

The governance of disease outbreaks in international health law

From Ebola to COVID-19 (Part II)

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In the first part of this two-part post, we broadly addressed the legal framework provided by the International Health Regulations (IHR), a binding legal instrument within the aegis of the World Health Organization (WHO). In the following subsections, we turn to two more legal dimensions, which were directly at stake during the 2014-2016 West African Ebola crisis and are also present in the COVID-19 pandemic, namely: 1) the role played by the United Nations Security Council (SC), particularly its Resolutions dealing with disease outbreaks; and 2) the link between, on the one hand, the protection of human rights – leading at times to tensions between individual liberties and the right to health – and, on the other hand, the WHO's recommendations when determining which public health measures are adequate for facing pandemics.

Ebola, COVID-19 and the SC: Are diseases threats to international peace and security?

During the West-African Ebola crisis of 2014, [the UN Security Council \(SC\) for the first time used its Chapter VII powers](#) to declare that a transboundary disease outbreak can constitute a threat to international peace and security (Resolution 2177). Before that, the SC had considered in 2000 that HIV/AIDS could destabilize countries (Resolution 1308). The SC relied on a broad definition of peace in 2014, while also pinpointing to the fact that Ebola aggravated a situation in West-African countries that was already unstable. With this bold move [leading to discussions around the securitization of health](#), the SC nonetheless refrained from issuing mandatory measures. The UN Secretary General [constituted an additional, ad hoc body](#): The United Nations Mission for Emergency Ebola Response (UNMEER). The assessment on its performance [is mixed](#). Moreover, the deployment of security forces by multiple countries, while contributing towards the implementation of more comprehensive measures, led to clashes with civilians.

Resolution 2177 challenged the role of the WHO during infectious disease outbreaks. During the more recent Ebola outbreak in the Democratic Republic of the Congo (DRC), the Security Council issued [another Resolution \(2439\)](#) in the same line of thought and in the middle of an armed conflict in the DRC in order to facilitate humanitarian access to the region. By contrast, in light of the COVID-19 pandemic, the SC issued [Resolution 2532\(2020\)](#) on 1 July, 2020. Evidently, the dimensions in the current pandemic are different, as it is not restricted to certain regions vulnerable to armed conflict. Nevertheless, the SC's Resolution on COVID-19 focuses only

on the pandemic's overlap with armed conflict and other humanitarian crises. It "demands" a ceasefire of 90 days, with the exception of operations against the Islamic State in Iraq and the Levant (ISIL/Da'esh), Al Qaeda, Al Nusra and other terrorist groups formally designated as such. Yet the resolution in question does not invoke Chapter VII of the UN Charter. Similar to Ebola in the DRC in 2019, but unlike the West African Ebola Crisis in 2014, COVID-19 per se was not seen as the source of a threat to international peace and security. Rather, its aggravating impact in specific pre-existing contexts of instability is the source of concern. Notably, the SC Resolution was reportedly approved only after references to the WHO were removed, a matter that previously led to disagreements between [the US and China](#). In sum, SC Resolution 2532(2020) is a good example to see how the specific regime of international health governance interacts with wider public international law.

COVID-19 and the international protection of human rights: Which public health measures are adequate?

The WHO's authority stemming from expertise is not coercive but rather contingent on recognition by its addressees. It is mostly exercised through non-binding acts. The WHO cannot constrain public authorities or individuals the same way domestic officials could. However, as seen in the West African Ebola crisis in 2014, its technical recommendations can be an exercise of authority in and of themselves. The WHO may provide standardized guidance taking into account the international dimension of outbreaks and is not too constrained by the national interests of states.

The WHO's authority is directly linked to issues of human rights. During the current crisis, the WHO has recommended the restriction on the liberty of movement through isolations for confirmed infected persons as well as quarantines for their contacts under Article 18 of the IHR. However, the WHO does not actively recommend community quarantines as currently practiced across the world during the COVID-19 crisis. These touch upon international human rights law applicable to emergency settings, because individual liberties are restricted without any concrete risk assessment. The balancing then takes place between the infringed rights at stake on the one side and the right to health on the other side.

Fighting COVID-19 showed a new dimension on how states' policies to promote the right to health can heavily clash with individual rights and even the right to health itself. The fact that people were confined in their homes most likely had a negative impact on some people's mental health and it was feared that especially women and children could be subjected to domestic violence. The underlying determinants of health included in the right to health were in a way undermined by state measures to fight COVID-19. Political decisions in this subject matter are very presuppositional and complex. In determining adequacy, public health measures must be evidence-based to justify the restrictions as effective in countering the spread of the disease. Politicians can call for medical experts' advice, but only democratically legitimized actors can be entrusted with the power to make decisions which have such a far-reaching impact. Here, public health intersects with a normative argument. The right to health also reflects the inherent tension between the individual and the collective dimension. Public health is not concerned with individual patients, but with population groups. It is disputed whether the human right to health can conceptualize

this notion as a collective group right, or as merely objective law applicable to cases involving individuals. The answer to this doctrinal question has an impact on balancing rights in concrete cases.

Conclusion

Finding common legal elements across multiple infectious disease outbreaks – whether H1N1 influenza, Ebola, COVID-19 or others – can yield valuable knowledge for future normative endeavors. Certain building blocks of international health governance play a vital role regardless of the specific infectious disease. Due regard to different social, economic and, certainly, legal contexts is warranted. Yet drawing upon past experiences is a necessary piece in the puzzle of devising a proper global disease outbreak preparedness and response. This holds even more true as international health law is [a still evolving field](#), both in research and in practice.

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