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State Responsibility for the Failure to Prevent the Spread of SARS-CoV-2

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I. Introduction

The Covid-19 pandemic has clearly demonstrated the vulnerability of the globalized world to the international spread of infectious diseases. The first cases of Covid-19 were identified in Wuhan – the capital city of Hubei Province in the People's Republic of China (China or PRC) – in December 2019. At the time, nothing was known about the disease, and doctors were simply alarmed by the growing number of viral pneumonia cases of an unknown cause. The virus rapidly spread across mainland China and, within a matter of weeks, migrated to other countries in Asia, Western Europe and the United States.[1] The outbreak was declared by the World Health Organization (WHO) to be a Public Health Emergency of International Concern on 30 January 2020 and a pandemic on 11 March 2020. As of 19 October 2020, there are more than 40 million registered cases and over 1.1 million of Covid-19-related deaths.[2] Most of the researchers, however, agree that the officially registered cases represent only a fraction of the actual infections.[3] The WHO estimates that up to 10% of the global population may have already contracted with the virus (although this estimate was based on unclear methodological grounds).[4] At the same time, even the number of deaths is undercounted in many countries, as demonstrated by considerable excess mortality since the beginning of the pandemic, in excess of expected mortality as well as the number of officially registered Covid-19 deaths.[5]

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[1] For the overview of the initial phase of the pandemic see C.Raina MacIntyre, 'Global Spread of COVID-19 and Pandemic Potential' (2020) 1(3) *Global Biosecurity* pp. 1-3.

[2] The up-date statistical data are available in the Coronavirus Resource Centre maintained by the Johns Hopkins University of Medicine (https://coronavirus.jhu.edu).

[3] See e.g. Centers for Disease Control and Prevention, *Coronavirus Disease 2019 (Covid-19). Commercial Laboratory Seroprevalence Surveys* (3 October 2020), available at: https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/commercial-lab-surveys.html (accessed 18 October 2020)

[4] Coronavirus: WHO estimates 10% of global population infected with COVID-19, DW, 5 October 2020, available at: https://www.dw.com/en/coronavirus-who-estimates-10-of-global-population-infected-with-covid-19/a-55162783 (accessed 18 October 2020).

[5] Centers for Disease Control and Prevention, *Excess Deaths Associated with COVID-19, by Age and Race and Ethnicity — United States, January 26–October 3, 2020*. (23 October 2020), available at https://www.cdc.gov/mmwr/volumes/69/wr/mm6942e2.htm (accessed 23 October 2020).

The above developments naturally beg the question of whether any State should face international legal responsibility for not taking timely and effective measures to prevent the cross-border spread of a lethal pathogen. This issue is the central question of this text. In order to answer it, the article proceeds as following: Section II summarizes the underlying rationale of preventing diseases; it then recapitulates, in Section III, the most relevant general rules of international law relating to state responsibility, the pertinent norms of the WHO International Health Regulations (IHR), and other applicable rules of international law. Finally, the article concludes in Section IV by briefly summarizing how these rules might apply to the PRC – the country that remains at the centre of the current pandemic, even if the number of its domestic cases is currently very low.

II. International Disease Prevention Implies Actions to Avoid Triggering Kill Chains

This section provides an overview of the chains of causation that can — in the context of a pandemic and independently of the actions of the government of the country whose citizens stand to suffer harm — lead to unintended but foreseeable harm to health (including loss of life) beyond the borders of the country at the chain stem; with the chains originating partly or wholly from the actions of the government of the country at the source. In short, we shall refer to these chains of causation as "kill chains."

Kill chains can arise fully intentionally, as evidenced by international and transnational armed conflicts worldwide. It is thus worth reiterating that the mechanisms of harm discussed below are only some of the possible ways of causing harm to health — ones exerting an effect across borders, unintentionally but foreseeably, and specifically in the context of epidemics.

Ethical responsibility, just as the spectrum of imaginable, unintentionally but foreseeably harmful actions, is context-dependent. It manifests differently before and after international spread occurs; before and after governments take steps to restrict movement across borders; and before and after a working vaccine becomes available. Failing to notify the WHO and other States about an evolving situation of public health concern with potential international implications gives rise to kill chains through a deficit of preparedness which extends beyond governments — that thus do not have a chance to consider restrictive and other measures in protection of their citizens — to medical staff unaware that an epidemic is underway and that there are signs and symptoms to look out for, thus posing a risk to health personnel. It also results in a deficit of vigilance on the part of international travellers visiting the affected areas. In the context of free or only partially restricted movement across borders, the lack of

transparency concerning case numbers and the territorial distribution of cases along with other significant epidemic data may similarly result in a deficit of preparedness and vigilance. Once a vaccine becomes available, the failure to fully cooperate with the global effort to carry out a comprehensive campaign of vaccination could impede or render impossible disease eradication, thus imposing indirect responsibility (at least in an ethical sense) for all of the harm related to the continuation of the epidemic beyond the vaccine-availability baseline.

Variables mediating the extent and scope of ethical responsibility include capacities and resources on the part of the governments concerned, as well as the specific characteristics of the infectious pathogen causing the pandemic. Capacities and resources may be self-evidently lacking in poor countries that already suffer from complex humanitarian emergencies, i.e., a combination of humanitarian crises and armed conflict and/or the aftermath of natural disaster(s).

The specific properties of different pathogens have a profound impact on the containment strategy to be employed. SARS-CoV-2 is particularly difficult to contain. Its transmission often results from pre-symptomatic or asymptomatic carriers via a mixture of droplets and aerosols. To identify infected persons poses great challenges due to the imperfect sensitivity and specificity of test results. Outward signs and symptoms are difficult to recognize as these are mostly non-specific.[6] Mortality is unevenly distributed across age groups and is mediated by specific co-morbidities (pre-existing chronic health conditions). This is already leading to visible signs of the lack of sufficient societal solidarity, even as hospitalizations affect a large — potentially, in places, overwhelmingly large — number of people of all ages. The treatment of hospitalized individuals is varied, complex and, in any case, demanding, posing a risk to health personnel. Lasting health damage (e.g., pulmonary, cardiac, vascular, renal and neurological damage) has been observed in a significant number of recovered patients, including conditions requiring lasting treatment (e.g., dialysis).

Even with full commitment to identify all possibly infected persons (and their contacts), to isolate as well as test them, and, if necessary, to treat them from as early on as possible, perfect outcomes may not be attained. Major non-pharmaceutical interventions may be required to reduce the number of contacts and the possibility of exposure in general society, to slow down and eventually halt community spread. These intervention measures carry potentially very high economic costs as well as disruptive effects to health care services that may become inaccessible as a result of the epidemic. The measures in question may carry

[6] More specific symptoms such as anosmia (loss of smell) do not consistently manifest in all cases.

major political costs, too, if they do not enjoy sufficient public support; with varying social costs if the measures encounter resistance and enforcement action follows.

What is necessary, as well as what is possible under such circumstances will thus differ from what is required in fighting a pathogen that can be effectively treated (e.g., bubonic plague, if identified); is insect-borne and thus differently transmitted (e.g., the mosquito-borne West Nile Virus); is more unlikely to be transmitted in the pre-symptomatic stage and renders patients largely immobile in the symptomatic stage (e.g., Ebola Virus); is overall difficult to transmit from person to person (e.g., anthrax); presents with more obvious signs, symptoms and prevalence patterns (e.g., cholera) or more specific symptoms (e.g., measles).

In the case of SARS-CoV-2, certain standards of expectation may nonetheless be set. At a minimum, countries are required to (1) coordinate their efforts with a view to commonly accepted goals, and, per consequence, to not undermine others' efforts at trying to contain the threat; (2) to provide assistance to each other to share the burden of the implications of the necessary interventions, e.g., the economic costs, and to globally coordinate and optimally allocate the availability of scarce goods, such as medications, medical equipment, or (prospectively) vaccines; (3) be transparent, and, per consequence, to not actively impede the public availability of epidemic data; (4) do what capacities and resources permit them to do in terms of testing, contact-tracing and isolating infected persons in their respective territory.

The failure to do any or all of the above gives rise to kill chains by resulting in in-bound and out-bound travellers' deficit of vigilance, destination country governments' deficit of preparedness, and shortages of key medications and medical equipment or the inadequate availability thereof in relation to dynamically shifting demand, as well as, overall, it elongates the reach of pandemic-related kill chains in space and time.

Unfortunately, in the context of the Covid-19 pandemic, a considerable number of countries have engaged, or are still engaging at the time of writing this article, in some or all of the bad practices implied above, i.e., demonstrating no interest in internationally coordinating steps against the pandemic, not providing assistance within their means to others in need, not being sufficiently transparent or actively seeking to hide information from the public, and/or not being interested in tracing case contacts and in testing all persons showing possible signs and symptoms of COVID-19 disease.

III. Rules of State Responsibility for the Failure to Prevent Pandemics

III.1. General Rules

Under public international law, States can be held responsible for their internationally wrongful acts. A State commits an internationally wrongful act when its action or inaction (omission) constitutes a breach of its international obligations (such as those which are included in the IHR) and if they can be attributed to that State. However, the responsibility of a State may only arise if there is an injury to another State and if one can establish a causal link between the internationally wrongful act and such an injury. The latter is understood as a requirement of a clear causal chain that is foreseeable by a State that is potentially responsible.[7]

Having said this, it also needs to be added that there might be circumstances that will preclude the wrongfulness of an act of a State. This may include grounds such as *force majeur*, state of necessity or distress.[8] For example, *force majeur* relates to material impossibility of performance of international obligations due to occurrence of an irresistible force or of an unforeseen event, beyond the control of the State. If responsibility is established, a State is required to make full reparation for the injury caused by its internationally wrongful act. These general rules of customary international law are codified and further elaborated in the draft Articles on Responsibility of States for Internationally Wrongful Acts (ARSIWA) prepared by the International Law Commission (ILC).[9] According to this document, an action or omission can be attributed to a State only when it is committed by a State organ (or when a person or entity is acting as an agent of the State and exercising elements of governmental authority). However, this notion also includes actions and omission of non-central public bodies that are only partially controlled by the government (e.g. local authorities).[10]

An injury as such is understood broadly as any damage, irrespectively of whether it is of material (e.g. economic or related to harm to the health of the relevant population) or moral character.[11] At the same time, there is no requirement to show a "fault" on the side of a State concerned (i.e. intention to harm other States). In addition, it should be bear in mind that lawfulness of the action or inaction under domestic law, does not affect the qualification of

[7] See James Crawford, *State Responsibility – The General Part* (Oxford University Press, 2013).
[8] For more detailed discussion see Federica Paddeu, Freya Jephcott, *COVID-19 and Defences in the Law of State Responsibility: Part I*, EJIL Talk!, (17 March 2020), https://www.ejiltalk.org/covid-19-and-defences-in-the-law-of-state-responsibility-part-i/ (accessed 18 October 2020).
[9] International Law Commission, *Responsibility of States for Internationally Wrongful Acts* (2001), draft annexed to General Assembly resolution 56/83 of 12 December 2001, and corrected by UN Doc. A/56/49(Vol. I)/Corr.4.
[10] Ibid., Art. 4.
[11] Ibid., Art. 31.

the act under international law.[12] Unfortunately, the ARSIWA does not explain how the responsibility is to be allocated in situation where there are multiple state actors responsible for wrongdoing.[13] Although the document prepared by the ILC has never been formally accepted by States as a binding instrument (e.g. in the form of an international convention), it is widely seen as a reflection of rules of customary international law that in principle is applicable to all States.[14] Its rules are also widely referred to by international courts, tribunals and quasi-judicial bodies.

III.2. State Responsibility under the WHO's IHR

The WHO is the United Nations' specialized agency responsible for international public health. Its decision-making body, the World Health Assembly (WHA), is entitled to adopt regulations concerning "sanitary and quarantine requirements and other procedures designed to prevent the international spread of disease".[15] These regulations do not require ratification but automatically enter into force and become binding on all Member States, except those that choose to formally opt-out. This approach is based on the realization that global health security requires both sound public health systems and a well-coordinated international network of information, surveillance, and response.[16]

The first such regulation was created in 1951, when the WHA adopted the International Sanitary Regulations (ISR) aiming "to ensure the maximum security against the international spread of disease with minimum interference with world traffic",[17] covering six diseases — cholera, plague, epidemic (louse-borne) typhus, relapsing fever, smallpox, and yellow fever — whose outbreak had to be reported to the WHO by the national authorities. The ISR had a limited scope as it only applied to the listed reportable diseases and only required minor commitments from member states of the World Health Organization as its most important

[12] Ibid., Art. 32.
[13] International Law Commission, *Report on the Work of Its Fifty-Third Session, Draft Articles on Responsibility of States for Internationally Wrongful Acts*, U.N. Doc. A/56/10, at 42–43 (2001), pp. 124–25.
[14] James R. Crawford, 'State Responsibility', in *Max Planck Encyclopedias of International Law* (2006), available at: https://opil.ouplaw.com/view/10.1093/law:epil/9780199231690/law-9780199231690-e1093 (accessed 18 October 2020).
[15] Art. 21 of the WHO Constitution.
[16] Lawrence O. Gostin, *Global Health Law* (Harvard University Press, 2014) p. 175.
[17] Fidler points out that "the development of international governance on infectious diseases… reflected the non-intervention principle of the Westphalian system. The regime's focus was on the management of state interactions – trade and travel – not on the public health conditions and problems that existed within the sovereign territories of states… This non-interventionary approach held even when governments knew that the trade frictions created by germs could be mitigated by reducing infectious disease problems before the pathogens spread to other countries." David Fidler, *SARS, Governance and the Globalization of Disease* (Palgrave MacMillan, 2004) pp. 29-30.

goal was to control pandemics "with minimum interference with world traffic". Even though in 1969 the ISR was renamed to International Health Regulations (IHR), its scope of application kept shrinking as the World Health Assembly first excluded louse-borne typhus and relapsing fever from its remit, then in 1981 the smallpox, in view of its global eradication. Eventually the IHR only applied to cholera, plague, and yellow fever.

The fragility of the regulation, however, was spectacularly revealed by two major outbreaks: in 2003, the appearance of the severe acute respiratory syndrome (SARS) in China, followed by a novel strain of pathogenic Influenza A (H5N1) in Thailand in 2004. In both cases, effective international cooperation was initially lacking as the national authorities did not report the emergence of these new viruses, enabling them to spread across borders. It became undeniable that the Regulations' framework was inefficient to handle the international spread of diseases.[18] Consequently, the international community decided to completely overhaul the IHR.

In 2005, the WHA adopted the revision of the IHR that included major modifications. Most importantly, Art. 2 stated that the IHR's purpose is "the protection of all people of the world from the international spread of disease", i.e. the Regulations became applicable to every disease that could pose an international risk, and States Parties have an obligation to immediately notify the WHO of unexpected or unusual public health events that seem serious enough to constitute a public health emergency of international concern (Arts. 6-7). Such public health events include anything that "(1) has a serious public health impact; (2) is unusual or unexpected; (3) might be internationally virulent; and (4) is likely to trigger a significant risk of international travel or trade restrictions".[19] Moreover, States Parties have the obligation to develop certain minimum core public health capacities[20] and establish National IHR Focal Points and WHO IHR Contact Points for urgent communications between States Parties and WHO (Art. 4). These obligations, however, are focusing on preparing for the outbreak of diseases instead of prevention.

Based on the available information, the Director-General of the WHO has to determine whether the event reported by a state constitutes a public health emergency of international

[18] David P. Fidler, Lawrence O. Gostin, 'The New International Health Regulations: An Historic Development for International Law and Public Health' (2006) 34(1) *The Journal of Law, Medicine & Ethics* p. 85.
[19] Anastasia Telesetsky, 'International Governance of Global Health Pandemics' (2020) 24(3) *ASIL Insights* p. 2. https://www.asil.org/insights/volume/24/issue/3/international-governance-global-health-pandemics (accessed 10 September 2020).
[20] The core capacity requirements for surveillance and response are set forth in Annex 1 of the International Health Regulations. These requirements, however, are predominantly procedural in nature, ensuring that the state is able to determine the existence of an outbreak. Still, A.4(c) calls for the immediate implementation of preliminary control measures in such situations.

concern (PHEIC) (Art. 12) and in such cases health measures must be initiated and completed without delay based on scientific principles and the available scientific evidence of risk to health (Art. 43). While states are under a legal obligation to implement appropriate health measures, these are ultimately decided by the states themselves. The Director-General can only issue non-binding, temporary recommendations (Art. 15) or even standing recommendations for the states to act in such situations (Art. 16). The WHO might recommend various measures including the implementation of quarantine or other health measures or denying entry to suspect or affected persons (Art. 18). While proclamations of PHEICs have been criticized in the past for being premature or unjustified and thus having grave economic and political consequences,[21] States might disregard these recommendations if they consider them too intrusive and the prevention of the international spread of disease can be achieved through other means. Yet, these different health measures should still "achieve the same or greater level of health protection than WHO recommendations" (Art. 43(a)). Coupled with the fact that the IHR only call for States to collaborate and assist each other "to the extent possible" (Art. 44) in reacting to serious public health events, and that it grants no enforcement powers to the WHO, it is easy to see that establishing state responsibility for the violation of the IHR is extremely difficult when the international community faces a novel public health threat, in the absence of scientific consensus considering the best ways to counter the spread of a hitherto unknown virus.[22]

III. 3. State Responsibility under Other Rules of International Law

Customary international law acknowledges that it is the duty of each state 'not to allow knowingly its territory to be used for acts contrary to the rights of other States'.[23] This means that states have to act with due diligence to try to prevent any significant transboundary harm originating from their territories. However, while this obligation of acting with due care is an objective standard, its application is inevitably context-dependent, as different countries have differing social and economic conditions that result in different available resources and

[21] José E. Alvarez, 'The WHO in the Age of Coronavirus' (2020) 114(4) *American Journal of International Law* p. 584.
[22] Indeed, the fact the IHR wants to ensure that international travel and trade remains as little affected by restrictions as possible could arguably contribute to the spread of pandemics.
[23] International Court of Justice, *Corfu Channel Case* (United Kingdom of Great Britain and Northern Ireland v. Albania), 9 April 1949, ICJ Reports 1949, p. 22. See also the Pulp Mills case, where the Court held that "a State is thus obliged to use all the means at its disposal in order to avoid activities which take place in its territory, or in any area under its jurisdiction, causing significant damage". International Court of Justice, Pulp Mills on the River Uruguay (Argentina v. Uruguay), 20 April 2010, ICJ Reports 2010, para. 101.

opportunities to act.[24] Moreover, states are not obligated to absolutely prevent the harm but to attempt to do so, or to exert their 'best possible efforts to minimize the risk'.[25]

Beyond the general no-harm principle, specific branches of public international law create particular obligations. The right to life enshrined in Art. 6 of the International Covenant on Civil and Political Rights[26] necessarily requires States to adopt positive measures 'to address the general conditions in society that may give rise to direct threats to life or prevent individuals from enjoying their right to life with dignity', including life-threatening diseases.[27] Similarly, Art. 12 of the International Covenant on Economic, Social and Cultural Rights,[28] protecting the right to health, obligates States parties to take steps for the 'prevention, treatment and control of epidemic, endemic, occupational and other diseases' and create conditions to assure 'medical service and medical attention in the event of sickness'.[29] The Committee on Economic, Social and Cultural Rights emphasized that this obligation includes 'the creation of a system of urgent medical care in cases of accidents, epidemics and similar health hazards, and the provision of disaster relief and humanitarian assistance in emergency situations' and 'States' individual and joint efforts to, *inter alia*, make available relevant technologies, using and improving epidemiological surveillance and data collection on a disaggregated basis, the implementation or enhancement of immunization programmes and other strategies of infectious disease control'.[30] In the context of the Covid-19 pandemic, the Committee even pointed out that "States have extraterritorial obligations related to global efforts to combat COVID-19."[31]

Leaving aside the problem of the enforcement of the above identified international rules, all those standards have important legal limitations (e.g. in terms of their scope or

[24] Joanna Kulesza, *Due Diligence in International Law* (Brill Nijhoff, 2016) p. 263.
[25] International Law Commission, Draft Articles on Prevention of Transboundary Harm from Hazardous Activities, with Commentaries (2001) *Yearbook of the International Law Commission, Vol. II.* p. 154. It might be argued that this principle derives from the principle of sovereign equality of states. See Jutta Brunnée, 'Sic Utere Tuo Ut Alienum Non Laedas', in *Max Planck Encyclopaedias of Public International Law* (2010), para. 8. https://opil.ouplaw.com/view/10.1093/law:epil/9780199231690/law-9780199231690-e1607 (accessed 19 October 2020).
[26] UN General Assembly, *International Covenant on Civil and Political Rights*, 16 December 1966, United Nations, Treaty Series, vol. 999, p. 171.
[27] Human Rights Committee, *General Comment No. 36: Article 6 – Right to Life*, UN Doc. CCPR/C/GC/36. para. 26.
[28] UN General Assembly, *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, United Nations, Treaty Series, vol. 993, p. 3.
[29] The WHO Constitution also explicitly acknowledges the right to health in its Preamble, providing that "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."
[30] Committee on Economic, Social and Cultural Rights, *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Article 12)*, UN Doc. E/C.12/2000/4. para. 16.
[31] Committee on Economic, Social and Cultural Rights, *Statement on the Coronavirus Disease (COVID-19) Pandemic and Economic, Social and Cultural Rights*, UN Doc. E/C.12/2020/1 para. 20.

applicable thresholds), making it difficult to hold States responsible for the outbreak and spread of the virus. In this context, it should also be noted that international state responsibility can only be determined at the international level, either in the course of the proceeding in the International Court of Justice (e.g. on the basis of Art. 75 of the WHO Constitution),[32] or at some other international court that enjoys jurisdiction, initiated by states that have suffered injury. Such determination is not possible in front of national courts of an injured country, as states enjoy immunity pursuant to the general principle of international law of '*par in parem non habet jurisdictionem*'[33].

IV. Conclusion

An international pandemic is supposed to be the *par excellence* example of a situation warranting global cooperation, and each country should act swiftly and effectively to prevent the further spread of the virus as it can cause harm to health in other countries' populations as well. However, as explained in Section III, establishing state responsibility under the general and special rules of international law is extremely difficult as the reaction to a novel health hazard in the absence of scientific consensus regarding the best way to suppress the virus inevitably leads to different strategies adopted by different countries. Indeed, even the WHO has changed its recommendations concerning the wearing of face masks by healthy

[32] Article 75 provides: "Any question or dispute concerning the interpretation or application of this Constitution which is not settled by negotiation or by the Health Assembly shall be referred to the International Court of Justice …." On the possibility to use this avenue to bring the PRC to the International Court of Justice see Peter Tzeng, 'Taking China to the International Court of Justice over Covid-19', *EJIL-TALK!* (4 February 2020), https://www.ejiltalk.org/taking-china-to-the-international-court-of-justice-over-covid-19/ (accessed 20 October 2020).

[33] 'Equals have no sovereignty over each other'. See e.g. International Court of Justice, *Jurisdictional Immunities of the State (Germany v. Italy: Greece intervening)*, 3 February 2012, ICJ Reports 2012, p. 99. However, the Attorney General of the US state of Missouri filed a lawsuit on 21 April 2020 against various Chinese agencies to recover ""the enormous loss of life, human suffering, and economic turmoil experienced by all Missourians from the COVID-19 pandemic that has disrupted the entire world." See *The State of Missouri v. The People's Republic of China, The Communist Party of China, National Health Commission of The People's Republic of China, Ministry of Emergency Management of The People's Republic of China, Ministry of Civil Affairs of The People's Republic of China, People's Government of Hubei Province, People's Government of Wuhan City, Wuhan Institute of Virology, and Chinese Academy of Sciences*, (United States District Court for the Eastern District of Missouri Southeastern Division). https://ago.mo.gov/docs/default-source/press-releases/2019/prc-complaint.pdf?sfvrsn=86ae7ab_2 (accessed 19 October 2020). See further Chimène I. Keitner, 'To Litigate a Pandemic: Cases in the United States Against China and the Chinese Communist Party and Foreign Sovereign Immunities' (2020) 19(2) *Chinese Journal of International Law* pp. 229-236.

individuals between April and June 2020.[34] The same is true for its travel advice for the Wuhan region.[35]

In the context of the Covid-19 pandemic, most discussions concerned the responsibility of the PRC, but the responsibility of other States for different actions or inactions, taken during the pandemic, cannot be excluded either (e.g. when countries have not implemented required restrictions or have not done this in a timely manner leading to the spread of the disease outside their territory). As far as the PRC is concerned, one may think about various alleged failures of that country in handling the pandemic in its early phase. In this context, it is submitted that China tolerated for years the functioning of so-called wet markets — with very poor or no supervision even though the SARS outbreak was already linked to them[36] — as well as that it initially suppressed the information about the outbreak of the new disease,[37] did not undertake necessary actions to contain it, did not immediately disclose the information about possible human-to-human transmission of SARS-CoV-2, and delayed reporting the outbreak to the WHO. For some time, China was also reluctant to admit the official field mission of the organization to the city of Wuhan. There also researchers who claim, on the basis of indirect evidence, that information about the number of infections was suppressed also at the later stages of the local epidemic (from February to March 2020), thereby creating a false picture of the severity of the Covid-19 outbreak.[38] The proponents of this narrative argue that all these mismanagements have contributed to a wider spread of the disease, not only in the territory of China but also beyond its borders, eventually leading to the current global pandemic.

Applying the relevant rules of international law to the actions taken by the PRC in the context of the Covid-19 pandemic, in order to establish its international responsibility, is not

[34] World Health Organization, *Advice on the Use of Masks in the Context of COVID-19: Interim Guidance, 6 April 2020.*; *Advice on the Use of Masks in the Context of COVID-19: Interim Guidance, 5 June 2020* (accessed 18 October 2020).
[35] World Health Organization, *Advice for International Travel and Trade in Relation to the Outbreak of Pneumonia Caused by a New Coronavirus in China*, 10 January 2020, https://www.who.int/news-room/articles-detail/who-advice-for-international-travel-and-trade-in-relation-to-the-outbreak-of-pneumonia-caused-by-a-new-coronavirus-in-china (accessed 18 October 2020).
[36] Robert G. Webster, 'Wet Markets—A Continuing Source of Severe Acute Respiratory Syndrome and Influenza?' *Lancet* (17 January 2004) 363(9404) pp. 234–236.
[37] H Davidson, 'Chinese Inquiry Exonerates Coronavirus Whistleblower Doctor' *The Guardian* (20 March 2020) <https://www.theguardian.com/world/2020/mar/20/chinese-inquiry-exonerates-coronavirus-whistleblower-doctor-li-wenliang> (accessed 18 October 2020).
[38] Mai He, Li Li, Louis P Dehner, Lucia Dunn, 'Cremation Based Estimates Suggest Significant Under- and Delayed Reporting of COVID-19 Epidemic Data in Wuhan and China', *medRxiv* 2020.05.28.20116012; doi: https://doi.org/10.1101/2020.05.28.20116012 (accessed 18 October 2020).

an easy task.[39] The first problem concerns determination of the pertinent facts, many of which still remain obscure and might never be ascertained (e.g. as to the origin of the virus). Second, it may be also difficult to establish a causal relationship between the specific injury (e.g. loss of lives or economic damage) and the mishandling of the health crisis by a specific country.[40] In this context, it should be noted that most of the developed countries affected by the virus stayed idle even after it became clear that SARS-CoV-2 is easily transmissible between humans (and after numerous warnings issued by the WHO). Therefore, it is unclear whether the injury should be deemed a result of their (in)actions or if it can be attributed to other countries, such as the PRC. Third, one has to also identify specific applicable international legal obligations that have been potentially violated. The most relevant legal framework that should be looked at is provided in the revised IHR. In this context, particularly important are provisions of Arts. 6-7, which call for immediate notification of the WHO in case of an event that seems serious enough to constitute a public health emergency of international concern. Still, as seen above, the IHR does not clarify the substantive content of States' obligations, which makes the determination of their responsibility very difficult beyond the potential breach of this procedural obligation.

[39] Those difficulties predate the Covid-19 pandemic, see Matiangai Sirleaf, 'Responsibility for Epidemics' (2018-2019) 97(2) *Texas Law Review* pp. 285-351.
[40] David P. Fidler, 'COVID-19 and International Law: Must China Compensate Countries for the Damage?' *Just Security* (27 March 2020) https://www.justsecurity.org/69394/covid-19-and-international-law-must-china-compensate-countries-for-the-damage-international-health-regulations/ (accessed 22 October 2020).

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