Ebola and Emerging Infectious Diseases in Armed Conflict: Contemporary Challenges in Global Health Security Laws and Policies

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List of abbreviations:

AP	Additional Protocol to the Geneva Conventions
DRC	Democratic Republic of Congo
CBDR	Common but Differentiated Responsibility
CE	Complex Emergency
CESCR	Committee on Economic, Social and Cultural Rights
CIL	Customary International Law
DG	Director-General
EC	Emergency Committee
EID	Emerging Infectious Disease
EVD	Ebola Virus Disease
CDC	U.S. Centers for Disease Control and Prevention
CESCR	Committee on Economic, Social and Cultural Rights
GC	Geneva Conventions
GHSA	Global Health Security Agenda
GOARN	Global Outbreak and Response Network
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social, and Cultural Rights
IHL	International Humanitarian Law

IHR	International Health Regulations (1969 or 2005)
IHRL	International Human Rights Law
MSF	Médecins Sans Frontières/Doctors Without Borders
NGO	Non-Governmental Organization
PHEIC	Public Health Emergency of International Concern
POW	Prisoner of War
UDHR	Universal Declaration of Human Rights
U.N.	United Nations
UNMEER	United Nations Mission for Ebola Emergency Response
UNSC	United Nations Security Council
WHO	World Health Organization

I. INTRODUCTION

The threat of pandemic infectious disease is not a new phenomenon in the world.[1] However, since the end of the Cold War and the beginning of the 21st century, outbreaks of emerging infectious diseases ("EIDs") threaten the health and safety of citizens all over the world.[2] Globalization[3] has added significant challenges to global health security, including the global movement of people and goods that may carry infectious agents and the increased use of electronic communications which can contribute to unnecessary panic, further complicating outbreak management.[4] Additional factors that contribute to the resurgence of infectious disease include human behavior and culture, land use for economic development and urbanization,

1. *See* DAVID P. FIDLER, INTERNATIONAL LAW AND PUBLIC HEALTH: MATERIALS ON AND ANALYSIS OF GLOBAL HEALTH JURISPRUDENCE 127 (2000) (explaining that the global crisis in infectious disease is not new, and in 1996 the WHO DG argued that the world stands "on the brink of a global crisis in infectious diseases . . . No country is safe from them. No country can any longer afford to ignore their threat . . . infectious diseases are attacking us on multiple fronts. Together they represent the world's leading cause of premature death. At least 17 million people were killed by them last year, including 9 million children who die from such preventable causes as diarrhea and pneumonia. Millions more were disabled even though effective measures to prevent them were available.") [hereinafter FIDLER, INTERNATIONAL LAW AND PUBLIC HEALTH]; *see also* David P. Fidler, *Return of the Fourth Horseman: Emerging Infectious Diseases and International Law*, 81 MINN. L. REV. 771, 773, 780 (1997) [hereinafter Fidler, *Return of the Fourth Horseman*].

2. WORLD HEALTH ORG. [WHO], MANAGING EPIDEMICS: KEY FACTS ABOUT MAJOR DEADLY DISEASES 11 (2018) [hereinafter WHO MANAGING EPIDEMICS]; *see also* Reid Wilson, *Ebola Outbreak Highlights Global Rise in Epidemics*, THE HILL (Aug. 19, 2019, 12:39 PM), https://thehill.com/policy/international/455764-ebola-outbreak-highlights-global-rise-in-epidemics ("Public health is really closely tied to the social, political and economic issues of the world. Where they go awry, public health can quickly go awry . . . This is a worldwide phenomenon that is happening. Public health is struggling, with a number of diseases in a number of cases.").

3. Globalization is defined as "[t]he increased interconnectedness and interdependence of peoples and countries is generally understood to include two interrelated elements: the opening of borders to increasingly fast flows of goods, services, finance, people, and ideas across international borders; and the changes in institutional and policy regimes at the international and national levels that facilitate or promote such flow." INST. OF MED., THE INFLUENCE OF GLOBAL ENVIRONMENTAL CHANGE ON INFECTIOUS DISEASE DYNAMICS: WORKSHOP SUMMARY 404 (2014).

4. World Health Org. [WHO], The World Health Report 2007: A Safer Future: Global Public Health Security in the 21st Century 12 (2007) [hereinafter WHO World Health Report 2007].

and microbial adaptation and change.[5] All of these challenges and more were observed during the 2014–2016 Ebola Virus Disease ("EVD") outbreak in West Africa.[6] Similar to SARS[7] and Zika,[8] the 2014–2016 West African EVD outbreak demonstrated the interconnected nature of the modern world and re-emphasized the need for more coordination of disease outbreak management on a global scale.[9]

Beginning in August 2018, the second largest EVD outbreak in history repeated a similar pattern in the eastern part of the Democratic Republic of Congo ("DRC").[10] Nevertheless, there are a number of significant differences in this EVD outbreak beginning in 2018 in the Eastern DRC that have complicated the global health emergency response, more so than other serious EID outbreaks of the 21st century. This time, it is important to consider the intricate involvement of many international actors[11], including the World Health Organization ("WHO") and its Emergency Committee ("EC") established under the International Health Regulations (2005) ("IHR (2005)"), the United Nations Security Council ("UNSC"), and many non-state armed groups active in the region. Since global health policy concerning EIDs depends on a myriad of factors and global actors, this note will demonstrate how global health policy is also

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5. FIDLER, INTERNATIONAL LAW AND PUBLIC HEALTH, *supra* note 1, at 128.

6. *2014-2016 Ebola Outbreak in West Africa*, CTR. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/vhf/ebola/history/2014-2016-outbreak/index.html (last visited Jan. 7, 2019).

7. WHO MANAGING EPIDEMICS, *supra* note 2, at 15.

8. *Id.*

9. DAVID P. FIDLER, INTERNATIONAL LAW AND INFECTIOUS DISEASES 5–6 (1999) ("The global nature of the infectious disease threat also appears in the strategies being crafted by public health authorities. These strategies emphasize that infectious diseases must be handled through a global, coordinated approach. This message suggests that States cannot deal with infectious disease threats on their own but must engage in international cooperation . . . The global dimension of infectious diseases, and the need for international co-operation, bring international law into focus as a key mechanism through which States agree to pursue common interests and values. As with other global problems, international law plays an important role in the attempts to deal with infectious diseases.").

10. BBC NEWS, *Ebola Outbreak in DR Congo Now Second Worst in History*, BBC.COM (Nov. 30, 2018), https://www.bbc.com/news/world-africa-46398267.

11. Wilson, *supra* note 2 ("It is no longer sufficient to leave outbreak response to health-centric organizations such as WHO and CDC or nongovernmental groups like Doctors Without Borders . . . Instead, they require comprehensive intervention across sectors, from peacekeeping to economic development.").

integrally intertwined with international law and relies greatly on effective international cooperation. To fully understand these moving parts, it is advantageous to closely examine the relationship between International Humanitarian Law ("IHL"), International Human Rights Law ("IHRL"), and global health policy for EID outbreaks.[12] Part II of this note provides a background to the relevant domains of IHRL, IHL, disaster and humanitarian response, and global health security as set forth by the IHR (2005) to better understand the nuanced intersection among the fields when discussing issues of global health policy for EIDs. Part III analyzes the challenges and gaps found in these intersections and discusses the consequent implications for the Eastern DRC EVD outbreak beginning in 2018. Finally, this note concludes with a discussion of supportive and alternative methods for the international community in managing the EVD outbreak amidst the region's insecurity.

II. BACKGROUND

A. INTERNATIONAL HUMAN RIGHTS LAW

Health has played a consistent role in the history of the development of international human rights. The United Nations ("U.N.") Charter (1945) emphasized the need for international cooperation in Chapter IX, particularly in finding solutions to health problems.[13] In 1946, the WHO Constitution, as established under U.N. Charter Article 57, declared that the WHO's objective is the "attainment by all peoples of the highest possible level of health."[14] In 1948, the Universal Declaration of Human Rights ("UDHR") referenced this same objective for health in Article 25(1): "everyone has the right to a standard of living adequate for the health of himself and his family, including food, clothing, housing and medical care, and necessary social services."[15] In 1966, the International Covenant on Economic, Social and Cultural Rights ("ICESCR") stated in Article 12 that "The States Parties . . . recognize the right of

12. Fidler, *supra* note 9, at 5–6.

13. U.N. Charter, art. 55(b); JOHN TOBIN, THE RIGHT TO HEALTH IN INTERNATIONAL LAW 27 (2012).

14. Constitution of the World Health Organization, art. 1, July 22, 1948, 14 U.N.T.S. 185 [hereinafter WHO Constitution].

15. G.A. Res. 217 (III) A, Universal Declaration of Human Rights, art. 25(1) (Dec. 10, 1948).

everyone to the enjoyment of the highest attainable standard of physical and mental health"[16] and to achieve this, highlighted the "prevention, treatment and control of epidemic, endemic, occupational and other diseases"[17] as a vital prerequisite for success. The drafting history of this provision demonstrates that the object and purpose of this provision was to obligate States to address the prevention of disease and malnutrition, two major factors which pose obstacles for achieving health for all.[18] Additionally, the Committee on Economic, Social and Cultural Rights ("CESCR") General Comment 14 discussed ICESCR Article 12(2)(c), stating that "[t]he right to treatment includes the creation of a system of urgent medical care in cases of accidents, epidemics and similar health hazards, and the provision of disaster relief and humanitarian assistance in emergency situations"[19] and "[t]he control of diseases refers to States' individual and joint efforts to . . . make available relevant technologies, using and improving epidemiological surveillance and data collection on a disaggregated basis, the implementation or enhancement of immunization programmes and other strategies of infectious disease control."[20] Thus, international human rights law has been developed to ensure health for all.

B. INTERNATIONAL HUMANITARIAN LAW

The history of IHL is equally influenced by the desire to protect health for all. Even before the Geneva Conventions ("GC") of 1949 came into effect after World War II, the Lieber Code (1863) codified the duty to medically treat wounded and sick combatants during the American Civil War.[21] During World

16. International Covenant on Economic, Social and Cultural Rights, Art. 12(1), Dec. 16, 1966, S. Treaty Doc. No. 95-19, 993 U.N.T.S. 3 [hereinafter ICESCR].

17. *Id*. at art. 12(2)(c).

18. TOBIN, *supra* note 13, at 267–68.

19. Committee on Economics, Social, and Cultural Rights [hereinafter CESCR], General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12), adopted at the Twenty-Second Session of the CESCR, art. 16, U.N. Doc. No. E/C.12/2000/4 (Aug. 11, 2000) [hereinafter CESCR General Comment No. 14]; ADVANCING THE HUMAN RIGHT TO HEALTH 380 (José M. Zuniga et al. eds., 2013).

20. CESCR General Comment No. 14, *supra* note 19.

21. RICHARD SHELLY HARTIGAN, LIEBER'S CODE AND THE LAW OF WAR 59 (1983); INT'L COMM. OF THE RED CROSS, *Rule 110. Treatment and Care of the Wounded, Sick and Shipwrecked*, IHL DATABASE, https://ihl-databases.icrc.org/customary-ihl/eng/docs/v1_rul_rule110.

War I, Article 23 of the League of Nations Covenant provided that "The Members of the League agree to encourage and promote the establishment and cooperation of duly authorized voluntary national Red Cross organisations having as purposes the improvement of health, the prevention of disease, and the mitigation of suffering throughout the world."[22] This Article sought to achieve peace, security, and preserve state sovereignty with a call to mitigate suffering while reflecting humanitarian concerns that were later incorporated into the future of IHL as seen today.[23]

When the Geneva Conventions ("GC") of 1949 and its Additional Protocols ("AP") of 1977 came into effect, providing medical care for wounded and sick combatants was enumerated in GC I and II, and this protection of health was expanded in GC IV and AP I to include noncombatants.[24] Since GC III covers treatment for prisoners of war ("POW"), a vast number of provisions protect health, including but not limited to prohibiting cruel treatment and torture (including medical or scientific experimentation), providing exceptions for liberty of movement if required in the best interest of the POW's health, ensuring healthy internment conditions and provisions to prevent epidemics, and giving medical inspections and treatment free of cost.[25] Additionally, GC III affords special protections for medical personnel, which are also referenced in the other GCs, APs, and established in Customary International Law ("CIL").[26] States around the world have widely developed advancements in military medicine such as sanitation and immunizations, anesthesia and antibiotics, faster evacuations

22. TOBIN, *supra* note 13, at 23.

23. *Id.*

24. Geneva Convention (I) for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field, Aug. 12, 1949, art. 12, 15 [hereinafter GC I]; Geneva Convention (II) for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of Armed Forces at Sea, Aug. 12, 1949, art. 12, 18 [hereinafter GC II]; Geneva Convention (IV) Relative to the Protection of Civilian Persons in Time of War, Aug. 12, 1949, art. 16 [hereinafter GC IV]; Protocol Additional to the Geneva Conventions of 12 August 1949, and Relating to the Protection of Victims of International Armed Conflicts (Protocol I), June 8, 1977, art. 10 [hereinafter AP I].

25. Geneva Convention (III) Relative to the Treatment of Prisoners of War, August 12, 1949, arts. 3, 13, 15, 21–22, 26, 29–31, 51, 110–13, 130 [hereinafter GC III].

26. *See generally* GC III, art. 33; GC I, art. 24–26; GC II, art. 36; GC IV, art. 2; GCs Common, art. 3; AP II, art. 9; INT'L COMM. OF THE RED CROSS, RULE 25. MEDICAL PERSONNEL, IHL DATABASE, https://ihl-databases.icrc.org/customary-ihl/eng/docs/v1_rul_rule25.

via air transportation, and overall improvements in protective uniforms and equipment.[27] These developments demonstrate the importance and customary nature of protecting health in armed conflict. IHL also specifically codifies additional protections for medical units (such as hospitals) and transports.[28]

These regulations seek to limit the severe impact that war has on health because not only does war result in more injuries and casualties, but it also alters the human-microbe environment, producing increased opportunities for more pathogens, destroying public health infrastructures, and complicating disease mitigation.[29] Additionally, though IHL is intended to regulate a party's actions during armed conflict, provisions meant to protect civilians are frequently violated.[30] As a State's public health infrastructures are often deeply rooted in civilian infrastructure, IHL should also protect these mechanisms. However, as is often observed with water and sanitation systems, parties frequently disrupt civilian water supply systems in armed conflict and violate IHL, which can result in disastrous health circumstances for everyone involved.[31] For example, UNICEF's executive director likened deliberate attacks on water and sanitation to attacks on vulnerable children because of UNICEF's finding in 2019 that "children under five who live in conflict zones are 20 times more likely to die from diarrhoeal diseases linked to unsafe water than from direct violence as a result of war."[32] Access to medical care has long been identified as a worldwide challenge that must be overcome in order to achieve universal health coverage.[33]

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27. *See generally* Tanisha M. Fazal, *Dead Wrong? Battle Deaths, Military Medicine, and Exaggerated Reports of War's Demise*, 39 INT'L SEC. 95, 95–101 (2014).

28. INT'L COMM. OF THE RED CROSS, RULE 28. MEDICAL UNITS, IHL DATABASE, https://ihl-databases.icrc.org/customary-ihl/eng/docs/v1_rul_rule28; INT'L COMM. OF THE RED CROSS, RULE 29. MEDICAL TRANSPORTS, IHL DATABASE, https://ihl-databases.icrc.org/customary-ihl/eng/docs/v1_rul_rule29.

29. Fidler, *supra* note 9, at 222.

30. *Id.* at 234.

31. *Id.*

32. Kate Hodal, *Dirty Water 20 Times Deadlier to Children in Conflict Zones Than Bullets – UNICEF*, THE GUARDIAN (March 22, 2019), https://www.theguardian.com/global-development/2019/mar/22/dirty-water-20-times-deadlier-to-children-in-conflict-zones-than-bullets-unicef.

33. David B Evans, Justine Hsu, & Ties Boerma, *Universal Health Coverage and Universal Access*, 91 BULL. OF THE WORLD HEALTH ORG. [WHO] 545, 546 (2013), https://www.who.int/bulletin/volumes/91/8/13-125450/en/; *SDG*

However, access is severely diminished in situations of armed conflict and lack of it can be the cause of more casualties than violence from war.[34] This emerging trend is exemplified by a study of conflict in the DRC region which found that the mortality rate was higher in unstable provinces of the east and most of the deaths were from easily preventable and treatable illnesses rather than from violence.[35] As a result of the development of these provisions, protecting health is a core concept of IHL.

C. DISASTER AND HUMANITARIAN RESPONSE

Responding to complex humanitarian emergencies such as armed conflict or widespread disease outbreaks requires a large-scale coordinated humanitarian response and collaboration between the "host government and major humanitarian relief organizations."[36] Complex emergencies ("CEs") or complex humanitarian emergencies are defined by the U.S. Centers for Disease Control and Prevention ("CDC") as "situations affecting large civilian populations which usually involves a combination of factors including war or civil strife, food shortages, and population displacement, resulting in significant excess mortality."[37] Due to the sharp increase of non-international conflicts,[38] parties have aimed to undermine "the lives and livelihoods of civilian populations associated with opposing factions" alongside the quest to gain economic and political power.[39] As a result of the increase of non-international conflicts, the delivery of humanitarian assistance has evolved.[40]

For example, the number of nongovernmental organizations

3: Ensure Healthy Lives and Promote Wellbeing for All at All Ages, WORLD HEALTH ORG., https://www.who.int/sdg/targets/en/.

34. ADVANCING THE HUMAN RIGHT TO HEALTH, *supra* note 19, at 385.

35. GLOBAL HEALTH: DISEASES, PROGRAMS, SYSTEMS, AND POLICIES 1684 (Michael H. Merson et al. eds., 2018).

36. HEALTH IN HUMANITARIAN EMERGENCIES 43–44 (David A. Townes et al. eds., 2018).

37. GLOBAL HEALTH: DISEASES, PROGRAMS, SYSTEMS, AND POLICIES, *supra* note 35, at 1672 (quoting Brent T. Burkholder & Michael J. Toole, *Evolution of Complex Disasters*, 346 THE LANCET, 1012, 1015 (1995)).

38. The authors outline the historical progression of armed conflict, stating that "in 1993, 43 of 47 active conflicts were civil wars." HEALTH IN HUMANITARIAN EMERGENCIES, *supra* note 36, at 18–19.

39. GLOBAL HEALTH: DISEASES, PROGRAMS, SYSTEMS, AND POLICIES, *supra* note 35, at 1676.

40. *Id.*

("NGOs") and humanitarian aid agencies "operating in these complex settings has increased dramatically."[41] However, lower profile CEs do not attract the same level of alarm in the media, and humanitarian responses for these situations are much lower, even if the threat to the populations affected is just as severe as a higher profile CE.[42] If humanitarian assistance is provided, armed groups may use it to advance their efforts, using it as a resource to attract populations that the group will then target.[43] Targeting noncombatants is a violation of IHL, especially for humanitarian workers and facilities,[44] yet, in many recent conflicts, armed groups intentionally target health facilities, including those supported by humanitarian assistance.[45]

Another frequent result of CEs is gender-based violence, which can be particularly severe in conflict and post-conflict areas.[46] It is important to recognize that generalizations indicating that gender-based violence against women is always present in war, that rebel groups are more likely to report higher rates of sexual violence, or that such violence is always perpetuated by combatants are misconceptions and debunked by variance theory.[47] However, despite these generalizations, it is still equally important to consider CEs with a gendered perspective. Gender is just one of many determining factors, as vulnerable populations, such as children and refugees, also have a heightened risk of violence and are disadvantaged during humanitarian emergencies due to social and economic inequalities.[48] During the 2014–2016 West African EVD outbreak, "[b]y August 2014, approximately 55-60% of all Ebola fatalities in Guinea, Liberia, and Sierra Leone were women."[49] In this case, "sociocultural intensive barriers to women's access to appropriate health information . . . worsened the

41. *Id.* at 1679–80.
42. *Id.* at 1680.
43. *Id.*
44. *Id.* at 1681.
45. *Id.* at 1680–81.
46. *Id.* at 1686–87.
47. Dara Kay Cohen, Amelia Hoover Green & Elisabeth Jean Wood, *Wartime Sexual Violence: Misconceptions, Implications, and Ways Forward*, U.S. INST. OF PEACE SPECIAL REP. 323 (2013).
48. *See* Fionnuala Ní Aoláin, *Women, Vulnerability, and Humanitarian Emergencies*, 18 MICH. J. GENDER & L. 1, 5–6 (2011).
49. Florence Shu-Acquaye, *The Ebola Virus Prevention and Human Rights Implications*, 12 U. MASS. L. REV. 2, 31 (2017).

susceptibility of women to Ebola" because there was inadequate gender-sensitive information provided, allowing for a proliferation of the disease.[50] During CEs that are primarily caused from widespread disease outbreaks, the roles of women in society also contribute to greater risk of morbidity, as seen in the 2014–2016 EVD outbreak where women were the primary caregivers who tended to the sick and performed "funeral rites like washing bodies and preparing the for burial."[51]

D. GLOBAL HEALTH SECURITY AND THE INTERNATIONAL HEALTH REGULATIONS (2005)

The terms 'public health security,' 'global public health security,' and 'public health emergency legal preparedness' have all emerged in the 21st century.[52] The WHO 2007 World Health Report defined public health security as "the activities required, both proactive and reactive, to minimize vulnerability to acute public health events that endanger the collective health of national populations."[53] Global health security also includes "the health consequences of human behavior, weather-related events and infectious diseases, and natural catastrophes and man-made disasters . . .".[54] Finally, public health emergency preparedness brings in the legal aspect to the aforementioned definitions, in both a proactive and reactive manner to best prepare and respond to such emergencies.[55]

One of the first global health security concerns of the 21st century was Severe Acute Respiratory Syndrome ("SARS"), taking place over just six months in 2002–2003,[56] yet touching 26 countries and resulting in over 8,000 cases.[57] After the SARS outbreak shook the world, 'comprehensive collective security' emerged in a U.N. report that argued that the "emergence of new infectious diseases, a resurgence of older diseases and a spread

50. *Id.* at 33.

51. *Id.* at 32.

52. *See* THÉRÈSE MURPHY, HEALTH AND HUMAN RIGHTS 58–59 (2013).

53. WHO WORLD HEALTH REPORT 2007, *supra* note 4, at 1; MURPHY, *supra* note 52, at 58–59.

54. WHO WORLD HEALTH REPORT 2007, *supra* note 4, at 1; MURPHY, *supra* note 52, at 59.

55. MURPHY, *supra* note 52, at 59.

56. *CDC SARS Response Timeline*, CENTERS FOR DISEASE CONTROL AND PREVENTION, https://www.cdc.gov/about/history/sars/timeline.htm (last visited Jan. 7, 2019).

57. MURPHY, *supra* note 52, at 61–62.

of resistance to a growing number of mainstay antibiotic drugs . . . signify a dramatic decay in local and global public health capacity."[58] In 2005, Kofi Annan, then Secretary General of the U.N., called public health the "best defence against biological terrorism,"[59] supporting an expanded role of the UNSC to take action in the event of an "overwhelming outbreak of infectious disease that threatens international peace and security."[60] This development of urgency in the international community accelerated the International Health Regulations (1969) ("IHR (1969)") review process, resulting in the IHR (2005).[61]

The IHR (2005) was an important development in global health governance, seeking to "balance the state's right to protect . . . with obligations to take health-protecting actions in ways that do not unnecessarily interfere with international trade and travel."[62] Throughout the ten-year IHR (1969) revision process, it became "apparent that public health had emerged as critical to virtually every major global governance issue, ranging from national and international security, trade, and economic development, to environmental protection and human rights."[63] As global health expert Lawrence Gostin wrote during the revision process, the IHR (2005) "could serve as a model for effective public-health governance."[64] He identified a number of the main principles of global health governance as: "broad jurisdiction over conditions of international public health importance . . . national public-health preparedness by enforcing standards, creating incentives, and cultivating developmental and technical assistance [and] human rights protection by incorporating the Siracusa principles."[65] The IHR (2005) takes an "all-risk approach . . . [which allows for] more public health legitimacy, flexibility, and adaptability,"[66] through new reforms,

58. *Id.* at 63.

59. *Id.*

60. *Id.*

61. *See* David P. Fidler & Lawrence O. Gostin, *The New International Health Regulations: An Historic Development for International Law and Public Health*, 34 J. L. MED. & ETHICS 85, 85 (2006).

62. WHO, INTERNATIONAL HEALTH REGULATIONS (2005) art. 2, 3.4 (3d ed. 2016) [hereinafter IHR (2005)]; Fidler & Gostin, *supra* note 61, at 86.

63. Fidler & Gostin, *supra* note 61, at 86.

64. Lawrence O. Gostin, *The International Health Regulations and Beyond*, 4 THE LANCET INFECTIOUS DISEASES 606, 606 (2004).

65. *Id.*

66. Fidler & Gostin, *supra* note 61, at 86–87.

including: a robust mission, emphasizing the WHO's core public health purposes, functions, and essential services, broad scope and flexibly to cover diverse health threats, global surveillance via official and unofficial data sources, and strengthening of national public health systems by "setting performance criteria, measuring outcomes, and holding states accountable," just to name a few.[67]

While application of the IHR (1969) was limited to outbreaks of cholera, plague, and yellow fever (smallpox was removed from this list after a revision in the 1970s following its global eradication),[68] the IHR (2005) greatly expands the application by requiring States to "notify the WHO . . . of *all events* which may constitute a public health emergency of international concern within its territory" *(emphasis added)*.[69] It defines a public health emergency of international concern ("PHEIC") as "an extraordinary event which is determined . . . (i) to constitute a public health risk to other States through the international spread of disease and (ii) to potentially require a coordinated international response."[70] The IHR (2005) also provides a decision instrument to assist States in making this determination.[71]

E. THE EASTERN DRC EVD OUTBREAK BEGINNING IN 2018

The tenth EVD outbreak in the DRC was declared on August 1, 2018 and has since become the second largest in history.[72] The case that set off the initial alarm occurred in Mangina, located in the Mabalako Health Zone of North Kivu province (north-eastern DRC), when a woman was admitted, and subsequently discharged, from a local health center.[73] She

67. Lawrence O. Gostin, *International Infectious Disease Law: Revision of the World Health Organization's International Health Regulations*, 291 J. AM. MED. ASS'N 2623, 2623 (2004).

68. *Id.* at 2624.

69. IHR (2005), *supra* note 62, art. 6(1).

70. *Id.* art. 1(1).

71. *Id.* at Annex 2.

72. *New Ebola Outbreak Declared in North Kivu*, MÉDECINS SANS FRONTIÈRES (Sept. 5, 2018), https://www.msf.org/new-ebola-outbreak-declared-north-kivu; BBC News, *Ebola Outbreak in DR Congo Now Second Worst in History*, BBC.COM (Nov. 30, 2018), https://www.bbc.com/news/world-africa-46398267.

73. MÉDECINS SANS FRONTIÈRES, *supra* note 72; WORLD HEALTH ORG. REG'L OFFICE FOR AFR., *Ebola Virus Disease: Democratic Republic of the Congo*

died at home shortly after. When her family began to show similar symptoms, a joint investigation by the DRC Ministry of Health and the WHO found six more suspect cases.[74]

Compared to the 2014–2016 West African EVD outbreak, there are a number of significant differences presented in this Eastern DRC EVD outbreak beginning in 2018. It is taking place in the Democratic Republic of Congo ("DRC"), the country where EVD was first discovered in 1976,[75] and started in the North Kivu province of the Eastern DRC, which has been a conflict zone for decades and where violence continues today.[76] North Kivu province houses an even denser population than Guinea, Liberia, and Sierra Leone combined, and shares borders with four more provinces and two other countries.[77] This subregion of the DRC has a history of insecurity and presence of well over one hundred active non-state armed groups,[78] which still remain in the region after conflicts such as the DRC independence in 1960, the 1994 Rwandan genocide just across the border, and the civil war that established the regime of former President Joseph Kabila.[79] It should be noted that not only are the non-state armed groups active in the ongoing internal armed conflict, but there is also a significant presence from the National Congolese Police and the Armed Forces of the Democratic Republic of Congo.[80] All groups are responsible for the rapes, kidnappings, and killings that have continued throughout the region for decades.[81] As a result, there are over one million internally

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External Situation Report 01, WORLD HEALTH ORG. (Aug. 7, 2018), https://apps.who.int/iris/bitstream/handle/10665/273640/SITREP_EVD_DRC_20180807-eng.pdf?ua=1 [hereinafter *WHO External Situation Report 01*].

74. MÉDECINS SANS FRONTIÈRES, *supra* note 72.

75. Alison Agnew, *A Combative Disease: The Ebola Epidemic in International Law*, 39 B.C. INT'L & COMP. L. REV. 97, 99 (2016).

76. *See* JASON STEARNS, NORTH KIVU: THE BACKGROUND TO CONFLICT IN NORTH KIVU PROVINCE OF EASTERN CONGO 7–10 (2012).

77. *WHO External Situation Report 01*, *supra* note 73; J. Stephen Morrison & Judd Devermont, *North Kivu's Ebola Outbreak at Day 90: What Is To Be Done?*, CSIS BRIEFS (Nov. 2018), https://www.csis.org/analysis/north-kivus-ebola-outbreak-day-90-what-be-done.

78. *Armed Group Maps*, SULUHU, https://suluhu.org/congo/mapping/ (mapping of non-state armed groups).

79. Kimiko de Freytas-Tamura, *Trek into Congo Forest Reveals an Ebola Crisis Fueled by Violence*, N.Y. TIMES (Dec. 26, 2018), https://www.nytimes.com/2018/12/26/world/africa/ebola-congo.html.

80. U.S. DEP'T OF STATE, DEMOCRATIC REPUBLIC OF THE CONGO: 2018 HUMAN RIGHTS REPORT 7–19 (2018), https://www.state.gov/wp-content/uploads/2019/03/Democratic-Republic-of-the-Congo-2018.pdf.

81. *Kivu Security Tracker*, CONGO RESEARCH GRP., https://kivusecurity.org

displaced people living in North Kivu province, as well as refugees from nearby countries including Uganda, Burundi, and Tanzania.[82]

Although this is the tenth time the DRC has experienced an EVD outbreak, the security situation in the eastern part of the country, particularly North Kivu and Ituri provinces, has made managing this outbreak especially challenging.[83] Traditional methods of contact tracing and isolation of cases are necessary to respond to highly contagious diseases,[84] but data from the WHO in February 2019 (six months after the start of the outbreak), reported that 43% of EVD deaths were "found dead in their communities—not isolated in hospitals in the late stages of the illness, when the disease is most infectious. And nearly half of those diagnosed with [EVD] had not previously been identified as contacts of people who had contracted the virus."[85] The fact that so many EVD cases were still unknown to healthcare professionals and officials at this time demonstrates the unpredictability of the current geographic spread of the disease.[86] While the outbreak was centralized around North Kivu for the first six months, this pattern of scattered clusters of cases then moved farther south to Goma (the much larger capital of North Kivu province), the southeastern provinces of the DRC, and across State borders.[87]

Meanwhile, threats of violence impede access to some communities.[88] Even though there are new technologies, such as large-scale ring vaccination initiatives and effective trials of two different EVD treatments,[89] all supporting EVD management

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/map (tracking security incidents in North and South Kivu).

82. Morrison & Devermont, *supra* note 77, at 4.

83. *See* Lawrence O. Gostin et al., *Ebola and War in the Democratic Republic of Congo: Avoiding Failure and Thinking Ahead*, 321 J. AM. MED. ASS'N 243, 243 (2019).

84. *Id.*

85. Amy Maxmen, *Violence Propels Ebola Outbreak Towards 1,000 Cases*, 567 NATURE 153, 153–54 (2019), https://www.nature.com/articles/d41586-019-00805-7.

86. *Ebola Outbreak Crisis Update*, MÉDECINS SANS FRONTIÈRES (Sept. 13, 2019), https://www.msf.org/drc-2018-ebola-outbreak-crisis-update.

87. *Id.*; Lisa Schnirring, *Ebola Spreads to 3rd DRC Province – South Kivu*, CTR. FOR INFECTIOUS DISEASE RES. & POL'Y (Aug. 16, 2019), http://www.cidrap.umn.edu/news-perspective/2019/08/ebola-spreads-3rd-drc-province-south-kivu; *see also* De Freytas-Tamura, *supra* note 79.

88. Gostin et al., *supra* note 83, at 243.

89. *Emergency Preparedness, Response: Ebola Virus Disease – Democratic Republic of the Congo*, WORLD HEALTH ORG. (Aug. 15, 2019),

efforts in this outbreak, attacks on health centers, civilians, and aid workers have perpetuated community distrust, even leading to active resistance.[90] On February 27, 2019, the security situation was so serious that Médecins Sans Frontières/Doctors Without Borders ("MSF") was forced to suspend all activities in Katwa and Butembo[91] due to numerous attacks by non-state armed groups on their EVD treatment centers.[92] Such attacks against healthcare facilities, aid workers, and EVD patients severely threaten the effective management of this EVD outbreak due to its extremely infectious nature.[93] Another external factor that has played a significant role in the insecurity and mistrust in the region was the DRC's presidential election, which was held in December 2018 after being delayed the preceding two years.[94] Many of the active armed groups opposed President Kabila at the start of the outbreak, and rumors that the government was using this EVD outbreak to prolong Kabila's tenure even longer led to further community distrust in EVD response efforts.[95]

Another difference is that two months after the DRC's Ministry of Health declared the outbreak, the WHO's EC convened under the IHR (2005) and decided that this outbreak did not yet constitute a PHEIC.[96] However, the Committee did emphasize the "need to intensify response activities and strengthen vigilance."[97] The UNSC then passed Resolution 2439

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https://www.who.int/csr/don/15-august-2019-ebola-drc/en/.

90. Morrison & Devermont, *supra* note 77, at 4.

91. Helen Branswell, *Ebola Response Teams Scrambling to Care for Patients After Attacks Set Back Efforts*, STAT NEWS (Mar. 1, 2019), https://www.statnews.com/2019/03/01/ebola-response-teams-scrambling-to-care-for-patients-after-attacks-set-back-efforts/.

92. *Medical Activities Suspended After Ebola Treatment Centre Attack*, MÉDECINS SANS FRONTIÈRES (Feb. 28, 2019), https://www.msf.org/medical-activities-suspended-after-ebola-treatment-centre-attack.

93. *See* Branswell, *supra* note 91 (discussing the challenge of containing EVD in what is "effectively a war zone").

94. Morrison & Devermont, *supra* note 77, at 4; *Take as Directed – CSIS*, GLOBAL HEALTH POL'Y CTR. (Jan. 2019), https://soundcloud.com/csis-57169780/ebola-crisis-in-drc-critical-context (discussing the impact of the 2018 election on EVD outbreak management).

95. *See Take as Directed — CSIS, supra* note 94.

96. Gostin et al., *supra* note 83, at 243; Morrison & Devermont, *supra* note 77, at 1.

97. WORLD HEALTH ORG. REG'L OFFICE FOR AFR., *Ebola Virus Disease: Democratic Republic of the Congo External Situation Report 24*, (Jan. 16, 2019), https://apps.who.int/iris/bitstream/handle/10665/279604/SITREP_EVD_DRC_20190116-eng.pdf.

on October 30, 2018, condemning the actions of armed groups in the region and demanding that they respect IHL, as well as calling out the rest of the international community for more support in managing this outbreak.[98] However, despite UNSC Resolution 2439, there was a severe lack of mobilization of domestic and international support from October 2018 through April 2019, much less than the level observed in the 2014–2016 West African EVD outbreak.[99]

In April 2019, the Director-General ("DG") of the WHO convened the EC again to evaluate whether to declare the outbreak a PHEIC, due to a significant increase in cases and violence in spring 2019.[100] The EC recommended against declaring a PHEIC, advice which Dr. Tedros (DG of the WHO) took.[101] He also reiterated the severity of the outbreak for those in the affected areas, calling for more international support in the form of resources and funding.[102] Nevertheless, without a declaration of a PHEIC, the international community still lacked the momentum needed to make any real headway in ending the outbreak.[103] Not long after, in June 2019, an EVD case was detected in Uganda, prompting Dr. Tedros to call another EC meeting, which again resulted in no declaration of a PHEIC.[104] Although the "Committee acknowledged that recent cases in Uganda constitute international spread of disease," the EC still decided the possible consequences of declaring a PHEIC in the

98. Morrison & Devermont, *supra* note 77, at 7.

99. *See id.* at 3; Jasmine Aguilera et al., *The Congo Outbreak Began a Year Ago. Here's What to Know About the Public-Health Emergency*, TIME.COM (Aug. 1, 2019), https://time.com/5606544/ebola-outbreak-drc-uganda/.

100. *Statement on the Meeting of the International Health Regulations (2005) Emergency Committee for Ebola Virus Disease in the Democratic Republic of the Congo on 12th April 2019*, WORLD HEALTH ORG., (Apr. 12, 2019), https://www.who.int/news-room/detail/12-04-2019-statement-on-the-meeting-of-the-international-health-regulations-(2005)-emergency-committee-for-ebola-virus-disease-in-the-democratic-republic-of-the-congo-on-12th-april-2019.

101. Dr. Tedros Ghebreyesus, Dir. Gen., WHO, IHR Emergency Committee on Ebola Virus Disease in the Democratic Republic of Congo, North Kivu (Apr. 12, 2019), https://www.who.int/dg/speeches/detail/ihr-emergency-committee-on-ebola-virus-disease-in-the-democratic-republic-of-congo-north-kivu.

102. *Id.*

103. Helen Branswell, *After Ebola Spills into Uganda, WHO Decides against Emergency Declaration,* STAT (June 14, 2019), https://www.statnews.com/2019/06/14/ebola-uganda-who-no-emergencydeclaration/.

104. Dr. Tedros Ghebreyesus, Dir. Gen., WHO, IHR Emergency Committee on Ebola in North Kivu, Democratic Republic of the Congo (June 14, 2019) https://www.who.int/dg/speeches/detail/ihr-emergency-committee-on-ebola-in-north-kivu-democratic-republic-of-the-congo.

region weighed more than the benefits, stating that the "ongoing response would not be enhanced by formal Temporary Recommendations under the IHR (2005)."[105]

In July 2019, Dr. Tedros called the EC to meet one more time after an EVD case was detected in Goma, the highly populated capital city of North Kivu province with an international airport.[106] At this meeting, the EC recommended Dr. Tedros to declare the Eastern DRC EVD outbreak beginning in 2018 a PHEIC.[107] While the main new concern was the case in Goma, the EC expressed continued concern about the intensity of the outbreak, the constantly shifting hotspots, the state of insecurity in the region, and the effect of community distrust on outbreak management efforts.[108] Additionally, the EC was worried about the possibility of epidemic extension since it was almost one year into the outbreak and there was still not enough funding or response coordination across international actors.[109] Finally, the EC and Dr. Tedros made explicit statements about ensuring that all countries keep their borders open, and that no travel or trade restrictions be imposed.[110] The economic impact on the region that could result from such restrictions was one of the main reasons the WHO was so hesitant to declare a PHEIC earlier in the outbreak.[111] However,

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105. *Statement on the Meeting of the International Health Regulations (2005) Emergency Committee for Ebola virus disease in the Democratic Republic of the Congo*, WORLD HEALTH ORG. (June 14, 2019), https://www.who.int/news-room/detail/14-06-2019-statement-on-the-meeting-of-the-international-health-regulations-(2005)-emergency-committee-for-ebola-virus-disease-in-the-democratic-republic-of-the-congo.

106. EMERGENCY COMM. FOR EBOLA VIRUS DISEASE IN THE DEM. REP. CONGO, *Statement on the Meeting of the International Health Regulations (2005) Emergency Committee for Ebola virus disease in the Democratic Republic of the Congo*, WORLD HEALTH ORG. (June 17, 2019), https://www.who.int/ihr/procedures/statement-emergency-committee-ebola-drc-july-2019.pdf; *see also* Chiara Giordano, *Ebola Outbreak: First Case Discovered in DRC's Goma City, Home to 2 Million People*, INDEPENDENT (July 14, 2019), https://www.independent.co.uk/news/world/africa/congo-ebola-outbreak-goma-first-case-who-spread-emergency-a9004746.html (describing Goma as a "densely populated area").

107. *See* EMERGENCY COMM. FOR EBOLA VIRUS DISEASE IN THE DEM. REP. CONGO, *supra* note 106, at 6.

108. *Id.* at 3.

109. *Id.*

110. *Id.*

111. *See* Lawrence Gostin, *WHO 4th Emergency Committee Under the International Health Regulations to Review the Ebola Epidemic in the Democratic Republic of Congo*, O'NEILL INST. FOR NAT'L & GLOB. HEALTH L. (July 17, 2019), https://oneill.law.georgetown.edu/news/who-4th-emergency-

even after declaring a PHEIC in July 2019, many global health actors continued to criticize the lack of international response, posing two common questions: "Why now? What will be done differently?"[112]

In August 2019, the UNSC made a statement reiterating its grave concern about the Eastern DRC EVD outbreak beginning in 2018 and highlighting the urgency and need for international cooperation in the EVD response.[113] The Security Council once again clearly condemned "all attacks against and threats intentionally directed against medical personnel and humanitarian personnel," emphasizing the dangerous security situation and calling "for an immediate cessation of hostilities by all armed groups."[114] Yet, the UNSC stopped there, releasing only a statement regarding the recent declaration of a PHEIC and drawing attention to the security situation.[115]

Thus, the developments of this outbreak across one year demonstrate that the complex situation of a highly infectious disease outbreak occurring in a region fraught with armed groups, a severe lack of community trust for medical and humanitarian workers, and during a historic election in the country, has made responding to this EVD outbreak in the eastern DRC especially challenging.[116]

III. ANALYSIS

Part III of this note analyzes the relationships among IHRL, IHL, and global health policy for EIDs. First, it will discuss the gaps and challenges in application of these intersections, drawing special attention to the application of the IHR (2005), which is intended to provide a framework for responding to infectious disease outbreaks.[117] Second, it will present a number

committee-under-the-international-health-regulations-to-review-the-ebola-epidemic-in-the-democratic-republic-of-congo/.

112. Laurie Garrett, *The World Bank Has the Money to Fight Ebola But Won't Use It,* FOREIGN POLICY (July 22, 2019, 12:40 PM), https://foreignpolicy.com/2019/07/22/the-world-bank-has-the-money-to-fight-ebola-but-wont-use-it/.

113. U.N. President of the Security Council, *Statement by the President of the Security Council*, 2, U.N. Doc. S/PRST/2019/6 (Aug. 2, 2019).

114. *Id.* at 2.

115. *Id.* at 1.

116. *See* EMERGENCY COMM. FOR EBOLA VIRUS DISEASE IN THE DEM. REP. CONGO, *supra* note 106, at 2.

117. IHR (2005), *supra* note 62, at 10.

of relevant tools and methods that the international community can employ to address the current needs in the Eastern DRC EVD outbreak beginning in 2018.

A. GAPS AND CHALLENGES AMONG IHRL, IHL, AND THE IHR (2005)

1. International Human Rights Law

Due to the nature of infectious disease outbreaks, the application of the IHR (2005) often restricts many human rights.[118] While IHRL does protect the right to health,[119] like much of IHRL, limitations and derogations apply to the right to health, as certain rights must be restricted in order to protect the community.[120] Article 4 of the International Covenant on Civil and Political Rights ("ICCPR") provides for derogation during public emergencies which threaten the State as long as such measures remain consistent with the State's other international legal obligations and are not discriminatory.[121] Additionally, soft law standards such as the Siracusa principles on the limitation and derogation provisions of the ICCPR ("Siracusa principles")[122] were established in 1984 and provide general guidelines for the rationalization of limitations of human rights by responding to "concerns about the violation of individual human rights that could occur when a state acts to protect the public good, but however, limits the rights of individuals."[123] Thus, such measures must meet eight minimum requirements,[124] but in terms of EID control, this can be boiled

118. Gostin, *supra* note 64, at 2626.

119. Virginia Leary, *The Right to Health in International Human Rights Law*, 1 HEALTH & HUM. RTS. 1, 24 (1994).

120. *See* FIDLER, INTERNATIONAL LAW AND PUBLIC HEALTH, *supra* note 1, at 127.

121. International Covenant on Civil and Political Rights art. 4(1), Dec. 19, 1966, 999 U.N.T.S. 14668.

122. Provisional Agenda Item, Commission on Human Rights, The Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights, U.N. Doc. E/CN.4/1985/4 (Sept. 28, 1985) [hereinafter The Siracusa Principles].

123. Shu-Acquaye, *supra* note 49, at 23.

124. *Id.* at 25 ("In the context of limitations in light of public health, the Siracusa Principles necessitate that any measures that limit individual human rights be: 1) provided for and carried out in accordance with law, 2) directed toward a legitimate objective of general interest, 3) strictly necessary in a democratic society to achieve the objective, 4) be least intrusive and restrictive

down to being "necessary, proportionate, and fair."[125]

Quarantine measures are an example of a restriction that poses a challenge for reconciliation of IHRL and effective global health policies for EIDs. Article 21 of the WHO Constitution grants the World Health Assembly the power to adopt provisions regulating a number of areas, which includes: "sanitary and quarantine requirements and other procedures designed to prevent the international spread of disease."[126] During the 2014–2016 West African EVD outbreak, the impact of quarantine measures on human rights was extensive.[127] Because Guinea, Liberia, and Sierra Leone did not have strong enough healthcare systems to handle the EVD outbreak, they declared national states of emergency and implemented quarantines and lockdowns.[128] Not only did such measures "restrict people's right to liberty and freedom of movement, but also impacted on [people's] livelihood[s], contribut[ed] to food insecurity, loss of employment, and access to health care."[129] Though quarantine can be an effective tool for managing the spread of disease,[130] in the case of the 2014–2016 West African EVD outbreak, such measures were not fully effective because they were not adequately monitored, not based on scientific evidence, were arbitrarily applied, and were overly broad in implementation.[131] As a result of these ineffective quarantines, vulnerable communities experienced increased stigma, fear, and shame, and the disease actually spread further.[132] The challenge found in IHRL principles and the use of global health policies for EIDs, such as the IHR (2005), is that even the revised IHR (2005) does not address the "legal standards and fair processes necessary for isolation, quarantine, and other compulsory

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to achieve the objective, 5) be based on scientific evidence, 6) be neither arbitrary nor discriminatory in application and of limited duration, 7) be respectful of human dignity, and 8) be subject to review.").

125. The Siracusa Principles, *supra* note 122, at 3.

126. Chiara Giorgetti, *International Health Emergencies in Failed and Failing States*, 44 GEO. J. INT'L L. 1347, 1363–64 (2013); Tsung-Ling Lee, *Making International Health Regulations Work: Lessons From The 2014 Ebola Outbreak*, 49 VAND. J. TRANSNAT'L L. 931, 953 (2016).

127. Andra Le Roux-Kemp, *International and Operational Responses to Disease Control: Beyond Ebola and Epistemological Confines*, 15 IND. HEALTH L. REV. 247, 274–75 (2018).

128. Agnew, *supra* note 75, at 109–10.

129. Le Roux-Kemp, *supra* note 127, at 274–75.

130. *Id.* at 284.

131. *Id.* at 275.

132. *Id.* at 275; Agnew, *supra* note 75, at 109.

measures."[133] This is a significant gap, because as evidenced through the 2014–2016 West African EVD outbreak and the quarantine of HIV-positive Haitian refugees in Guantanamo during the HIV/AIDS epidemic in the 1990s, there is enormous potential for abuse of quarantine measures,[134] which can lead to deprivation of human rights such as privacy and freedom of movement.

Another gap in the application of global health policies for EIDs and IHRL has to do with the capacity of States to implement their commitments under IHRL. As discussed, States that are party to the ICESCR recognize the right to health as defined in Article 12, which includes addressing the prevention of disease.[135] For disease prevention, the challenge is that while States are required to "take all appropriate measures subject to available resources to prevent such diseases,"[136] the States in which neglected diseases are most prevalent "are least able to counter the existing imbalance in disease prevention research and development."[137] This pattern was confirmed during the 2009 H1N1 outbreak, when an Independent Review Committee "found that health capacities were nowhere near 'a timely path to implementation worldwide'," which scholars have attributed to the "lack of capacity in many states in the Global South . . . [due to] historical vulnerability from slavery, colonialism, neocolonialism, bad governance, and neoliberal reform policies like structural adjustment."[138] Thus, this is where the "obligation of international co-operation under the right to . . . health . . . becomes significant."[139] Because these states lack the capacity to "progressively realize and ensure that a minimum core of a properly functioning health system and infrastructure, as well as adequate health-system capacity, exists for people to gain access to health services," the international community has

133. Gostin, *supra* note 64, at 2626.

134. *See* Le Roux-Kemp, *supra* note 127, at 282, 284.

135. ICESCR, *supra* note 16, subdiv. 2(c).

136. TOBIN, *supra* note 13, at 270.

137. *Id.*

138. *See, e.g.*, Matiangai Sirleaf, *Ebola Does Not Fall from the Sky: Structural Violence & International Responsibility*, 51 VAND. J. TRANSNAT'L L. 477, 521 (2018) (quoting Harvey V. Fineberg, WORLD HEALTH ORG., *Report of the Review Committee on the Functioning of the International Health Regulations (2005) in Relation to the Pandemic (H1N1) 2009*, at 9 (May 2011), http://www.who.int/ihr/WHA64_10_HVF_2011.pdf.).

139. TOBIN, *supra* note 13, at 270.

a collective responsibility to address this problem.[140] The ICESCR addresses the concept of 'collective responsibility' by providing that States should realize the rights in the Covenant "individually and through international assistance and co-operation, especially economic and technical."[141] During the 2014–2016 West African EVD outbreak, many international organizations, regional actors, and States supported epidemic control efforts on the ground.[142] However, such reliance on a single, more powerful state proved to be a risky method for epidemic management.[143] For example, Liberia relied on support from the United States during the 2014–2016 West African EVD outbreak, and when the focus shifted from managing EVD to Zika in 2016, the United States actually used EVD dedicated funds to address the Zika outbreak, leaving Liberia at a loss.[144] Thus, addressing the main challenge of building up States' capacities to implement the IHRL commitments that they made must involve international support and co-operation, because although international law respects boundaries, infectious diseases do not.[145]

2. International Humanitarian Law

An analysis of IHL principles in this context is equally important to consider, given the ongoing armed conflict situation in the eastern DRC. It has become more widely accepted that IHRL applies at all times, including during armed conflict.[146]

140. Le Roux-Kemp, *supra* note 127, at 289.

141. ICESCR, *supra* note 16, art. 12 subdiv. 2(c).

142. *See* Sirleaf, *supra* note 138, at 539–40.

143. *See id.* at 539.

144. *Id.*

145. *E.g.*, Fidler, *Return of the Fourth Horseman*, *supra* note 1, at 811–12 ("The structure of the international system is, however, irrelevant to the microbial world. Slogans like 'germs know no frontiers' and 'germs carry no passports' have been used since the founding of WHO. In international relations terms, pathogenic microbes constitute nonstate actors with transnational power.").

146. *Compare* Noam Lubell, *Challenges in Applying Human Rights Law to Armed Conflict*, 87 INT'L REV. OF THE RED CROSS 737, 738 (2005) (stating that Legal Consequences of the Construction of a Wall in the Occupied Palestinian Territory, Advisory Opinion, 2004 I.C.J. Rep. 136 (July 9) clarifies that "human rights law is not entirely displaced and can at times be directly applied in situations of armed conflict"), *with* Cordula Droege, *The Interplay Between International Humanitarian Law and International Human Rights Law in Situations of Armed Conflict*, 40 ISR. L. REV. 310, 316 (2007) (arguing that "the application of human rights in armed conflict is recognized in international

This applicability has the potential to provide greater protections to individuals in armed conflict.[147] While derogations are permissible under IHRL, this is not the case for IHL.[148] The principle of *lex specialis* says that the rule which is more specific should displace the more general rule,[149] and since IHL has more specific protections than IHRL in situations of armed conflict, it is especially important to consider the role IHL plays in protecting health during armed conflict. In terms of the relationship between IHL and IHRL, since it is established that IHRL and IHL can and do exist concurrently, IHL does not have to "displace" IHRL, but instead can provide additional protections which are relevant for this analysis.[150]

Although IHL is intended to protect health in armed conflict, in reality this protection is a commonly violated principle of IHL. Reports show that between January 2014 and December 2015, "there were 594 reported attacks on health care that resulted in 959 deaths and 1561 injuries in 19 countries facing emergencies."[151] One well-known and publicly criticized attack was when U.S. forces fired at the MSF hospital in Kunduz, Afghanistan in 2015, which the U.S. later claimed was an accident.[152] The WHO has recognized that "[a]ccess to health care cannot be guaranteed without first protecting the people who provide it . . . [and] attacks on health workers are doubly abhorrent, as they violate the rights of the workers and the rights of their patients."[153] Thus, a major challenge for the implementation of global health policies for EIDs in IHL involves compliance of parties in armed conflict with IHL.

Unfortunately, parties to an armed conflict may choose not to comply with IHL for a variety of reasons, which can lead to the kind of harmful situation seen in Kunduz.[154] States are

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humanitarian law, even if the detail of their interaction remains a matter of discussion").

147. Droege, *supra* note 146, at 335.

148. *See id.* at 341.

149. *Id.* at 338.

150. Lubell, *supra* note 146.

151. *WHO 2015 Report: WHO's Work in Emergency Risk and Crisis Management*, at 4; WHO Reference No. WHO/WHE/ERM/EXT/2016.4 (2016), https://apps.who.int/iris/bitstream/handle/10665/251551/WHO-WHE-ERM-EXT-2016.4-eng.pdf.

152. *On 3 October 2015, US Airstrikes Destroyed Our Trauma Hospital in Kunduz, Afghanistan, Killing 42 people,* MÉDECINS SANS FRONTIÈRES, https://www.msf.org/kunduz-hospital-attack-depth (last visited Apr. 12, 2019).

153. *WHO 2015 Report*, *supra* note 151, at 13.

154. *See* M. Cherif Bassiouni, *The New Wars and the Crisis of Compliance*

responsible for violations of IHL, as ingrained in CIL, the GCs, and APs.[155] Violations of IHL are serious and can lead to State liability at the international court level, as the obligation to respect IHL flows from the obligation to respect international law as a whole, and is codified in the four GCs, AP I, as well as many States' military manuals.[156] On the other hand, many non-state actors choose noncompliance because they are almost always in an asymmetrical relationship concerning the power of the State, thus they are left at a significant military disadvantage.[157] As a result, some non-state actors may compensate for this asymmetry by turning to "unconventional and unlawful means and methods of warfare," ultimately resulting in noncompliance with IHL.[158] Other factors leading to noncompliance of non-state armed groups include "little to no command and control structure, and little to no internal discipline . . . to enhance compliance . . . [and] no expectation of accountability for their noncompliance."[159] Non-international armed conflicts are complicated, and States are typically bound to Common Article 3 of the GCs.[160] Many of these conflicts end up falling under domestic criminal law, State security terrorism laws, and IHRL, not IHL.[161] Domestic policies for acts of non-state armed groups often include criminal repercussions, so "non-state actors have no inducement for compliance . . . if they are treated as common criminals, instead of lawful combatants."[162]

Since IHL can only protect health if its rules are followed by all actors in an armed conflict, there are a number of positive

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*with the Law of Armed Conflict by Non-State Actor*s, 98 J. CRIM. L. & CRIMINOLOGY 711, 765, 769 (2008) (discussing reasons why State and non-state parties to armed conflict comply or not comply with IHL); *see generally* MÉDECINS SANS FRONTIÈRES, *supra* note 152 (discussing the challenge of providing adequate healthcare in light of noncompliance with IHL principles).

155. Int'l Comm. of the Red Cross, *Rule 149. Responsibility for violations of International Humanitarian Law*, CUSTOMARY IHL DATABASE, https://ihl-databases.icrc.org/customary-ihl/eng/docs/v1_rul_rule149 (last visited Sept. 30, 2019).

156. Int'l Comm. of the Red Cross, *Rule 139. Respect for International Humanitarian Law*, CUSTOMARY IHL DATABASE, https://ihl-databases.icrc.org/customary-ihl/eng/docs/v1_rul_rule139 (last visited Sept. 30, 2019).

157. Bassiouni, *supra* note 154, at 714.

158. *Id.* at 714–15.

159. *Id.* at 715.

160. GCs, *supra* note 26, common art. 3.

161. *See* Bassiouni, *supra* note 154, at 731.

162. *Id.*; *see also id.* at 734, 756.

incentives that can counter a non-state actor's preference for noncompliance. First, States can offer a peace process, which, like the El Salvador conflict, affords the non-state actors a seat at the negotiating table.[163] Second, conflict resolution mechanisms, such as opening the door to negotiations, as seen with the French during the Algerian War, have shown to be strong inducers for compliance.[164] Third, but certainly not last, educating non-state armed groups in IHL can lead to compliance with its norms, assuming that the non-state actors "have the military discipline necessary to ensure . . . that compliance will be carried out by subordinates."[165] It should also be noted that built-in initiatives, such as unilateral declarations, may encourage non-state armed group compliance with IHL.[166] Thus, while noncompliance with IHL is a challenge that negatively affects health in armed conflict, understanding its foundation and the possibility for positive incentives is the first step to tackling this gap and effectively implementing global health policies for EIDs.

Following up on the previous discussion about quarantine procedures and IHRL in Part III, section A(i), a similar challenge is found in the relationship between quarantine procedures and IHL. In the 2014–2016 West African EVD outbreak, the use of force was employed to enforce separation and confinement of confirmed and suspected cases of EVD, in an effort to control the spread of the disease.[167] The military presence and militarization of EVD "reminded some generations of the relatively recent civil war, and . . . of colonial coercion in the name of promoting hygiene . . . creat[ing] a heightened sense of uncertainty and distrust . . . in communities."[168] Additionally, this militarization led to further measures such as "curfews, closed schools, restricted travel, and . . . community quarantines."[169] While quarantine is a core public health tool and can be very effective in managing disease outbreaks, in this

163. *Id.* at 789.

164. *Id.* at 789–90.

165. *Id.* at 790.

166. Michelle Mack, *Increasing Respect for International Humanitarian Law in Non-International Armed Conflicts*, INT'L COMM. FOR THE RED CROSS 19 (Feb. 2008), https://www.icrc.org/sites/default/files/topic/file_plus_list/0923-increasing_respect_for_international_humanitarian_law_in_non-international_armed_conflicts.pdf (last visited Sept. 30, 2019).

167. Le Roux-Kemp, *supra* note 127, at 281.

168. *Id.* at 282.

169. Agnew, *supra* note 75, at 109.

case the result of quarantine measures was not fully successful, instead sparking violence and unrest in urban areas and "driving people underground and jeopardizing the trust between people and health providers."[170] In fact, the effect of the 2014–2016 West African EVD outbreak has proven to be just as "destabilizing as war, prompting the U.N. Security Council to declare Ebola a threat to peace and security."[171] However, treating disease similar to the more 'typical' threats to peace and security (i.e. armed conflict) and invoking Chapter VII of the U.N. Charter can lead to over-militarization, which "instills fear, deters symptomatic individuals from seeking treatment, and has damaging socioeconomic consequences."[172] Instead, EIDs are a different type of 'war' which "should be fought primarily by those states and organizations with medical expertise and experience in combating disease epidemics, rather than military forces."[173] As a result, the potential for such militarization and use of force in EID outbreaks is a major challenge to effective implementation of global health policies for EIDs, and while some circumstances may call for such force, this decision should be made very carefully.

3. International Health Regulations (2005)

As discussed in the Background section, the IHR (1969) underwent an extensive revision process, resulting in the IHR (2005) used today.[174] Despite the revision, the IHR (2005) still faces significant challenges, namely with regard to funding, dispute resolution procedures, enforcement mechanisms, and incentives for compliance.[175] The 2014–2016 EVD outbreak is an example of the gap between the regulations on paper and in reality; the stunted effectiveness of the IHR (2005) is particularly illuminated by state noncompliance and with the WHO's reduced ability to coordinate stakeholders and respond decisively.[176] The IHR (2005) requires states to "develop, strengthen, and maintain . . . the capacity to detect, assess,

170. *Id.*
171. *Id.* at 128.
172. *Id.* at 124; *see also id.* at 128.
173. *Id.* at 124.
174. *See* Fidler & Gostin, *supra* note 61, at 85–86.
175. Agnew, *supra* note 75, at 116–18.
176. Lawrence O. Gostin et al., *The Global Health Law Trilogy: Towards a Safer, Healthier, and Fairer World*, 390 THE LANCET 1918, 1921 (2017).

notify and report events,"[177] yet it has been shown that the "WHO has routinely allowed states to delay fulfilling their responsibilities," perpetuating State noncompliance.[178] Enforcement and compliance go hand-in-hand because "[i]n the absence of enforceable legal sanctions, states have little incentive to comply with the IHR [(2005)]."[179] When States carry out a cost-benefit analysis, rationalistic States will put their self-interest first and come to the conclusion that the benefits of noncompliance outweigh the benefits of compliance, leading to routine violations of the IHR (2005).[180] This "lack of enforceable obligations hinders the global progress of international health security . . . since there is no external verification of a country's implementation process, self-reporting is the only official source of assessing IHR implementation . . . [and this] gap puts global health security in significant jeopardy."[181] Thus, while the IHR (2005) provides invaluable soft law standards, the lack of enforcement requirements is a major challenge because if States are not held accountable, the impact of the IHR (2005) becomes obsolete.[182]

In a similar way, lack of funding and resources also pose a challenge for effective implementation of the IHR (2005). Through the aforementioned cost-benefit analysis, States may not comply with their obligations under the IHR (2005) because they lack the financial capacity to do so.[183] Especially in failed and failing states,[184] noncompliance is not a voluntary choice, but a result due to poverty, lack of health capacity,[185] or challenges in executing effective control of the territory. These

177. IHR (2005), *supra* note 62, art. 5.

178. Gostin et al., *supra* note 176, at 1921.

179. Lee, *supra* note 126, at 965.

180. *Id.* at 966–67. Note that this cost-benefit analysis is not a straightforward process, but demonstrates why States, without enforceable legal sanctions for the IHR (2005), will continue to violate the IHR (2005).

181. *Id.* at 969.

182. During the revision process, the authors predicted that "the new IHR do not have a strong enforcement mechanism . . . [and] the lack of an enforcement mechanism in the new IHR may mean that non-compliance with rules on permissible health measures becomes a problem." Fidler & Gostin, *supra* note 61, at 91.

183. Lee, *supra* note 126, at 981.

184. Giorgetti, *supra* note 126, at 1357–58. The author defines failed States as: "unable to provide basic political and social goods to their people. Often, their health care systems are all but collapsed. Moreover, the spread of disease and new epidemics cannot be properly monitored and controlled."

185. Lee, *supra* note 126, at 980.

States need support to carry out their IHR (2005) obligations, but no such "external funding is available to assist failed or failing states in implementing their core IHR [(2005)] requirements . . . [and] absent this financial assistance, the situations in failed or failing states will remain unchanged, if not worsen."[186] In fact, it is a requirement that States assist each other in developing and maintaining strong domestic health systems, yet many States that have the capacity to support others do not provide it.[187] As a result, States lacking capacity turn to the WHO as a 'provider of last resort,' "providing access to health services when no one else can,"[188] because there is not an adequate health system already in place to respond to the issue, as intended by the IHR (2005). However, as seen during the 2014–2016 West African EVD outbreak, the WHO itself does not have the funding to thoroughly respond to a disease such as EVD.[189] The cost of building up an effective health system, as mandated by the IHR (2005), costs less than responding to an EID outbreak[190], yet when States cannot even manage to do this, it becomes a deadly cycle spurred by insufficient capacity to effectively implement global health policies for EIDs.

B. RELEVANT TOOLS AND METHODS FOR MANAGING THE EASTERN DRC EVD OUTBREAK BEGINNING IN 2018

1. Ensuring Security Through International Measures

The international community has learned a lot about epidemic preparedness and response from the 2014–2016 West African EVD outbreak.[191] However, the Eastern DRC EVD outbreak beginning in 2018 brings new challenges, namely the

186. *Id.* at 969.

187. Agnew, *supra* note 75, at 116.

188. WHO 2015 Report, *supra* note 151, at 11.

189. Agnew, *supra* note 75, at 111.

190. *See* Jennifer B. Nuzzo et al., *What Makes Health Systems Resilient Against Infectious Disease Outbreaks and Natural Hazards? Results From a Scoping Review*, 19 BMC PUB HEALTH 1, 2 (2019); *see generally* Hans Kluge et al., *Strengthening Global Health Security by Embedding the International Health Regulations Requirements Into National Health Systems*, 3 BMJ GLOB. HEALTH 1, 5 (2018).

191. *See generally* Lawrence O. Gostin & Ana S. Ayala, *Global Health Security in an Era of Explosive Pandemic Potential*, 9 J. NAT'L SECURITY L. & POL'Y 53, 70–72 (2017).

fact that this outbreak is occurring in a zone of armed conflict.[192] Thus, ensuring security is a vital step to managing the outbreak.[193] Unstable security in the region has other effects on EVD management as well. The WHO reported that while a decline in EVD case incidence has been observed, these "trends must be interpreted cautiously, as delayed detection of cases is expected following recent temporary disruption in response activities due to insecurity."[194] In addition to the fact that the security situation in the Eastern DRC remains underdefined, thus complicating the legal management of the conflict, it equally causes significant challenges for the DRC, WHO, and international community when it comes to effective EVD management.

During the 2014–2016 West African EVD outbreak, the UNSC unanimously adopted Resolution 2177.[195] While it did not invoke UNSC Chapter VII powers, Resolution 2177 did call on States to provide assistance in the form of technical expertise and supplies, and on the WHO to accelerate its response in officially declaring the outbreak as a threat to international peace and security.[196] This action incited international support to end the EVD outbreak, with over 100 States sponsoring the Resolution, and a representative from the Netherlands even recognizing the global urgency of the outbreak and declaring, "If we do not act now, people not dying of Ebola may die of starvation."[197] Similarly, in October 2018 the UNSC passed Resolution 2439, "voicing 'serious concern' over the deteriorating security situation impeding the response to the Ebola outbreak . . . [and demanding] that all armed groups respect international humanitarian law . . . call[ing] for heightened international engagement and an expanded U.N. response."[198] The UNSC referred back to Resolution 2177 (which referenced the 2014–2016 West African EVD outbreak), Resolution 2286 (which was passed in 2016 and called on parties to the conflict

192. Laurie Garrett, *Welcome to the First War Zone Ebola Crisis*, FOREIGNPOLICY (Oct. 18, 2018), https://foreignpolicy.com/2018/10/18/welcome-to-the-first-war-zone-ebola-crisis/.

193. *Id.*

194. Disease Outbreak News, *Ebola Virus Disease–Democratic Republic of the Congo*, WORLD HEALTH ORG. (Jan. 10, 2019), https://www.who.int/csr/don/10-january-2019-ebola-drc/en/.

195. S.C. Res. 2177, ¶ 3 (Sept. 18, 2014).

196. *Id.*; Sirleaf, *supra* note 138, at 529–30.

197. Sirleaf, *supra* note 138, at 531.

198. Morrison & Devermont, *supra* note 77.

to ensure access to humanitarian personnel), and Resolution 2409 (which was passed in 2018 and declared the conflict in the DRC to be a "threat to international peace and security," initiating UNSC Chapter VII powers).[199] Despite Resolution 2439 and a subsequent UNSC statement in August 2019, at the time of this writing there has not yet been the same level of international response as observed in the 2014–2016 West African EVD outbreak, and violence to health workers and facilities continues, further exacerbating the response efforts.[200]

The WHO's delay in declaring this outbreak to be a PHEIC under the IHR (2005),[201] even though the EC did make the decision just shy of one year after the start of the outbreak, could prompt States to view the hesitation as a signal that the outbreak is not as critical of an international concern as it is. The WHO has stated that the IHR (2005) and PHEIC status is meant to provide surrounding States and the international community a warning of serious international health emergencies, not to incite financial and logistical support for deadly disease outbreaks.[202] However, if this is the case, then

199. *Adopting Resolution 2439 (2018), Security Council Condemns Attacks by Armed Groups in Democratic Republic of Congo Jeopardizing Response to Ebola Outbreak*, UNITED NATIONS (Oct. 30, 2018), https://www.un.org/press/en/2018/sc13559.doc.htm.

200. Lawrence O. Gostin et al., *Fighting Novel Diseases Amidst Humanitarian Crises*, HASTINGS CENTER REPORT, Jan. – Feb. 2019, at 7.

201. Lisa Schnirring, *WHO Declares Public Health Emergency Over DRC Ebola*, CTR. FOR INFECTIOUS DISEASE RES. AND POL'Y (July 17, 2019), http://www.cidrap.umn.edu/news-perspective/2019/07/who-declares-public-health-emergency-over-drc-ebola; *Emergency Committee Press Conference - 14 June 2019*, WORLD HEALTH ORG. (June 14, 2019), https://www.who.int/news-room/detail/13-06-2019-emergency-committee-press-conference---14-june-2019; *Statement On the Meeting of the International Health Regulations (2005) Emergency Committee for Ebola Virus Disease in the Democratic Republic of the Congo on 12th April 2019*, WORLD HEALTH ORG. (Apr. 12, 2019), https://www.who.int/news-room/detail/12-04-2019-statement-on-the-meeting-of-the-international-health-regulations-(2005)-emergency-committee-for-ebola-virus-disease-in-the-democratic-republic-of-the-congo-on-12th-april-2019; *Statement On the October 2018 Meeting of the IHR Emergency Committee on the Ebola Virus Disease Outbreak in the Democratic Republic of the Congo*, WORLD HEALTH ORG. (Oct. 17, 2018), https://www.who.int/news-room/detail/17-10-2018-statement-on-the-meeting-of-the-ihr-emergency-committee-on-the-ebola-outbreak-in-drc; *WHO Director-General Press Briefing on Ebola Outbreak and Response in DRC*, WORLD HEALTH ORG. (Mar. 14, 2019), https://www.who.int/ebola/WHO BROLL_Ebola_DR_Congo_presser_UNOG_TEDROS_14MAR2019_final.pdf?ua=1.

202. Michael G. Baker & David P. Fidler, *Global Public Health Surveillance under New International Health Regulations*, 12 EMERGING INFECTIOUS DISEASES 7, 7 (2006).

the IHR (2005) is not equipped to handle this emerging trend of EID outbreaks in localized armed conflict zones, and other tools must be considered.

In addition to using the UNSC to support the security situation during the Eastern DRC EVD outbreak beginning in 2018, the Global Outbreak and Response Network ("GOARN") is an instrument created by the WHO which "creates an operational framework that links those with relevant expertise and skills for the purpose of keeping the international community alert of any threat of outbreaks in order to be prepared to respond."[203] GOARN's Guiding Principles for International Outbreak Alert and Response reflect GOARN's mission of "improv[ing] the delivery of international assistance in support of local efforts by partners in the Global Outbreak Alert and Response Network, and seek[ing] to promote the highest standards of professional performance in the field."[204] GOARN has been an extremely useful and effective resource for many disease outbreaks since its development in 2000,[205] as well as EIDs during the SARS outbreak and the 2012 EVD outbreak in the DRC.[206] Additionally, it has even demonstrated its capacity to do significant work in disease outbreaks in compromised security situations, such as Somalia.[207] Similarly, resources through GOARN could be implemented in the current Eastern DRC EVD outbreak beginning in 2018 to help bring about a more coordinated international response. GOARN's purpose of mobilizing a network of experts, resources, and international support is a vital contribution to management of EID outbreaks, as well as for support of the strengthening of health systems after an outbreak.[208] As of this writing, the GOARN website only provides a few short articles about the WHO's response[209] in the DRC and an update on GOARN's

203. Giorgetti, *supra* note 126, at 1375–76.

204. *Id.* at 1377.

205. John S. Mackenzie et al., *The Global Outbreak Alert and Response Network*, 9 GLO. PUBLIC HEALTH 1023, 1028–30 TBL. 1 (2014).

206. Giorgetti, *supra* note 126, at 1379–80.

207. *Id.* at 1381–82. GOARN responded to the 2017 cholera outbreak in Somalia. Note that "it was reported that the deteriorating security situation hampered control measures in the affected area."

208. Mackenzie et al., *supra* note 205, at 1036.

209. *WHO Applauds Rwanda's Ebola Preparedness Efforts*, GOARN (July 24, 2019), https://extranet.who.int/goarn/content/who-applauds-rwanda's-ebola-preparedness-efforts; *At 1-year Mark, We Mourn the Lives Lost, and Call for Solidarity*, GOARN (July 31, 2019), https://extranet.who.int/goarn/content/1-year-mark-we-mourn-lives-lost-and-call-solidarity.

involvement in the Eastern DRC EVD outbreak beginning in 2018 from August 2018, which states that the GOARN:

> "Operational Support Team has issued an alert to its network partners, providing an overview of the current situation and ongoing response activities . . . [and] the GOARN Steering Committee and WHO Regional Office for Africa conducted a joint coordination call for operational partners in Africa. GOARN partners continue to contribute to response activities."[210]

Thus, ensuring active deployment of GOARN resources for this Eastern DRC EVD outbreak beginning in 2018 could provide the push for more international political support and public engagement that is needed to fill the gaps in the current response efforts of this outbreak.

The Global Health Security Agenda ("GHSA"), created in 2014 with the mission of advancing a "world safe and secure from disease threats . . . bring[ing] together nations from all over the world to make new, concrete commitments, and . . . elevat[ing] global health security as a priority,"[211] is another useful tool that could be used during the Eastern DRC EVD outbreak beginning in 2018. It sets out a framework for countries to address their IHR (2005) commitments by providing eleven Action Packages designed to "help build state capacity to prevent, detect, and respond to threats posed by infectious disease . . . [which] member countries can utilize to help assess baseline national health security capacity."[212] The GHSA is commendable because it frames global health security as a 'shared responsibility,'[213] and international cooperation has already been highlighted as a key component of effective global health policy for EIDs. Since IHRL assigns the responsibility for combating epidemics to States, there is still a gap left over that must be filled in order to fully address the epidemic.[214] The theory of Common but Differentiated Responsibility ("CBDR") is

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210. *Ebola Virus Disease – Democratic Republic of the Congo*, GOARN, https://extranet.who.int/goarn/content/ebola-virus-disease-democratic-republic-congo (last visited Apr. 12, 2019).

211. GLOBAL HEALTH AGENDA, https://www.ghsagenda.org/about (last visited Sep. 17, 2019).

212. Sirleaf, *supra* note 138, at 545.

213. *Id.* at 547; Matiangai Sirleaf, *Responsibility for Epidemics*, 97 TEX. L. REV. 285, 341 (2018) [hereinafter Sirleaf, *Responsibility*].

214. Sirleaf, *Responsibility*, *supra* note 213, at 296.

based upon the "effort to achieve equity between richer countries in the Global North and poorer states in the Global South," with the richer countries taking on "higher obligations to combat environmental concerns to reflect consumption and production patterns, as well as the unequal distributions of risks that result in more devastating environmental consequences for poorer countries."[215] With a view towards solidarity and international cooperation, CBDR recognizes that "while all states are responsible for global environmental problems . . . some states are more responsible than others."[216] Though this is an environmental focus, it can be expanded to EIDs because these same values of shared responsibility and practical capacity to take concerted action can be effective "method[s] for addressing mutual risks posed by epidemics."[217] The GHSA actually uses CBDR because it differentiates based on need (when international actors came together to support the affected West African countries in both the immediate needs of their health facilities and overall strengthening of their health care system),[218] as well as capacity,[219] and it made a significant difference in the EVD response.[220] The United States stated that its rationale for joining the GHSA was because stopping diseases and other health threats that begin abroad before spreading to the country's borders is the most effective and least expensive way to protect Americans.[221] Considering the great potential impact the GHSA can have on serious outbreak situations, support for the GHSA should be increased, especially given the current security and disease conditions of the Eastern DRC EVD outbreak beginning in 2018.[222]

Following UNSC Resolution 2177 during the 2014–2016

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215. *Id.* at 314–15.
216. *Id.* at 317.
217. *Id.* at 321.
218. *Id.* at 341.
219. *Id.*
220. *Id.* at 326–27.
221. Sirleaf, *supra* note 138, at 546–47.
222. *See id.* at 546. ("For example, during the Ebola epidemic in Sierra Leone in November of 2015, only 35 percent of health facilities reported to their respective districts. By September 2016, with the help of the GHSA, this increased to 96 percent of health facilities. Early indications similarly show the GHSA is having an impact in Liberia. Prior to the 2014 Ebola outbreak, Liberia had very few trained 'disease detectives,' but with the support of the GHSA at the end of 2016 the country had a total of 115 trained 'detectives' covering all fifteen counties and ninety-two health districts. These initiatives will likely assist with early detection of epidemic diseases.").

West African EVD outbreak, the U.N. General Assembly established the first-ever U.N. emergency health mission called the U.N. Mission for Ebola Emergency Response ("UNMEER").[223] UNMEER's strategy was "based upon three pillars of action: immediate outbreak response, enhanced coordination and collaboration, and the mobilization of increased human and financial resources."[224] Specific to the 2014–2016 West African EVD outbreak, UNMEER's "primary object was to contain and prevent the spread of Ebola through case management and safe burial services, to treat infected individuals, and to provide services to affected communities."[225] Then U.N. Secretary-General Ban Ki-Moon described that the Mission "harnesses the capabilities and competencies of all the relevant United Nations actors under a unified operational structure to reinforce unity of purpose, effective ground-level leadership and operational direction in order to ensure a rapid, effective, efficient, and coherent response to the crisis."[226] This widespread U.N. response was able to bring together all relevant public health and international security interests at the U.N. level, and supported the WHO's response by providing expertise in humanitarian relief.[227] While UNMEER was only intended to act as a temporary measure to fill a much needed gap in EVD response during the 2014–2016 West African EVD outbreak, it might be worth considering the establishment of a permanent version of UNMEER for EIDs generally.[228] While UNMEER as a tool has a stronger public health and humanitarian response focus, incorporating such public health methods early on can contribute to setting the stage for a more significant legal response across the international community.

Finally, the Sendai framework for disaster reduction 2015–2030 ("Sendai Framework")[229] is a relatively new yet potentially

223. U.N. Secretary-General, Statement by the Secretary-General on the Establishment of the United Nations Mission for Ebola Emergency Response (UNMEER) (Sep. 19, 2014), https://www.un.org/sg/en/content/sg/statement/2014-09-19/statement-secretary-general-establishment-united-nations-mission.

224. Le Roux-Kemp, *supra* note 127, at 263.

225. Sirleaf, *Responsibility*, *supra* note 213, at 340.

226. Lee, *supra* note 126, at 946.

227. *Id.* at 947.

228. *U.N. Mission for Ebola Emergency Response (UNMEER)*, GLOB. EBOLA RESPONSE, https://ebolaresponse.un.org/un-mission-ebola-emergency-response-unmeer (last visited Sep. 14, 2019).

229. *See generally* Third U.N. World Conference, *Sendai Framework for Disaster Risk Reduction 2015-2030*, U.N. Doc ARES./69/283 (June 23, 2015),

impactful tool that could be used to support EVD management efforts during the Eastern DRC EVD outbreak beginning in 2018. It is a framework that intends to "reduce disaster risk and losses in lives, livelihoods and health and in the economic, physical, social, cultural and environmental assets of persons, businesses, communities and countries."[230] All four priority areas of the Sendai Framework (Understanding disaster risk; Strengthening disaster risk governance to manage disaster risk; Investing in disaster risk reduction for resilience; Enhancing disaster preparedness for effective response, and to "Build Back Better" in recovery, rehabilitation, and reconstruction)[231] can be translated to the management of EID outbreaks. Through the Sendai Framework, Disaster Risk Reduction can be integrated into other relevant health frameworks.[232] Thus, the Sendai Framework is another useful public health instrument, due to the fact that it links to other large global instruments such as the IHR (2005) and the Sustainable Development Goals.[233] This indicates the potential support it can bring to the management of the Eastern DRC EVD outbreak beginning in 2018.

Often, when issues with the IHR (2005) are raised, it is suggested that another revision take place to reconcile those problems.[234] However, given the tools available, strengthening these already-established mechanisms might prove to be more effective in response to the Eastern DRC EVD outbreak beginning in 2018.

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https://www.preventionweb.net/files/43291_sendaiframeworkfordrren.pdf [hereinafter *Sendai Framework*].

230. Sirleaf, *supra* note 138, at 548–49.

231. *Sendai Framework*, *supra* note 229, at 14.

232. Amina Aitsi-Selmi & Virginia Murray, *Protecting the Health and Well-being of Populations from Disasters: Health and Health Care in The Sendai Framework for Disaster Risk Reduction 2015-2030*, 31 PREHOSPITAL & DISASTER MED. 74, 77 (2015).

233. Ernest Tambo, *Improving Disaster Risk Reduction Preparedness and Resilience Approaches in Emergency Response Interventions in African Countries*, 6 INT'L J. PUB. HEALTH SCI. 183, 188 (2017).

234. Even global health specialist Lawrence Gostin suggested a revision may be warranted in order for the IHR (2005) to better address its implementation during armed conflicts. Lawrence Gostin (@LawrenceGostin), TWITTER (Jan. 10, 2019, 5:26 AM), https://twitter.com/LawrenceGostin/status/1083354423714373632; Lawrence Gostin (@LawrenceGostin), TWITTER (Jan. 9, 2019, 10:57 AM), https://twitter.com/LawrenceGostin/status/1083075232682905601.

2. Public Trust and The Role of Women in Community Engagement

As seen in the 2014–2016 West African EVD outbreak, community fear and distrust of governmental and international actors greatly complicated the EVD management response.[235] Likewise, the Eastern DRC EVD outbreak beginning in 2018 reflects similar fears,[236] and thus, building trust through community engagement is a key to effective management of this outbreak. With regard to the Eastern DRC EVD outbreak beginning in 2018, there has already been a long history of distrust of institutions due to the ongoing armed conflict.[237] Seven months after the start of the outbreak, studies already reported "low levels of trust in government institutions and widespread belief in misinformation about EVD," leading to the conclusion that "exposure to violence reduces political trust in general."[238] This low level of institutional trust and the widespread belief in misinformation (namely that EVD does not exist, or that an EVD outbreak is not happening in this region) in turn leads to "reduced adherence to EVD preventative behaviors" such as vaccinations.[239] This overall distrust of government and simultaneous belief in misinformation pose significant challenges for basic public health measures to contain the outbreak. To combat this, it is vital to build up community trust by "engaging locally trusted leaders and service providers . . . to build trust with Ebola responders who are not from these communities."[240] As an immediate response to the outbreak, one main focus should be on social mobilization and community engagement efforts to build trust in a transparent, sincere, and consistent manner.[241]

Women have the potential to play a significant role in this

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235. Patrick Vinck et al., *Institutional Trust and Misinformation in the Response to the 2018-19 Ebola Outbreak in North Kivu, DR Congo: A Population-Based Survey*, 19 LANCET INFECTIOUS DISEASES 529, 530 (2019).

236. *Id.* at 535–36.

237. *See id.* at 529.

238. *Id.* at 535.

239. *Id.*

240. *Id.* at 536; *see also Women Join Hands to Oust Ebola from the Democratic Republic of the Congo*, WORLD HEALTH ORG. REGIONAL OFF. FOR AFR., https://www.afro.who.int/news/women-join-hands-oust-ebola-democratic-republic-congo (last visited Apr. 12, 2019) (discussing the outreach efforts made by local women in Beni in the wake of the EVD outbreak).

241. Vinck et al., *supra* note 235, at 536.

effort, and the WHO has reported successful grassroots efforts by women to debunk misconceptions about EVD.[242] Women are a key population because both war and disease disproportionately affect women, and this is reflected in the current EVD outbreak in which over 60% of EVD cases were reported to be female at the beginning of 2019.[243] There are numerous factors that lead to this high rate of infection, and many are cultural in nature. The WHO report indicates that "[i]n Beni,[244] it's the women who run the households. They look after the children and they care for the sick . . . [and] are very reluctant to let the sick go outside the home for treatment because, to them, that signifies they've failed in their duty to look after the patient."[245] Not only are women in charge of the households, but also their duty as chief mourner when a family member dies puts them at heightened risk for EVD infection.[246]

The international community agreed that women play a significant role in peace and security when UNSC Resolution 1325[247] was passed in 2000.[248] The resolution sets forth four pillars, calling on all actors to increase participation of women at all levels of decision-making, specifically to protect women and girls from sexual and gender-based violence, improve intervention strategies in the prevention of violence against women, and frame relief and recovery measures for addressing international crises through a gendered lens.[249] Additionally, tapping into women as a resource[250] has already shown to be a

242. *See Women Join Hands to Oust Ebola from the Democratic Republic of the Congo*, *supra* note 240.

243. Disease Outbreak News, *supra* note 194.

244. Beni has been a major epicenter for EVD at the start of the Eastern DRC EVD outbreak beginning in 2018. *Crisis Update - August 2019*, MEDECINS SANS FRONTIERES (Aug. 30, 2019), https://www.msf.org/drc-ebola-outbreak-crisis-update.

245. *Women Join Hands to Oust Ebola From the Democratic Republic of the Congo*, *supra* note 240.

246. *Id.*

247. *See Security Council Resolution 1325*, PEACE WOMEN, https://www.peacewomen.org/SCR-1325.

248. *What Is UNSCR 1325? An Explanation of the Landmark Resolution on Women, Peace and Security*, U.S. INST. PEACE, https://www.usip.org/gender_peacebuilding/about_UNSCR_1325.

249. *Id.*

250. *See* Faras Ghani, *Q&A: Conflict, Resistance Hampering WHO's Ebola Efforts in DRC*, ALJAZEERA (Dec. 2, 2018), https://www.aljazeera.com/news/2018/12/qa-conflict-resistance-hampering-ebola-efforts-drc-181202091946851.html ("One of the things is knowing who to work with, who has the trust of the community and a relationship with them – different leaders,

smart move during this EVD outbreak, with the WHO partnering with Mama Mwatatu, a woman so well known in her community in North Kivu she has earned the nickname "Mother Counsellor of Beni."[251] Listeners of her radio show are mostly female,[252] so the impact she has had on the EVD management efforts in Beni has been significant. During her broadcast, she answers her listeners' questions about EVD, emphasizing the reality of the disease. If she is unable to answer a question, she "carefully notes it down and consults with WHO experts,"[253] thus establishing an invaluable partnership between the WHO and the local female community. Julienne Anoko, a social anthropologist working for the WHO, has also proven the power of women. For example, when she collaborated with the Collectif des Associations Feminines, the WHO was able to educate 132 women leaders about EVD and send them out to their local communities to conduct a two-week information campaign, explaining EVD vaccines, treatment, contact tracing, and the vulnerability of women and children to EVD, and ultimately reached over 600,000 people who would not have otherwise been reached due to fear and stigma.[254] These are just a few examples of ways in which women can contribute to the management of this EVD outbreak. Women are a key connection to the local population, and at a time when trust of authority figures is low and belief in misinformation is high, it is vital to reach all corners of affected communities. Recalling UNSC Resolution 1325 and considering women's heightened susceptibility and integrated role in disease management, empowering women to do global health work in their communities is an extremely effective way to combat this EVD outbreak, and strengthen global health security as a whole.

IV. CONCLUSION

The international community has learned a great deal about preparing for and managing EID outbreaks, as evidenced by the evolution of the IHR (2005). However, as new situations present themselves, such as the Eastern DRC EVD outbreak beginning

religious leaders, women's groups, etc.").

251. *Women Join Hands to Oust Ebola From the Democratic Republic of the Congo*, *supra* note 240.

252. *Id.*

253. *Id.*

254. *Id.*

in 2018 in an armed conflict zone, the application of these EID management tools must also adapt. This outbreak has proven to be especially challenging due to the highly contagious nature of EVD, the extremely dense population it is affecting, including internally displaced peoples and refugees, and the presence of armed groups and long-term conflict in the region.

Protection of health is deeply grounded in both IHRL and IHL, yet the laws and policies addressing EIDs are less than perfect. There are significant gaps in the application of IHRL and IHL principles that are meant to protect health, and many have argued that situations like the Eastern DRC EVD outbreak beginning in 2018 expose the inadequacy of global health laws and policies currently in place to respond to EIDs (i.e. the IHR (2005)). The emerging nature of EIDs in armed conflict zones presents many new issues in both the international legal and global health security fields. Preparedness for such CEs is thus of utmost importance. Without effective enforcement mechanisms and adequate funding, the capacity-building provisions of the IHR (2005) are nothing more than aspirational goals. Without international cooperation and support from States, NGOs, and other actors, the fear that the Eastern DRC EVD outbreak beginning in 2018 could become the largest EVD outbreak in history, or worse, that EVD could become endemic in the region, may very well come true.