Protecting International Travelers During the Pandemic: Charting the Way Forward

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Abstract

The cross-border mobility of individuals is governed by two international legal frameworks: the International Health Regulations and human rights law. International freedom of movement has been pervasively compressed and even suppressed in the global response to COVID-19. Going against the World Health Organization's recommendations, almost all countries around the world adopted some form of travel restriction, with most closing their borders. International law has long played a fundamental role in fostering cooperation among nations to strike a delicate equilibrium between public health and international mobility. However, COVID-19 seems to be just the latest episode in a saga of non-compliance, testing the authority and effectiveness of international law mechanisms in addressing the challenges raised by infectious diseases. If international law does not implement efficient therapies, human rights—including freedom of movement—will continue to fall victim to future pandemic outbreaks. This article argues that a promising avenue to harden the regulatory framework—hopefully enhancing compliance with its provisions—is to launch a process of "soft legalization." If the WHO increases the "precision" or "determinacy" of the regulatory framework, there is a greater chance it will enhance its normative "compliance pull." Regardless of the hard or soft nature of such instruments, what truly matters is the creation of visible markers about how and when States Parties may apply additional health measures that interfere with international mobility. It is also vital to increase the weight of human rights rules and principles in the balancing exercise between public health and freedom of movement. A coherent, holistic approach to international

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mobility requires a greater degree of precision about whether health measures comply with human rights standards.

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I. INTRODUCTION

Introducing the topic of COVID-19 does not necessitate heavy footnoting—only the most secluded of hermits would be able to claim that his life proceeded untouched by the coronavirus. For those of us who do not live in isolation, the experience has been vividly personal and impactful.[1] Pandemic outbreaks offer an opportunity to reflect upon how much infectious diseases and humans have in common. Viruses need to spread in order to survive. They rely on carriers—human beings—who harbor the infection and may pass it on to others. To disseminate to the point of becoming a pandemic, the disease needs to move freely from person to person and across borders.[2] Mobility is also vital for diverse facets of human life. Freedom of movement has been described as "the first and most fundamental of man's liberties"[3] and associated with the very idea of individual self-determination.[4]

International travelers, like any other people, may be exporters or importers of infection. Travel contributes significantly to the propagation of infectious diseases,[5] so thwarting contagion may require halting human mobility. During global public health emergencies, the freedom to move across borders—which we tend to take for granted—comes under

1. In the words of the United Nations Committee on Economic, Social and Cultural Rights, "[t]he COVID-19 pandemic . . . is having devastating impacts throughout the world on all spheres of life . . . ." Comm. on Econ., Soc. & Cultural Rts., Committee Statement on the Coronavirus Disease (COVID-19) Pandemic and Economic, Social and Cultural Rights, U.N. Doc. E/C.12/2020/1, ¶ 1 (Apr. 17, 2020), https://digitallibrary.un.org/record/3856957?ln=en.

2. A pandemic has been defined as "[a]n epidemic occurring over a very wide area, crossing international boundaries, and usually affecting a large number of people." *Pandemic*, A DICTIONARY OF EPIDEMIOLOGY (Miquel Porta ed., 6th ed. 2014).

3. MAURICE CRANSTON, WHAT ARE HUMAN RIGHTS? 31 (1973).

4. Colin Harvey & Robert P. Barnidge, Jr., *Human Rights, Free Movement, and the Right to Leave in International Law*, 19 INT'L J. REFUGEE L. 1, 2 (2007).

5. Mary E. Wilson, *Travel and the Emergence of Infectious Diseases*, 1 EMERGING INFECTIOUS DISEASES 39, 39 (1995); Douglas W. MacPherson & Brian D. Gushulak, *Human Mobility and Population Health: New Approaches in a Globalizing World*, 44 PERSPS. BIOLOGY & MED. 390, 391 (2001). As underlined by one author, "[d]isease has been the unwelcome traveling companion of international commerce throughout history . . . ." Allyn L. Taylor, *Health*, *in* THE OXFORD HANDBOOK OF UNITED NATIONS TREATIES 339, 339 (Simon Chesterman et al. eds., 2019).

attack and is even perceived somehow as "pathological."[6] Epidemics raise doubts about the value of freedom of movement and trigger questions about its limits, all of which need to be addressed by legal science—namely, international law.

The cross-border mobility of individuals is governed by two international legal frameworks: the International Health Regulations (IHR)[7] and human rights law.

The IHR, last revised in 2005, are the only international legal instrument purposely designed to coordinate the global response to epidemic outbreaks and enjoy almost universal membership in the form of the 196 States Parties, 194 of whom are World Health Organization (WHO) members.[8] Their purpose and scope are to "prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade."[9] The regulations protect the rights of individuals, in particular, of those who qualify as "travelers" (defined as "natural person[s] undertaking an international voyage").[10] To achieve its purpose, the IHR mandate the WHO to declare the emergence of a public health emergency of international concern (PHEIC)[11] and issue temporary recommendations addressed to States Parties on when and how to respond to transnational health threats.[12] Recommendations should take into account, *inter alia*, "scientific principles as well as available scientific evidence and information[,]" but also, and importantly, "health measures that,

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6. *See* Tim Cresswell, *Valuing Mobility in a Post COVID-19 World*, 16 MOBILITIES 51, 54 (2020).

7. International Health Regulations (2005), May 23, 2005, 2509 U.N.T.S. 79, https://treaties.un.org/doc/Publication/UNTS/Volume%202509/v2509.pdf. *See also* WORLD HEALTH ORG. [WHO], INTERNATIONAL HEALTH REGULATIONS (2005) (3d. ed. 2016), https://www.who.int/publications/i/item/9789241580496 (republishing the agreement with two minor amendments).

8. *See* WHO, *supra* note 7, app. 1. The IHR entered into force on June 15, 2007. *Id.* at 1.

9. *Id.* art. 2.

10. *Id.* art. 1(1). An "international voyage" includes "a voyage involving entry into the territory of a State other than the territory of the State in which that traveller [sic] commences the voyage[.]" *Id.*

11. A PHEIC is "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[.]" *Id.* art. 1(1). *See also id.* art. 12 (describing circumstances under which an international PHEIC is determined).

12. *Id.* art. 15.

on the basis of a risk assessment appropriate to the circumstances, are not more restrictive of international traffic and trade and are not more intrusive to persons than reasonably available alternatives that would achieve the appropriate level of health protection[.]"[13]

The rights of international travelers are also governed by human rights law. Freedom of movement across borders is enshrined in Article 12 of the International Covenant on Civil and Political Rights (ICCPR), which proclaims that "[e]veryone shall be free to leave any country, including his own' and that [n]o one shall be arbitrarily deprived of the right to enter his own country." [14]

International freedom of movement comprises two interdependent dimensions: the right to leave and the right to return.[15] The two facets are closely interrelated, as one becomes moot without the other. However, they satisfy different needs or aspirations. Individuals may want to leave their country for tourism, to migrate, or to seek refuge; differently, persons going in the opposite direction normally wish to return "home."[16] All individuals benefit from the right to leave, be they citizens, residents, or foreigners, even if they are in a given country illegally.[17] The legal protection covers temporary visits (for instance, for tourism) but also permanent leave for emigration purposes.[18]

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13. *Id.* art. 17.

14. International Covenant on Civil and Political Rights art. 12, Dec. 16, 1966, S. TREATY DOC. No. 95-20, 999 U.N.T.S. 171 [hereinafter ICCPR]. The Covenant, in force since 1976, is "probably the most important human rights treaty in the world." SARAH JOSEPH & MELISSA CASTAN, THE INTERNATIONAL COVENANT ON CIVIL AND POLITICAL RIGHTS 3 (3d ed. 2013). The ICCPR also protects "domestic" freedom of movement: "[e]veryone lawfully within the territory of a State shall, within that territory, have the right to liberty of movement and freedom to choose his residence." art. 12(1). Such domestic dimension is, however, beyond of the scope of this article.

15. Vincent Chetail, *Freedom of Movement and Transnational Migrations: A Human Rights Perspective*, *in* MIGRATION AND INTERNATIONAL LEGAL NORMS 47, 47, 54, 57 (T. Alexander Aleinikoff & Vincent Chetail eds., 2003); Francesca De Vittor, *Nationality and Freedom of Movement*, *in* THE CHANGING ROLE OF NATIONALITY IN INTERNATIONAL LAW 96, 97 (Serena Forlati & Alessandra Annoni eds., 2013).

16. Kathleen Lawand, *The Right to Return of Palestinians in International Law*, 8 INT'L J. REFUGEE L. 532, 540 (1996).

17. *See* U.N. Hum. Rts. Comm., CCPR General Comment No. 27: Article 12 (Freedom of Movement) ¶ 8, U.N. Doc. CCPR/C/21/Rev.1/Add.9 (Nov. 1 1999), https://digitallibrary.un.org/record/366604?ln=en.

18. *Id*.

The right to return has a narrower personal scope of application. This right "recognizes the special relationship of a person to that country."[19] The ICCPR only gives the right of entry into a country to persons who have a strong connection to that territory, for example, its nationals and residents.[20] In the words of one author, it is "innate in human nature to yearn to be back home."[21] This natural desire for a base or a homeland has been said to demonstrate the rational association of freedom of movement with the right to a nationality,[22] and in this sense the right to return is closely connected with the concept of nationality.[23] However, because the Covenant employs broad language ("his own country") without restricting this scenario to a nationality link, it is frequently argued that the provision also covers categories such as long-term (or permanent) residents.[24] Importantly, human rights treaties do not guarantee an unfettered right of access to a country other than one's own. In other words, there is no human right to enter a foreign state.[25] States have the sovereign power to decide matters over their territory and population, including border security and migration policies.[26]

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19. *Id.* ¶ 19.

20. *Id.* ¶ 20.

21. Daniel D.N. Nsereko, *The Right to Return Home*, 21 INDIAN J. INT'L L. 335, 336 (1981).

22. Maurice Cranston, *The Political and Philosophical Aspects of the Right to Leave and to Return*, *in* THE RIGHT TO LEAVE AND TO RETURN: PAPERS AND RECOMMENDATIONS OF THE INTERNATIONAL COLLOQUIUM HELD IN UPPSALA, SWEDEN, 19-20 JUNE 1972, at 21, 28 (Karel Vasak & Sidney Liskofsky eds., 1976).

23. *See* Rosalyn Higgins, *The Right in International Law of an Individual to Enter, Stay in and Leave a Country*, 49 INT'L AFFS. 341, 342 (1973); Lawand, *supra* note 16, at 540.

24. Chetail, *supra* note 15, at 57; *see* Jeremie Maurice Bracka, *Past the Point of No Return? The Palestinian Right of Return in International Human Rights Law*, 6 MELBOURNE J. INT'L L. 272, 298–300 (2005). *See also* U.N. Hum. Rts. Comm., *supra* note 17, ¶ 20 ("The language of article 12, paragraph 4, moreover, permits a broader interpretation that might embrace other categories of long-term residents, including but not limited to stateless persons arbitrarily deprived of the right to acquire the nationality of the country of such residence."). In principle, it is up to the individual to prove that the State in question is "his own country." *See, e.g.*, THE LAW AND PRACTICE OF EXPULSION AND EXCLUSION FROM THE UNITED KINGDOM 48 (Eric Fripp ed., 2015).

25. Karl Doehring, *Aliens, Admission*, *in* 1 ENCYCLOPEDIA OF PUBLIC INTERNATIONAL LAW 107, 107 (Rudolf Bernhardt ed. 1992); Chetail, *supra* note 15, at 57; De Vittor, *supra* note 15, at 96; Higgins, *supra* note 23, at 344.

26. U.N. Hum. Rts. Comm., CCPR General Comment No. 15: The Position of Aliens Under the Covenant, ¶ 5 (Apr. 11, 1986), https://www.refworld.org/pdfid/45139acfc.pdf. ("The [ICCPR] does not recognize

Both the IHR and the ICCPR safeguard international mobility, but with different goals and scopes of application. They should be considered in tandem as there is plenty of regulatory cross-fertilization. References to the human rights of travelers (but also other persons) were included in the IHR for the first time in the 2005 revision. The basic principles are stated as follows:

> 1. The implementation of these Regulations shall be with full respect for the dignity, human rights and fundamental freedoms of persons.
>
> 2. The implementation of these Regulations shall be guided by the Charter of the United Nations and the Constitution of the World Health Organization.
>
> 3. The implementation of these Regulations shall be guided by the goal of their universal application for the protection of all people of the world from the international spread of disease.
>
> 4. States have, in accordance with the Charter of the United Nations and the principles of international law, the sovereign right to legislate and to implement legislation in pursuance of their health policies. In doing so they should uphold the purpose of these Regulations.[27]

The connection between the IHR and human rights norms also stems from Article 57(1) of the IHR, pursuant to which "States Parties recognize that the IHR and other relevant international agreements should be interpreted so as to be compatible. The provisions of the IHR shall not affect the rights and obligations of any State Party deriving from other international agreements."[28]

While both the IHR and the ICCPR uphold international mobility, this protection is not absolute. The two legal

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the right of aliens to enter or reside in the territory of a State party. It is in principle a matter for the State to decide who it will admit to its territory.").

27. WHO, *supra* note 7, art. 3. Pursuant to Article 32, "[i]n implementing health measures under these Regulations, States Parties shall treat travellers with respect for their dignity, human rights and fundamental freedoms and minimize any discomfort or distress associated with such measures . . . ." *Id.* art. 32.

28. *Id.* art. 57(1).

frameworks recognize that in some cases it may be necessary to constrain the freedom of movement of individuals to protect other interests, for instance, public health.

As regards the IHR, temporary recommendations provide guidance to States Parties on what health measures to implement, based on the WHO's evaluation of three types of risk: "risk to human health, risk of international spread of disease and risk of interference with international travel."[29] Still, that assessment is not peremptory, as Article 43 allows States Parties to go beyond the WHO's recommendations:

> 1. These Regulations shall not preclude States Parties from implementing health measures, in accordance with their relevant national law and obligations under international law, in response to specific public health risks or public health emergencies of international concern, which:
>
> (a) achieve the same or greater level of health protection than WHO recommendations; or
>
> (b) are otherwise prohibited under Article 25, Article 26, paragraphs 1 and 2 of Article 28, Article 30, paragraph 1(c) of Article 31 and Article 33,
>
> provided such measures are otherwise consistent with these Regulations.[30]

There is, however, a major proviso: additional health measures "shall not be more restrictive of international traffic and not more invasive or intrusive to persons than reasonably available alternatives that would achieve the appropriate level of health protection."[31]

In a similar vein, human rights law recognizes that freedom of movement is not limitless. While Article 12(2) and (4) of the ICCPR establish a strong presumption in favor of freedom of

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29. *Emergencies: International Health Regulations and Emergency Committees*, WHO (Dec. 19, 2019), https://www.who.int/news-room/q-a-detail/emergencies-international-health-regulations-and-emergency-committees.

30. International Health Regulations (2005), *supra* note 7, art. 43.

31. *Id.*

movement,[32] it may be necessary to counterweight individual rights with other societal imperatives, namely, to avoid or mitigate potential injury to other persons and the broader community. Human rights treaties normally include two mechanisms that can interfere with the enjoyment of rights otherwise protected: limitations and derogations. Limitations should not affect the "core of the right,"[33] striking a balance between the protection of individual and community interests.[34] Differently, derogations result in the complete suspension of the right.[35] While the first mechanism restricts the exercise of some human rights, the second temporarily interrupts their enjoyment.

International freedom of movement has been pervasively compressed and even suppressed in the global response to COVID-19. When the WHO declared the novel coronavirus a PHEIC, it stated that it did 'not recommend any travel or trade restriction'.[36] This temporary recommendation was followed by several statements where, albeit adopting at times nuanced phrasing, the organization never expressly recommended the implementation of travel restrictions.[37] Yet, States Parties to the

32. HURST HANNUM, THE RIGHT TO LEAVE AND RETURN IN INTERNATIONAL LAW AND PRACTICE 122 (1987).

33. Brigit Toebes, *Human Rights and Public Health: Towards a Balanced Relationship*, 19 INT'L J. OF HUM. RTS. 488, 497 (2015).

34. Alessandra Spadaro, *COVID-19: Testing the Limits of Human Rights*, 11 EUROPEAN J. RISK REGUL. 317, 320 (2020).

35. *Id.* at 321; *see also* Toebes, *supra* note 33, at 496.

36. WHO, Statement on the Second Meeting of the International Health Regulations (2005) Emergency Committee Regarding the Outbreak of Novel Coronavirus (2019-nCoV) (Jan. 30, 2020) [hereinafter WHO, Statement on the Second Meeting], https://www.who.int/news/item/30-01-2020-statement-on-the-second-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-outbreak-of-novel-coronavirus-(2019-ncov); *see also* WHO, WHO Director-General's Statement on IHR Emergency Committee on Novel Coronavirus (2019-nCoV) (Jan. 30, 2020), https://www.who.int/dg/speeches/detail/who-director-general-s-statement-on-ihr-emergency-committee-on-novel-coronavirus-(2019-ncov) ("[T]here is no reason for measures that unnecessarily interfere with international travel and trade. WHO doesn't recommend limiting trade and movement.").

37. WHO, Key Considerations for Repatriation and Quarantine of Travelers in Relation to the Outbreak of Novel Coronavirus 2019-nCoV (Feb. 11, 2020) [hereinafter WHO, Key Considerations for Repatriation and Quarantine of Travelers], https://www.who.int/news-room/articles-detail/key-considerations-for-repatriation-and-quarantine-of-travellers-in-relation-to-the-outbreak-of-novel-coronavirus-2019-ncov; WHO, Updated WHO Recommendations for International Traffic in Relation to COVID-19 Outbreak (Feb. 29, 2020) [hereinafter WHO, Updated WHO Recommendations for International Traffic], https://www.who.int/news-room/articles-detail/updated-

IHR decided almost universally to disregard such recommendations. According to the WHO, 194 countries adopted some form of travel restriction, with 143 closing their borders.[38] In April 2020, around 90% of the world population lived in countries with restrictions on non-citizens and non-residents, and roughly 39% lived in countries with borders closed to everyone.[39]

Soon after travel restrictions spread like a global fever, several authors denounced them for breaching international

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who-recommendations-for-international-traffic-in-relation-to-covid-19-outbreak; WHO, COVID 19 Strategy Update (Apr. 14, 2020), https://www.who.int/publications/i/item/covid-19-strategy-update---14-april-2020; WHO, Statement on the Third Meeting of the International Health Regulations (2005) Emergency Committee Regarding the Outbreak of Coronavirus Disease (COVID-19) (May 1, 2020), https://www.who.int/news/item/01-05-2020-statement-on-the-third-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-outbreak-of-coronavirus-disease-(covid-19); WHO, Statement on the Fifth Meeting of the International Health Regulations (2005) Emergency Committee regarding the Coronavirus Disease (COVID-19) Pandemic (Oct. 30, 2020), https://www.who.int/news/item/30-10-2020-statement-on-the-fifth-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-coronavirus-disease-(covid-19)-pandemic; WHO, Statement on the Sixth Meeting of the International Health Regulations (2005) Emergency Committee regarding the Coronavirus Disease (COVID-19) Pandemic (Jan. 15, 2021), https://www.who.int/news/item/15-01-2021-statement-on-the-sixth-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-coronavirus-disease-(covid-19)-pandemic. *See* WHO, *2019 Novel Coronavirus (2019 nCoV): Strategic Preparedness and Response Plan* 10 (Feb. 4, 2020) [hereinafter WHO, *Strategic Preparedness and Response Plan*], https://www.who.int/publications/i/item/strategic-preparedness-and-response-plan-for-the-new-coronavirus.

38. WHO, Weekly Update on COVID-19, 8-15 April 2020, at 5 (May 7, 2020), https://www.who.int/publications/m/item/weekly-update-on-covid-19---15-april-2020; *see* Barbara von Tigerstrom et al., *The International Health Regulations (2005) and the Re-establishment of International Travel amidst the COVID-19 Pandemic*, 27 J. OF TRAVEL MED. 1 (2020) (claiming that all countries in the world implemented some sort of travel restriction); Organization for Economic Co-operation and Development [OECD], Managing International Migration Under COVID-19, http://www.oecd.org/coronavirus/policy-responses/managing-international-migration-under-covid-19-6e914d57/ (last updated June 10, 2020) (stating that the closure of national borders and enforcement of entry bans was "[t]he first and foremost measure in response to the COVID-19 pandemic"). *See also* Michael Kenwick & Beth A. Simmons, *Pandemic Response as Border Politics*, 74 INT'L ORG. E36, E41 (2020) (claiming that travel restrictions "are the policy of choice in most countries around the world.").

39. Phillip Connor, *More than Nine-in-Ten People Worldwide Live in Countries with Travel Restrictions amid COVID-19*, PEW RSCH. CTR. (Apr. 1, 2020), https://www.pewresearch.org/fact-tank/2020/04/01/more-than-nine-in-ten-people-worldwide-live-in-countries-with-travel-restrictions-amid-covid-19/.

law.[40] From this perspective, travel restrictions are not supported by scientific evidence, and even if they were, more effective alternatives could have been adopted with less restrictive effects, including procedures recommended by the WHO. Other commentators adopted a more nuanced approach, stressing the unprecedented nature of the pandemic and the need to contemplate multiple factors when evaluating the scientific justification and proportionality of additional health measures.[41]

Like prior agreements in the field of international health law, the IHR are repeatedly presented as a "balancing act" between the protection of public health and the maintenance of international trade and travel.[42] Regardless of whether travel restrictions meet the substantive and procedural requirements of Article 43, one thing is clear: there is a colossal gap between WHO's recommendations and States Parties' response. Several months into the epidemic, the Chair of the Review Committee on the Functioning of the International Health Regulations (2005) during the COVID-19 Response (Review Committee (COVID-19)) acknowledged that "[t]he role of WHO in relation to travel recommendations as well as incentives for States Parties to comply with their obligations related to travel measures need to be further examined."[43]

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40. Roojin Habibi et al., *Do Not Violate the International Health Regulations During the COVID-19 Outbreak,* 395 LANCET 664, 665 (2020); Benjamin Meier et al., *Travel Restrictions Violate International Law,* 367 SCIENCE 1436, 1436 (2020); Weijun Yu & Jessica Keralis*, Controlling COVID-19: The Folly of International Travel Restrictions,* HEALTH & HUM. RTS. J. (Apr. 6, 2020), https://www.hhrjournal.org/2020/04/controlling-covid-19-the-folly-of-international-travel-restrictions.

41. Barbara von Tigerstrom & Kumanan Wilson, *COVID-19 Travel Restrictions and the* International Health Regulations (2005), 5 BMJ GLOB. HEALTH 1, 2–3 (2020); *see* von Tigerstrom et al., *supra* note 38, at 2.

42. WHO, Global Crises – Global Solutions: Managing Public Health Emergencies of International Concern Through the Revised International Health Regulations, at 8, WHO/CDS/CSR/GAR/2002.4 (2002), https://apps.who.int/iris/bitstream/handle/10665/67300/WHO_CDS_CSR_GAR_2002.4.pdf?sequence=1&isAllowed=y; Paul DeMuro, *The International Health Regulations—Restricting Travel in Emergency Health Situations and Issues Health Care Providers Should Consider*, 19 HEALTH LAW. 14, 14 (2007); Roojin Habibi et al., *The Stellenbosch Consensus on Legal National Responses to Public Health Risks: Clarifying Article 43 of the International Health Regulations*, 1 INT'L ORGS. L. REV. 1, 6 (2020).

43. WHO, Statement to the Resumed 73rd World Health Assembly by the Chair of the Review Committee on the Functioning of the International Health Regulations (2005) During the COVID-19 Response (Nov. 9, 2020), https://www.who.int/news/item/09-11-2020-statement-73rd-wha-chair-of-the-

Like other epidemic cataclysms, COVID-19 is not only a threat to human health but also to human rights.[44] Almost all human rights are endangered both in the short and long term. Under human rights law, States have an obligation to protect human health by fighting to defeat the pandemic.[45] However, they also have a duty to protect other fundamental human rights such as freedom of movement. IHR's balancing exercise also features human rights rules and principles.[46] As stated by WHO Director-General, "[a]ll countries must strike a fine balance between protecting health, minimizing economic and social disruption, and respecting human rights."[47] This demanding

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review-committee-IHR-covid-19.

44. Karima Bennoune, *"Lest We Should Sleep": COVID-19 and Human Rights*, 114 AM. J. INT'L L. 666, 666 (2020); Alicia Ely Yamin & Roojin Habibi, *Human Rights and Coronavirus: What's at Stake for Truth, Trust, and Democracy?*, HEALTH & HUM. RTS. J. (Mar. 1, 2020), https://www.hhrjournal.org/2020/03/human-rights-and-coronavirus-whats-at-stake-for-truth-trust-and-democracy/; Human Rights Watch, *Human Rights Dimensions of COVID-19 Response* (Mar. 19, 2020, 12:01 A.M.), https://www.hrw.org/news/2020/03/19/human-rights-dimensions-covid-19-response#_Toc35446579; Bård Andreassen et al., *COVID-19: Human Rights Trade-offs, Challenges and Policy Responses* 1 (Norwegian Ctr. for Hum. Rts. Occasional Paper Series 13/2020), https://www.jus.uio.no/smr/english/research/publications/occasional-papers/oc-13-20.pdf.

45. International Covenant on Economic, Social and Cultural Rights, art. 12, Dec. 16, 1996, S. TREATY DOC. No. 95-19, 993 U.N.T.S. 3 ("States Parties . . . recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health . . . . The steps to be taken by the States Parties to . . . achieve the full realization of this right shall include those necessary for . . . [t]he prevention, treatment and control of epidemic, endemic, occupational and other diseases[.]").

46. David P. Fidler, *International Law and Global Public Health*, 48 U. KAN. L. REV. 1, 36 (1999); Lawrence Gostin, *Public Health Strategies for Pandemic Influenza: Ethics and the Law*, 295 JAMA 1700, 1702–03 (2006).

47. WHO, WHO Director-General's Remarks at the Media Briefing on COVID-19 - 11 March 2020 (Mar. 11, 2020), https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020; WHO, *Addressing Human Rights as Key to the COVID-19 Response*, 1–2 (Apr. 21, 2020), https://www.who.int/publications/i/item/addressing-human-rights-as-key-to-the-covid-19-response ("[A]s countries identify ways to address COVID-19, integrating human rights protections and guarantees into our shared responses is not only a moral imperative, it is essential to successfully addressing public health concerns . . . Many countries have implemented large-scale public health and social measures in an attempt to reduce transmission and minimize the impact of COVID-19, including quarantine and the restriction of movement of individuals. WHO emphasizes that any such measures should be implemented only as part of a comprehensive package of public health and social measures, and in accordance with Article 3 of the International Health Regulations (2005), be fully respectful of the dignity, human rights and fundamental freedoms of

exercise entails a process of evaluating and comparing competing values and interests. In the eloquent expression of one author, "[p]ublic health and human rights are inextricably intertwined; too much of one leads to the detriment of the other."[48] To be lawful, health measures must simultaneously promote public health and respect human rights without fully negating either of them.

The tension between international mobility and public health is anything but new. International law has long played a fundamental role in fostering cooperation among nations to strike a delicate equilibrium between (often) conflicting goals.[49] Disregard for the existing regulatory framework is not novel either. COVID-19 seems to be just the latest episode in a saga of "pathological"[50] or even "epidemic"[51] non-compliance with the IHR, yet again testing—in dramatic fashion—the authority and effectiveness of international law mechanisms in addressing the challenges raised by infectious diseases.[52] A thorough diagnosis is in order. As stated by the Review Committee (COVID-19), "[m]ember States and experts have expressed overwhelming support for the Regulations as a cornerstone of international

persons.").

48. Anna L. Grilley, Note, *Arbitrary, Unnecessary Quarantine: Building International and National Infrastructures to Protect Human Rights During Public Health Emergencies*, 34 WIS. INT'L L. J. 914, 921 (2017).

49. *See* David Fidler, *From International Sanitary Conventions to Global Health Security: The New International Health Regulations*, 4 CHINESE J. INT'L L. 325, 333 (2005).

50. Andrea Spagnolo, *(Non) Compliance with the International Health Regulations of the WHO from the Perspective of the Law of International Responsibility*, 18 GLOB. JURIST, ARTICLE NO. 20170025, at 1 (2018).

51. David Heymann et al., *Global Health Security: The Wider Lessons from the West African Ebola Virus Disease Epidemic*, 385 LANCET 1884, 1888 (2015).

52. Lawrence O. Gostin et al., Letter to the Journal, *Has Global Health Law Risen to Meet the COVID-19 Challenge? Revisiting the International Health Regulations to Prepare for Future Threats*, 48 J.L. MED. & ETHICS 376, 379 (2020); Benjamin Mason Meier et al., *The World Health Organization in Global Health Law*, 48 J.L. MED. & ETHICS 796, 797 (2020); David P. Fidler, *To Fight a New Coronavirus: The COVID-19 Pandemic, Political Herd Immunity, and Global Health Jurisprudence*, 19 CHINESE J. INT'L L. 207, 207, 213 (2020); Gian Luca Burci, *The Outbreak of COVID-19 Coronavirus: Are the International Health Regulations Fit for Purpose?*, EJIL:TALK! (Feb. 27, 2020), https://www.ejiltalk.org/the-outbreak-of-covid-19-coronavirus-are-the-international-health-regulations-fit-for-purpose/; Armin von Bogdandy & Pedro Villarreal, *International Law on Pandemic Response: A First Stocktaking in Light of the Coronavirus Crisis* 2, 25 (Max Planck Inst. for Compar. L. Rsch. Paper Series No. 2020-07), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3561650.

public health and health security law. However, there is also agreement that several areas need improving in order for the world to be better prepared for the next pandemic."[53] If international law does not implement efficient therapies, human rights—including freedom of movement—will continue to fall victim to future pandemic outbreaks.

Many believe that the cause of IHR's ailments is the absence of effective enforcement mechanisms. Because no sanctions are foreseen in case of violation, States Parties have little incentive to fulfill their duties.[54] When they disregard their obligations, they face no consequences,[55] so ultimately non-compliance pays off.[56] Breaches of the IHR are not met with firm reproach by the WHO. The organization is normally careful not to antagonize members about the measures they adopt,[57] and the same

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53. Interim Progress Rep. of the Rev. Comm. on the Functioning of the Int'l Health Reguls. During the COVID-19 Response, WHO Exec. Bd., 148th Sess., Prov. Agenda Item 14.2, ¶ 8, W.H.O. Doc. EB/148/19 (Jan. 12, 2021) [hereinafter Interim Progress Report of the Rev. Comm. (COVID-19)], https://apps.who.int/gb/ebwha/pdf_files/EB148/B148_19-en.pdf.

54. David Bishop, *Lessons from SARS: Why the WHO Must Provide Greater Economic Incentives for Countries to Comply with International Health Regulations*, 36 GEO. J. INT'L L. 1173, 1193 (2005); Tsung-Ling Lee, *Making International Health Regulations Work: Lessons from the 2014 Ebola Outbreak*, 49 VAND. J. TRANSNAT'L L. 931, 965 (2016).

55. Rep. of the Rev. Comm. on the Functioning of the Int'l Health Reguls. (2005) in Relation to Pandemic (H1N1) 2009, 64th World Health Assembly, Prov. Agenda Item 13.2 ¶ 24, A64/10 (May 5, 2011) [hereinafter Rep. of the Rev. Comm. (H1N1)], https://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_10-en.pdf?ua=1 ("The most important structural shortcoming of the IHR is the lack of enforceable sanctions. For example, if a country fails to explain why it has adopted more restrictive traffic and trade measures than those recommended by WHO, no legal consequences follow."); Colin McInnes, *WHO's Next? Changing Authority in Global Health Governance after Ebola*, 91 INT'L AFFS. 1299, 1314–15 (2015); Pedro Villarreal, *The (Not-So) Hard Side of the IHR: Breaches of Legal Obligations*, UNIV. GRONINGEN: GLOB. HEALTH L. GRONINGEN (Feb. 26, 2020), https://www.rug.nl/rechten/onderzoek/expertisecentra/ghlg/blog/the-not-so-hard-side-of-the-ihr-breaches-of-legal-obligations-26-02-2020; *see* Ali Tejpar & Steven J. Hoffman, *Canada's Violation of International Law During the 2014-16 Ebola Outbreak*, 54 CANADIAN Y.B. INT'L L. 366, 370 (2016).

56. *See* Jennifer B. Nuzzo & Gigi Kwik Gronvall, *Global Health Security: Closing the Gaps in Responding to Infectious Disease Emergencies*, 4 GLOB. HEALTH GOVERNANCE 10 (2011), http://blogs.shu.edu/wp-content/blogs.dir/109/files/2011/08/spring2011.pdf; Catherine Z. Worsnop, *Provoking Barriers: The 2014 Ebola Outbreak and Unintended Consequences of WHO's Power to Declare a Public Health Emergency*, 11 GLOB. HEALTH GOVERNANCE 7, 20 (2017), http://blogs.shu.edu/ghg/files/2017/05/GHG-Special-Issue-Reform-of-the-World-Health-Organization.pdf#page=8.

57. Stefania Negri, *Communicable Disease Control*, *in* RESEARCH

happened during the outburst of COVID-19[58]. In addition, there is no structured procedure to monitor and review the conformity of States Parties' measures with the IHR.[59] The Review Committee (COVID-19) notes:

The lack of a robust compliance evaluation and accountability mechanism was identified during the interviews as reducing incentives for adequate preparedness and cooperation under the Regulations and as deterring timely notifications of events and public health information. Such criticism was raised in particular with regard to the adoption of additional health measures in view of their transboundary social and economic consequences. A robust system of compliance evaluation built into the Regulations was cited during the interviews as a potential approach to strengthening the overall framework of the Regulations and its credibility as a legal instrument; such an approach could include consideration of a universal peer review mechanism.[60]

As acknowledged by the Chair of the Review Committee, the IHR "lack . . . teeth".[61] The stark contrast between WHO's recommendations and States Parties' reactions begs the question of whether the current regime is too *soft* to induce

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HANDBOOK ON GLOBAL HEALTH LAW 265, 299 (Gian Luca Burci & Brigit Toebes eds., 2018); Antoine Puyvallée & Sonja Kittelsen, *"Disease Knows No Borders": Pandemics and the Politics of Global Health Security*, *in* PANDEMICS, PUBLICS, AND POLITICS 59, 66 (Kristian Bjørkdahl & Benedicte Carlsen eds., 2019).

58. Kelley Lee et al., *Global Coordination on Cross-border Travel and Trade Measures Crucial to COVID-19 Response*, 395 LANCET 1593, 1593 (2020); Sara Davies & Clare Wenham, *Why the COVID-19 Response Needs International Relations*, 96 INT'L AFFS. 1227, 1231 (2020).

59. Susan L. Erikson, *The Limits of the International Health Regulations: Ebola Governance, Regulatory Breach, and the Non-Negotiable Necessity of National Healthcare*, *in* THE GOVERNANCE OF DISEASE OUTBREAKS 349, 358 (Leonie Vierck et al. eds., 2017) (criticizing Article 56 of the IHR because "[i]ts language and procedural instructions . . . are tautological").

60. Interim Progress Report of the Rev. Comm. (COVID-19), *supra* note 53, ¶ 12. *See also id.* ¶¶ 18, 35; WHO Director-General, WHO Director-General's Opening Remarks at the 148th Session of the Executive Board (Jan. 19, 2021), https://www.who.int/director-general/speeches/detail/who-director-general-s-opening-remarks-at-148th-session-of-the-executive-board (discussing a new proposal currently being pilot-tested under the "Universal Health and Preparedness Review," an initiative launched in November 2020).

61. Lothar H. Wieler, WHO, Statement to the 148th Executive Board by the Chair of the Review Committee on the Functioning of the International Health Regulations (2005) During the COVID-19 Response (Jan. 19, 2021), https://www.who.int/news/item/19-01-2021-statement-to-the-148th-executive-board-by-the-chair-of-the-review-committee-on-the-functioning-of-the-international-health-regulations-(2005)-during-the-covid-19-response.

compliance and should be *hardened*. Governmental decisions about what measures to implement during a pandemic outbreak, and when, are often made in a context of scientific uncertainty.[62] This is especially so when the nature and dangerousness of the disease is unknown: the decision-making process is surrounded by interrogations about the incubation period, mode of transmission, fatality rate, etc.[63] In similar fashion, this article posits that decisions about whether to implement additional health measures are marked by legal uncertainty. Governments are under pressure to act rapidly without having clear instructions about whether certain measures interfere unnecessarily with international traffic and thereby breach the IHR. Conducting a balancing exercise under medical and legal uncertainty may understandably cloud one's assessment of the values and risks involved and tip the balance in the wrong direction.

This article argues that a promising avenue to harden the regulatory framework—hopefully enhancing compliance with its provisions—is to launch a process of "soft legalization." This proposal departs from the concept of "legalization", defined by Abbott and colleagues as

> a particular set of characteristics that institutions may (or may not) possess. These characteristics are defined along three dimensions: obligation, precision, and delegation. *Obligation* means that states or other actors are bound by a rule or commitment or by a set of rules or commitments. Specifically, it means that they are *legally* bound by a rule or commitment in the sense that their behavior thereunder is subject to scrutiny under the general rules, procedures, and discourse of international law, and often of domestic law as well. *Precision* means that rules unambiguously define the conduct they require, authorize, or proscribe. *Delegation* means that third parties have been granted authority to implement, interpret, and apply the rules; to resolve disputes; and (possibly) to make further rules.[64]

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62. Jonathan Suk, *Sound Science and the New International Health Regulations*, 1 GLOB. HEALTH GOVERNANCE, Fall 2007, at 1, 2 , http://www.ghgj.org/Suk_Sound%20Science%20and%20IHR.pdf; *see* Weituo Zhang & Bi-yun Qian, Correspondence, *Making Decisions to Mitigate COVID-19 with Limited Knowledge*, 20 LANCET INFECTIOUS DISEASES 1121, 1121 (2020).

63. SARA DAVIES ET AL., DISEASE DIPLOMACY 120–22 (2015); Suk, *supra* note 62, at 2; Kenwick & Simmons, *supra* note 38, at E38.

64. Kenneth W. Abbott et al., *The Concept of Legalization*, 54 INT'L ORG.

As each of the different dimensions is independent and may vary in intensity, the concept of legalization ranges from situations of "hard" legalization, to cases of "soft" legalization, to instances of complete absence of legalization.[65] "Soft legalization" takes place where one or more dimensions of legal arrangements (obligation, precision, or delegation) are weakened or relaxed.[66] According to Abbot and Snidal:

> softer legalization is often easier to achieve than hard legalization. This is especially true when the actors are states that are jealous of their autonomy and when the issues at hand challenge state sovereignty. Soft legalization also provides certain benefits not available under hard legalization. It offers more effective ways to deal with uncertainty, especially when it initiates processes that allow actors to learn about the impact of agreements over time.[67]

This article's premise is that it is more feasible—at least in the short-term—to gradually harden the precision dimension of the regime[68] than to enhance its enforceability.[69] Indeed,

401, 401 (2000) (emphasis in original).

65. *Id.* at 401–02.

66. Kenneth W. Abbott & Duncan Snidal, *Hard and Soft Law in International Governance*, 54 INT'L ORG. 421, 422–23. *But see, e.g.*, Ryan Goodman & Derek Jinks, *How to Influence States: Socialization and International Human Rights Law*, 54 DUKE L.J. 621, 675 (2004) (merging precision in the concept of obligation into what they term "precision of obligations"); Kal Raustiala, *Form and Substance in International Agreements*, 99 AM. J. INT'L L. 581, 588–89 (2005) (arguing that "imprecision does not alter the legal quality of rules").

67. Abbot & Snidal, *supra* note 66, at 423.

68. *See, e.g.*, Louis Bélanger & Kim Fontaine-Skronski, *'Legalization' in International Relations: A Conceptual Analysis*, 51 SOC. SCI. INFO. 238, 251 (2012) (suggesting the consensus is that precision is the least important of the three dimensions of legalization).

69. There are, however, important interactions between the precision and the delegation dimension. Gregory Shaffer & Mark A. Pollack, *Hard and Soft Law*, *in* INTERDISCIPLINARY PERSPECTIVES ON INTERNATIONAL LAW AND INTERNATIONAL RELATIONS 197, 213–214 (Jeffrey L. Dunnoff & Mark A. Pollack eds., 2013) ("[L]ow precision combined with a low degree of delegation provides a wide range of state and non-state actors with the ability to interpret opportunistically a vague set of legal provisions, and is therefore likely to impose few, if any, real constraints on states parties. By contrast, low precision combined with high delegation to third-party dispute settlement systems grants international judges or arbitrators wide latitude to issue authoritative interpretations of vague treaty provisions and can result in growing constraints on states over time.").

endowing the regime with greater enforceability would require an extraordinary level of political compromise that seems almost impossible to attain if one considers the level of disregard for the regime as it currently stands. A more modest but probably more efficient solution, hitherto surprisingly overlooked in the literature, is to seek to build consensus about the regime and incrementally fine-tune its provisions. An important (even if partial) reason for non-compliance with the IHR is the degree of uncertainty about the correct scope and interpretation of its provisions—namely Article 43. "A precise rule specifies clearly and unambiguously what is expected of a state or other actor (in terms of both the intended objective and the means of achieving it) in a particular set of circumstances. In other words, precision narrows the scope for reasonable interpretation."[70] The rationale behind this proposal is straightforward: if the WHO increases the "precision" or "determinacy" of the regulatory framework, there is a greater chance it will enhance its normative "compliance pull."[71] A higher degree of precision would limit States Parties' discretion to deviate from the regime, thereby enhancing its effectiveness and credibility.

The article proceeds as follows: the second Part expands the analysis of the current legal framework, briefly sketched above. For deviations to the general principle of international mobility contained in the IHR and in human rights law to be considered lawful, States Parties must report and justify them. However, both fields of international law are plagued with non-compliance. The third Part proposes to remedy this problem by employing different normative tools. Regardless of the hard or soft nature of such instruments, what truly matters is the creation of visible markers about how and when States Parties may apply additional health measures that interfere with international mobility. As discussed in the fourth Part, it is also vital to increase the weight of human rights rules and principles in the balancing exercise between public health and freedom of movement. A coherent, holistic approach to international mobility requires a greater degree of precision about whether health measures comply with human rights standards. The fifth

70. Abbott et al., *supra* note 64, at 412.

71. *See* Thomas M. Franck, THE POWER AND LEGITIMACY AMONG NATIONS 50–66 (1990) (discussing how a rule's determinacy affects its legitimacy); *see also* ABRAM CHAYES & ANTONIA HANDLER CHAYES, THE NEW SOVEREIGNTY: COMPLIANCE WITH INTERNATIONAL REGULATORY AGREEMENTS 126–27 (1996) (arguing that "parties can more readily adapt their conduct" when the substantive norms of an organization are more transparent and concrete).

Part calls for a change of organizational mindset, suggesting some non-normative reforms that may increase the efficiency of the WHO's approach to international law. Finally, the sixth Part offers some broader reflections on the role in international mobility in a post-pandemic world.

II. ESCAPE ROUTES, SAFEGUARDS, AND DETOURS

Both the IHR and the ICCPR recognize that in grave situations it may be indispensable to constrain the (international) freedom of movement of individuals to protect collective health. The fact that the WHO never recommended (at least explicitly) the implementation of travel restrictions does not automatically render these measures unlawful under the IHR—so long as the requirements of Article 43 are respected. When implementing additional health measures, states should also bear in mind the important connections between the IHR and human rights, namely, the fact that such measures may result in the introduction of limitations to or of derogations from the human right to freedom of movement. Therefore, human rights treaties play a central role in the interpretation of additional health measures under Article 43 of the IHR.[72]

The IHR establish a code of conduct on how State Parties should react to international public health emergencies.[73] Temporary recommendations play a central role in this regard. They are based on scientific principles and available scientific evidence and information.[74] Albeit described by the IHR itself as

72. Habibi et al., *supra* note 42, at 46; *see also id.* at 67 ("It is clear the IHR was conceived to be closely intertwined with international human rights law and international trade law. With respect to human rights law, Article 43 sets limitations to additional health measures by deferring to the rights contained in the [Universal Declaration of Human Rights], ICCPR and other international and regional human rights treaties. This symbiosis suggests that in cases where an additional health measure may curtail the rights and freedoms of individuals, states should at minimum apply the principles of legitimacy, necessity and proportionality to guide them in understanding the limited circumstances under which they may legally deviate from their human rights obligations.").

73. Meier et al., *supra* note 52, at 797 ("The IHR codify WHO's legal authority to lead international efforts 'to prevent, protect against, control and provide a public health response to the international spread of disease.'").

74. International Health Regulations (2005), *supra* note 7, art. 17(c); *see also id.* art. 1(1) (defining scientific principles as "the accepted fundamental laws and facts of nature known through the methods of science[,]" while defining scientific evidence as "information furnishing a level of proof based on the established and accepted methods of science").

"non-binding advice[,]"[75] recommendations lay down a benchmark that allows to compare measures adopted by States Parties with the actions recommended by the WHO.

The IHR enable the WHO to recommend the refusal of entry of suspect and affected persons and refusal of entry of unaffected persons to affected areas,[76] but does not mention the closure of borders.[77] According to Ferhani and Rushton, "[t]he IHR's overall orientation is firmly against the imposition of border restrictions[.]"[78] Consistent with its position in previous PHEICs, the WHO never explicitly recommended the implementation of travel restrictions.[79] This advice was based on

75. *Id.* art. 1(1) ("'temporary recommendation' means non-binding advice issued by WHO pursuant to Article 15 for application on a time-limited, risk-specific basis, in response to a public health emergency of international concern, so as to prevent or reduce the international spread of disease and minimize interference with international traffic").

76. *Id.* art. 18(1) ("'Suspect' means those persons, baggage, cargo, containers, conveyances, goods or postal parcels considered by a State Party as having been exposed, or possibly exposed, to a public health risk and that could be a possible source of spread of disease."); *see also id.* at art. 1(1) ("'Affected' means persons, baggage, cargo, containers, conveyances, goods, postal parcels or human remains that are infected or contaminated, or carry sources of infection or contamination, so as to constitute a public health risk; 'Affected area' means a geographical location specifically for which health measures have been recommended by WHO under these Regulations").

77. Robert Steffen, *Influenza in Travelers: Epidemiology, Risk, Prevention, and Control Issues*, 12 CURRENT INFECTIOUS DISEASE REP. 181, 182 (2010); Sarah Goldfarb, *The Phase-Out and Sunset of Travel Restrictions in the International Health Regulations*, 41 BROOKLYN J. INT'L L. 781, 803 (2016).

78. Adam Ferhani & Simon Rushton, *The International Health Regulations, COVID-19, and Bordering Practices: Who Gets In, What Gets Out, and Who Gets Rescued?*, 41 CONTEMP. SEC. POL'Y 458, 459–60 (2020); *see also* Ruud Koopmans, *A Virus that Knows No Borders? Exposure to and Restrictions of International Travel and the Global Diffusion of COVID-19*, at 2 (Wissenschaftszentrum Berlin für Sozialforschung (WZG) Discussion Paper No. SP VI 2020-103, Oct. 2020), https://www.econstor.eu/handle/10419/225533 ("[t]he WHO's sceptical [sic] attitude towards travel restrictions is to some extent built into its remit, which is based on the International Health Regulations").

79. *See* Annelies Wilder-Smith & Sarah Osman, *Public Health Emergencies of International Concern: A Historic Overview*, 27 J. TRAVEL MED. 1, 1–8 (2020) (describing the five events declared a PHEIC under the IHR, namely the 2009 H1N1 influenza pandemic, Ebola (2013–2015 and 2018–2020), poliomyelitis (2014 to present), and Zika (2016)); Gian Luca Burci, *The Legal Response to Pandemics: The Strengths and Weaknesses of the International Health Regulations*, 11 J. INT'L HUMANITARIAN LEGAL STUD. 204, 214 (2020) ("[T]he Secretariat and the public health expertise represented in the emergency committees share a bias against general travel and trade restrictions as ineffective and counterproductive; recommendations in previous PHEICs focus on responsible behavior [sic] by travelers or exit screenings at international

a consolidated body of scientific evidence according to which travel restrictions are not effective, and at most delay the peak of a pandemic by a few days to weeks.[80] Such measures achieve modest results, only delaying the initial spread of the disease, and must be combined with infection prevention and control measures to considerably reduce transmissions.[81]

States Parties to the IHR may deviate from temporary recommendations by applying additional health measures. However, pursuant to Article 43 of the IHR, a decision to implement additional health measures shall be based upon the following elements:

> (a) scientific principles;
>
> (b) available scientific evidence of a risk to human health, or where such evidence is insufficient, the available information including from WHO and other relevant intergovernmental organizations and international bodies; and
>
> (c) any available specific guidance or advice from WHO.[82]

If such measures "significantly interfere with international traffic[,]" the State Party "shall provide to WHO the public health rationale and relevant scientific information for it."[83] Importantly, the following measures are generally considered as "significant interference": "refusal of entry or departure of international travellers, baggage, cargo, containers, conveyances, goods, and the like, or their delay, for more than

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airports.").

80. *See, e.g.*, Paolo Bajardi et al., *Human Mobility Networks, Travel Restrictions, and the Global Spread of 2009 H1N1 Pandemic*, PLOS ONE, Jan. 2011, at 7; Ana LP Mateus et al., *Effectiveness of Travel Restrictions in the Rapid Containment of Human Influenza: A Systematic Review*, 92 BULLETIN OF THE WHO 868, 872–73 (2014), https://www.who.int/bulletin/volumes/92/12/14-135590.pdf; Nicole A. Errett et al., *An Integrative Review of the Limited Evidence on International Travel Bans as an Emerging Infectious Disease Disaster Control Measure*, 18 J. EMERGENCY MGMT. 7, 13 (2020); Asami Anzai et al., *Assessing the Impact of Reduced Travel on Exportation Dynamics of Novel Coronavirus Infection (COVID-19)*, 9 J. CLINICAL MED. 600, 601 (2020).

81. Matteo Chinazzi et al., *The Effect of Travel Restrictions on the Spread of the 2019 Novel Coronavirus (COVID-19) Outbreak*, 368 SCIENCE 395, 400 (2020).

82. International Health Regulations (2005), *supra* note 7, art. 43(2).

83. *Id.* art. 43(3).

24 hours."[84] The WHO assesses these additional health measures and may request the State to reconsider their application.[85] States also have the obligation of reporting measures to the WHO within forty-eight hours of implementation, together with their health rationale, unless they are covered by a temporary or standing recommendation.[86] States "shall within three months review such a measure, taking into account the advice of WHO" and the criteria set forth in Article 43(2).[87]

Human rights law also offers States some escape routes from their obligations, through the mechanisms of limitations and derogations. Specifically, apropos limitations to freedom of movement, Article 12(3) of the ICCPR provides:

> The above-mentioned rights [that is, the right to leave] shall not be subject to any restrictions except those which are provided by law, are necessary to protect national security, public order (ordre public), public health or morals or the rights and freedoms of others, and are consistent with the other rights recognized in the present Covenant.[88]

According to the Human Rights Committee,

> [t]he permissible limitations which may be imposed on the rights protected under article 12 must not nullify the principle of liberty of movement, and are governed by the requirement of necessity provided for in article 12, paragraph 3, and by the need for consistency with the other rights recognized in the Covenant.[89]

The right to return is not bound by the restrictions contained in Article 12(3) of the ICCPR.[90] Article 12(4) only states that "[n]o one shall be arbitrarily deprived of the right to

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84. *Id.*
85. *Id.* art. 43(4).
86. *Id.* art. 43(5).
87. *Id.* art. 43(6).
88. ICCPR, *supra* note 14, art. 12(3).
89. U.N. Hum. Rts. Comm., *supra* note 17, ¶ 2.
90. Barbara von Tigerstrom, *The Revised International Health Regulations and Restraint of National Health Measures*, 13 HEALTH L.J. 35, 64 n.147 (2005); Richardson & Devine, *supra* note 10, at 132–33.

enter his own country."[91] The Human Rights Committee clarifies:

> In no case may a person be arbitrarily deprived of the right to enter his or her own country. The reference to the concept of arbitrariness in this context is intended to emphasize that it applies to all State action, legislative, administrative and judicial; it guarantees that even interference provided for by law should be in accordance with the provisions, aims and objectives of the Covenant and should be, in any event, reasonable in the particular circumstances. The Committee considers that there are few, if any, circumstances in which deprivation of the right to enter one's own country could be reasonable.[92]

The Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights ("Siracusa Principles") offer useful guidance in this context.[93] The Principles establish several requirements for limitations to be lawful:

> Whenever a limitation is required in the terms of the Covenant to be "necessary", this term implies that the limitation:
>
> (a) Is based on one of the grounds justifying limitations recognized by the relevant article of the Covenant;

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91. ICCPR, *supra* note 14, art. 12(4).

92. U.N. Hum. Rts. Comm., *supra* note 17, ¶ 21; Chetail, *supra* note 15, at 58 (arguing that the term "arbitrarily" may imply that there are some limits to the exercise of the right).

93. The Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights, in note verbale dated Aug. 24, 1984 from the Permanent Representative of the Netherlands to the United Nations Office at Geneva addressed to the Secretary-General, U.N. ESCOR, 41st Sess., annex, U.N. Doc. E/CN.4/1985/4 (Sept. 28, 1984) [hereinafter Siracusa Principles], https://digitallibrary.un.org/record/497167?ln=en; Lawrence O. Gostin & Benjamin E. Berkman, *Pandemic Influenza: Ethics, Law, and the Public's Health*, 59 ADMIN. L. REV. 121, 146 (2007) ("The Siracusa Principles . . . are widely recognized as a legal standard for measuring the validity of limitations on human rights."); Habibi et al., *supra* note 42, at 53 (describing the Siracusa principles as "[n]on-binding but authoritative").

(b) Responds to a pressing public or social need;

(c) Pursues a legitimate aim, and

(d) Is proportionate to that aim.[94]

The Siracusa Principles also contain a provision dealing specifically with limitations of rights for public health reasons, stating:

> Public health may be invoked as a ground for limiting certain rights in order to allow a State to take measures dealing with a serious threat to the health of the population or individual members of the population. These measures must be specifically aimed at preventing disease or injury or providing care for the sick and injured.[95]

In addition, the Siracusa Principles reinforce the connection between human rights treaties and the IHR when they provide that in the case of limitations on public health grounds, "[d]ue regard shall be had to the International Health Regulations of the World Health Organization."[96]

Instead of being limited, the human right to freedom of movement may be derogated. Derogation clauses operate as an escape valve, allowing States to suspend some human rights obligations in extreme scenarios.[97] There is a sort of continuum between the two types of measures, and states should only resort to derogations when limitations are insufficient.[98] Derogations require a more demanding assessment of the seriousness of the threat to public interests, and the implications it will have in the protection of other human rights. Article 4(1) of the ICCPR

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94. Siracusa Principles, *supra* note 93, ¶ 10.

95. *Id.* ¶ 25.

96. *Id.* ¶ 26; Stefania Negri, *supra* note 57, at 289–90 ("[S]uch a reference to the IHR is particularly noteworthy because it stresses that in times of public health emergency national authorities have to comply with both the Regulations and human rights treaties, and that they are called to ensure consistency and coordination between the obligations stemming therefrom.").

97. Emilie M. Hafner-Burton et al., *Emergency and Escape: Explaining Derogations from Human Rights Treaties*, 65 INT'L ORG. 673, 674 (2011).

98. Spadaro, *supra* note 34, at 321–22; Dominic McGoldrick, *The Interface Between Public Emergency Powers and International Law*, 2 INT'L J. CONST. L. 380, 384 (2004).

permits the derogation of otherwise legally protected rights as long as several requirements are met:

> In time of public emergency which threatens the life of the nation and the existence of which is officially proclaimed, the States Parties to the present Covenant may take measures derogating from their obligations under the present Covenant to the extent strictly required by the exigencies of the situation, provided that such measures are not inconsistent with their other obligations under international law and do not involve discrimination solely on the ground of race, colour, sex, language, religion or social origin.[99]

Due to its severe impact—yet to be fully determined—COVID-19 can be said to be one of those circumstances where the "life of the nation" is at stake and so the derogation of certain human rights may be justified.[100] There are, however, important safeguards and requirements to the derogation of human rights, which are based on the principles of legality and the rule of law.[101] According to the Siracusa Principles, "provisions . . . allowing for certain derogations in a public emergency are to be interpreted restrictively."[102] The assessment of whether the circumstances require derogation from a certain right is subject to the principle of strict proportionality.[103]

The imposition of travel restrictions in response to an epidemic outbreak is not a novelty—rather, it has long become the rule.[104] In addition, countries frequently breach their

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99. ICCPR, *supra* note 14, art. 4(1).

100. Spadaro, *supra* note 34, at 322; Tobias Vestner & Altea Rossi, *COVID-19: The 'Fine Balance' Under Human Rights Law*, GENEVA CTR. FOR SEC. POL'Y (April 17, 2020), https://www.gcsp.ch/global-insights/covid-19-fine-balance-under-human-rights-law; Audrey Lebret, *COVID-19 Pandemic and Derogation to Human Rights*, 7 J.L. & BIOSCIENCES 1, 5 (2020).

101. U.N. Hum. Rts. Comm., General Comment No. 29: Derogations During a State of Emergency, ¶ 16, U.N. Doc. CCPR/C/21/Rev.1/Add.11 (Aug. 31, 2001), https://digitallibrary.un.org/record/451555?ln=en; *see also* Siracusa Principles, *supra* note 93, ¶ 61.

102. Siracusa Principles, *supra* note 93, ¶ 63.

103. U.N. Hum. Rts. Comm., *supra* note 101, ¶ 4; *see also* Siracusa Principles, *supra* note 93, ¶¶ 51–57.

104. Lawrence O. Gostin, *Influenza A(H1N1) and Pandemic Preparedness Under the Rule of International Law,* 301 JAMA 2376, 2377–78 (2009); Morenike Folayan & Brandon Brown, Letter to the Editor, *Ebola and the Limited Effectiveness of Travel Restrictions*, 9 DISASTER MED. & PUB. HEALTH PREPAREDNESS 92, 92 (2015); Wendy Rhymer & Rick Speare, *Countries'*

obligations to report additional measures[105] and explain their scientific and public health rationale.[106] This has also been the case in the COVID-19 crisis: while practically all countries on earth adopted some form of travel restriction, by the end of February 2020, only thirty-eight countries had reported such measures to the WHO.[107] It seems evident that many such measures went unreported. In previous outbreaks, it was suggested that the WHO be more proactive and emphatic in requesting States Parties to justify their measures.[108] While the WHO has the power to "name and shame" violating States, this tool has not been deployed.[109] The priority seems to be to engage States in multilateral cooperation without questioning their decisions.

The panorama is equally bleak on the human rights front. The Siracusa Principles provide that "[i]n determining whether derogation measures are strictly required by the exigencies of the situation, the judgment of the national authorities cannot be accepted as conclusive."[110] Governments have the burden of

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Response to WHO's Travel Recommendations During the 2013-2016 Ebola Outbreak, 95 BULLETIN OF THE WHO 10, 13 (2017).

105. WHO, STRENGTHENING RESPONSE TO PANDEMICS AND OTHER PUBLIC-HEALTH EMERGENCIES: REPORT OF THE REVIEW COMMITTEE ON THE FUNCTIONING OF THE INTERNATIONAL HEALTH REGULATIONS (2005) AND ON PANDEMIC INFLUENZA (H1N1) 2009, at 62, 80–81 (2011), https://apps.who.int/iris/bitstream/handle/10665/75235/9789241564335_eng.pdf?sequence=1&isAllowed=y; David P. Fidler, *Epic Failure of Ebola and Global Health Security*, 21 BROWN J. WORLD AFFS. 179, 189 (2015).

106. WHO, *Report of the Ebola Interim Assessment Panel*, ¶ 17 (July 1, 2015), https://www.who.int/csr/resources/publications/ebola/report-by-panel.pdf; Trygve Ottersen et al., *Ebola Again Shows the International Health Regulations are Broken: What can be Done Differently to Prepare for the Next Epidemic?*, 42 AM. J. L. & MED. 356, 377 (2016); Lee, *supra* note 54, at 965.

107. WHO, Updated WHO Recommendations for International Traffic, *supra* note 37. Subsequent updates by the WHO are silent on whether the organization received more reports from States Parties.

108. Kumanan Wilson et al., *Strengthening the International Health Regulations: Lessons from the H1N1 Pandemic*, 25 HEALTH POL'Y & PLAN. 505, 508 (2010); WHO, *supra* note 105, at 113.

109. Adam Kamradt-Scott, *WHO's to Blame? The World Health Organization and the 2014 Ebola Outbreak in West Africa*, 37 THIRD WORLD Q. 401, 411 (2016); Worsnop, *supra* note 56, at 11, 20; Rep. of the Rev. Comm. (H1N1), *supra* note 55, ¶ 27. In 2011, the Review Committee suggested that the WHO posted on its event information site "all temporary and standing recommendations issued under the IHR as well as information on Member States that institute additional measures and their rationales for these, and the status of WHO's request for such a rationale." *Id.* This suggestion was never implemented.

110. Siracusa Principles, *supra* note 93, ¶ 57.

justifying their measures. As highlighted by the Human Rights Committee on its statement on derogations from the ICCPR in connection with COVID-19:

> Where measures derogating from the obligations of States parties under the Covenant are taken, the provisions derogated from and the reasons for the derogation must be communicated immediately to the other States parties through the Secretary-General. *Notification by a State party must include full information about the derogating measures taken and a clear explanation of the reasons for taking them, with complete documentation of any laws adopted*.[111]

The Committee stated that while several countries had already notified the Secretary-General of measures they had taken or were planning to implement which would derogate from the ICCPR, several other States Parties had adopted measures without a formal notification (the Committee urged them to submit a notification immediately).[112] The statement delineates the different requirements and conditions that States must comply with in order to align their measures with human rights standards. As emphasized by the Siracusa Principles, measures should not be "imposed merely because of an apprehension of potential danger."[113] States should identify the measures they have implemented or plan to implement and explain specifically why they believe they are appropriate to the risks created by the pandemic.[114]

Experience shows that governments' notices of derogation often leave much to be desired: they are "too general, too brief, and do not give a clear indication of what articles . . . have been suspended."[115] In the context of COVID-19, States did not even

111. U.N. Hum. Rts. Comm., Statement on Derogations from the Covenant in Connection with the COVID-19 Pandemic, ¶ 2, U.N. Doc. CCPR/C/128/2 (April 30, 2020) (emphasis added), https://digitallibrary.un.org/record/3863948?ln=en.

112. *Id.* ¶ 1. The Committee added that "[T]he implementation of the obligation of immediate notification [is] essential for the discharge of its functions, as well as for the monitoring of the situation by other States parties and other stakeholders[.]" *Id.* ¶ 2.

113. Siracusa Principles, *supra* note 93, ¶ 54.

114. *See id.* ¶ 52.

115. JAIME ORAÁ, HUMAN RIGHTS IN STATES OF EMERGENCY IN INTERNATIONAL LAW 77 (Ian Brownlee ed. 1992); Laurence Helfer, *Rethinking Derogations from Human Rights Treaties*, 115 AM. J. INT'L L. 20, 21, 26 (2021)

explain why a derogation was necessary instead of a restriction.[116] It is even harder to determine whether decisions are justified when States do not report the measures they implement. As many of these measures are being lifted, they may never be reviewed by the competent bodies.

A troubling question is what consequences—if any—potential breaches of international law will have. One of the things the IHR and human rights law have in common is pervasive non-compliance. According to the Siracusa Principles, "[e]ffective remedies shall be available to persons claiming that derogation measures affecting them are not strictly required by the exigencies of the situation."[117] However, the IHR does not incorporate a system to investigate human rights violations. As stated by the Review Committee on the Functioning of the International Health Regulations (2005) and on Pandemic Influenza (H1N1) 2009 (Review Committee (H1N1)), "[t]here is no systematic monitoring by WHO of instances where human rights are not respected in implementing the IHR. Furthermore, WHO does not have a mandate to investigate whether particular measures constitute violations of this provision in the IHR."[118] Still, the Committee went on to add:

> It appears to be a weakness that WHO does not monitor whether human rights are being respected in implementing the IHR. Even if WHO does not have a mandate to investigate, it is in the spirit of the IHR for WHO to consult with States Parties when the media report practices that may be seen as violations of human rights and, in turn, the IHR. Such respect is important for public acceptance of the IHR.[119]

("Most notices of derogation are short simple statements listing which rights have been suspended and for how long, and citing to domestic laws or decrees; only a few states have offered more detailed statements justifying their actions.").

116. Niall Coghlan, *Dissecting COVID-19 Derogations*, VERFASSUNGSBLOG (May 5, 2020), https://verfassungsblog.de/dissecting-covid-19-derogations/.

117. Siracusa Principles, *supra* note 93, ¶ 56.

118. WHO, note 105, at 63. *But see* Rana Moustafa Essawy, *The WHO: The Guardian of Human Rights During Pandemics?*, EJIL: TALK! (June 15, 2020), https://www.ejiltalk.org/the-who-the-guardian-of-human-rights-during-pandemics ("[T]he WHO has the power to monitor and evaluate states' compliance with human rights obligations in the context of a COVID-19 response.").

119. WHO, *supra* note 105, at 64; *see* Negri, *supra* 57, at 300 (suggesting that a "human rights impact assessment" be introduced to review public health measures notified to the WHO); *see also* Tsung-Ling Lee, *Global Health in a Turbulence Time: A Commentary*, 15 ASIAN J. WTO & INT'L HEALTH L. & POL'Y 27, 51 (2020). However, it is questionable whether the WHO is willing to assume

The only mechanism available to review measures implemented under the IHR susceptible of breaching human rights is to refer them to the United Nations monitoring system.[120] The ICCPR provides for the existence of a Human Rights Committee, to which States Parties must periodically submit reports.[121] However, it has not been very effective. Like what happens with the WHO, without reports, there is no monitoring, much less enforcement.

Regardless of the (ill)legality of travel restrictions, the universal refusal by States Parties to follow WHO's advice raises red flags about the authority of the regime and its effectiveness in coordinating countries' reactions to international health crises. A regime that is routinely disregarded runs the risk of becoming an embarrassing legal relic. In the next section we examine how a more precise regime can bring about greater compliance with WHO's rules and recommendations and help restore its credibility.

III. SETTING CLEARER SIGNPOSTS

COVID-19 exposed in conspicuous fashion the fragilities of the international regime for infectious disease control. For the IHR not to become dead letter, the WHO must rethink the way it deploys the wide array of legal tools at its disposal. While the organization has been created to be "an orchestrator"[122] in the global arena, it has yet to achieve its full potential as a "norm entrepreneur."[123] The WHO is endowed with "impressive normative powers."[124] However, historically it has not used

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a more active role in protecting human rights when there is not even a mechanism in place to monitor and review compliance with the IHR itself.

120. Brigit Toebes et al., *Toward Human Rights-Consistent Responses to Health Emergencies: What is the Overlap Between Core Right to Health Obligations and Core International Health Regulation Capacities?*, 22 HEALTH & HUM. RTS. J. 99, 109 (2020).

121. ICCPR, *supra* note 14, arts. 28, 40.

122. Tine Hanrieder, *WHO Orchestrates? Coping with Competitors in Global Health*, *in* INTERNATIONAL ORGANIZATIONS AS ORCHESTRATORS 191, 191 (Kenneth W. Abbott et al. eds., 2015).

123. Obijiofor Aginam, *Mission (Im)possible? The WHO as a 'Norm Entrepreneur' in Global Health Governance*, *in* LAW AND GLOBAL HEALTH 559, 559 (Michael Freeman et al. eds., 2014).

124. Lawrence O. Gostin et al., *The Normative Authority of the World Health Organization*, 129 PUB. HEALTH 854, 856 (2015). The organization has a "wide mandate in the field of international health standard-setting." Allyn L. Taylor, *Global Health Law*, *in* GLOBAL HEALTH DIPLOMACY 37, 45 (Ilona Kickbusch et

conventional international law instruments effectively to shape global health policy.[125] The IHR and the 2003 Framework Convention on Tobacco Control (FCTC) are the only two binding normative frameworks adopted thus far. While the Convention has been presented as a turning point in WHO's use of international law instruments,[126] it stands as a rare exception to its traditional hesitation in exercising "hard" legislative powers. When the IHR were revised in 2005, some authors welcomed them as "unprecedented in the history of the relationship between international law and public health."[127] Being "founded on sound international law," the regulations were "expected to carry significant legal clout."[128] Yet, despite being formally binding,[129] in practice States perceive the IHR as recommendations rather than legal obligations.[130] It has been

al. eds., 2013).

125. *See* Obijiofor Aginam, *International Law and Communicable Diseases*, 80 BULLETIN OF THE WHO 946, 949 (2002); Benedict Kingsbury & Lorenzo Casini, *Global Administrative Law Dimensions of International Organizations Law*, INT'L ORGS. L. REV. 319, 352 ("[A]lthough WHO was conceived in 1948 as a normative organization with powers to adopt conventions and make binding regulations . . . it has engaged in explicit law-producing functions much less than many other agencies."); *see also* Lorenzo Casini, *The Expansion of the Material Scope of Global Law*, *in* RESEARCH HANDBOOK ON GLOBAL ADMINISTRATIVE LAW 25, 33 (Sabino Cassese ed., 2016) (noting that the WHO has "produced significantly fewer norms than other institutions.").

126. The FCTC "was the first treaty concluded under the World Health Organization (WHO)'s Constitution in the half-century since the organization had been created" and "signaled a new willingness by WHO leadership and the broader health community to deploy international law as a powerful governance tool for protecting public health." Suerie Moon, *Global Health Law and Governance: Concepts, Tools, Actors and Power*, *in* RESEARCH HANDBOOK ON GLOBAL HEALTH LAW 24, 24 (Gian Luca Burci & Brigit Toebes eds., 2018).

127. David Fidler & Lawrence Gostin, *The New International Health Regulations: An Historic Development for International Law and Public Health*, 34 J. L. MED. & ETHICS 85, 93 (2006).

128. Bishop, *supra* note 54, at 1189.

129. Steven A. Solomon, *Instruments of Global Health Governance at the World Health Organization*, *in* GLOBAL HEALTH DIPLOMACY 187, 192 (Ilona Kickbusch et al. eds., 2013) ("Regulations are legally binding for Member States, creating 'hard' obligations under international law."); *see also id.* at 191. In face of an historical record of non-compliance, the issue arose during the negotiation process, but ultimately it was decided to maintain the binding nature of the IHR. MARK W. ZACHER & TANIA J. KEEFE, THE POLITICS OF GLOBAL HEALTH GOVERNANCE 41 (2008).

130. David P. Fidler, *The Role of International Law in the Control of Emerging Infectious Diseases*, 95 BULLETIN DE L'INSTITUT PASTEUR 57, 63 (1997). Former WHO Legal Counsel Gian Luca Burci summarizes the problem: Critics have even questioned the binding legal nature of the IHR 2005 given the lack of enforcement or even compliance monitoring mechanisms and the

argued that the regulations resemble a "soft law" document,[131] compliance with which is based on persuasion. From this perspective, the WHO should stop envisioning its legislative role as "merely observational"[132] and take international law "more seriously."[133]

Like other fields of international collaboration, global health law comprises "hard" but also "soft" law rules.[134] Actually, non-binding standards take central stage in WHO's normative panorama.[135] Several factors explain the preference for non-

apparent disregard of states parties for WHO's recommendations. However, if it is eventually determined (by the Health Assembly, for example, or a judicial body) that states parties may breach the IHR through Article 43 measures that exceed WHO recommendations, then consequentially those recommendations acquire a legal force that goes beyond their apparently hortatory nature. The ambiguity of the text and the absence of jurisprudence on this point leave the legal bases for the accountability mechanism in Article 43 uncertain.

Burci, *supra* note 52.

131. Fidler, *supra* note 130, at 63–64; *see* James G. Hodge, Jr., *Global Legal Triage in Response to the 2009 H1N1 Outbreak*, 11 MINN. J. L. SCI. & TECH. 599, 608 (2010) (positing that the IHR are more a soft guide than a legal mandate); *see also* Caroline Sell, Note, *Ebola and Emerging Infectious Diseases in Armed Conflict: Contemporary Challenges in Global Health Security Laws and Policies*, 29 MINN. J. INT'L L. 187, 215 (2020) ("the IHR (2005) provides invaluable soft law standards[.]"). In a similar vein, Silver refers to the "quasi-legal nature of the Regulations," stating that they "are non-binding." Arielle Silver, Note, *Obstacles to Complying with the World Health Organization's 2005 International Health Regulations*, 26 WIS. INT'L L. J. 229, 247 n.110 (2008).

132. Allyn L. Taylor, *Making the World Health Organization Work: A Legal Framework for Universal Access to the Conditions for Health*, 18 AM. J.L. & MED. 301, 343 (1992).

133. David Fidler, *The Future of the World Health Organization: What Role for International Law*, 31 VAND. J. TRANSNAT'L L. 1079, 1081 (1998); *see* Virdzhiniya Georgieva, *The Challenges of the World Health Organization: Lessons from the Outbreak of COVID-19*, *in* BALKAN YEARBOOK OF EUROPEAN AND INTERNATIONAL LAW 249, 273 (2021) (positing that COVID-19 reveals WHO's "normative deficit:" the organization is still dominated by a medical-technocratic mindset and has "turned its back on international law.").

134. Setsuko Aoki, *International Legal Cooperation to Combat Communicable Diseases: Increasing Importance of Soft Law Frameworks*, 1 ASIAN J. WTO & INT'L HEALTH L. & POL'Y 543, 553 (2006); Brigit Toebes, *Global Health Law: Defining the Field*, *in* RESEARCH HANDBOOK ON GLOBAL HEALTH LAW 2, 2 (Gian Luca Burci & Brigit Toebes eds., 2018).

135. Gian Luca Burci, *Global Health Law: Present and Future*, *in* RESEARCH HANDBOOK ON GLOBAL HEALTH LAW 486, 489 (Gian Luca Burci & Brigit Toebes eds., 2018); Gostin et al., *supra* note 124, at 855; *see* Eric C. Ip, *The Constitutional Economics of the World Health Organization*, 16 HEALTH ECON. POL'Y & L. 325, 336 (2021) ("With the notable exceptions of the FCTC and the IHR (2005), the WHO generally prefers technical and scientific solutions over policy-driven rulemaking, and prefers to deploy guidelines and recommendations over 'hard' international treaty law."). *See also* JOSÉ E. ALVAREZ, INTERNATIONAL ORGANIZATIONS AS LAWMAKERS 222 (Oxford Univ.

binding instruments. First, soft norms are easier to negotiate and agree upon that binding, enforceable obligations.[136] Second, even if not strictly mandatory, duties imposed by soft rules may also hold some sway over States.[137] In fact, in some cases soft law regimes may be even more effective than formally binding ones.[138] With time and a good track record of compliance, soft law regimes may evolve from indicative principles towards more binding instruments.[139]

Taking international law "more seriously" does not necessarily entail the use of hard law utensils. While some believe that WHO's reluctance to pass binding instruments has undermined its efficiency, the organization can still achieve its purposes effectively if it unlocks the full potential of soft legal devices. The WHO needs to make better use of its normative powers to proactively promote the protection of international mobility during public health emergencies. Both soft and hard law instruments may be effective in shaping States Parties' behavior if they are robust enough.[140] The WHO should build on

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Press 2006) (The WHO, like other specialized United Nations agencies, makes "a conscious effort to side-step the question of binding effect in favor of standard-setting that intentionally lies along a spectrum of authority, from binding to non-binding.").

136. Kevin A. Klock, Note, *The Soft Law Alternative to the WHO's Treaty Powers*, 44 GEO. J. INT'L L. 821, 831–32 (2013); Lawrence O. Gostin & Benjamin Mason Meier, *Introducing Global Health Law*, 47 J.L. MED. & ETHICS 788, 791 (2019).

137. Frederick M. Burkle, Jr., *Global Health Security Demands a Strong International Health Regulations Treaty and Leadership From a Highly Resourced World Health Organization*, 9 DISASTER MED. & PUB. HEALTH PREPAREDNESS 568, 571 (2015); Simon Rushton, *Global Governance Capacities in Health: WHO and Infectious Diseases*, *in* GLOBAL HEALTH GOVERNANCE 60, 76 (Adrian Kay & Owain Williams eds., 2009) ("[T]hrough their very participation in regimes, states internalize the norms which the agreement embodies. Compliance then becomes a routine act—often codified in domestic bureaucratic procedures—rather than a conscious decision.").

138. Aoki, *supra* note 134, at 553; *see* Kal Raustiala & Anne-Marie Slaughter, *International Law, International Relations, and Compliance*, *in* HANDBOOK OF INTERNATIONAL RELATIONS 538, 538 (Walter Carlsnaes et al. eds., 1st ed. 2013).

139. Lawrence O. Gostin, *Redressing the Unconscionable Health Gap: A Global Plan for Justice*, 4 HARV. L. & POL'Y REV. 271, 272–73 (2010); Lawrence O. Gostin et al., *Towards a Framework Convention on Global Health*, 91 BULLETIN OF THE WHO 790, 792 (2013), https://www.who.int/bulletin/volumes/91/10/12-114447.pdf.

140. Catherine Regis & Florian Kastler, *Improving the World Health Organization's Normative Strategy with Respect to Global Health Goals: What Should We Aim For?*, 51 REVUE BELGE DE DROIT INTERNATIONAL [R.B.D.I.] 138, 149–150 (2018); *see also* Klock, *supra* note 136, at 823.

existing rules and launch a process of soft legalization by endowing its regulatory framework with greater precision and clarity.

The IHR lay down vague standards of appropriate behavior for States Parties during a public health emergency. There is an excessive degree of uncertainty surrounding the precise scope and correct interpretation of Article 43.[141] What measures achieve the same or greater level of health protection than WHO recommendations? When are they "not more restrictive of international traffic and not more invasive or intrusive to persons than reasonably available alternatives that would achieve the appropriate level of health protection[?]" What do the expressions "significant" and "significant interference" mean?[142] How are "scientific principles" and "available scientific evidence of a risk to human health" defined? When is there "insufficient evidence"? What are "relevant intergovernmental organizations and international bodies" that can offer information? To what degree should States Parties comply with available specific guidance or advice from the WHO?

Article 43 raises more questions than answers. During a public health emergency, the IHR fail to provide clear guidance to public officials, even if governments wish to comply with them.[143] As a result, domestic emergency and public health laws

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141. Lauren Z. Asher, *Confronting Disease in a Global Arena*, 9 CARDOZO J. INT'L & COMP. L. 135, 143 (2001); Jennifer Shkabatur, *A Global Panopticon? The Changing Role of International Organizations in the Information Age*, 33 MICH. J. INT'L L. 159, 172 (2011); Habibi et al., *supra* note 42, at 6; Burci, *supra* note 79, at 214, 216; Allyn L. Taylor et al., Comment, *Solidarity in the Wake of COVID-19: Reimagining the International Health Regulations*, 396 LANCET 82, 83 (2020); Caroline Foster, *Justified Border Closures Do Not Violate the International Health Regulations 2005*, EJIL:TALK! (June 11, 2020), https://www.ejiltalk.org/justified-border-closures-do-not-violate-the-international-health-regulations-2005/. *See also* Gregory C. Shaffer & Mark A. Pollack, *Hard vs. Soft Law: Alternatives, Complements, and Antagonists in International Governance*, 94 MINN. L. REV. 706, 715 (2010) (discussing the difference between hard and soft law). Shaffer and Pollack remark: "if an agreement is formally binding but its content is vague so that the agreement leaves almost complete discretion to the parties as to its implementation, then the agreement is soft along a second dimension." *Id.*

142. *See* Implementation of the International Health Regulations (IHR), Sixty-Sixth Session of the Reg'l Comm. of the Who for the Americas, ¶ 63, W.H.O. Doc. CD55/12, Rev.1, (Sept. 16, 2016), https://www.paho.org/hq/dmdocuments/2016/CD55-12-e.pdf (considering that the Final Plan for the Implementation of the International Health Regulations should provide a clear definition of the term "significant" in "significant interference" as used in Article 43).

143. Burci, *supra* note 79, at 214; Habibi et al., *supra* note 42, at 8; *see* Asher,

end up guiding States Parties' behavior, even if they contradict the regulations.[144] *Ex post*, this lack of clarity also makes it difficult to judge whether States Parties' behavior was lawful or not.[145] As stated by Gostin, DeBartolo and Katz, there is a "cavernous" gap between the IHR's norms and their real-world impact.[146] Davies and Wenham sum up the problem in the following terms:

Many governments are convinced that the right to decide their trade and travel bans belongs with them alone and not the WHO, despite the IHR (2005). The WHO needs to establish the pattern linking global and national responses, decisions around travel restrictions and the epidemic curve. Then it needs to establish the political conditions under which a state would comply with the IHR recommendations or otherwise, to rebuild trust and incorporate this into the IHR process.[147]

Article 43 is a complex provision, to say the least. Is it necessary to enhance the regime's clarity. The Review Committee (COVID-19) is currently conducting an article-by-article analysis of the regulations. The goal is to "examine whether the perceived shortcomings in their effectiveness during the COVID-19 response stem from the design of the Regulations or from challenges in their implementation."[148] Reducing ambiguity and providing clearer guidance on the precise meaning and scope of each one of the concepts used is crucial. The goal is to ensure that norms express a well-defined, operable normative commitment. Normally a greater degree of precision is associated with "highly elaborated or dense" provisions, "detailing conditions of application, spelling out

supra note 141, at 143.

144. *See* Hodge, *supra* note 131, at 608; Interim Progress Report of the Rev. Comm. (COVID-19), *supra* note 53, ¶ 36 ("The Committee recognizes that States Parties have sovereign rights and can implement measures under national laws or regulations, which may interfere with international traffic. The relationship between national legislation and obligations under international law needs to be examined.").

145. Burci, *supra* note 79, at 214; Habibi et al., *supra* note 42, at 8; *see also* Pedro A. Villarreal, *The World Health Organization's Governance Framework in Disease Outbreaks: A Legal Perspective*, *in* THE GOVERNANCE OF DISEASE OUTBREAKS 243, 259 (Leonie Vierck et al. eds., 2017) ("The broad wording of IHR provisions can give way to an expansion or reduction of its applicability in future instances, depending on who is interpreting them.").

146. Lawrence O. Gostin et al., *The Global Health Law Trilogy: Towards a Safer, Healthier, and Fairer World*, 390 LANCET 1918, 1921 (2017).

147. Davies & Wenham, *supra* note 58, at 1247.

148. Interim Progress Report of the Rev. Comm. (COVID-19), *supra* note 53, ¶ 14.

required or proscribed behavior in numerous situations, and so on."[149] Different tools may be used to create visible signposts about how and when States Parties may (or may not) apply additional health measures that interfere with international mobility.

A. AUTHORITATIVE SOURCES

According to von Bogdandy and Villarreal, the IHR "reflect a range of 'best practices' developed throughout the course of decades, if not centuries, and they certainly provide a yardstick against which state responses can be measured."[150] The problem is that real-life cases were never tested against this yardstick through jurisprudential practice. The IHR contains mechanisms for the settlement of disputes between two or more States Parties[151] or between WHO and one or more States Parties[152] concerning the interpretation or application of its provisions. However, the first mechanism is not binding, whereas the second is not fully structured. They have never been used and are basically "dormant[.]"[153]

The previous incarnation of the IHR (the International Health Regulations 1969) also featured a formalized dispute settlement system.[154] However, it was rarely used, with States Parties rather resorting to the "good offices" of WHO's Secretariat to settle a vast number of questions and disputes.[155] The Secretariat's interpretations acquired some authoritative value as they were stated in the Director-General's report to the WHO Committee on the International Surveillance of Communicable Diseases, and if approved by that expert group,

149. Abbott et al., *supra* note 64, at 413.

150. von Bogdandy & Villarreal, *supra* note 52, at 11.

151. International Health Regulations (2005), *supra* note 7, art. 56(1)–(4).

152. *Id.* art. 56(5).

153. Leonie Vierck, *The Case Law of International Public Health and Why its Scarcity is a Problem*, *in* THE GOVERNANCE OF DISEASE OUTBREAKS 113, 117 (Leonie Vierck et al. eds., 2017).

154. WHO, *International Health Regulations (1969)*, art. 93, https://www.who.int/csr/ihr/ihr1969.pdf.

155. *See* DAVID M. LEIVE, 2 INTERNATIONAL REGULATORY REGIMES 578 (1976); *see also* David P. Fidler, *Return of the Fourth Horseman: Emerging Infectious Diseases and International Law*, 81 MINN. L. REV. 771, 848 n.401 (1997) (stating that there was no record of the mechanism being used since 1974).

included in the report to the WHO's plenary body.[156] These interpretations were often approved by the Health Assembly and incorporated as a footnote to the next edition of the regulations.[157] According to Alvarez, such interpretations were a sort of soft law since they had no *stare decisis* effect and did not add to existing obligations,[158] and combined a regulatory role with a dispute settlement one.[159] Importantly, this flexible dispute settlement practice allowed for the formation of an informal jurisprudence on the interpretation of the IHR.[160]

The inexistence of a binding dispute settlement mechanism under the IHR (2005) undermines not only the enforcement of its provisions[161] but also the pedagogical role that prior rulings could play in shaping States Parties' decisions. The only alternative is to pursue any dispute settlement mechanisms established under other international agreements.[162] More importantly for our purposes, this prevents the formation of a coherent body of case law to assist in the proper construction of Article 43.[163] As noted by Vierck, "[i]n fields such as international public health law, which are highly driven by empirical science, this leads to increased invisibility of the legal argument and natural fallacy arguments."[164] Even though there is an important institutional practice of engagement of State Parties with the Secretariat and the Office of the Legal Counsel to receive advice on the interpretation and implementation of the IHR,[165] this guidance is not collected in a systematic manner and made available to all States Parties and other stakeholders.

While there is no visible case law on the interpretation and implementation of the IHR, there is a growing body of jurisprudence coalescing in the broader field of Global Health.

156. ALVAREZ, *supra* note 135, at 451.

157. *Id.* at 225, 451; LEIVE, *supra* note 155, at 572.

158. ALVAREZ, *supra* note 135, at 225.

159. *Id.* at 600.

160. Zacher & Keefe, *supra* note 129, at 40.

161. *See* Fidler, *supra* note 49, at 390; Lawrence O. Gostin et al., Viewpoint, *The International Health Regulations 10 Years on: The Governing Framework for Global Health Security*, 386 LANCET 2222, 2225 (2015).

162. International Health Regulations (2005), *supra* note 7, art. 56(4).

163. *See* Burci, *supra* note 52; Vierck, *supra* note 153, at 117.

164. Vierck, *supra* note 153, at 142.

165. *See* Villarreal, *supra* note 145, at 246; Gian Luca Burci & Claudia Nannini, The Office of the Legal Counsel of the World Health Organization 36 (Aug. 22, 2018) (unpublished manuscript) (available online at SSRN), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3229184.

The WHO can draw on a set of principles that have been articulated in other issues that call for a balancing exercise between public health law and individual rights. Fidler underlines several fundamental canons: the epidemiological and scientific basis of public health measures, the principle of non-discrimination, and the "least restrictive measure" test.[166] According to the author, these principles form "a jurisprudential template against which many aspects of national and international action on public health are, and will increasingly be, measured."[167]

Because the IHR commands that its provisions be interpreted in a manner that is compatible with other relevant international agreements,[168] reference is also to be made to the rich jurisprudence of World Trade Organization (WTO). The duty to base additional health measures upon scientific principles and available evidence parallels similar requirements in trade agreements, namely the Agreement on the Application of Sanitary and Phytosanitary Measures (SPS Agreement).[169] Therefore, decisions issued by WTO panels and Appellate Body may be useful interpretive tools when examining Article 43 of

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166. David Fidler, *Global Health Jurisprudence: A Time of Reckoning*, 96 GEO. L.J. 393, 401–02 (2008).

167. *Id.* at 402; *see also* Adem Koyuncu, *Legal Balancing of Conflicting Rights*, *in* ENCYCLOPEDIA OF PUB. HEALTH 833, 837 (Wilhelm Kirch ed., 2008).

168. International Health Regulations (2005), *supra* note 7, art. 57(1).

169. Fidler & Gostin, *supra* note 127, at 91; Fidler, *supra* note 49, at 382; *see* Agreement on the Application of Sanitary and Phytosanitary Measures art. 2(2), Apr. 15, 1995, 1867 U.N.T.S. 493 ("Members shall ensure that any sanitary or phytosanitary measure is applied only to the extent necessary to protect human, animal or plant life or health, is based on scientific principles and is not maintained without sufficient scientific evidence, except as provided for in paragraph 7 of Article 5."); *see also id.* art. 5(1) ("Members shall ensure that their sanitary or phytosanitary measures are based on an assessment, as appropriate to the circumstances, of the risks to human, animal or plant life or health, taking into account risk assessment techniques developed by the relevant international organizations."). For a detailed comparison, see Jan Wouters & Bart De Meester, *Safeguarding Coherence in Global Policy-Making on Trade and Health: The EU-WHO-WTO Triangle*, 2 INT'L ORGS. L. REV. 295, 327 (2005); Huei-chih Niu, *A Comparative Perspective on the International Health Regulations and the World Trade Organization's Agreement on the Application of Sanitary and Phytosanitary Measures*, 1 ASIAN J. WTO & INT'L HEALTH L. & POL'Y 513, 531–38 (2006); Craig Murray, *Implementing the New International Health Regulations: The Role of the WTO's Sanitary and Phytosanitary Agreement*, 40 GEO. J. INT'L L. 625, 632–33 (2009); Tsai-Yu Lin, *The Forgotten Role of WHO/IHR in Trade Responses to 2009 A/H1N1 Influenza Outbreak*, 44 J. WORLD TRADE 515, 520–22 (2010); Benn McGrady & Christina S. Ho, *Identifying Gaps in International Food Safety Regulation*, 66 FOOD & DRUG L. J. 183, 189–90 (2011).

the IHR.[170] Drawing on the consolidated body of WTO case law, the Stellenbosch Consensus formulates the following rules:

First, before implementing additional health measures, states must consider whether there is a rational relationship between the measure being implemented and the scientific principles and available scientific evidence cited to support them. Second, scientific evidence may be derived from minority or non-dominant scientific experts, but the evidence must represent more than just an opinion and must consist of a *bona fide* scientific risk assessment exercise. Third, in determining whether a measure is necessary to achieve a stated objective, the measure must contribute substantially to the objective. Alternatives will be deemed as 'reasonably available' if they practically serve the level of health protection chosen by a state and are not simply alternatives "in theory."[171]

Returning to the WHO universe, there is another form of institutional practice that can be an important source of empirical experience and insight—the reports issued by the Review Committee on the Functioning of the International Health Regulations (2005).[172] Over the years, review committees

170. Tsai-Yu Lin, *supra* note 169, at 521–22; Habibi et al., *supra* note 42, at 45–46, 60 ("Even if not an authoritative source of interpretation, case law from the WTO may provide invaluable insight or logic, and it certainly qualifies as a supplementary means of interpretation . . . since WTO case law constitutes an authoritative expression of the obligations in force for WTO members."); *see also* Foster, *supra* note 141 ("Together the IHR and the SPS Agreement form the leading international instruments on health-based border closures, whether to persons or to goods. Helpful insights into how the IHR may function in relation to border closures can be gained by reading the IHR in the light of the SPS Agreement."). *Cf.* Comm. on Sanitary & Phytosanitary Measures, Submission by the WHO, *The Revision of the International Health Regulations (IHR)*, ¶¶ 3–4, WTO Doc. G/SPS/GEN/59 (Mar. 5, 1998), https://docs.wto.org/imrd/directdoc.asp?DDFDocuments/q/G/SPS/GEN59.pdf. During the revision process that led to the IHR (2005), the WHO stated: "Both the World Trade Organization Sanitary and Phytosanitary Measures Agreement (SPS) and the World Health Organization International Health Regulations (IHR) are committed to the principle of protecting health while interfering as little as possible with international trade. Potential strengthening of each of these documents through mutual acceptance and acknowledgement must be explored." *Id.* at ¶ 3. The January 1998 draft even included a specific reference to the SPS agreement. *Id.* at ¶ 4.

171. Habibi et al., *supra* note 42, at 59–60.

172. *See* Const. of the WHO art. 50, July 22, 1946, 14 U.N.T.S. 185. So far, the Director General has convened four IHR review committees: the Review Committee on the Functioning of the IHR and on Pandemic (H1N1) 2009, the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation, the Review Committee on Role of the IHR in the Ebola Outbreak and Response, and the Review Committee on

have been assessing WHO and States Parties' responses to public health emergencies and making recommendations for improvement of the regulations. While these reports do not have binding nature, they may prompt a response by the World Health Assembly and foster institutional and regulatory reform.[173]

Valuable assistance can also be found in the *Stellenbosch Consensus*, a combined effort by a group of twenty scholars with recognized expertise in global health law to reach a jurisprudential consensus on the interpretation of Article 43.[174] The Statute of the International Court of Justice directs the court to apply "the teachings of the most highly qualified publicists" as a "subsidiary means" when it "decide[s] in accordance with international law such disputes as are submitted to it."[175] While this rule only formally applies to the court, it is commonly assumed to reflect customary international law.[176] Helmersen argues that the International Court of Justice uses four elements when trying to identify "the most highly qualified publicists:" the quality of the work, the expertise and official positions of the author(s), and agreement between multiple authors.[177] There seems to be little doubt that the authors of the *Stellenbosch Consensus* profusely meet these requirements.[178] The experience and expertise of the authors guarantees their commentary a central and influential place in any future discussion about the correct scope and meaning of

the Functioning of the International Health Regulations (2005) during the COVID-19 Response. *IHR Review Committees*, WHO, https://www.who.int/teams/ihr/ihr-review-committees (last visited Nov. 29, 2021).

173. Villareal, *supra* note 145, at 270.

174. *See generally* Habibi et al., *supra* note 42.

175. Statute of the International Court of Justice art. 38, Oct. 24, 1945, 33 U.N.T.S. 993; *see generally* Michael Peil, *Scholarly Writings as a Source of Law: A Survey of the Use of Doctrine by the International Court of Justice*, 1 CAMBRIDGE J. INT'L & COMP. L. 136 (2012) (surveying the use of scholarly doctrine in the ICJ).

176. Sondre Torp Helmersen, *Finding 'the Most Highly Qualified Publicists': Lessons from the International Court of Justice*, 30 EUR. J. INT'L L. 509, 511 (2019).

177. *Id.* at 513–26.

178. Authors of the *Stellenbosch Consensus* were selected according to five criteria: "1) public international law scholar; 2) qualified as a lawyer or appointed as a full-time core faculty at a law school; 3) focus at least half of one's scholarly activities on global health; 4) author of relevant peer-reviewed articles published within the last five years; and 5) independent of other scholars, supervisors, governments, and other directive entities." Habibi et al., *supra* note 42, at 9.

Article 43.[179]

Epidemic outbreaks are one of those types of cataclysmic events that often unleash profound paradigm changes. The revision process that led to the 2005 version of the IHR was dramatically accelerated by the emergence of the Severe Acute Respiratory Syndrome (SARS).[180] COVID-19 represents the harshest test to the regulations to date, prompting a discussion about the need for assertive reform.[181] Without downplaying the challenges that States Parties may face in implementing the regulations,[182] this article posits that increasing the precision or determinacy of norms would harden the regime and increase its compliance pull.[183]

The high degree of scientific uncertainty that characterizes most pandemic outbreaks cautions against the belief that it would be possible to codify, in advance, the proper health measures to implement by States during a pandemic.[184] As

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179. *See* Sandesh Sivakumaran, *The Influence of Teachings of Publicists on the Development of International Law*, 66 INT'L & COMP. L.Q. 1, 18 (2017) ("[T]here is a special place for Commentaries in the teachings of publicists. Often, a treaty provision is rather succinct and its meaning is difficult to discern. A teaching that explores the meaning of the provision looking into its object and purpose, situating it in context, considering its drafting history, analysing subsequent practice, and canvassing relevant literature—can prove influential. It is particularly in the interpretation of the law that Commentaries have proven valuable.").

180. Aginam, *supra* note 123, at 569; Allyn L. Taylor, *International Law and Public Health Policy*, *in* INTERNATIONAL ENCYCLOPEDIA OF PUBLIC HEALTH 667, 675 (2008).

181. Meier et al., *supra* note 52, at 796, 798; Taylor et al., *supra* note 141, at 83; Jaemin Lee, *IHR 2005 in the Coronavirus Pandemic: A Need for a New Instrument to Overcome Fragmentation?*, AM. SOC. INT'L L. (June 12, 2020), https://www.asil.org/insights/volume/24/issue/16/ihr-2005-coronavirus-pandemic-need-new-instrument-overcome-fragmentation#_edn2.

182. *See* Silver, *supra* note 131, at 239–43 (noting that global health security relies on the capacity of States that may not necessarily have sufficient resources and infrastructures); Hans Kluge et al., *Strengthening Global Health Security by Embedding the International Health Regulations Requirements into National Health Systems*, 3 BMJ GLOB. HEALTH 1, 1 (2018).

183. *See* Carol A. Heimer, *The Uses of Disorder in Negotiated Information Orders: Information Leveraging and Changing Norms in Global Public Health Governance*, 69 BRIT. J. SOCIO. 910, 925 (2018). According to Heimer, the 2005 revision of the IHR already initiated this process of hardening, helping to "move the IHR from the realm of 'soft law' further into the domain of 'hard law' . . . by making the rules more specific and more obligatory, by adding processes for interpretation of law and for dispute settlement, and by inserting rudimentary enforcement mechanisms." *Id.* However, as COVID-19 abundantly demonstrates, the IHR provisions are still too "soft," in the sense that they engender too much uncertainty.

184. *See* Pedro A. Villarreal, *Responses to the COVID-19 Crisis: The Exposed*

stated by the Pan American Health Organization during the last revision of the IHR,

> Each urgent event is unique, and just as it is impossible to give a list of diseases . . . , there is no way to describe measures appropriate for each event in advance. The proposed model is a compromise: the list of measures that could be taken to prevent international spread of disease—at embarkation, during travel, and at point of entry—is not extensive, and should be contained in the new IHR.[185]

We are not advocating the creation of a rigid template on how States should react in the context of a PHEIC. Such an endeavor would be doomed to fail. As Villarreal rightly points out, "it would perhaps be too much to ask . . . for a legal instrument to very specifically enunciate all possible instances of its application. Expecting such a level of anticipation from lawmaking would inevitably end in frustration."[186] That is why the IHR does not impose a mathematical formula about what specific health measures to implement, and when, but rather uses flexible concepts to allow enough regulatory space to national authorities to decide how to respond in face of their own contingencies.[187] The "prototype" reaction is set, on a case-by-case basis, by WHO when it issues its temporary recommendations. Compliance with that mold is like a sort of legal safe harbor.[188] States Parties are free to deviate from that

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Limits of the International Health Regulations, UNIV. GRONINGEN: GLOB. HEALTH L. GRONINGEN (Feb. 25, 2020), https://www.rug.nl/rechten/onderzoek/expertisecentra/ghlg/blog/responses-to-the-covid-19-crisis-25-02-2020 ("Can there be *ex ante* criteria meant to provide guidance for all potential future measures?") (emphasis added).

185. 53d Sess. of the Reg. Comm. of WHO for the Americas, 43d Directing Council, International Health Regulations, ¶ 3.9, WHO Doc. CD43/11 (July 11, 2001), https://www.paho.org/english/gov/cd/cd43_11-e.pdf.

186. Villarreal, *supra* note 184.

187. *See* Gian Luca Burci, *Health and Infectious Disease*, *in* THE OXFORD HANDBOOK ON THE UNITED NATIONS 679, 682–83 (Thomas G. Weiss & Sam Daws eds., 2d ed. 2018) ("The centralization of decision-making powers in WHO and the relative strictness of IHR-based obligations are counterbalanced by the parties' right under Article 43 to apply national health measures going beyond WHO's recommendations or even breaching some of their obligations when considered necessary to respond to PHEICs or public health risks. This possibility, subject to a rather timid monitoring by WHO staff, was the outcome of an extremely difficult negotiation.").

188. J. Benton Heath, *Global Emergency Power in the Age of Ebola*, 57 HARV.

blueprint as long as they report and justify measures in excess to the ones recommended by the WHO.

Von Bogdandy and Villarreal claim that "[t]he IHR represent, to this day, the international consensus on how to deal with pandemics."[189] However, as COVID-19 demonstrates in graphic detail, States often deviate from the pattern devised by the WHO in a way that defies any scientific or legal consensus. A case in point is the implementation of blanket travel bans covering nationals and residents. As we have argued elsewhere,[190] it seems extremely difficult to demonstrate the public health rationale of such measures, and therefore they seem to breach Article 43 of the IHR. In addition, such travel bans are clearly a violation of the right of return, a right protected by human rights treaties. These draconian measures can hardly be considered as the outcome of a proper balancing exercise.

In between the safe harbor of strict adherence to WHO's advice and unhindered (and unchecked) freedom by States to claim their measures are taken for the protection of public health, there is a vast grey area in need of further exploration. Even if States Parties are willing to comply with the IHR, they need to have more precise coordinates about how to navigate to the "legal safe harbor"—be it because they decide to adhere to WHO's advice; or because they validly implement measures that are not more restrictive of international traffic than reasonably available alternatives that would achieve the appropriate level of health protection. Therefore, we do not propose to dictate *ex ante* a rigid model of behavior on the face of uncertainty—which would defy scientific but also legal rationality; but rather to increase the system's precision. In clarifying grey areas, borderlines are the low-hanging fruit. There should be clearer parameters about what additional health measures comply (in general) with the last section of Article 43(1)b)—and therefore consistent with the regulations—and which ones are undoubtedly excessive, and thus run afoul of the IHR.

Regardless of the instrument chosen, the most important

INT'L L.J. 1, 23–24 (2016); *see* Bishop, *supra* note 54, at 1189.

189. von Bogdandy & Villarreal, *supra* note 52, at 11.

190. *See* Fernando Dias Simões, *COVID-19 and International Freedom of Movement: A Stranded Human Right?*, 20 YALE J. HEALTH POL'Y L. & ETHICS (forthcoming) (manuscript at 11), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3781792; *see also* Villarreal, *supra* note 184 ("Some measures, such as blanket bans of all travelers from a specific country, could always be seen as prima facie excessive.").

thing is to provide clear coordinates that enable States to navigate safely through the tempest of pandemic outbreaks. This effort should draw on the different sources of "authority" discussed above, which are the product of almost two centuries of international collaboration. This reform process should engage different professionals in an interdisciplinary effort to "translate epidemiology into international law[.]"[191] The next sub-sections examine how different legal instruments may increase the effectiveness of the regime by boosting its precision.

B. REVISING THE IHR

The IHR is the only binding set of international rules governing the fight against infectious diseases, so it may seem the obvious *locus* to address the insufficiencies of the regime. Regulations are adopted by the Health Assembly under a unique treaty-making procedure:[192] the World Health Assembly has the power to adopt regulations[193] that become binding on States Parties unless they "contract out."[194] Consent by States Parties is not given through ratification but rather results from accession to or ratification of the WHO Constitution.[195] This

191. Fidler, *supra* note 130, at 57, 63–64.

192. Kathleen J. Choi, *A Journey of a Thousand Leagues: From Quarantine to International Health Regulations and Beyond*, 29 U. PA. J. INT'L L. 989, 1006–07 (2008); Obijiofor Aginam, *Globalization of Infectious Diseases, International Law and the World Health Organization: Opportunities for Synergy in Global Governance of Epidemics*, 11 NEW ENG. J. INT'L & COMP. L. 59, 63–64 (2004).

193. Const. WHO art. 21 ("The Health Assembly shall have authority to adopt regulations concerning: (a) sanitary and quarantine requirements and other procedures designed to prevent the international spread of disease . . . ."); *see also* von Bogdandy & Villarreal, *supra* note 52, at 4 (arguing that endowing the Health Assembly with such regulatory power demonstrates "enormous trust in technical rule-making fostered by experts, technocrats and diplomats.").

194. Const. WHO art. 22 ("Regulations adopted pursuant to Article 21 shall come into force for all Members after due notice has been given of their adoption by the Health Assembly except for such Members as may notify the Director-General of rejection or reservations within the period stated in the notice."); *see also* Gregory Shaffer, *International Law and Global Public Goods in a Legal Pluralist World*, 23 EUR. J. INT'L L. 669, 677–78 (2012) (arguing that opt-out rules generate greater participation than opt-in rules, facilitating collective action for collective goals); Solomon, *supra* note 129, at 192 (stating that States normally do not 'opt out', and none did so in the case of the IHR (2005)). According to the WHO, *supra* note 8, app. 2, only two States formulated reservations.

195. Suzanne Zhou, *What Difference Would a Binding International Legal Instrument on Alcohol Control Make? Lessons from the World Health Organization Framework Convention on Tobacco Control's Impact on Domestic*

mechanism makes the adoption of regulations in the area of infectious diseases much faster and simpler.[196] However, it may also hinder efforts to introduce significant changes as States are free to "opt out" of novel provisions.[197]

Amendments to the IHR may be proposed by any State Party or by the Director-General. These proposals are then considered by the Health Assembly.[198] Over the years, there have been frequent calls for a revamp of the IHR. However, Member States normally show little interest in reforming the regulations. In 2011, the Review Committee (H1N1) considered it preferable to focus on more rigorous implementation of Article 43 as it stands than to amend it.[199] As an intermediate option, the Committee also suggested increasing transparency about additional health measures adopted by States Parties by reporting them on the event information site.[200]

It is doubtful whether a greater measure of transparency would be enough to address concerns about non-compliance. The magnitude of the non-compliance with WHO's temporary recommendations may reignite calls for more forceful measures to address IHR's shortcomings. Goldfarb, for instance, has suggested that the IHR be revised to include a framework of "sunsetting phase-out provisions that instruct Member States on when and to what extent to implement certain travel restrictions."[201] This type of proposal aligns with our goal of densifying the regime by giving more precise instructions about how and when States should implement certain health measures. Other proposals, much more confrontational, include giving a veto power to the WHO before the adoption on any additional health measures,[202] the removal of voting privileges,

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Litigation, 12 EUR. J. RISK REGUL. 514, 516–17 (2020).

196. Meier et al., *supra* note 52, at 797.

197. David Fidler, Perspectives, *Globalization, International Law, and Emerging Infectious Diseases*, 2 EMERGING INFECTIOUS DISEASES 77, 81 (1996); Michelle Forrest, *Using the Power of the World Health Organization: The International Health Regulations and the Future of International Health Law*, 33 COLUM. J.L. & SOC. PROBS. 153, 162 (2000).

198. International Health Regulations (2005), *supra* note 7, art. 55; Const. WHO art. 2(k).

199. Rep. of the Rev. Comm. (H1N1), *supra* note 55, ¶ 86.

200. *Id*.

201. Goldfarb, *supra* note 77, at 810–11.

202. *See* WHO, The International Response to Epidemics and Application of the International Health Regulations: Rep. of a WHO Informal Consultation, at 10, WHO Doc. WHO/EMC/IHR/96.1 (Dec. 11–14, 1995), https://apps.who.int/iris/handle/10665/63595 ("Consideration should be given to refraining from

[203] or even the revocation of recalcitrant States' membership of the World Health Assembly.[204]

There are many difficulties surrounding the adoption of binding normative devices in the field of global public health.[205] Mandatory commitments are normally received with greater suspicion by State Parties, wary of losing their sovereign discretion to decide how to react to an outbreak.[206] While these bold proposals seek to increase compliance with the IHR, governments are probably not keen on limiting their sovereign powers and giving more teeth to the regulations. Other proposals—even less likely to gather consensus—involve going beyond the IHR. Fleming has suggested the creation of a framework convention on infectious travel in which States Parties would agree on what travel restrictions could be applied in cases of public health emergencies.[207] A specific section on

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applying grades 3 and 4 until such measures are approved by a specific expert group convened at extremely short notice under the auspices of WHO.").

203. *See, e.g.*, WHO, Amendments to the Const., Fifty-Second World Health Assembly, annex 1, WHO Doc. A52/24 (Apr. 7, 1999), https://apps.who.int/gb/archive/pdf_files/WHA52/ew24.pdf (proposing a constitutional amendment that would have suspended voting privileges of member states under "exceptional circumstances").

204. Nuzzo & Gronvall, *supra* note 56, at 10.

205. *See* Burci, *supra* note 135, at 508; Taylor, *supra* note 124, at 48 ("The concept of sovereignty looms large in the international system and states are generally loath to sacrifice their freedom of action through the development of binding international commitments . . . An emerging challenge in global health lawmaking is the limited scope of entities that are subject to international law."); Steven J. Hoffman et al., *Assessing Proposals for New Global Health Treaties: An Analytical Framework*, 105 AM. J. PUB. HEALTH 1523, 1523–24 (2002) (discussing costs of international treaties and risks of coercion and paternalism by powerful member countries); Klock, *supra* note 136, at 830; Allyn L. Taylor, *Global Governance, International Health Law and WHO: Looking Towards the Future*, 80 BULLETIN OF THE WHO 975, 976 (2002) (arguing that the problem with using binding international law devices is that they are "inherently limited" in the field of global health).

206. Lawrence O. Gostin & Devi Sridhar, *Global Health and the Law*, 370 NEW ENG. J. MED. 1732, 1737 (2014); Taylor, *supra* note 124, at 48; Worsnop, *supra* note 56, at 21–22; *see also* Burci, *supra* note 79, at 216 (stating that states tend to manage health emergencies based on their individual risk assessment and political considerations, and are not favorable to proposals to delegate more power to an International Secretariat).

207. Matthew Fleming, *Combating the Spread of Disease: The International Health Regulations*, 50 COLUM. J. TRANSNAT'L L. 805, 824–25 (2012); Lee, *supra* note 181 (suggesting the creation of a convention to address the problem of fragmentation of international law regimes that interact with the IHR); Courtney Maccarone, *Crossing Borders: A TRIPS-Like Treaty on Quarantines and Human Rights*, 36 BROOK. J. INT'L L. 781, 796 (2011) (suggesting the creation of a treaty, drawing inspiration from WTO's Agreement on Trade-

public health emergencies could also be included in the (highly aspirational) idea of creating a framework convention on global health.[208]

Even if States Parties have a change of heart and decide to amend the IHR, this would entail a long, bureaucratic process, likely to drag on for several years. In fact, the last revision took a full decade.[209]

C. FRAMING RECOMMENDATIONS EFFECTIVELY

A different avenue for improvement—one that does not require any normative change—is to enhance the effectiveness of temporary recommendations. The weakness of the IHR in achieving its stated purpose is often explained by the use of non-binding recommendations. When a PHEIC is declared, WHO's Director-General has the power to issue temporary recommendations after consulting with the emergency committee.[210] Such recommendations may include "*health measures* to be implemented by the State Party experiencing the [PHEIC], or by other States Parties, regarding persons, baggage, cargo, containers, conveyances, goods and/or postal parcels to *prevent or reduce the international spread of disease and avoid unnecessary interference with international traffic*."[211]

Through temporary recommendations, the WHO exercises authority in the epidemiological domain.[212] Temporary

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Related Aspects of Intellectual Property Rights (TRIPS), but which would be limited to the standards applicable to quarantine).

208. *See* Lawrence O. Gostin, *A Proposal for a Framework Convention on Global Health*, 10 J. INT'L ECON. L. 989, 990 (2007).

209. *See* WHO, 48th World Health Assembly Res. WHA48.7, 12th plen. mtg. at 7–8, WHO Doc. WHA48/1995/REC/1, (May 12, 1995) (requesting the Director-General to prepare a revision of the IHR).

210. International Health Regulations (2005), *supra* note 7, arts. 15(1), 12(2), 49; Lawrence O. Gostin et al., *The Legal Determinants of Health: Harnessing the Power of Law for Global Health and Sustainable Development*, 393 LANCET COMM'NS 1857, 1885 (2019) ("Declaration of a PHEIC under the IHR carries normative weight under international law, and allows WHO to alert and engage the international community.").

211. International Health Regulations (2005), *supra* note 7, art. 15(2) (emphasis added).

212. Armin von Bogdandy & Pedro Villarreal, *Critical Features of International Authority in Pandemic Response: The WHO in the COVID-19 Crisis, Human Rights and the Changing World Order* 14 (Max Planck Inst. for Compar. Pub. L. & Int'l L. Research Paper No. 2020-18); von Bogdandy & Villarreal, *supra* note 52, at 15; LAWRENCE O. GOSTIN, GLOBAL HEALTH LAW 193 (2014).

recommendations clearly qualify as one of the elements that, according to the IHR, shall be the base of the decision to implement additional health measures ("any available specific guidance or advice from WHO").[213] They convey WHO's suggestions about the best measures to adopt, offering a "reliable reference and a kind of default normative guidance in the absence of diverging national considerations."[214] Temporary recommendations may also offer some guidance on how to align State's response with human rights.[215] This central role in shaping States Parties' responses also derives from WHO's power to request a justification for additional health measures.[216] The hope is that reporting obligations "nudge" States to comply with temporary recommendations.[217]

While temporary recommendations are not binding, they "carry the normative weight of WHO authority in global health governance"[218] and thus may be described as soft normative instruments. However, they patently have little sway over States Parties.[219] An apparently easy way to ensure greater compliance would be to give temporary recommendations

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213. International Health Regulations (2005), *supra* note 7, art. 43(2)(c); Habibi et al., *supra* note 42, at 26.

214. Burci, *supra* note 79, at 216.

215. Fidler & Gostin, *supra* note 127, at 90–91; Benjamin Meier et al., *Rights-Based Approaches to Preventing, Detecting, and Responding to Infectious Disease*, 82 INT'L LIBR. ETHICS L. & NEW MED. 217, 243 (2020); GOSTIN, *supra* note 212, at 193.

216. International Health Regulations (2005), *supra* note 7, art. 43(3), 43(5); *see also* Spagnolo, *supra* note 50, at 4 (referring to Article 43 of IHR).

217. Robert Frau, *Law as an Antidote: Assessing the Potential of International Health Law Based on the Ebola-Outbreak 2014*, 7 GOETTINGEN J. INT'L L. 225, 237 (2016); *see* Lawrence O. Gostin, *Meeting Basic Survival Needs of the World's Least Healthy People: Toward a Framework Convention on Global Health*, 96 GEO. L. J. 331, 376, 380 (2008).

218. Meier et al., *supra* note 215, at 243; Hanrieder, *supra* note 122, at 209 ("Although such recommendations are not formally binding, the uncertainty and public pressure surrounding health crises endow them with considerable compliance pull."); Heath, *supra* note 188, at 23 ("WHO emergency recommendations, though technically nonbinding, have the capacity to alter both the behavior or individuals and the legal obligations of states."); Alexandra L. Phelan et al., Viewpoint, *The Novel Coronavirus Originating in Wuhan, China: Challenges for Global Health Governance*, 323 JAMA 709, 710 (2020).

219. Burci, *supra* note 79, at 213 ("[A] weakness of the IHR 2005, in dramatic display since the declaration of the COVID-19 PHEIC, is the failure or refusal of many states to follow WHO's temporary recommendations, in particular with regard to disruptive international measures such as border closures, travel restrictions and trade limitations.").

binding nature.[220] However, strong resistance can be expected from States Parties to the imposition of binding obligations.[221] In addition, even if recommendations became mandatory, that would not automatically guarantee that States would abide by them.

The effectiveness of temporary recommendations depends on States perceiving them as credible. The almost universal non-compliance with WHO's original temporary recommendation may have to do with the fact that the statement was too terse and not accompanied by a clear, detailed justification that could assuage States Parties' fears and anxieties. According to a report commissioned by the New Zealand government, "WHO advice on travel restrictions is very general and does not address the needs of islands or consider very severe pandemics."[222] Temporary recommendations should—as much as possible under the circumstances—be context-specific; taking into account, *inter alia*, the type of disease, different regional conditions and socio-economic factors.[223] If recommendations are too broad and imprecise, they may create the impression among States Parties that such advice is incorrect and something bolder is needed.[224]

It is true that WHO's official position somewhat evolved with time. While the first statement was unequivocally against the implementation of any travel restrictions,[225] later

220. Lawrence O. Gostin & Rebecca Katz, *The International Health Regulations: The Governing Framework for Global Health Security*, 94 MILBANK Q. 264, 306 (2016); Robert Frau, *Combining the WHO's International Health Regulations (2005) with the UN Security Council's Powers: Does it Make Sense for Health Governance?*, *in* THE GOVERNANCE OF DISEASE OUTBREAKS: INTERNATIONAL HEALTH LAW: LESSONS FROM THE EBOLA CRISIS AND BEYOND, 327, 331, 334, 335 (Leoni Vierck et al. eds., 2017).

221. David P. Fidler, Perspective, *Emerging Trends in International Law Concerning Global Infectious Disease Control*, 9 EMERGING INFECTIOUS DISEASES 285, 287 (2003) ("If history is any guide, member states will not allow WHO to issue binding regulations on an ad hoc basis.").

222. Nick Wilson et al., *Rationale for Border Control Interventions and Options to Prevent or Delay the Arrival of Covid-19 in New Zealand: Final Commissioned Report for the New Zealand Ministry of Health*, N.Z. MINISTRY HEALTH 2 (2020), https://www.health.govt.nz/system/files/documents/publications/final_report_for_moh_-_border_control_options_for_nz_final.pdf.

223. von Bogdandy & Villarreal, *supra* note 52, at 14; Villarreal, *supra* note 184.

224. *See, e.g.*, Eskild Petersen et al., Editorial, *COVID-19 Travel Restrictions and the International Health Regulations – Call for an Open Debate on Easing of Travel Restrictions*, 94 INT'L J. INFECTIOUS DISEASES 88, 89 (2020); von Tigerstrom & Wilson, *supra* note 41, at 1.

225. *See* WHO, Statement on the Second Meeting, *supra* note 36.

pronouncements added ambivalent and flexible language, denoting that such measures could be adopted in some circumstances.[226] This shift towards a more nuanced approach—which may have been influenced by the almost universal non-compliance with the original recommendations—seeks to strike a more flexible and conciliatory tone. However, it might also have reinforced the perception that the original advice was wrong.[227] It can be argued that, if States Parties had doubts about the effectiveness of the measures recommended by the WHO, they could have approached the organization requesting further advice.[228] Still, statements that require clarification and elucidation can hardly qualify as an effective form of guidance. In addition, requesting and receiving more detailed feedback takes time, something that States Parties dearly lack during a pandemic emergency.

The WHO needs to rebuild trust in the credibility of its temporary recommendations. The more detailed and well-reasoned the advice, the greater the probability that it will deter the implementation of additional health measures. This entails putting all of WHO's technical weight behind every single recommendation directed to States Parties but also devising smart communications strategies that are meaningful for their addressees.[229] In 2011, the Review Committee (H1N1) recommended that WHO enhance the WHO event information site to "make it an authoritative resource for disseminating reliable, up-to-date and readily accessible international epidemic information. States Parties should be able to rely on the EIS as a primary source for information on epidemiological status, risk assessment, response measures and their rationales."[230] The Review Committee (COVID-19) is also looking into ways of improving temporary recommendations:

> The Committee is considering whether the international

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226. *See* WHO, Strategic Preparedness and Response Plan, *supra* note 37; Key Considerations for Repatriation and Quarantine of Travellers, *supra* note 37; WHO, Updated WHO Recommendations for International Traffic, *supra* note 37. *See also* Raymond C.F. Yiu et al., *Evaluating the WHO's Framing and Crisis Management Strategy During the Early Stage of COVID-19 Outbreak*, 4 POL'Y DESIGN & PRAC. 94, 100 (2020); Burci, *supra* note 79, at 215.

227. Fidler, *supra* note 52, at 211.

228. *See* International Health Regulations (2005), *supra* note 7, arts. 13(3), (6).

229. *See* GOSTIN, *supra* note 212, at 203–04.

230. Rep. of the Rev. Comm. (H1N1), *supra* note 55, ¶ 27.

> spread of COVID-19 was due to inconsistent implementation of health measures by States Parties or insufficient WHO recommendations in relation to international traffic. The Committee is reviewing aspects of WHO's advice and recommendations on international travel and States Parties' implementation of additional health measures, including: evidence on the effectiveness and timeliness of both WHO's travel advice and the travel restrictions implemented by States Parties . . . .
>
> . . . .
>
> . . . . There may be insufficient incentives for States Parties to comply with temporary recommendations. Nuanced enforcement options may be needed, targeting early and late phases of the pandemic. WHO should work on identifying the minimal essential information required from States Parties to serve as a foundation for further guidance to help all States Parties prepare and respond most efficiently.[231]

Temporary recommendations are based on scientific principles and available scientific evidence and information. When issuing them, the WHO acts as a "choice architect[,]" that is, someone responsible for organizing the context in which other people decide.[232] As demonstrated by behavioral science scholarship, decision-makers are subject to "framing," meaning that the way information is conveyed influences their decisions.[233] Like all human beings, government officials are subject to cognitive biases.[234] To increase the sway of temporary recommendations over States Parties, the WHO should attach greater attention to how advice is formulated. The way the message is framed and conveyed is almost as important as its

231. Interim Progress Report of the Rev. Comm. (COVID-19), *supra* note 53, ¶¶ 35–36.

232. *See* Richard H. Thaler et al., *Choice Architecture*, *in* THE BEHAVIORAL FOUNDATIONS OF PUBLIC POLICY 428, 428 (Eldar Shafir ed., 2013).

233. The groundbreaking work in this area of study can be found in Amos Tversky & Daniel Kahneman, *The Framing of Decisions and the Psychology of Choice*, 211 SCI. 453 (1981). For a review of the literature, see generally Dennis Chong & James N. Druckman, *Framing Theory*, 10 ANN. REV. POL. SCI. 103 (2007).

234. *See* Sandra Nutley & Jeff Webb, *Evidence and the Policy Process*, *in* WHAT WORKS? EVIDENCE-BASED POLICY AND PRACTICE IN PUBLIC SERVICES 13, 13–14 (Huw T.O. Davies et al. eds., 2000).

contents.[235] Temporary recommendations may be ineffective if the advice is too abstract, vague, or poorly outlined. While WHO's recommendations set forward the "prototype" measures to be adopted by States, it is important to persuasively explain why certain public health measures are recommended while others are not. States Parties bear the burden of justifying deviations from WHO's model response, but the WHO also has the duty to explain why it is adopting that model in the first place. The more persuasive and credible the recommendation, the greater the chance that States will assent and act upon it.

D. Other Non-Binding Instruments

Instead of launching a formal revision of the IHR, the WHO can consider the creation of soft law instruments specifically addressing travel restrictions. Non-binding normative devices align well with the traditional ethos of the WHO, which favors a non-mandatory approach.[236] In the absence of binding dispute settlement mechanisms, soft law instruments may play an important informative and pedagogical role.[237] Much of the WHO's normative authority is exerted through recommendations, resolutions, guidelines, and codes of practice.[238] Its preparation is not as time-consuming as with more formal instruments. Because its focus is on objective scientific and technical expertise, the language of soft law instruments may sound more familiar and palatable to public health officials than formal international law instruments.[239] Despite this informality, these documents are instruments of

235. For useful suggestions on how to communicate scientific advice efficiently, see generally Karen Bogenschneider & Thomas Corbett, EVIDENCE-BASED POLICYMAKING 193–226 (2010).

236. *See supra* notes 134–35 and accompanying text.

237. C. M. Chinkin, *The Challenge of Soft Law: Development and Change in International Law*, 38 INT'L & COMP. L.Q. 850, 862 (1989).

238. *See* Burci, *supra* note 135, at 489.

239. *Id.* at 513. With regard to guidelines, for instance, the WHO states that they "should be tailored to a specific audience, such as public health policy-makers, health programme managers, health care providers, patients, caregivers, the general public and other stakeholders." WHO Exec. Bd., 137th Sess., Prov. Agenda Item 7, WHO Guidelines: Development and Governance: Report of the Secretariat, ¶ 5, WHO Doc. EB137/5 (May 20, 2015), https://apps.who.int/iris/bitstream/handle/10665/251527/B137_5-en.pdf?sequence=1&isAllowed=y.

normative[240] and epistemic authority.[241] They reflect the organization's key role as a provider of technical-scientific guidance and expertise.[242] In the past, they have proved successful in tackling several challenges.[243] However, they also raise questions about the growing transfer of power from States Parties to the secretariat and its level of expertise and legitimacy.[244]

Soft law instruments may be used to achieve different goals. Borrowing from the classification adopted by Chinkin,[245] it is possible to think about two helpful uses of these normative tools in the case at hand.

First is *elaborative soft law*, which consists of "principles that provide guidance to the interpretation, elaboration, or

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240. Gian Luca Burci, *The World Health Organization at 70: Challenges and Adaptation*, 16 INT'L ORGS. L. REV. 229, 238 (2019).

241. Jan Klabbers, *The Normative Gap in International Organizations Law: The Case of the World Health Organization*, 16 INT'L ORGS. L. REV. 272, 282–97 (2019).

242. Hanrieder, *supra* note 122, at 195; Ian Johnstone, *Law-Making by International Organizations: Perspectives from IL/IR Theory*, *in* INTERDISCIPLINARY PERSPECTIVES ON INTERNATIONAL LAW AND INTERNATIONAL RELATIONS 266, 274 (Jeffrey L. Dunoff & Mark A. Pollack eds., 2012).

243. Mateja Platise, *Hands Tied? The Law Governing the World Health Organization*, *in* LAW AND PRACTICE OF THE WORLD HEALTH ORGANISATION (Nigel D. White et al. eds.) (forthcoming) (manuscript at 12); *see also* Davies & Wenham, *supra* note 58, at 1229. The use of soft law standards has been effective, for instance, in the fight against malaria and tuberculosis. *See generally* SHARIFAH SEKALALA, SOFT LAW AND GLOBAL HEALTH PROBLEMS (2017) (discussing the effectiveness of soft law, as opposed to hard law, in combating the spread of malaria, tuberculosis, and AIDS). The Pandemic Influenza Preparedness Framework, adopted by the WHO in 2011 as a non-binding resolution, "has played a tremendous role in facilitating the international sharing of influenza samples and in ensuring greater access to vaccines." Andrew Chang, *WHO's Response to the COVID-19 Pandemic: Assessment and Recommendations* 6 (Nat'l Council for Sci. & the Env't Pol'y Paper, 2020), https://www.gcseglobal.org/gcse-essays/world-health-organizations-role-combatting-covid-19-pandemic-brief-overview.

244. Burci, *supra* note 240, at 237–38.

245. Christine Chinkin, *Normative Development in the International Legal System*, *in* COMMITMENT AND COMPLIANCE: THE ROLE OF NON-BINDING NORMS IN THE INTERNATIONAL LEGAL SYSTEM 21, 30 (Dinah Shelton ed., 2003). In the words of Shelton, "it is rare to find soft law standing in isolation; instead, it is used most frequently either as a precursor to hard law or as a supplement to a hard law instrument." Dinah Shelton, *Introduction: Law, Non-Law and the Problem of 'Soft Law'*, *in* COMMITMENT AND COMPLIANCE: THE ROLE OF NON-BINDING NORMS IN THE INTERNATIONAL LEGAL SYSTEM 1, 10 (Dinah Shelton ed., 2003).

application of hard law."[246] From this perspective, soft law instruments would enable the WHO to increase the degree of detail and precision of provisions because they would elaborate on the IHR's binding rules without being formally binding themselves.[247] This would be a sort of commentary on Article 43, much in the way of the *Stellenbosch Consensus*.[248] Soft law tools could also have varying scopes, by being: formulated as general instructions, applicable to all PHEICS, or issued on a case-by-case basis, adjusting to the specific contours of a particular outbreak.[249]

Second is *emergent hard law*, which consists of "principles that are first formulated in non-binding form with the possibility, or even aspiration, of negotiating a subsequent treaty, or harden into binding custom through the development of state practice and *opinio juris*."[250] In this case, soft law instruments could serve as building blocks towards a future codification process, giving the organization greater freedom to experiment with more expansive and precise standards.[251] The

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246. Chinkin, *supra* note 245, at 30. For arguments that soft law instruments can be used to interpret existing binding rules, see Andrea de Guttry, *Is the International Community Ready for the Next Pandemic Wave? A Legal Analysis of the Preparedness Rules Codified in Universal Instruments and of Their Impact in the Light of the COVID-19 Experience*, 20 GLOB. JURIST 1, 18 (2002). Regarding the role of "elaborative soft law" in WTO law, see Mary E. Footer, *The (Re)turn to Soft Law in Reconciling the Antinomies in WTO Law*, 11 MELB. J. INT'L L. 241, 263 (2010).

247. *See* A.E. Boyle, *Some Reflections on the Relationship of Treaties and Soft Law*, 48 INT'L & COMP. L.Q. 901, 903, 905 (1999).

248. *See* Habibi et al., *supra* note 42, at 8–9.

249. As explained by Aoki,

> [C]ontaining a severe infectious disease is a competition with time, requiring the earliest possible actions among the actors concerned. Since each international emerging infectious disease crisis has its own specific course of events, it is difficult for already adopted treaties to function adequately in such a crisis. Neither could a framework convention, which can be used for any type of transnational health crisis work nearly well enough, as additional action plans to be made shortly after the occurrence of a disease are essential to properly address the problem. (However, the combination of a framework convention and additional instruments built-up in a timely fashion might be useful, a seen in the field of international environmental protection.).

Aoki, *supra* note 134, at 553.

250. Chinkin, *supra* note 245, at 30.

251. Gostin et al., *supra* note 124, at 858.

WHO could use soft law norms to devise provisions that go beyond the existing ones and serve as a laboratory for a future evolution of the regime.

In either case, the focus should be on precision and intelligibility. Norms should be drafted with an eye on feasibility, avoiding an aspirational tone. The clearer and more unambiguous the standard of conduct, the greater the chance that States Parties will conform to it, or at least come close to doing so.

Soft law instruments can assume different forms and shapes. Article 23 of the Constitution of the WHO empowers the Health Assembly to "make recommendations to Members with respect to any matter within the competence of the Organization."[252] Under this provision, the Health Assembly could make a recommendation on what type of measures they should apply during epidemic outbreaks, as well as when and how these measures should be implemented.[253] This could help overcome the lack of agreement on binding standards applicable to these situations and serve as a stepping-stone towards a more binding type of commitment in the future.[254]

Another option in the WHO's vast arsenal of norm-setting instruments is the creation of even less formalized instruments, such as guidelines. Over the years, different organs of the WHO—including the Assembly, the Board, and the Secretariat—have been using this type of document to shape governmental behavior and coordinate international action.[255] In the words of the WHO Secretariat, "Guidelines are one of the key means through which the Organization fulfils its technical leadership in health."[256] Guidelines "address an area of uncertainty and an unmet need for guidance," putting forward

252. Const. WHO art. 23. Recommendations are normally approved through resolutions of the World Health Assembly. Solomon, *supra* note 129, at 189.

253. *See* von Tigerstrom & Wilson, *supra* note 41, at 3.

254. *See* Toebes, *supra* note 134, at 9; Chang, *supra* note 243, at 8.

255. PETER MALANCZUK, AKEHURST'S MODERN INTRODUCTION TO INTERNATIONAL LAW 54 (1997) ("[G]uidelines, although explicitly drafted as non-legal ones, may nevertheless in actual practice acquire considerable strength in structuring international conduct."). A repository of WHO guidelines can be found at *WHO Guidelines*, WORLD HEALTH ORG., https://www.who.int/publications/who-guidelines (last visited Feb. 8, 2022).

256. WHO Exec. Bd., *supra* note 239, ¶ 2. "A WHO guideline is any document [developed by the World Health Organization] containing recommendations about health interventions, whether these are clinical, public health or policy recommendations." WHO, WHO HANDBOOK FOR GUIDELINE DEVELOPMENT 1 (2d ed. 2014).

recommendations that are "based on a systematic and comprehensive assessment of the balance of a policy's or intervention's potential benefits and harms and explicit consideration of other relevant factors."[257] A recommendation tells the intended end-user of the guideline what he or she can or should do in specific situations to achieve the best health outcomes possible, individually or collectively.[258] It offers a choice among different interventions or measures having an anticipated positive impact on health and implications for the use of resources.[259]

Over the years, the WHO has been issuing guidelines enunciating general principles and giving technical advice on how to design effective, legal, and ethical interventions during a pandemic.[260] However, these documents are too general and

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257. WHO Guidelines, *supra* note 239, ¶ 5. According to Hill and Pang, the WHO produces guidelines to "respond[] to the demands of its 193 member states. Rapid increases in scientific knowledge have sometimes led to conflicting recommendations. Experts can disagree about important issues . . . and WHO is often seen as the final arbiter." Suzanne Hill & Tikki Pang, Comment, *Leading by Example: A Culture Change at WHO*, 369 LANCET 1842, 1843 (2007).

258. *See* WHO, WHO HANDBOOK, *supra* note 256, at 1.

259. *See id.*

260. *See*, *e.g.*, WHO, *supra* note 42, at 13–18; WHO, WHO Checklist for Influenza Pandemic Preparedness Planning, WHO Doc. WHO/CDS/CSR/GIP/2005.4 (2005), https://www.who.int/influenza/resources/documents/FluCheck6web.pdf; WHO, Ethical Considerations in Developing a Public Health Response to Pandemic Influenza, WHO Doc. WHO/CDS/EPR/GIP/2007.2 (2007), https://www.who.int/csr/resources/publications/WHO_CDS_EPR_GIP_2007_2c.pdf?crazycache=1; WHO, PANDEMIC INFLUENZA PREPAREDNESS AND RESPONSE: A WHO GUIDANCE DOCUMENT (2009), https://apps.who.int/iris/bitstream/handle/10665/44123/9789241547680_eng.pdf?sequence=1&isAllowed=y; WHO, *supra* note 7; WHO, Assessment Tool for Core Capacity Requirements at Designated Airports, Ports and Ground Crossings, WHO Ref. No. WHO/HSE/IHR/LYO/2009.9 (Oct. 2009), https://www.who.int/publications/i/item/WHO-HSE-IHR-LYO-2009-9; WHO, Summary of Key Information Practical to Countries Experiencing Outbreaks of A(H5N1) and Other Subtypes of Avian Influence, WHO Ref. No. WHO/OHE/PED/GIP/EPI/2016.1 (July 1, 2016), https://www.who.int/publications/i/item/WHO-OHE-PED-GIP-EPI-2016.1; WHO, GUIDANCE FOR MANAGING ETHICAL ISSUES IN INFECTIOUS DISEASE OUTBREAKS (2016), https://apps.who.int/iris/handle/10665/250580; WHO, Pandemic Influenza Risk Management: A WHO Guide to Inform and Harmonize National and International Pandemic Preparedness and Response, WHO Doc. No. (May 2017), https://apps.who.int/iris/handle/10665/259893; WHO, Essential Steps for Developing or Updating a National Pandemic Influenza Preparedness Plan, WHO Doc. No. WHO/WHE/IHM/GIP/2018.1 (2018), https://apps.who.int/iris/bitstream/handle/10665/272253/WHO-WHE-IHM-GIP-2018.1-eng.pdf?ua=1; WHO, A CHECKLIST FOR PANDEMIC INFLUENZA

vague, and do not address travel restrictions in a comprehensive manner. In 2019, the WHO reported that it was drafting guidelines on the effectiveness of exit-entry screening measures so as to "better inform[] States Parties about the effectiveness of additional health measures."[261] As we have seen, there is great uncertainty regarding the precise scope and correct interpretation of the IHR, namely Article 43. Guidelines could be used to supplement the broader, binding "guidelines" that result from the IHR.[262] The focus should be on giving more precise directions, instructions, and practical tips on what measures to adopt (and when and how) in a pandemic scenario, based on the "methods of professional practice."[263]

Guidelines could be elaborated to apply to public health emergencies in general or focus on the specific context of a particular pandemic. In the case of "standing" guidelines, they could even be incorporated as an annex to the IHR. Annex 2 to the IHR, for instance, contains a "decision instrument for the assessment and notification of events" that may constitute a PHEIC.[264] The annex includes several examples but makes it clear that they "are not binding and are for indicative guidance purposes to assist in the interpretation of the decision instrument criteria."[265] Including guidelines as an annex to

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RISK AND IMPACT MANAGEMENT: BUILDING CAPACITY FOR PANDEMIC RESPONSE (2018), https://www.who.int/publications/i/item/9789241513623.

261. Rep. by the Dir. Gen., Ann. Rep. on the Implementation of the Int'l Health Reguls., 72d World Health Assembly, Prov. Agenda Item 11.2, ¶ 16, WHO Doc. A72/8 (Apr. 4, 2019), https://apps.who.int/iris/handle/10665/328559?locale-attribute=ru&.

262. Pedro Villarreal, *Pandemic Declarations of the World Health Organization as an Exercise of International Public Authority: The Possible Legal Answers to Frictions Between Legitimacies*, 7 GOETTINGEN J. INT'L L. 95, 105 (2016). According to Burci, guidance and advisory documents

> can probably be seen as complementary to IHR-based recommendations and falling within a broader grant of authority to the secretariat to provide assistance and support to member states and other actors in the fight against communicable diseases . . . . [T]hey certainly play an important role, secure the credibility and legitimacy of WHO as the central hub of the response against the COVID-19 outbreak and strengthen the overall purpose of the IHR 2005.

Burci, *supra* note 52.

263. Gostin & Sridhar, *supra* note 206, at 1733; Villarreal, *supra* note 262, at 108–09.

264. International Health Regulations (2005), annex 2.

265. *Id.*

future editions of the IHR would be easier than amending the regulations themselves and could increase the visibility of such soft law norms, as they would become an integral part of the regulations (despite their non-binding nature). Guidelines could also be regularly reviewed and updated as necessary.

IV. BUILDING STRONGER BRIDGES

Whatever the nature of the instruments used, it is essential to harden the nexus between public health and human rights, particularly the right to freedom of movement. Human rights law is an integral part of what has been termed "global health law." In the formulation of Bridget Toebes, this broad regulatory field

> consists of a limited set of binding and non-binding instruments adopted in the framework of the World Health Organization (WHO), in an interaction with both hard and soft law standards recognized in other branches of international law, including human rights law, international humanitarian law, international environmental law, international trade, property and investment law.[266]

One of the essential features of this field is its multidisciplinarity. Global health law, by nature, needs to connect and engage with other fields of international law, including human rights law.[267] The importance of this connection became evident during the HIV/AIDS pandemic, which revealed in dramatic fashion how compulsory public health measures may breach human rights.[268] In particular, framing travel restrictions as a violation of human rights played a central role in the campaign to abolish HIV-related travel

266. Toebes, *supra* note 134, at 2–3.

267. Burci, *supra* note 135, at 514; *see* Julio Frenk & Suerie Moon, *Governance Challenges in Global Health*, 368 NEW ENG. J. MED. 936, 937–39 (2013); Taylor, *supra* note 124, at 38.

268. Joseph Dute, *Communicable Diseases and Human Rights*, 11 EUR. J. HEALTH L. 45, 46 (2004); David P. Fidler, *Constitutional Outlines of Public Health's "New World Order"*, 77 TEMP. L. REV. 247, 283 (2004); B.M. Meier & W. Onzivu, *The Evolution of Human Rights in World Health Organization Policy and the Future of Human Rights Through Global Health Governance*, 128 PUB. HEALTH 179, 181 (2014).

restrictions.[269] Still, this stands as an isolated instance where the protection of fundamental rights achieved notoriety in the public health policy arena.[270] During the last IHR revision process, WHO's Secretariat stated:

> The implementation of the Regulations may involve actions or measures by States Parties that affect human rights and freedoms protected by relevant treaties and rules of customary international law. Measures such as isolation and quarantine, the imposition of medical examination, vaccination or prophylaxis, the collection and transmission of personal information, and the destruction of personal property could affect or interfere with the enjoyment of rights such as privacy, *freedom of movement*, security of person, liberty and the right to private property.

The main instrument reviewed in this connection has been the International Covenant on Civil and Political Rights (1966), as an almost universal treaty and part of the so-called Bill of Human Rights. In this connection, however, several of the rights and freedoms spelt out in the Covenant and relevant for the application of the draft Regulations allow limitations based, inter alia, on public health considerations. Particular reference can be made to Articles 9 and 10 (liberty and security of person), *Article 12 (liberty of movement)*, Article 17 (right to privacy), Article 18 (freedom of thought, conscience and religion), Article 19 (freedom of expression), Article 21 (right of peaceful assembly), and Article 22 (freedom of association). The formulation of such "qualified" rights allows for better synergy between the draft Regulations and the Covenant.[271]

It is worth noting that, despite the Secretariat's recognition of freedom of movement as one of the human rights that may be affected by the implementation of the IHR, it did not mention

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269. Simon Rushton, *The Global Debate over HIV-Related Travel Restrictions: Framing and Policy Change*, 7 GLOB. PUB. HEALTH S159, S161 (2012).

270. David P. Fidler, *SARS: Political Pathology of the First Post-Westphalian Pathogen*, 31 J.L. MED. & ETHICS 485, 497 (2003).

271. Intergov'tal Working Gp. on Rev'n of the Int'l Health Reguls., WHO, Review and Approval of Proposed Amendments to the International Health Regulations: Relations with Other International Instruments, ¶¶ 29–30, WHO Doc. A/IHR/IGWG/INF.DOC./1 (Sept. 30, 2004) (emphasis added), https://apps.who.int/gb/IHR/pdf_files/IHR_IGWG_ID1-en.pdf.

travel restrictions to exemplify such danger.

When the final text was approved, many authors hailed the new IHR as strengthening the connection between human rights law and public health.[272] The novel provisions were seen as a welcome addition,[273] revealing the WHO's willingness to exert its influence on matters of human rights and its "new normative discourse" on global health.[274] The inclusion of such language made human rights rules and principles part and parcel of the accurate interpretation and implementation of the IHR, imposing on States Parties the obligation to ensure that they comply with both legal frameworks.[275]

Although there was strong support for including refences to human right protections during negotiations,[276] the final text's protections are too general.[277] The IHR does not even specify

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272. Patricia C. Kuszler, *Global Health and the Human Rights Imperative*, 2 ASIAN J. WTO & INT'L HEALTH L. & POL'Y 99, 116 (2007); Jonathan B. Tucker, *Updating the International Health Regulations*, 3 BIOSECURITY & BIOTERRORISM: BIODEFENSE STRATEGY PRAC. & SCI. 338, 345 (2005); Lance Gable, *The Proliferation of Human Rights in Global Health Governance*, 35 J. L. MED. & ETHICS 534, 539 (2007); Meier et al., *supra* note 215, at 247 ("The IHR brought human rights explicitly into the realm of global governance for infectious diseases."); GOSTIN, *supra* note 212, at 202 ("The IHR (2005) represent a landmark in global governance, with their three-pronged strategy on health security, international trade, and human rights.").

273. *See* Fidler & Gostin, *supra* note 127, at 87; *see also* Michael G. Baker & David P. Fidler, *Global Public Health Surveillance Under the New International Health Regulations*, 12 EMERGING INFECTIOUS DISEASES 1058, 1058 (2006).

274. David P. Fidler, *Architecture Amidst Anarchy: Global Health's Quest for Governance*, GLOB. HEALTH GOVERNANCE 12 (Apr. 1, 2007), http://blogs.shu.edu/ghg/files/2013/02/Fidler_Architecture-amidst-Anarchy-Global-Health%E2%80%99s-Quest-for-Governance_Spring-2007.pdf; Gostin, *supra* note 217, at 378 ("[T]he revised IHR was, in many respects, the high-water mark for the exercise of normative power, as the agency exerted its influence on matters of trade and human rights.").

275. *See* Fidler & Gostin, *supra* note 127, at 87.

276. Mary Whelan, *Negotiating the International Health Regulations* 9 (The Graduate Inst., Geneva, Global Health Programme Working Paper No. 1, 2008), https://repository.graduateinstitute.ch/record/4066?ln=en.

277. Heidi L. Lambertson, Comment, *Swatting a Bug Without a Flyswatter: Minimizing the Impact of Disease Control on Individual Liberty Under the Revised International Health Regulations*, 25 PENN ST. INT'L L. REV. 531, 544–45 (2006); Andraž Zidar, *WHO International Health Regulations and Human Rights: From Allusions to Inclusion*, 19 INT'L J. HUM. RTS. 505, 506 (2015); Gostin, *supra* note 217, at 379 ("[T]he regulations simply parrot the mantra of 'full respect for the dignity, human rights and fundamental freedoms of persons.'"). More optimistically, Gable argues that "[t]he inclusion of human rights language in the IHRs, however cursory, recognizes the importance of human rights considerations in health governance and helps to further solidify the connection between health and human rights." Gable, *supra* note 272, at

which human rights treaties it is referring to when it alludes to "human rights,"[278] and only two provisions expressly mention human rights.[279] The IHR states that its implementation is to be "guided by the Charter of the United Nations and the Constitution of the World Health Organization."[280] According to Davies and Youde, these documents "acknowledge the importance of human rights, but they provide little in terms of a framework or structure for their implementation – certainly far less than the myriad of subsequent human rights treaties that have emerged since then."[281] The Provisions are drafted in a way that raises doubts about how human rights are to be protected, and to what extent.[282]

The IHR does not explain how to balance public health with the protection of human rights. While the IHR's stated purpose is to avoid unnecessary interference with international traffic and trade, the regulations make no reference to avoiding unnecessary interference with individual freedom.[283] The focus seems to be on minimizing the economic consequences of travel restrictions, not the protection of individual rights.[284] Still, it can be said that the tenet of avoiding "unnecessary interference with international traffic" can be used as a parameter to protect the rights of individuals.[285]

539.

278. JEREMY YOUDE, BIOPOLITICAL SURVEILLANCE AND PUBLIC HEALTH IN INTERNATIONAL POLITICS 170 (2010).

279. Jeremy Youde, *Mediating Risk Through the International Health Regulations and Bio-Political Surveillance*, 59 POL. STUD. 813, 825 (2011).

280. International Health Regulations (2005), *supra* note 7, art. 3(2). Fidler, *supra* note 113, at 1089 ("[T]he WHO Constitution foreshadowed the importance of other areas of international law to WHO's mission by embedding references to human rights, international trade, and environmental conditions."). However, the WHO Constitution does not mention civil and political rights. Erin Pauley, *Human Rights in the Midst of Quarantine*, 13 LOY. U. CHI. INT'L L. REV. 71, 80–81 (2016).

281. Sara E. Davies & Jeremy Youde, *The IHR (2005), Disease Surveillance, and the Individual in Global Health Politics*, 17 INT'L J. HUM. RTS. 133, 144 (2013).

282. Belinda Bennett & Terry Carney, *Public Health Emergencies of International Concern: Global, Regional, and Local Responses to Risk*, 25 MED. L. REV. 223, 237 (2017); Zidar, *supra* note 277, at 506; Toebes, *supra* note 33, at 492; von Bogdandy & Villarreal, *supra* note 52, at 17; Paul Quinn, *Crisis Communication in Public Health Emergencies: The Limits of 'Legal Control' and the Risks for Harmful Outcomes in a Digital Age*, 14 LIFE SCIS. SOC'Y & POL'Y, no. 4, at 1, 9 (2018).

283. *See* Lambertson, *supra* note 276, at 544.

284. *Id.*

285. *See* DeMuro, *supra* note 42, at 14.

The application of the IHR often collides with the protection of individual rights.[286] The inclusion of specific references to human rights in the IHR was motivated by the reaction to the 2003 SARS outbreak, which highlighted the need to balance public health and human rights protection.[287] However, according to Davies and Wenham, "[h]uman rights is the long-neglected core capacity of the IHR."[288] When implementing the IHR in practice, public officials may be oblivious to the human rights implications of health measures.[289] Just like the IHR, the interpretation of human rights rules during public health crises is rife with difficulty. While the IHR allude to human right protection, this is more of a rhetorical statement than a legal commitment, leaving too much discretion to governments in devising their policies in the name of "public health."[290] The problem is compounded by the vague language normally employed in human rights treaties.[291] In the end, the right to international freedom of movement is beset with vagueness and ambiguity on both legal frameworks.

COVID-19 is a vivid reminder that, when implementing measures to address a public health emergency, governments have to conform to both the IHR and human rights rules and principles. The WHO needs to strengthen the connection between the two legal frameworks.[292] A proper balancing

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286. Sell, *supra* note 131, at 207; Goldfarb, *supra* note 77, at 793. Sam Halabi, *Multipolarity, Intellectual Property, and the Internationalization of Public Health Law*, 35 MICH. J. INT'L L. 715, 731–32 (2014) ("Individual rights, especially those historically characterized as 'civil' or 'political,' often faced curtailment in the name of public health measures."). The risk of violation is even greater because governments may use emergency powers to pass laws that evade judicial or legislative scrutiny. Bennett & Carney, *supra* note 281, at 237.

287. DAVID P. FIDLER, SARS, GOVERNANCE AND THE GLOBALIZATION OF DISEASE 152 (2004); YOUDE, *supra* note 277, at 166.

288. Davies & Wenham, *supra* note 58, at 1244.

289. Lawrence Gostin & Jonathan M. Mann, *Towards the Development of a Human Rights Impact Assessment for the Formulation and Evaluation of Public Health Policies*, 1 HEALTH & HUM. RTS. 58, 59 (1994); Jonathan M. Mann, *Medicine and Public Health, Ethics and Human Rights*, 27 HASTINGS CTR. REP., May/June 1997, at 6, 9 (1997).

290. Joseph Amon, *Health Security and/or Human Rights?*, *in* ROUTLEDGE HANDBOOK OF GLOBAL SECURITY 293, 294–95 (Simon Rushton & Jeremy Youde eds., 2014); *see* Davies & Youde, *supra* note 281, at 144; Asher, *supra* note 141, at 144.

291. Louise Doswald-Beck & Sylvian Vité, *International Humanitarian Law and Human Rights Law*, 33 INT'L REV. RED CROSS 94, 106 (1993) ("[T]he major difficulty of applying human rights law as enunciated in the treaties is the very general nature of the treaty language.").

292. Sarah E. Davies, *Infectious Disease Outbreak Response: Mind the*

exercise calls for visible signposts, based on scientific evidence and informed by international best practices. Again, it is necessary to harden the precision element of the regime, making the interaction between global health and human rights law more visible and cogent.

There have been calls to include more explicit and specific references to human rights standards in the very text of the IHR. Using more vigorous language about the importance of complying with human rights provisions could increase their weight in the implementation of the regulations.[293] Specific references to the human right to freedom of movement, for instance,[294] would increase its normative prominence. It is also necessary to clarify the interaction between the imposition of additional health measures under Article 43 of the IHR and the mechanisms of limitation and derogation. It has been argued that the requirement that measures "not be more restrictive of international traffic and not more invasive or intrusive to persons than reasonably available alternatives that would achieve the appropriate level of health protection" has parallels with the formula of "equivalent protection" developed in human rights law.[295] How to operationalize these legal doctrines in practice remains a challenge. Freedom of movement is protected by important safeguards, but they need to be reinforced and fine-tuned to be effective—otherwise they are just soft proclamations.

Another way of promoting greater articulation between the IHR and human rights rules and principles would be to expressly incorporate by reference the Siracusa Principles into the IHR.[296] This would add important substantive and

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Rights Gap, 25 MED. L. REV. 270, 289 (2017); Fidler, *supra* note 133, at 1110; Meier et al., *supra* note 215, at 247–48.

293. Davies & Youde, *supra* note 281, at 144; YOUDE, *supra* note 278, at 171.

294. *See* Youde, *supra* note 279, at 826–27.

295. Spagnolo, *supra* note 50, at 4. *See generally* Paul De Hert & Fisnik Korenica, *The Doctrine of Equivalent Protection: Its Life and Legitimacy Before and After the European Union's Accession to the European Convention on Human Rights*, 13 GER. L.J. 874 (2012) (discussing the development of the doctrine of equivalent protection).

296. Lawrence O. Gostin, *World Health Law: Toward a New Conception of Global Health Governance for the 21st Century*, 5 YALE J. HEALTH POL'Y L. & ETHICS 413, 423 (2005); Lambertson, *supra* note 277, at 544. The applicability of the Siracusa Principles is already implicit in the references made in the IHR to human rights. GOSTIN, *supra* note 212, at 183 ("The emphasis on human dignity may suggest that international human rights law, such as the Siracusa Principles, is relevant in interpreting and implementing the IHR . . . .That is, human rights principles should be applied where there is uncertainty in the IHR.").

procedural safeguards into the implementation of public health measures. The Principles have been considered by international courts to determine the validity of measures adopted by States, denoting that they function well in a real-life context.[297] As stated by one author, such incorporation "would also shift the IHR's heavy focus on minimalizing trade interference by putting more emphasis on the human element of public health law."[298] However useful in raising the profile of human rights principles, this solution may not be sufficient. The fact is that the Siracusa Principles were not drafted specifically with public health emergencies in mind, and thus may be too broad and general.[299] More guidance is needed, even if in the form of soft law instruments.

Recognizing the need for more detailed, robust guidelines, several institutions stepped in and offered thematic guidance on how to deal with different risks for human rights arising from COVID-19.[300] In the field of international travel, the only guidance available was offered by the Human Rights Committee,[301] the United Nations Committee on Migrant Workers, and the United Nations Special Rapporteur on the Human Rights of Migrants.[302] Sun argues that the Human Rights Committee should issue an authoritative comment on restrictions and derogations to the ICCPR during public health crises.[303] This General Comment could examine in detail the canons of necessity and proportionality and how they should be

297. Gostin & Berkman, *supra* note 93, at 146.

298. Lambertson, *supra* note 276, at 554–55.

299. *See* Nina Sun, Viewpoint, *Applying Siracusa: A Call for a General Comment on Public Health Emergencies*, 22 HEALTH & HUM. RTS. J. 387, 387 (2020).

300. *See, e.g.*, *COVID-19 Guidance from Supranational Human Rights Bodies*, INT'L JUST. RES. CTR., https://ijrcenter.org/covid-19-guidance-from-supranational-human-rights-bodies (last updated Oct. 27, 2021); Off. U.N. High Comm'r Hum. Rts., COVID-19 Guidance (May 13, 2020), https://www.ohchr.org/Documents/Events/COVID-19_Guidance.pdf; Lisa Reinsberg, *Mapping the Proliferation of Human Rights Bodies' Guidance on COVID-19 Mitigation*, JUST SECURITY (May 22, 2020), https://www.justsecurity.org/70170/mapping-the-proliferation-of-human-rights-bodies-guidance-on-covid-19-mitigation/.

301. *See* U.N. Hum. Rts. Comm., *supra* note 111.

302. U.N. Comm. on Migrant Workers & U.N. Special Rapporteur on the Human Rights of Migrants, Joint Guidance Note on the Impacts of the COVID-19 Pandemic on the Human Rights of Migrants (May 26, 2020), https://www.ohchr.org/Documents/Issues/Migration/CMWSPMJointGuidanceNoteCOVID-19Migrants.pdf.

303. Sun, *supra* note 299, at 387.

applied during pandemics. As Sun rightly points out, General Comment No. 27 (Freedom of Movement) makes limited reference to public health.[304]

Other authors have also suggested the adoption of instruments such as interpretive general comments specifically on infectious disease control and the implementation of the IHR.[305] These documents could be drafted by human rights treaties bodies, by the WHO itself, or, even better, in a joint venture between these entities. According to the ICCPR, the Human Rights Committee shall issue "general comments as it may consider appropriate, to the States Parties."[306] These commentaries have strong normative value.[307] They are a form of authoritative soft law that interprets and elaborates on the provisions of human rights treaties.[308] A general comment specifically on the tension between public health measures and freedom of movement, while non-binding, could be a useful interpretive tool, offering guidance in determining whether certain additional health measures breach human rights standards.

V. COMPLEMENTARY THERAPIES

The COVID-19 pandemic is a stark reminder of the shortcomings of global health law in addressing public health crises in a way that respects human rights standards. There is much work to do on boosting the precision (and therefore effectiveness) of the regulatory framework and striking a balance between public health and the protection of the right to international freedom of movement. In addition, taking international law seriously (in all its forms, and for both "hard" and "soft" law) also entails a change in the WHO's strategies and

304. *Id.* at 389 n.5.

305. Meier et al., *supra* note 215, at 248.

306. ICCPR, *supra* note 14, art. 40(4).

307. *See* Dinah Shelton, *The Legal Status of Normative Pronouncements of Human Rights Treaty Bodies*, *in* COEXISTENCE, COOPERATION AND SOLIDARITY 553, 562 (Holger Hestermeyer et al. eds., 2012).

308. Kasey McCall-Smith, *Interpreting International Human Rights Standards: Treaty Body General Comments as a Chisel or a Hammer*, *in* TRACING THE ROLES OF SOFT LAW IN HUMAN RIGHTS 27, 29 (Stéphanie Lagoutte et al. eds., 2016); Dinah Shelton, *Commentary and Conclusions*, *in* COMMITMENT AND COMPLIANCE: THE ROLE OF NON-BINDING NORMS IN THE LEGAL SYSTEM 345, 451 (Dinah Shelton ed., 2003).

approaches.[309]

First, a change in terms of human resources is required. Harnessing the normative potential of the WHO requires taking lawyers more seriously. Traditionally, the WHO has been mostly staffed with professionals with a medical background, and legal experts are clearly a minority.[310] This explains why the WHO sees little importance in adopting standard-setting instruments. This probably also diminishes the ability of the Secretariat to give proper legal advice to States Parties, particularly regarding (un)lawful measures under Article 43 of the IHR.[311] In addition, it also helps to explain why the WHO is not vocal when faced with human rights violations.[312] Finally, the absence of lawyers in the WHO's institutional milieu is probably also one of the reasons why the institution never pushed for the creation of a more formalized dispute settlement mechanism.[313]

The WHO should involve more lawyers with varied backgrounds and expertise, including international law and human rights, in its workforce.[314] Having more professionals that specialize in human rights working at the WHO could increase the visibility of the field within the organization and instill human rights-based approaches and policies.[315]

More attention also needs to be paid to the addressees of the WHO's normative instruments. Decisions to impose travel restrictions are normally not taken by public health officials but rather by ministries of trade, tourism, or foreign affairs, who may not be aware of their state's obligations under the IHR.[316]

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309. *See* José E. Alvarez, *The WHO in the Age of the Coronavirus*, 114 AM. J. INT'L L. 578, 587 (2020) ("COVID-19 is the kind of crisis that may ultimately drive organizational change.").

310. Aginam, *supra* note 123, at 562–63; Steven J. Hoffman & John-Arne Røttingen, *Split WHO in Two: Strengthening Political Decision-Making and Securing Independent Scientific Advice*, 128 PUB. HEALTH 188, 189 (2014); Fidler, *supra* note 133, at 1112; *see* Alvarez, *supra* note 309, at 585.

311. Adam Kamradt-Scott, *The International Health Regulations (2005): Strengthening Their Effective Implementation and Utilisation*, 16 INT'L ORG. L. REV. 242, 260–61 (2019).

312. Alvarez, *supra* note 309, at 586.

313. *See* Eric Stein, *International Integration and Democracy: No Love at First Sight*, AM. J. INT'L L. 489, 499 (2008); Vierck, *supra* note 153, at 140.

314. *See* Gostin et al., *supra* note 124, at 861; *see also* Alvarez, *supra* note 309, at 583. According to Burci and Nannini, the Office of the Legal Counsel is increasingly familiar with different areas of international law relevant to the work of the WHO. Burci & Nannini, *supra* note 165, at 36.

315. Thérèse Murphy & Noel Whitty, *Is Human Rights Prepared? Risk, Rights and Public Health Emergencies*, 17 MED. L. REV. 219, 241 (2009).

316. Kamradt-Scott, *supra* note 311, at 261; *see also* Habibi et al., *supra* note

The problem is compounded by the cross-sector nature of the issues, which requires experts from different fields who may compete to see whose advice is more important to the issues at hand.[317] The WHO Secretariat needs to devise new communication strategies and engage with a broader range of public officials, not just from health departments.

Beyond the technical-legal interpretation of the rules, there should also be room for diplomatic cooperation.[318] The IHR was negotiated by diplomats,[319] and diplomacy can be a complementary route for their implementation. Burci has recently suggested the creation of a consultation mechanism to allow discussion among states enacting travel restrictions within the scope of Article 43.[320] Other non-adjudicatory mechanisms can also be considered. Alvarez suggested the creation an ombudsperson, expert committees, or even the possibility of WHO's lawyers issuing legal interpretations (even if not authoritative) when solicited.[321]

There is also much room for cross-institutional learning. Global health law was developed more recently than other branches of international law.[322] The IHR acknowledges the potential for interaction with other fields and seeks to ensure their compatibility. The potential for conflict is high, especially in the absence of unified adjudicatory systems. The WHO should cooperate with well-established institutions, in particular the WTO and United Nations agencies in the field of human rights. Their experience in international law would be beneficial in enhancing the WHO's legal capacities and portfolio. There is no international organization specifically dedicated to international travel that can serve as an interlocutor in the interplay between mobility and public health.[323] Still, as the

42, at 6.

317. *See* DAVID FAIRMAN ET AL., NEGOTIATING PUBLIC HEALTH IN A GLOBALIZED WORLD 31 (2012).

318. *See* Davies & Wenham, *supra* note 58, at 1227, 1229.

319. Annamarie Bindenagel Šehović, *Health Diplomacy: For Whom? By Whom? For What?*, 9 REGIONS & COHESION 161, 161 (2019).

320. Burci, *supra* note 79, at 216. This would entail more diplomacy experts in the secretariat, something that it currently lacks. Hoffman & Røttingen, *supra* note 310, at 190.

321. Alvarez, *supra* note 309, at 583.

322. *See* Brigit Toebes, *International Health Law: An Emerging Branch of Public International Law*, 55 INDIAN J. INT'L L. 299, 300 (2015).

323. Rey Koslowski, *The International Travel Regime*, *in* GLOBAL MOBILITY REGIMES 51, 57 (Rey Koslowski ed., 2011). The United Nations World Tourism Organization (UNWTO) might seem an obvious candidate, but its remit focuses

guardian of the IHR, the WHO should assume its natural role as one of the leading international organizations in the arena of international mobility coordination.

It has been stated that the WHO is "distinguishable from other actors in the global health community for its unrivaled capacity to create law."[324] However, the WHO has been clearly punching below its (normative) weight. As a global orchestrator in the health field, the WHO should make its voice heard in the normative undertakings of other organizations whenever they overlap with its mandate.[325] COVID-19 should serve as a turning point in the organization's approach to legal instruments and professionals. While international law is no vaccine against viruses and lawyers are not medical doctors, they both have a role to play in mitigating some of the unnecessary human suffering caused by travel restrictions.

VI. CONCLUSION

Pandemics are by no means a novel phenomenon: they are "a regular feature of human existence."[326] In 2011, the WHO Review Committee charged with reviewing IHR functioning during the H1N1 pandemic ominously cautioned that "[t]he world is ill-prepared to respond to a severe influenza pandemic" and predicted that "tens of millions at risk of dying in a severe pandemic."[327] One decade later, those words sound prophetical. The inadequacies of the IHR in promoting international cooperation have been well-documented in previous outbreaks. More surprising than the severity and global spread of COVID-19 is only the jaw-dropping lack of compliance with the regulations.

According to Gostin, the regulations have "become arguably the most important global health treaty of the twenty-first century."[328] They are still, for better or worse, the only legally binding international instrument governing international

essentially on tourism, not the international travel regime in general. *Id.*

324. Chang, *supra* note 243, at 8.

325. Shawn H. E. Harmon, *International Public Health Law: Not So Much WHO as Why, and Not Enough WHO and Why Not?*, 12 MED. HEALTH CARE & PHIL. 245, 251–52 (2009); Gostin, *supra* note 208, at 996.

326. Adam Kamradt-Scott, *Preparing for the Next Pandemic*, *in* THE HANDBOOK OF GLOBAL HEALTH POLICY 539, 541 (Garrett W. Brown et al. eds., 2014).

327. Rep. of the Rev. Comm. (H1N1), *supra* note 55, ¶¶ 18, 46.

328. GOSTIN, *supra* note 212, at 178.

response to the cross-border spread of infectious diseases. The IHR (2005) is the latest stage in a long process of international cooperation to strike a balance between the protection of public health and the safeguard of international mobility. This is, admittedly, "a difficult tightrope to walk."[329] In the words of Gostin, "the international community cannot have it both ways—unimpeded travel and trade, with full public health protection."[330] However, the stereotypical response to an epidemic outbreak cannot be to immediately shut down national borders. Travel restrictions not only do not have any public health rationale but also—more worryingly—affect the human right to freedom of movement in a disproportionate way. There is no balancing exercise when one plate of the scale is completely ignored. In the words of a United Nations expert, "[a] life in which your physical health is guaranteed but every other right has been taken away—that would be meaningless."[331]

"Diseases know no borders" is a well-known cliché in the field of infectious disease control.[332] Still, time and again States rush to close down borders whenever there is a pandemic outbreak.[333] One of the reasons for this is the low normative prominence of the human right to freedom of movement. General Comment No. 27 proclaims that "[l]iberty of movement is an indispensable condition for the free development of a person" that "interacts with several other rights enshrined in the Covenant."[334] One author adds emphatically about the freedom of movement: "[w]ithout it, other rights are precarious. Universally recognised values, such as mutual aid, humanity,

329. Rushton, *supra* note 137, at 73.

330. Lawrence Gostin, *International Infectious Disease Law: Revision of the World Health Organization's International Health Regulations*, 291 JAMA 2623, 2624 (2004).

331. Gabrielle Bruney, *My Concern Is that Authoritarians May Use COVID-19 as a Cover*, ESQUIRE (Jun. 15, 2020), https://www.esquire.com/news-politics/a32474899/fionnuala-ni-aolain-interview-coronavirus-covid-19-lessons/ (quoting U.N. Special Rapporteur Fionnuala Ní Aoláin).

332. *See*, *e.g.*, Ferhani & Rushton, *supra* note 78, at 458; Dute, *supra* note 268, at 47.

333. Charles Kenny, *Pandemics Close Borders—And Keep them Closed*, POLITICO (March 25, 2020, 4:30 A.M.), https://www.politico.com/news/magazine/2020/03/25/trump-coronavirus-borders-history-plague-146788 (providing historical examples of countries who imposed travel restrictions in response to a pandemic); *see also supra* notes 38–40.

334. U.N. Hum. Rts. Comm., *supra* note 17, ¶ 1. One author has even claimed that "[t]he right to travel is the basis of all other rights, since they depend upon freedom of movement." Darren J. O'Byrne, *On Passports and Border Controls*, 28 ANNALS TOURISM RSCH. 399, 413 (2001).

hospitality, comity, mutual intercourse, and good faith, all depend on the right to free movement for their efficacy."[335] Despite these solemn proclamations, the truth is that little attention has been paid to this right, including in academic scholarship. When thinking about human rights, freedom of movement is not one of the first rights that spring to mind.[336] While it has been argued that "minimum interference with international movement is . . . the leading principle in the field of international travel[,]"[337] this right has little weight in practice, and is one of the first human rights to be sacrificed in the name of public health.

While breaches of the IHR have occurred in previous outbreaks, the scale of violations during the COVID-19 crisis is simply baffling. Maximum interference became an almost universal rule, in that states have clearly exceeded the recommended control measures, despite uncertain and potentially negative consequences for the global economy and with little, if any, benefit for public health. Beyond the technical-legal shortcomings of the regime discussed in this article, the pervasive disregard for the IHR raises broader questions that merit serious reflection.

First, what role and importance should international mobility have in a globalized world? It has been argued that "[t]he age of globalization is the age of universal contagion."[338] At least in the short term, the pandemic already changed the way we think about global mobility.[339] But will it have more permanent effects? Will the traumatic experience of COVID-19 lead to some form of deglobalization? Are travel restrictions just "the first step towards the downfall of an exaggerated, unsustainable form of globalisation?"[340] In their discussion about migration, Harvey and Barnidge state that "[i]f 'liberty of

335. Satvinder S. Juss, *Free Movement and the World Order*, 16 INT'L J. REFUGEE L. 289, 289 (2004).

336. *See* Tamás Foldesi, *The Right to Move and Its Achilles' Heel, the Right to Asylum*, 8 CONN. J. INT'L L. 289, 289 (1993).

337. Aart Hendriks, *The Right to Freedom of Movement and the (Un)Lawfulness of AIDS/HIV Specific Travel Restrictions from a European Perspective*, 59 NORDIC J. INT'L L. 186, 191 (1990).

338. MICHAEL HARDT & ANTONIO NEGRI, EMPIRE 136 (2001).

339. E. Tendayi Achiume et al., *Introduction to the Symposium on COVID-19, Global Mobility and International Law*, 114 AJIL UNBOUND 312, 313 (2020).

340. Joachim Voth, *Trade and Travel in the Time of Epidemics*, *in* ECONOMICS IN THE TIME OF COVID-19, at 93, 94 (Richard Baldwin & Beatrice Werder di Mauro eds., 2020) (ebook).

movement is an indispensable condition for the free development of a person,' then what is an 'indispensable' human right is increasingly seen by developed states as an 'inconvenient' human right."[341] Is freedom of movement also increasingly perceived as a bothersome feature of the globalized world that should be forfeited during international public health emergencies? Freedom of movement is critical to the functioning of the modern global order. But should the global order turn into a *global border* whenever there is a pandemic outbreak?

Second, what does the reaction of governments to COVID-19 tell us about modern societies? Both liberal and less democratic regimes resorted to travel restrictions as their weapon of choice in curbing the spread to the virus. Does this reflect a shift toward authoritarian responses to infectious diseases?[342] Is there an ideological consensus forming about the acceptability of restricting international freedom of movement during epidemics? And if so, are the IHR—and their firm posture against travel restrictions—being abrogated through subsequent practice? Is non-compliance with Article 43 and the human right to freedom of movement becoming the new normal? And are these provisions fated to slowly fade into legal irrelevance?

Both of these unsettling questions need to be addressed by International Law. Our proposal—admittedly modest—is to encourage greater compliance with the regime by rethinking and rephrasing it. We need a renewed and broader consensus on the criteria that should determine the reasonable balance between public health and international mobility. Medical and legal experts should be brought together to inflate a measure of scientific certainty into the regime. The legal scale that measures the lawfulness of national reactions during pandemics needs to be calibrated—lest it become an obsolete tonic in the museum of international law.

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341. Harvey & Barnidge, *supra* note 4, at 1.

342. *See* Fidler, *supra* note 52, at 210; *see generally* Samuli Seppänen, *Ideological Responses to the Coronavirus Pandemic: China and its Other*, 16 U. PA. ASIAN L. REV. 24 (2020) (discussing how the pandemic operates as an instance of ideological contestation between "Western" liberal democracies and China); Stephen Thomson & Eric C. Ip, *COVID-19 Emergency Measures and the Impending Authoritarian Pandemic*, 7 J.L. & BIOSCIENCES 1, 7 (2020) (discussing how COVID-19 has served as an impetus for regressions to authoritarian across the world).