR's weaknesses in safeguarding human rights in four key domains: (a) the right to health; (b) other economic, social and cultural rights that underlie health; (c) the necessity and proportionality of human rights limitations in emergency responses; and (d) the imperative for international assistance and cooperation to achieve global solidarity.

3.1 *The Realization of the Right to Health*

The right to health, while implicitly central to the IHR, has been neglected in the COVID-19 response. To protect the right to health, states are obligated to take steps for "the prevention, treatment and control of epidemic, endemic, occupational and other diseases",[84] including through public health measures such as immunization, surveillance, information campaigns and other infectious disease control strategies, which are grounded in scientific evidence.[85]

80 World Health Organization, *supra* note 51, art. 32(c).

81 Toebes et al, *supra* note 78.

82 *International Covenant on Economic, Social and Cultural Rights*, art. 2.1.

83 World Health Organization, *Review and Approval of Proposed Amendments to the International Health Regulations: Proposal by the Chair*, (A/IHR/IGWG/2/2, 24 January 2005).

84 *International Covenant on Economic, Social, and Cultural Rights*, art. 12.2.

85 CESCR, *supra* note 32.

In the initial months of the pandemic, WHO called for human rights to "continue to serve as a beacon for how countries respond to this and other public health emergencies."[86] In May 2020, the WHA echoed this call to action in a resolution that urged member states to implement national plans that ensure the conditions necessary to realize health through "respect for human rights and fundamental freedoms and paying particular attention to the needs of people in vulnerable situations, promoting social cohesion, taking the necessary measures to ensure social protection and protection from financial hardship, and preventing insecurity, violence, discrimination, stigmatization and marginalization".[87] Yet this invocation of human rights and the right to health has not been successful: governments have failed to adopt effective COVID control measures in a timely manner, they have faced difficulties in ensuring the availability, accessibility, acceptability and quality of COVID-19-related health coverage, experienced shortages in the trained workforce and essential medical care, including diagnostic tests, ventilators, and oxygen, and in personal protective equipment (PPE) for health-care workers and other frontline staff.[88] Moreover, there have been significant disruptions in non-COVID-19 health services, with these disruptions most substantial in low- and middle-income countries with the greatest impacts on outpatient services, prevention/screening and community-based services.[89]

3.2 *The Realization of Economic, Social and Cultural Rights*

Beyond the right to health, a range of economic, social and cultural rights underlie public health, including rights to adequate housing; water and sanitation; food; education; social security, among others. Timely and effective measures are required to support the enjoyment of these rights for people affected by emergency restrictions, including through support for employment and livelihoods, housing, food, education, social protection and health.[90] Yet, national responses to COVID-19 have consistently failed to take appropriate measures to protect these rights, resulting in policy responses that have obstructed the right to education, prevented individuals from purchasing basic

86 World Health Organization, 'Addressing human rights as key to the COVID-19 response', <www.who.int/publications/i/item/addressing-human-rights-as-key-to-the-covid-19-response>, 21 April 2020.

87 World Health Assembly, *COVID-19 Response (2020)*.

88 Lisa Forman and Jillian Kohler, 'Global health and human rights in the time of COVID-19: Response, restrictions and legitimacy' (2020) 19:5 *Journal of Human Rights* pp. 1–10.

89 World Health Organization, *Pulse survey on continuity of essential health services during the COVID-19 pandemic: interim report*.

90 Office of the High Commissioner for Human Rights, *COVID-19 Guidance* (2020).

necessities, closed off necessary support services, facilitated gender-based violence, and widened health inequities across populations.[91] Such inequalities in social determinants translate into differentiated risks of infection and death for vulnerable populations. These impacts are expected to get worse, with estimates that COVID will push almost 150 million people, 1.4 per cent of the global population, into extreme poverty.[92]

While WHO Director-General Tedros Adhanom Ghebreyesus has urged countries to "strike a fine balance between protecting health, minimizing economic and social disruption, and respecting human rights",[93] doing so has been left to the inclination of individual states, with fairly poor outcomes. The IHR has offered limited oversight and support of this broader range of human rights that underlie public health.

3.3 *The Necessity and Proportionality of Rights Limitations*

Pandemic responses raise an imperative to limit civil and political rights to protect public health. The Siracusa Principles require that any such limitations are necessary, proportionate, and non-discriminatory.[94] However, many governments have engaged in unnecessary and disproportionate abuses of rights—from implementing selective bans on international travel; to using criminal law to compel compliance with COVID-19 measures; to abusing surveillance technologies to clamp down on civil society.[95]

The IHR's invocations of necessity, scientific evidence, proportionality and non-discrimination for implementing various IHR provisions has done little to mitigate overly restrictive public health measures that fail these criteria. The case of travel restrictions under Article 43 illuminates this gap: The WHO has

91 Human Rights Watch, *School Closures Particularly Hard on Children with Disabilities* (2020); Disability Rights International, *Disability rights during the pandemic: A global report on findings of the COVID-19 Disability Rights Monitor* (2020); High Court of South Africa, *Equal Education and Others* v. *Minister of Basic Education and Others* (2020); Human Rights Watch, *UK: Children in England Going Hungry with Schools Shut* (2020); UN Women, *From Insight to Action, Gender Equality in the Wake of COVID-19* (2020).

92 World Bank, 'COVID-19 to add as many as 150 million extreme poor by 2021' <www.worldbank.org/en/news/press-release/2020/10/07/covid-19-to-add-as-many-as-150-million-extreme-poor-by-2021>, 7 October 2020.

93 WHO Director General, *Media Briefing 11 March 2020*. <www.who.int/dg/speeches/detail/who-directorgeneral-s-opening-remarks-at-the-media-briefing-on-covid19---11-march-2020>, 7 October 2020.

94 UN Commission on Human Rights, *supra* note 19.

95 Roojin Habibi et al., 'Do Not Violate the International Health Regulations During the COVID-19 Outbreak' (2020) *Lancet* pp. 664–666; Sharifah Sekalala et al., 'Health and Human Rights are Inextricably Linked in the COVID-19 Response' (2020) *BMJ Global Health*.

consistently since March 2020 issued practical guidance, guidelines, and statements to assist countries in implementing travel restrictions under this provision in ways that balance the protection of public health and human rights.[96] While WHO Director-General Tedros has argued forcefully that "to suggest that we must choose between health and human rights is completely wrong," states have consistently ignored WHO advice.[97] In this regard, neither the IHR nor the Siracusa Principles have proved sufficient to adequately protect human rights during the COVID-19 response.

3.4 *Facilitating Solidarity and Cooperation in the Global Response*

Aligned with UN and WHO calls for global solidarity, human rights obligations of international assistance and cooperation are central to the COVID-19 response, requiring that countries coordinate efforts to reduce the economic and social impacts of health threats, cooperate with the WHO, and share data, health research, medical equipment, supplies, and best practices.[98] Under treaties such as the ICESCR, states have an obligation to realise economic, social and cultural rights, including health, in other jurisdictions through international assistance and cooperation.[99] Yet, in responding to the pandemic, many governments have implemented nationalist measures or sanctions that restrict the flow of essential goods, including health equipment and pharmacological therapeutics (eg, COVID-19 vaccines), or which obstruct the export of vital medical equipment needed by the world's most vulnerable.[100] Such actions contravene the imperative in Article 44 of the IHR for international collaboration and assistance in the development, strengthening and maintenance of national public health capacities to respond to infectious disease threats.[101] Amid these attacks on global solidarity, while the WHO Director-General has continued to champion the right to health as a moral imperative in the COVID-19 response, the institution has also frequently resorted to the language of morality and values like solidarity rather than law, undermining to some extent the centrality of law and rights in the WHO response. Moreover, many governments have failed to provide sufficient support in response to the

96 WHO and ICAO, *Joint Statement on COVID-19 (11 March 2020)*.

97 T. Adhanom, 'HRLC Annual Lecture (11 December, 2020c)'. HRLC Annual Lecture, University of Nottingham. (20).

98 CESCR, *Statement on the Coronavirus Disease (COVID-19) Pandemic and Economic, Social and Cultural rights* (2020).

99 ICESCR, *supra* note 84, art. 2.

100 CESCR, *Statement on universal and equitable access to vaccines for COVID-19* (E/C.12/2020/2); OHCHR, *Emergency Measures and COVID-19: Guidance* (2020).

101 World Health Organization, *supra* note 51, art. 44.

pandemic, threatening the health and human rights of the most marginalized populations.

4 Institutional Interpretations and Reform to Align the IHR with Human Rights

Global health institutions can strengthen the protection of human rights in the IHR including through partnerships with human rights institutions that harmonize global health law and human rights law and provide avenues for human rights accountability in global health governance.

4.1 *Bringing Together Multiple Institutions/Regimes*

The WHO Constitution has helped to structure the WHO's policies and programs over its lifetime.[102] For instance, the WHO has worked closely with regional organizations in Latin America and Africa to center human rights within health programs, leading to the adoption of the *2010 PAHO Resolution on Health and Human Rights* to mainstream human rights in national health ministries and PAHO technical programs and a *2012 AFRO Resolution on Health and Human Rights* to strengthen legal and institutional measures to promote human rights.

More broadly, however, the WHO has been reticent to frame violations of the IHR as human rights violations, and has struggled to mainstream human rights, leaving the IHR system to focus on ostensibly non-human rights considerations like capacity building and national legislation for states that were trying to implement the IHR. This has created opportunities for other actors both within and outside the UN system,[103] and created a vacuum about the extent to which rights are considered integral to the understanding of the IHR. For instance, while the WHO focused on national legislation as part of core capacities, the Joint External Evaluation (*'JEE'*) Tool, which aimed to measure the ways in which states complied with the IHR, failed to center human rights in how it measured state responses to the IHR. Human rights, when they have been articulated within WHA resolutions, tend to focus instead on the rights of the most vulnerable and on non-discrimination.

102 L. Gostin, B. Meier, R. Thomas, V. Magar, and T. Ghebreyesus, '70 Years of Human Rights in Global Health: Drawing on a Contentious Past to Secure a Hopeful Future', (2018) 392 *The Lancet* pp. 2731–2735.

103 Chelsea Clinton and Devi Sridhar, *Governing Global Health: Who runs the world and why?* (Oxford University Press, New York, 2017).

Even before COVID-19, there were attempts to create a more coordinated framework between the WHO and other UN agencies to realize human rights in global health. In 2017, Dr. Tedros established a *Framework of Cooperation* between the WHO and the Office of the United Nations High Commissioner for Human Rights (OHCHR) to support human rights-based approaches at country level,[104] and the WHO's *Global Programme of Work* (*2019–23*) placed the right to health at the core of WHO's mandate. The COVID-19 crisis has amplified calls for the WHO to focus on human rights, especially in its interpretation of the IHR, with WHA resolutions increasingly recognizing the centrality of human rights in this respect.[105]

However, there is also a need to ensure that the WHO creates better partnerships between the IHR and the human rights system. This partnership would be in line with Article 1b of the WHO Constitution which calls for effective collaboration with other UN agencies, and with the IHR's recognition of the interrelated nature of human rights, relying on the UN Charter and the WHO Constitution as key reference texts in this interpretation. This reinforcement underscores that human rights must be respected, protected and fulfilled when states are trying to respond to infectious diseases.

4.2 *Linking IHR and Siracusa Principles*

There is a strong necessity to harmonize global health law and human rights standards if international law is to strengthen institutional responses to infectious diseases. Yet this harmonization is complicated by the fact that, in global health crises, competing rights necessitate balancing conflicting imperatives. While COVID-19 has underscored the commonality of limiting rights within an infectious disease crisis, it is less clear how necessary such limitations and even derogations are. Global health law will need to better clarify the Siracusa Principles safeguards of necessity, legitimacy and proportionality to ensure that rights are not unduly violated.

By contrast, UN bodies have considered the principle of proportionality in much further detail. In relation to indiscriminate mass surveillance by the UK and US governments after the 11 September 2001 attacks, a subsequent UN General Assembly resolution stated that "surveillance and/or interception of communications (…) as well as the collection of personal data, in particular

104 World Health Organization, *Agreement signed between WHO and UN human rights agency to advance work on health and human rights*, <www.who.int/life-course/news/who-unhcr-agreement-on-health-and-human-rights/en/>, 8 July 2020.

105 World Health Organization, *Thirteenth General Programme of Work 2019–2023* (res WHA71.1,10).

106 UNGA, *Res. 68/167*, (UN Doc. A/RES/68/167, 2014).

when carried out on a mass scale, may have [a negative effect] on the exercise and enjoyment of human rights."[106] In practice, this means that surveillance laws must not include blanket provisions, must be clear, and can only be used for a legitimate aim in order to ensure that the individual is protected from arbitrary interference. Legal reforms in response to COVID-19 will need to bolster the Siracusa Principles through contemporary human rights interpretations like these.

4.3 *Multi-sectoral Accountability*

The WHO already relies on a diverse range of human rights institutions to provide normative guidance and state monitoring on the right to health. For instance, General Comment 14 confirms that the right to health entails obligations to prevent, treat and control epidemic, endemic, occupational and other diseases and that states have a core obligation to "adopt and implement a national public health strategy and plan of action" to ensure that they are prepared for responding to pandemics. Human rights treaty bodies like the CESCR play a vital role in facilitating accountability for human rights obligations, including through recommendations over time that contribute to the progressive realization of the right to health at the country level.[107] Moreover, Article 5 of the ICESCR Optional Protocol enables individuals to seek interim measures to avoid possible irreparable damage to the victim or victims of alleged violations,[108] and could be utilized to protect economic, social and cultural rights implicated under the IHR. Additionally, different Special Rapporteurs within the UN system have sought to expand the normative framing of pandemic preparedness under the right to health[109] to include the role of non-state actors, to think about financial systems such as austerity, which leave public institutions underfunded and vulnerable, and to consider pandemic preparedness in the context of human rights within planetary health.[110] The WHO could use normative guidance like this to give states better human rights guidance under

107 Benjamin Mason Meier, Marious De Milliano, Averi Chakraborti, and Yuna Kim, 'Accountability for the human right to health through treaty monitoring: Human rights treaty bodies and the influence of concluding observations,' (2017) 13:2 *Global Public Health* pp. 1–19.

108 UNGA, *Optional Protocol to the International Covenant on Economic, Social and Cultural Rights*, (res. A/RES/63/117, 10 December 2008).

109 Dainius Puras, *UN Special Rapporteur on the right to the highest attainable standard of health – report to the General Assembly*, (A/75/163, 16 July 2020), para. 8.

110 Baskut Tuncak, 'Duty to Prevent Exposure to the COVID-19 Virus: Report of the Special Rapporteur on the implications for human rights of the environmentally sound management and disposal of hazardous substances and wastes' *Human Rights Council* (A/HRC/45/12, 13 October 2020).

the IHR through mechanisms like the JEE Tool, which is a voluntary process initiated at the request of the country to help identify the most urgent needs within national health systems, prioritize efforts and enhanced preparedness, response and action, and engage current and prospective donors and partners in targeting resources in the most effective way.[111]

By example, the WHO has managed to harness normative guidance on access to medicines from UN General Assembly resolutions and Special Rapporteur reports to decisively set the agenda for access to essential medicines as an essential component of the right to health.[112] This movement, which began with access to antiretrovirals, in the HIV/AIDS response has during COVID-19 been rearticulated to pre-empt intellectual property arguments around COVID-19 vaccines.[113] In April 2020, the UN General Assembly acknowledged the crucial role of the WHO in coordinating the international response, and called on member states to increase R&D funding for tools to combat COVID-19.[114] This resolution gave the WHO the mandate to set up the WHO's ACT-Accelerator, which brings together a number of international organizations and provides a platform for the consolidation of funding efforts and resource sharing. The Accelerator aimed to speed up the end of the pandemic through supporting the development and equitable distribution of tools designed to combat COVID-19. Work and investment across the four pillars—diagnostics, therapeutics, vaccines, and health system strengthening—is aimed not just at R&D, but also to redress inequities through global distribution of technologies and vaccines.[115] Through both these events, the WHO has attempted to reiterate the primacy of human rights over intellectual property rights. Although these moves have not been totally successful, they have enabled some of the poorest countries in the world to gain access to COVID vaccines through COVAX and have also created the space for broader rights arguments for the TRIPS waiver.

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111 World Health Organization, *Joint External Evaluation* (*JEE*) <*www.alliancehsc.org*>, 8 July 2020.

112 World Health Assembly, *Resolution* 56.30/2003.

113 Sharifah Sekalala, Timothy Fish Hodgson, Hadijah Namyalo, Moses Mulumba, Lisa Forman and Benjamin Mason Meier, 'Decolonising human rights: Analysing the broader inequalities due to intellectual property laws for the COVID-19 vaccine' (2021) *BMJ Global Health*.

114 United Nations General Assembly. *International Cooperation to Ensure Global Access to Medicines, Vaccines and Medical Equipment to Face COVID-19* (*Resolution 74/274*), (United Nations, New York, 2020), <www.undocs.org/en/A/RES/74/274>, 7 July 2020.

115 Mark Eccleston-Turner and Harry Upton, 'International Collaboration to Ensure Equitable Access to Vaccines for COVID-19: The ACT-Accelerator and the COVAX Facility' (2021) 99:2 *The Milbank Quarterly* pp. 426–449.

For the IHR to be interpreted in light of the right to health and vice-versa, there needs to be greater multi-sectoral accountability that links the WHO to UN human rights bodies,[116] and gives WHO authority to explicitly address human rights compliance through existing IHR tools such as the JEE. Additionally, other tools within the broader UN system could be used to push for stronger human rights compliance. For example, the *Universal Periodic Review* ('*UPR*') is a unique accountability process, which involves a review of the human rights records of all UN Member States. The UPR is a State-driven process, under the auspices of the Human Rights Council, which provides the opportunity for each State to declare what actions they have taken to improve the human rights situations in their countries and to fulfill their human rights obligations. The UPR has been recognized as a useful tool in creating greater state compliance with the right to health.[117] The role of civil society actors in the UPR process could enhance the already existing role for civil society within the IHR process. The WHO has already begun exploring the ways in which it contributes to mechanisms such as the UPR through contributing to data on key health challenges for the SDGs, and this could potentially be another way of embedding core human rights component of the IHR across the UN system.[118] In looking beyond the COVID-19 pandemic, there may be utility in creating separate indicators that look at the intersection between human rights and global health governance through, for instance, pandemic laws that comply with human rights law, creating systems that can ensure easier judicial review for marginalized groups and communities, investment in public health systems, and emergency plans for pandemics that include economic social cultural safeguards such as education for children, food, housing, etc.

Looking beyond the IHR in this way seems imperative since it is unclear how far IHR reform can go in resolving some of these identified weaknesses. For instance, the WHO committee that reviewed the function of the IHR during COVID-19 instead recommended a range of actions to strengthen IHR implementation.[119] The IHR is also more or less by-passed by the *Independent Panel for Pandemic Preparedness and Response* ('*IPPPR*'), appointed by the WHO

116 Toebes et al, *supra* note 77, pp. 99–112.

117 S. Sekalala, H. Masud and R. Bosco, 'Using human rights mechanisms to address corruption within the health sector' (2020) 13:1 *Global Health Action*.

118 Judith Bueno de Mesquita, Rebekah Thomas et al, 'Monitoring the Sustainable Development Goals through Human Rights Accountability Reviews' (2018) 96 *Bulletin of the World Health Organization* p. 627.

119 World Health Organization, 'Strengthening preparedness for health emergencies: implementation of the International Health Regulations (2005)' (A74/9.Add.1, 5 May 2021), para. 6.

Director-General to review WHO's response to COVID-19, including through the IHR. After earlier indicating that "[t]he global pandemic alert system is not fit for purpose",[120] the IPPPR final report recommends institutional reforms such as creating a Global Health Threats Council to elevate leadership, financing and accountability for pandemics, and adopting a WHO Pandemic Treaty to "address gaps in the international response, clarify responsibilities between States and international organizations, and establish and reinforce legal obligations and norms."[121] Negotiations on both the Pandemic Treaty and IHR revisions are ongoing, leaving considerable uncertainty about the future of global health law on pandemics and the bolstering of human rights concerns under the IHR.[122]

Conclusion

The COVID pandemic underscores the need to strengthen the inclusion of human rights within the IHR, as well as bolster the linkages between this instrument and the WHO and the international human rights system more broadly. The extent of human rights violations in implementing IHR health measures such as travel restrictions, states of emergency, and quarantines indicate the need for better guidance and oversight of states during future health emergencies. This guidance could extend to strengthening Siracusa Principles criteria for restrictions of rights and extending these criteria to address the IHR's impact on economic, social and cultural rights and especially the right to health. Yet improving the protection of human rights under the IHR must extend beyond normative shifts into improved institutional mechanisms. Currently, accountability for human rights is entirely separate from that of the IHR. Human rights implementation is the primary mandate of UN human rights institutions and mechanisms (such as the OHCHR, HRC, CESCR and UPR) that were not part of the development of the IHR and which do not see the IHR within their purview. WHO will need to more fully engage with these actors in monitoring the IHR if it is to better protect human rights in

120 *Ibid*, p. 6.

121 The Independent Panel for Pandemic Preparedness and Response, 'COVID-19: Make it the last pandemic', <www.theindependentpanel.org/wp-content/uploads/2021/05/COVID-19-Make-it-the-Last-Pandemic_final.pdf>, 30 May 2021.

122 Priti Patnaik, 'Pandemic Treaty opponents have bought time till a Special Session of WHA in Nov, supporters manage to keep pressure on 25 May 2021', <www.genevahealthfiles.com/2021/05/25/pandemic-treaty-opponents-have-bought-time-till-a-special-session-of-wha-in-nov-supporters-manage-to-keep-pressure-on/>, 30 May 2021.

future health emergencies. Stronger institutional linkages of this sort could guard against the watering down of human rights protections under the IHR and partially remedy the 'soft' nature of many of these obligations and the absence of consequences for states that violate human rights duties. For now, given uncertainty about the nature of IHR reform and given the potential for multiple new pandemic institutions, the extent to which the IHR's weaknesses around human rights can be resolved may be contingent on resolving these inter-regime problems. In the absence of such linkages, the responsibility for bolstering the IHR's weaknesses on human rights is likely to continue to fall on human rights bodies, civil society and scholars.

Recommendations for reform

- Normative reform:
  - Strengthen IHR alignment with human rights and include economic, social and cultural rights.
  - Revise the Siracusa Principles to address economic, social and cultural rights and bolster the criteria of necessity, proportionality and non-discrimination.
- Institutional reform:
  - Bolster WHO guidance and monitoring of human rights through IHR tools like the JEE
  - Initiate use of the UN UPR to monitor state realisation of human rights under the IHR