

The WHO's Mixed Human Rights Messages

*José E. Alvarez**

1 Introduction

The WHO has portrayed itself – and has been seen as – a human rights organisation. It repeatedly affirms that the right to health, affirmed in its Constitution, is the multi-faceted legal obligation that human rights bodies, including the International Covenant on Economic, Social and Cultural Rights (ICESCR) Committee, say it is. It claims that human rights provide the crucial architecture for its endeavors and that it “mainstreams” human rights throughout its operations. Closer examination reveals, however, that the WHO is not a reliable ally in implementing either human rights or specifically the right to health. The WHO does not treat the right to health or health care as imposing the legal obligations on either its member States or on itself that it formally endorses. The WHO's operational response to COVID and other contemporary pandemics reveals a gap – indeed a chasm – between the organisation's human rights rhetoric and its actions.

This essay first describes the gaps between the WHO's affirmations in favor of human rights, including the human right to health, and its legal instrument for handling international public health emergencies: the International Health Regulations (IHR). Second, it illustrates some of the consequences of the Organization's failures to follow through on its human rights rhetoric during the current pandemic. Third, it questions whether these failings are being taken seriously by those seeking to reform the Organization or the global health regime and canvasses why many remain opposed to a change in the WHO's human rights posture. It concludes by outlining five general reasons for believing that the WHO would do better at preventing and mitigating pandemics if it embraced more fully and genuinely a human rights framework.

2 The Human Rights Rhetoric of the WHO

The WHO's rhetoric is consistent with its founding document, the first treaty to proclaim a fundamental and non-discriminatory right to health and health

* Herbert and Rose Rubin Professor of International Law at New York University School of Law.

care.¹ The WHO's Constitution – described by some of its earliest promoters as the “Magna Carta for world health”² – established an organisation that has reportedly “mainstreamed” human rights concepts and thinking throughout its operations. Its World Health Assembly, which proclaimed the ‘right to health as a fundamental human right’ and identified ‘the health aspect of human rights’ to be within the competence of the organisation, had, as of 2017, reaffirmed these commitments in over 60 subsequent resolutions ‘that address human rights on a variety of WHO programs, including health development, women’s health, reproductive health, child and adolescent health, nutrition, HIV/AIDS, tobacco, violence, mental health, essential medicines, indigenous peoples’ health, and emergencies’.³ The WHO’s establishment, in 2012, of a ‘gender, equity and rights team’ bureaucratized the organisation’s commitment to human rights mainstreaming.⁴ Strengthening that unit, argued Tedros Ghebreyesus during his successful campaign to become the WHO’s current Director-General, was essential to the Organization’s reform efforts to ensure that core principles of health as a human right ‘was engrained into the mindset and attitudes of [WHO] staff (...) to make sure that WHO staff take this core value of the organisation to heart and truly believe in it’.⁵ In a pre-election interview, Ghebreyesus drew from his experience as Ethiopia’s former health minister the lesson that denial of equitable health access was a ‘violation of the human right to health’ demanding ‘urgent action’.⁶ He argued that the WHO must ‘put the right to health at the core of its functions, and be the global vanguard to champion them’.⁷ He also pledged that if elected he would make sure that human rights would be ‘the responsibility of each and every unit’ of the organisation.⁸

1 See WHO Constitution, preamble (1948), affirming as one of its basic principles that ‘[t]he 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’.

2 See Lawrence O. Gostin, *Global Health Law* (Harvard University Press 2014) 91, quoting Thomas Parran and Frank G. Boudreau.

3 Benjamin Mason Meier, ‘Human rights in the World Health Organization: Views of the Director-General Candidates’ (2017) 19 *Health and Human Rights Journal*, 293.

4 See the WHO’s description of its ‘Gender, Equity, and Human Rights Team’ at <<https://www.who.int/teams/gender-equity-and-human-rights>>, last accessed (as any subsequent URL) on 7 July 2022.

5 Meier (n 3) 295 (quoting Ghebreyesus).

6 *Ibid.*, 294.

7 *Ibid.*, 293.

8 *Ibid.*, 295.

The WHO's website, like its Director-General, emphasizes the singular importance of human rights – and not only the right to health – to its mission. Visitors to that website searching for 'human rights' are directed to the right to health in the WHO's Constitution, along with the contemporaneous affirmation of that right in the Universal Declaration of Human Rights of 1948.⁹ They are reminded that the right to health is an 'inclusive' right that requires proactive actions by governments to protect other human rights, including to enable access to potable water, sanitation, adequate food, nutrition and housing, healthy occupational and environmental conditions, and health-related education and information.¹⁰ The WHO affirms that it works with members and others to 'support the realization of the right to health through technical assistance, normative guidance and support'.¹¹ In support, readers of the website are directed to the WHO's 13th General Programme of Work (2019–2025) which seeks to advance Sustainable Development Goal 3 through 'mainstreaming human rights, gender and health equity' throughout all organisational policies and programs.¹² The WHO claims adherence to human rights standards that develop the capacity of "duty-bearers" to meet obligations owed to "rights-holders" derived from UN human rights mechanisms, including human rights treaty bodies and the Universal Periodic Review.¹³

There is no daylight between the WHO's and the ICESCR Committee's descriptions of the right to health. Consider the Fact Sheet on the right to health that the WHO has co-authored with the Office of the United Nations High Commissioner for Human Rights (OHCHR).¹⁴ That description effectively reaffirms the contents of the ICESCR Committee's oft-cited General Comment No. 14.¹⁵ Like the ICESCR, the WHO accepts that the right to health embraces not only "freedoms" in the form of constraints on State actors (banning, for

9 See <https://www.who.int/health-topics/human-rights#tab=tab_1>.

10 *Ibid.*

11 See <https://www.who.int/health-topics/human-rights#tab=tab_3>.

12 *Ibid.*

13 See <https://www.who.int/health-topics/human-rights#tab=tab_2>.

14 OHCHR and WHO, 'The Right to Health', Fact Sheet No. 31 (June 2008), at <<https://www.ohchr.org/en/publications/fact-sheets/fact-sheet-no-31-right-health#:~:text=The%20Fact%20Sheet%20explains%20what,international%20accountability%20and%20monitoring%20mechanisms>> (henceforth 'Fact Sheet'). Like the WHO's website, this Fact Sheet identifies the WHO as one of the UN bodies paying increasing attention to this right, alongside human rights treaty-monitoring bodies, the Human Rights Council, and the Special Rapporteur on the right of everyone to the highest attainable standard of physical and mental health. *Ibid.*, 1.

15 ICESCR, 'General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art 12)' (11 August 2000) UN Doc E/C.12/2000/4 (henceforth "ICESCR General Comment").

example, non-consensual medical treatment) but also “entitlements” to government action (such as timely, equal access to systems of health protection, prevention, treatment, and control of diseases and essential medicines, the provision of health-related education and information, and participation in health-related decision-making).¹⁶ Drawing from myriad human rights treaties as well as the WHO's Constitution,¹⁷ the WHO affirms, as does General Comment No. 14, that non-discrimination is ‘a key principle (...) crucial to the enjoyment of the right’.¹⁸ Its description of the right to health adopts the ICESCR's ‘respect, protect, and fulfil’ framework.¹⁹ Like the ICESCR Committee, the WHO affirms that States are required to take specific legislative and other steps without delay to ensure to all within their jurisdiction and without discrimination, a ‘minimum level of access to the essential material components’ of that right.²⁰

16 Fact Sheet (n 14) 3–4.

17 See, e.g., Fact Sheet (n 14) Annex, 41. See also ICESCR General Comment (n 15) paras. 18–27 (elaborating on states' obligations of non-discrimination and equal treatment in the ICESCR, arts. 2.2 and 3, and describing that obligation as extending to any action that ‘has the *intention* or the *effect* of discriminating on the grounds of race, color, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status, sexual orientation or civil, political, social or other status’ (emphasis added)).

18 Fact Sheet (n 14) 4 and 7–8 (noting that discrimination is linked to the marginalization of specific groups, is at the root of ‘structural inequalities in society’ and explaining that marginalized groups ‘often bear a disproportionate share of health problems’). The Fact Sheet notes that the demands of equal treatment means that states must ‘ensure equality’ and provide for the specific needs of groups that have ‘higher mortality rates or vulnerability to specific diseases’, *Ibid.*, 7; see also 11–22 (detailing the specific treaty obligations owed to specific groups including women, children, and migrants). ‘[T]here is no justification’ according to this statement, ‘for the lack of protection of vulnerable members of society from health-related discrimination, be it in law or in fact’. *Ibid.*, 8. Apart from listing of relevant treaties recognizing the right to health, the Fact Sheet identifies other prominent international instruments and forums that embrace the right to health as a human right. *Ibid.*, Annex. The Fact Sheet also acknowledges that the general comments or recommendations issued under the relevant human rights treaty bodies, such as ICESCR General Comment No. 14, are an ‘authoritative’ interpretation of the underlying treaty obligations. *Ibid.*, 10.

19 Compare ICESCR General Comment (n 15) paras. 30–37, to Fact Sheet (n 14) 25–28. Consistent with the ICESCR Committee's interpretation that states' obligations to protect include duties to ‘ensure that the privatization of the health sector’ does not undermine the availability, accessibility, acceptability, and quality of health facilities, goods and services, ICESCR General Comment, para. 35, the Fact Sheet affirms that the duty to protect ‘requires States to prevent third parties from interfering with the right to health’. Fact Sheet, 26.

20 Fact Sheet (n 14) 5; see also ICESCR General Comment (n 15) para. 30. Like the ICESCR Committee, the WHO affirms that essential care and services must be as ‘available,

The WHO accepts that the right to health is ‘interdependent, indivisible and interrelated’ with other human rights since it contributes to and may be essential to fulfilling basic rights to food, water, an adequate standard of living and housing.²¹ Its co-authored description of the right to health also proclaims that states owe extraterritorial obligations to assist others to attain the right to health.²²

On occasion, the WHO has followed through on its touted commitment to human rights by using them to criticize discrete actions by WHO members. Its Report on ‘Ending Hospital Detention for Non-Payment of Bills’, for example, describes the practice of detaining patients at hospitals or other medical facilities to seek payment of medical care as a violation of numerous human rights treaties, including the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights (ICCPR), and the ICESCR.²³ That Report criticizes such domestic laws on the grounds that they insufficiently implement relevant human rights obligations and highlights the “knowledge gaps” that explain why such practices persist.²⁴ As this indicates, when it wants to be, the WHO Secretariat can be quite specific about the civil and political legal obligations owed by states under the ICCPR as well as what the right to health entails under the ICESCR. It is capable of calling out human rights violations when it sees them.²⁵

accessible, acceptable and of good quality’ as its possible within a state’s resources. Compare Fact Sheet, 4 and 25 to ICESCR General Comment (n 15) paras. 43–44.

21 Fact Sheet (n 14) 6.

22 Compare ICESCR General Comment (n 15) paras. 38–42 and 45 to Fact Sheet (n 14) 22–25 (discussing the ‘obligations on states and responsibilities of others’ and affirming that states ‘in a position to assist’ others must do so). The Fact Sheet states that the role of international assistance and cooperation comes into play ‘if a State is unable to give effect to economic, social and cultural rights on its own, and requires assistance from other States to do so’. Fact Sheet (n 14) 23. For an attempt to explicate the full dimensions of states’ extraterritorial or global obligations to respect, protect, and fulfill the right to health, see, e.g., Benjamin Mason Meier, Judith Bueno de Mesquita and Caitlin R. Williams, ‘Global Obligations to Ensure the Right to Health: Strengthening Global Health Governance to Realise Human Rights in Global Health’ (2021) 3 *Yearbook of International Disaster Law*, 3 ff.

23 WHO, ‘Ending Hospital Detention for Non-Payment of Bills: Legal and Health Financing Policy Options’ (2020) 4–6.

24 *Ibid.*, 5–6, where the report explains that ‘[s]ome health care providers are not fully aware of their legal obligations and seem not to know that hospital detention is illegal’.

25 Compare Philip Alston’s critique of the human rights rhetoric of the World Bank to its operational activities in ‘The World Bank as a Human Rights-Free Zone’ (Intersentia) published on line by CUP on 13 April 2019, <<https://www.cambridge.org/core/books/doing-peace-the-rights-way/world-bank-as-a-human-rights-free-zone/D016DCD96DB065B7E86B2ED6B49C6725>>. Notably, the WHO does not face a Constitutional

The WHO has portrayed its responses to Public Health Emergencies of International Concern (PHEICs), including its response to the COVID pandemic, as fully in line with its commitment to focus on, and mainstream, human rights. Indeed, early in the COVID crisis, the WHO released a prescient statement 'Addressing Human Rights as Key to the COVID-19 Response'.²⁶ That document reiterates the WHO's constitutional commitment to health as a human right, affirms that human rights frameworks provide a 'crucial structure' that can strengthen national and international responses to pandemics, and describes the integration of human rights protections as essential to responding to public health concerns.²⁷ That statement also enumerates seven concerns emerging from States' early responses to COVID: the risks of stigmatization of and discrimination against certain communities and groups; failures to address the ways stay at home and other measures were adversely affecting women and children; adverse health consequences on other vulnerable populations such as persons with disabilities, the homeless, refugees, migrants and prisoners; disproportionate or illegitimate quarantines and other restrictive measures; shortages in or misdirection of supplies, goods or equipment (from masks to testing kits); and failures to address obligations of international assistance and cooperation.²⁸ This statement shows that the Organization accepts, at least in principle, that governments have duties to protect the human rights of their own nationals as well as others present in their territory.

The Organization's latest COVID-19 Strategic Preparedness and Response Plan, seeking to draw lessons from the mishandling of prior pandemics and covering the period from 1 February 2021 through 31 January 2022, also refers to human rights.²⁹ It indicates that the Organization needs to 'ensure a gender-responsive and equitable response based on a respect for human rights';³⁰ acknowledges that government COVID responses have been accompanied by adverse human rights consequences, such as a 'steep rise in the incidence of gender-based violence';³¹ and highlights concerns generated by what it calls a "me first" approach to vaccination.³² The Strategy Plan recommends that

"political prohibition" that Bank lawyers have sometimes deployed to fence off human rights. *Ibid.*, 377–81.

26 WHO, 'Addressing Human Rights as Key to the COVID-19 Response' (21 April 2020).

27 *Ibid.*, 1.

28 *Ibid.*

29 WHO, 'COVID-19 Strategic Preparedness and Response Plan' – 1 February 2021 to 31 January 2022, Foreword from the Director-General, at vi.

30 *Ibid.*, 'About this Document', at viii.

31 *Ibid.*, 2.

32 *Ibid.*, 7.

'all countries conduct a substantive, gender, equity and inclusion analysis, in line with existing human rights frameworks'.³³ This would be, it contends, consistent with the WHO's commitment to 'gender equality, health equity and human rights' and mainstream such concerns throughout its 'operations from the outset' through impact assessment and reporting.³⁴

Many observers have been persuaded by the WHO's oft-expressed affirmations that it is a human rights organisation.³⁵ For some, an important point of evidence are the IHR as revised in 2005. Those revisions, undertaken in light of concerns over States' responses to prior transnational health threats such as SARS, have been praised for being "embedded" in other international legal regimes, particularly human rights.³⁶ The various provisions in the 2005 IHR that refer to human rights may help to explain why then UN Secretary-General Annan described those regulations as an important step in moving humanity towards 'larger freedom'.³⁷

Cracks in the WHO's human rights edifice begin to appear, however, if one examines those ostensibly "human rights friendly" IHR. The IHR begin promisingly by purporting to require States to respond to public health emergencies 'with full respect for the dignity, human rights and fundamental freedoms of persons'.³⁸ But this promise, in an instrument that fails to even mention the right to health or the various components of that right as affirmed by the ICESCR's General Comment No. 14, is undermined by the rest of the IHR. What

33 *Ibid.*, 12.

34 *Ibid.*, 12–13. A pillar in the WHO's Plan focuses on improving surveillance, epidemiological investigation, and other data gathering since, it notes, data stratified along different criteria (such as gender and other demographic factors) are central to a "Human Rights Based Approach to Data", *Ibid.*, 14.

35 See, e.g., Meier (n 3) 293, affirming that the WHO 'has long worked to address human rights as part of its organizational efforts' and noting that the WHO has adhered to UN Secretary-General demands that human rights be 'incorporated into decision-making and discussion' through the UN system through commitments made by its World Health Assembly and Executive Board to adhering to a 'rights-based approach to health'.

36 See, e.g., Gian Luca Burci and Mark Eccleston-Turner, 'Preparing for the Next Pandemic: the International Health Regulations and World Health Organization during COVID-19' (2020) 2 *Yearbook of International Disaster Law*, 261, 266 ('human rights are strongly and directly embedded in the 2005 iteration of the Regulations'). See also David P. Fidler and Lawrence O. Gostin, 'The New International Health Regulations: An Historic Development for International Law and Public Health' (2006) 34 *Journal of Law Medicines and Ethics*, 85; Bruce Plotkin, 'Human Rights and Other Provisions in the Revised International Health Regulations (2005)' (2007) 121 *Public Health*, 840.

37 See Report of the UN Secretary-General, 'In Larger Freedom: Towards Development, Security and Human Rights for All' (21 March 2005) UN Doc A/59/2005.

38 IHR, art. 3(1).

the specific human rights articles of the IHR actually recognize, often weakly and imprecisely and, given what has happened over two years during the COVID pandemic, ineffectually, are only some of the “constraints” on States imposed under, for example, Article 4 of the ICCPR.³⁹ The IHR's Articles 3.1, 23.2, 23.3, 23.4, 23.5, 31.1, 31.2, 32, 42, 43, 45.1, 45.2, and 45.3 recognize some human rights “limits” on what governments can do in response to global health threats. These provisions authorise States to apply only certain measures with respect to travelers and permit additional medical examinations only if these are ‘the least intrusive and invasive’ (art. 23.2); require ‘prior expressed consent’ from travelers with respect to medical examination, vaccination, prophylaxis or other health measures (art. 23.3), require travelers to be informed of any risks associated with vaccinations or prophylaxis (art. 23.4), and require States to apply additional health measures ‘in accordance with established national or international safety guidelines or standards’ (art. 23.5). The IHR's Articles 31 and 32 impose additional limits on health measures directed at travelers. Article 42 generally requires States to apply health measures without delay and ‘in a transparent and non-discriminatory manner’. Article 45 imposes certain restrictions on States with respect to the personal data they collect or receive, including to protect individuals’ privacy.

The most famous limit on State action contained in the IHR, Article 43, permits States to implement health measures in response to public health risks or public health emergencies of international concern that are not authorised by the WHO but only if these achieve the same or greater level of health protection than WHO recommendations, are backed by scientific principles, and are not more restrictive of international traffic. That provision also intriguingly suggests that it ‘does not preclude’ States from taking these additional non-WHO approved health measures ‘in accordance with their relevant national law and obligations under international law’.⁴⁰ The oblique inference – that States can only take health measures that are in accord with, for example, their human rights obligations – is one of the only places in the IHR that might be read as

39 Under the ICCPR's art. 4 states can derogate only from some of the human rights obligations imposed under that treaty in time of public emergencies and only to the extent ‘strictly required’ by the exigencies of the situation. Art. 4 bars discrimination on the basis of race, color, sex, language, religion or social origin and does not permit states to subject persons, even during emergencies, to ‘cruel, inhuman or degrading treatment’. These specific limits on governments’ actions even during medical emergencies under human rights law are not explicitly mentioned in the IHR.

40 See also IHR, art. 57 (recognizing that IHR should be interpreted as being compatible with the rights and obligations of states under other international agreements). But notably, art. 57.2, which enumerates certain interests that states have in common that should remain protected notwithstanding the IHR, does not mention human rights regimes.

an acknowledgement that governments must strictly limit their actions even during a medical emergency in order to respect the rights of their own populations (and not only foreign travelers).

While the IHR's selective limits on prophylactic actions are a welcome advance on the prior IHR, these regulations do not clearly affirm the civil and political rights owed to all persons within a State's jurisdiction or the multifaceted right to health that the WHO, along with the ICESCR's Committee, has otherwise endorsed. The IHR recognize that WHO members are, at least with respect to travelers, "duty-bearers", but they do not explicitly acknowledge that States also owe duties of positive action on behalf of "rights-holders" designed to protect all persons' rights to privacy, due process, or health care.⁴¹ The IHR are not a vehicle to implement the manifold 'respect, protect, and fulfill' obligations imposed under the right to health.⁴² And when the IHR do manage to mention some component aspects of the right to health as affirmed by both the WHO and General Comment No. 14, such as the requirement for transparency, they fall far short of what international human rights law demands. The IHR's vague demand that States make their health measures 'transparent' and apply them without discrimination is a far cry from the precise human rights obligations imposed under relevant law as articulated by the WHO itself. The brief reference to a right to information falls far short of enumerating the various entitlements at issue – including to timely access to essential medicines, basic health services, all forms of health-related education and information, and to broad participation to health-related decision-making.⁴³ Nor do the IHR say anything about the broad scope of the obligation not to discriminate, including its application to both *de facto* and *de jure* actions or States' duties to "ensure equality" by taking proactive actions to rectify predictably adverse health consequences resulting from structural racism.⁴⁴

The IHR make no mention of States' duties to ensure a core minimum level of access to health care.⁴⁵ This is surprising for a set of rules intent on enhancing the capacity of States to identify in a timely manner health threats that pose a risk of transnational transmission and requiring States to satisfy

41 See (n 13). The IHR affirm only certain freedoms from government constraint (such as freedom from certain invasive medical procedures) but make no mention of entitlements under the ICCPR, the ICESCR, or customary law – as to timely access to medical attention or medicines. See (n 16 and n 20).

42 See (n 19).

43 See (n 16).

44 See (n 17 and 18).

45 See (n 20).

'core capacity requirements' to make this possible.⁴⁶ Indeed, the revised IHR received considerable praise for departing from centuries of interstate efforts that focused solely on limits on State measures 'at the border', namely at ports and airports. Annex 1 of the IHR famously extends the WHO's scrutiny to a State's internal health care system and its capacity to keep track of internal outbreaks of disease with potential to spread abroad. And yet, that Annex's 'core capacity requirements for surveillance and response' exist in a normative vacuum – as if the capacity of States to satisfy these capacities have nothing to do with State obligations, under the right to health, to ensure minimal access to health care. The IHR do not acknowledge, much less impose as part of WHO members' responsibilities, duties on States to diminish infant/child mortality, provide medical assistance, especially primary health care, take positive measure to combat diseases and malnutrition, ensure occupational health and safety and address environmental threats to health, provide pre-natal and post-natal health care, raise awareness and ensure access to accurate health information, and develop preventive health care.⁴⁷ The IHR do not recognize that States that fail to satisfy these duties – essential to satisfying minimum standards of the right to health for their populations – will hardly be in a position to satisfy the 'core capacity requirements' needed to notify others of potential health risks.

That the IHR, the most significant legal instrument adopted by the WHO (outside the Tobacco Control Treaty) fail so utterly in advancing the WHO's goal of adopting a human rights framework as a "crucial" underpinning for protecting global health speaks volumes about the WHO's lack of genuine interest in (or perhaps aversion to) human rights.⁴⁸

Quite apart from the IHR's human rights gaps, there is little to suggest that the WHO's actions in response to COVID reflect a genuine effort to "mainstream" human rights. The WHO's own distillation of the human rights challenges posed by COVID in its April 2020 Report has not generated the all-the-organisation exertions one would expect from such challenges.⁴⁹ Moreover, the WHO's latest COVID Strategic Plan, like the IHR, wastes a valuable opportunity to address the relevant human rights obligations that States (and arguably the organisation) have. It is not the robust endorsement of a human rights framework for dealing

46 See IHR, Annexes 1 and 2.

47 Compare, e.g., John Tobin, *The Right to Health in International Law* (OUP 2011). For a particular example of an attempt at international judicial enforcement of components of the right to health, see Inter-American Court of Human Rights, *Cuscul Piraval et al v Guatemala* (23 August 2018).

48 See (n 27).

49 See (n 26).

with the ongoing pandemic that one would expect from the WHO's rhetoric. Rather than using the language of obligation, that Plan, in common with the WHO's general statements during the pandemic, suggests that States have only a "moral" or "ethical" obligation to invest in essential health care, cooperate with others to avoid a "me-first" approach that leads to vaccine nationalism, or adopt human rights sensitive policies (including with respect to data collection). Even the Strategic Plan's posture on risk mitigation measures directed at travelers at points of entry fails to mention the IHR legal obligations directly on point.⁵⁰ While the WHO's April 2020 Report, in common with virtually all reports on the key failings evident during the COVID pandemic, identifies the continuing challenge that States fail to respect their 'obligations of international assistance and cooperation',⁵¹ its latest Strategic Plan does not clarify what those "obligations" actually are or the ways the seven COVID challenges that the WHO identified back in April 2020 might be amenable to a human rights frame for addressing them.⁵²

The Strategic Plan mentions in passing that its widely praised initiative to effectuate global solidarity, COVAX, needs to 'tak[e] into account gender, human rights, and equity considerations'.⁵³ This vague injunction does not mention that under interpretations of the ICESCR that the WHO itself has suggested are "authoritative",⁵⁴ States in a position to lend assistance to others are under a legal (and not merely a "moral") obligation to do so. The absence of global cooperation and solidarity is not just, as the WHO suggests here and elsewhere 'strategically and economically self-defeating'.⁵⁵ The possibility that vaccine nationalism may violate international law's efforts to impose

50 'Strategic Plan', at 14.

51 See (n 26) at 3. The WHO is not alone in resisting a human rights frame of analysis for examining the challenges of COVID-19. The two leading policy frames for diagnosing the challenges of COVID for the global health regime embrace either a "security" or a "solidarity" frame. See Jennifer M. Welsh, 'International Cooperation Failures in the Face of the COVID-19 Pandemic' at viii, 10–11 (2022) (American Academy of Arts & Sciences). Welsh emphasises the latter, describing a reversion during COVID to a 'more traditional, state-centric model' characterized by short-sighted 'beggar-thy-neighbor' sovereign strategies, *Ibid.*, at vii–viii, 6. A report for the US-based Council on Foreign Relations, on the other hand, seems closer to the former. See Sylvia Mathews Burwell et al., 'Improving Pandemic Preparedness' (2020) 78 Independent Task Force Report, Council on Foreign Relations.

52 See (n 28).

53 'Strategic Plan', at 17.

54 See (n 18).

55 *Ibid.*, 7. Welsh (n 51) 67, argues that the WHO seems intent on getting states to see their responsibilities for pandemic preparedness and response as pragmatically desirable and not purely a matter of "charity". Compare Matiangai Sirleaf, 'Disposable Lives: COVID-19,

extraterritorial duties on States in the course of pandemics (including under the ICESCR) either does not occur to the Plan's drafters or, more likely, is actively resisted.

Neither does it apparently occur to the organisation that all of the six strategic objectives in its Strategic Plan for the 2021–2022 period (the suppression of transmission, the reduction of exposure, the countering of misinformation, the need to protect the vulnerable, reduce mortality and morbidity, and accelerate equitable access to all COVID tools – from diagnostics to vaccines) could be enriched and fortified by referring to the right to health.⁵⁶ And while that Plan identifies an impressive number of committees and teams formed to address a polycentric 'crisis that touches every aspect of every society', there is no mention that these groups, whether at the global, regional, or national level, should include human rights experts.⁵⁷

As all this suggests, the WHO does not treat either human rights or the right to health as fundamentally related to its principal goal: to prevent or mitigate pandemics.

3 Consequences

Although it is sometimes said that the IHR's key failing is the absence of hard enforcement provisions,⁵⁸ the problem is more profound. The WHO's disastrous response to COVID cannot be corrected merely by adding some "teeth" to the IHR's reporting obligations. Long before COVID, based on the WHO's experiences during prior pandemics, it has been evident that health emergencies, officially proclaimed or not, often lead to the impairment of virtually every right in the human right canon.⁵⁹ The drafters of the 2005 IHR clearly knew

Vaccines, and the Uprising' (2021) 121 Columbia Law Review Forum 71, 85 (criticizing the WHO's "philanthropic" model for COVAX).

56 See 'Strategic Plan', at 10.

57 *Ibid.*, 21.

58 See, e.g., Eyal Benvenisti, 'The WHO – Destined to Fail?: Political Cooperation and the COVID-19 Pandemic', (2020) 114 AJIL, 588, arguing that the WHO's institutional structure relies on a cooperation model that does not require monitoring or enforcing its rule; José E. Alvarez, 'The WHO in the Age of the Coronavirus' (2020) 114 AJIL, 578, 582–583, discussing the WHO's "overreliance" on persuading states to comply on the basis of self-interest in lieu of "name and shame" techniques found in some other regimes, including human rights.

59 See, e.g., Mاتيанgai Sirleaf, 'Ebola Does Not Fall from the Sky: Structural Violence & International Responsibility' (2021) 51 Vanderbilt Journal of Transnational Law, 477; Karima Bennouna, "'Lest We Should Sleep" COVID-19 and Human Rights' (2020) 114 AJIL 666, 669.

that mandatory isolations and quarantines, if neither necessary or proportionate, violate civil and political rights such as the freedom of movement and can even amount to arbitrary detention;⁶⁰ that government attempts to derogate from other civil, political, social, cultural, or economic rights need to be subject to clear limits (including with respect to their prolongation); and that health emergencies cannot be used, in any case, to undermine fundamental rights – to life, to preventing torture or cruel, inhuman, or degrading treatment, or to recognition before the law.⁶¹ An organisation ostensibly devoted to mainstreaming human rights could not possibly claim not to know that all human rights treaties bar discrimination at least with respect to a State's own internal population – with some, including the ICESCR, extending that prohibition beyond enumerated categories to encompass *de facto* or *de jure* denials of equality based on 'other status'.⁶²

The IHR's human rights avoidance, imprecision, and limitations (such as its preoccupation with the rights of travelers), probably undertaken to protect the Organization's "apolitical" or "scientific" neutrality,⁶³ help explain its helplessness in limiting autocracies, and even some ostensible democracies, from overreaching during COVID. The human rights gaps and omissions in the IHR – and not only the WHO's reticence to criticize States by name and deed – must share the blame for the WHO's failings *vis-à-vis* for example: Hungary (where a decree in response to a 'state of danger' was used to suspend protective laws, cancel scheduled elections, and create new crimes); Bolivia (where the government postponed elections); Israel (which shut down its courts); the United States (where the COVID health emergency continues to be used to close its border even to asylum seekers); or, China, South Korea, and Singapore (all of which deployed intrusive surveillance of persons that seemed to infringe human rights).⁶⁴ From the Philippines to Jordan to Thailand, emergency

60 See, e.g., ICCPR, art. 4(1); ICESCR, art. 4 (limiting derogations to such limitations as are 'determined by law' and only as 'compatible with the nature of these rights and solely for the purpose of promoting the general welfare in a democratic society'). For recognition of the emerging problems with state responses to COVID even in its earliest days, see, e.g., Armin von Bogdandy and Pedro A. Villarreal, 'International Law on Pandemic Response: A First Stocktaking in Light of the Coronavirus Crisis' (Max Planck Paper Series, No. 2020-7) 17–20; Adina Ponta, 'Human Rights in the Time of the Coronavirus' (ASIL Insight, 20 April 2020).

61 See, e.g., ICCPR, art. 4(2).

62 ICESCR, art. 2(2).

63 See discussion *infra* at notes 84–85.

64 See, e.g., Selam Gebrekidan, 'For Autocrats, and Others, Coronavirus Is a Chance to Grab Even More Power' (NY Times, 14 April 2020).

powers have been directed at political dissenters or critical media outlets and not only those posing genuine threats to health.⁶⁵

Many States have also ignored their primary human rights duty: to avoid de facto or de jure discrimination in responding to COVID.⁶⁶ The consequence has been a global “color of COVID” phenomenon whereby rates of infection or death or degree of access to care, medicines or vaccines correspond, all too often, to the color of one’s skin or other disfavored status.⁶⁷ Low caste persons in India, those with the “wrong” skin pigmentation or having indigenous status in Brazil, or members of Latinx, Indigenous, or Black communities in the United States have been among those paying the steepest price.⁶⁸ Countries around the world, rich or poor, have used proclamations of public health emergencies to trample, disproportionately, and sometimes with clear intent, those who they have made vulnerable through long-standing structural impediments to access to health care – from ethnic minorities to immigrants. In the face of all of this, the WHO has failed to mobilize shame against even the most egregious human rights violations during COVID, including, most recently, lengthy shutdowns of populous Chinese cities.⁶⁹

65 Much of the documentation of these COVID horrors has been left to human rights regimes and their interlocutors, including UN human rights treaty bodies. See, e.g., *Compilation of statements by human rights treaty bodies in the context of the COVID-19 pandemic*, Sept. 2020, at <https://www.ohchr.org/sites/default/files/External_TB_statements_COVID_19.pdf>. See also *Internal HRTB toolkit of treaty law perspectives and jurisprudence in the context of COVID-19*, May 2020, at <https://www.ohchr.org/sites/default/files/External_TB_statements_COVID19.pdf>.

66 Note that even states, like the United States, which have not ratified the ICESCR and are therefore not subject to that treaty’s right to health, have ratified other treaties, such as the International Convention on the Elimination of All Forms of Racial Discrimination (CERD), which ban discrimination with respect to, among other things, “the right to public health” and “medical care”. CERD, art. 5 (e)(iv). For powerful indictments of states’ actions in the age of COVID with a focus on violations of CERD, see, e.g., Sirleaf (n 55).

67 The structural discriminations and its impact in the shadow of COVID has generated a voluminous literature across scientists, health care professions, political scientists, and lawyers. See, e.g., Matthew Zagor, ‘Human Rights and Structural Inequality in the Shadow of Covid-19 – A New Chapter in the Culture Wars?’, ANU Legal Studies Research Paper No. 21.29, 8 October 2021, at <https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3937777> (forthcoming Australian Yearbook of International Law); José E. Alvarez, ‘The Case for Reparations for the Color of COVID’ (2022), 7 UCI Journal of International, Transnational, and Comparative Law, 7.

68 See (n 67), Annex A (written by Daniel Rosenberg).

69 See, e.g., Li Yuan, ‘China’s Zero Covid Strategy Shows Perils of Autocracy’ (NY Times, 14 April 2022) B1. The WHO’s mixed human rights messages are suggested by its ambivalent approach to population-wide responses such as China’s. While at some points in the COVID pandemic, the WHO praised the government of China for such mass

In case after case over the past two years, the WHO has also ignored “positive” human rights obligations to advance the human right to health and health care among States’ own populations. The WHO responses to governments’ (often fatal) omissions with respect to enabling access to care, vaccines, and protective equipment to minorities, stateless persons, internal migrants, and prospective asylum seekers have been muted, even when these ignore the recommendations of the WHO itself or national health experts. Trump’s and Bolsonaro’s notorious failures to act were not called to account within the organisation – despite the fact that both leader’s tendency to underplay the health threat and repeated failures to compel prevention measures while promoting harmful falsehoods about how the disease spreads or may be “cured” were manifest violations of the right to accurate medical information.

Only late in the pandemic, faced with a virulent form of vaccine nationalism that was hard to ignore, did the WHO articulate, but only in the form of a moral or pragmatic imperative, States’ collective duties to cooperate to advance the right to health outside their borders.⁷⁰ The lack of attention in the IHR (and elsewhere in the organisation) to the “entitlements” individuals have under the right to health helps explain why the WHO has appeared to be helpless in responding to these, equally harmful, forms of government “underreach”.⁷¹

As the COVID death toll, newly revised by the WHO to encompass, as of this writing, some 15 million worldwide, and the ever-growing evidence of a “color of COVID” phenomenon, both illustrate, the WHO’s human rights concerns back in April 2020 have been sadly vindicated.⁷² The WHO’s failures to denounce specific instances of government overreach or underreach, a

responses, see, e.g., Report of the WHO-China Joint Mission on Coronavirus Disease 2019 (COVID-19), 16–24 Feb. 2020, at <<https://www.who.int/docs/default-source/coronavirus/who-china-joint-mission-on-covid-19-final-report.pdf>>, its recommendations call only for individualized quarantines. Bogdandy and Villarreal (n 60) 20. As of this writing, although China’s resort to mass quarantines has drawn considerable criticism from pandemic experts, the WHO has not offered either praise or criticism of China’s current mass quarantines.

70 Compare Olivier De Shutter et al., ‘Commentary to the Maastricht Principles on Extraterritorial Obligations of States in the Area of Economic, Social and Cultural Rights’ (2012) 34 *Human Rights Quarterly*, 1084.

71 See, e.g., David E. Pozen and Kim Lane Scheppele, ‘Executive Underreach, in Pandemics and Otherwise’ (2020) 114 *AJIL*, 608.

72 See, e.g., Katie Shephard and Niha Masih, ‘Nearly 15 million deaths related to covid-19, WHO estimates’ (Washington Post, 5 May 2022) at <<https://www.washingtonpost.com/health/2022/05/05/covid-excess-global-deaths-nearly-15-million/>>. For evidence documenting the ‘color of COVID’, see, e.g., José E. Alvarez, ‘The Case for Reparations for the Color of COVID’ (forthcoming *UC Irvine J. of Int’l, Transnat’l, and Comparative Law* 2022), available on SSRN at <https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3942085>.

predictable consequence of that organisation's failure to treat human rights as genuine legal obligations, have not been seen as praiseworthy defences of its neutrality. They have, instead, diminished its authority, particularly among those who see the organisation's passivity as enabling human rights violations.

4 To Change or Not to Change?

The human rights gaps in the global health regime as revealed by recent pandemics is not a secret among some scholars advocating change. Since 2008, Laurence O. Gostin and his colleagues in public health law have proposed to rectify the global health regime's human rights gaps through a new "Framework Convention on Global Health".⁷³ Their proposed treaty, newly prescient in the age of the coronavirus, seeks to build on and reinforce the ICESCR's General Comment 14 on the right to health.⁷⁴ Readers of this Yearbook are doubtless aware that another initiative, presumptively applicable to pandemics, the ILC's 2016 Articles on the 'Protection of persons in the event of disasters' also rely heavily on human rights sources and scholarship in their black letter articles and commentaries.⁷⁵ More recently, one expert group has produced a statement of principles intended to safeguard vaccine research.⁷⁶ Of that Statement's seven core principles to protect relevant healthcare professionals, four identify

73 Lawrence O. Gostin and Eric A. Friedman, 'Imagining Global Health with Justice: Transformative Ideas for Health and Well-Being While Leaving No One Behind' (2020) 108 *Georgetown Law Journal*, 1435.

74 *Ibid.*, 1570.

75 ILC, Draft Articles on the protection of persons in the event of disasters, with commentaries, *Yearbook of the International Law Commission* (2016) vol. 11, Part Two. See, e.g., *Ibid.*, art. 4 (affirming the need to respect and protect human dignity), art. 5 (indicating that affected persons are entitled to respect for and protection of their human rights), art. 6 (affirming the principles of humanity and on the basis of non-discrimination), art. 7 (addressing the need for inter-state cooperation and citing, in support, the UN Charter, arts. 55 and 56, and the special significance of human rights), art. 10 (affirming duties of the affected state to protect persons and provide assistance), art. 11 (affirming duty of affected state to seek external assistance (including under international human rights law)), art. 13 (affirming duty of the affected state not to reject assistance arbitrarily – in part because of its duty to protect life), and art. 16 (affirming duties on the affected state to protect relief personnel, equipment and goods).

76 The Second Oxford Statement on International Law Protections of the Healthcare Sector During Covid-19: Safeguarding Vaccine Research, 11 August 2020, at <<https://www.law.ox.ac.uk/news/2020-08-12-second-oxford-statement-international-law-protections-health-care-sector-during-covid#:~:text=The%20statement%20calls%20on%20states,relevant%20multilateral%20processes%20and%20deliberations>>.

principles of human rights law or international humanitarian law as vital to that enterprise.⁷⁷ Experts in human rights, public health, and migration have drawn heavily on human rights protections in issuing ‘Principles of protection for migrants, refugees, and other displaced persons during COVID’.⁷⁸ And the need to rely heavily on human rights and avoid relegating them to traditional human rights institutions clearly inspired the *Institut de Droit International’s* 2021 Resolution on Epidemics, Pandemics and International Law.⁷⁹

WHO insiders engaged in post-COVID reforms of the Organization and of the broader global health regime must be aware of these high-profile initiatives.⁸⁰ But it remains unclear whether they will be inspired by them to correct the WHO’s decidedly mixed human rights messages. Consider the US proposal for a set of “targeted” amendments to the IHR.⁸¹ That proposal accepts the existing framework of the IHR but would add, among other things, early warning alerts and triggers for action, enhancements to permit more rapid sharing of information and enable greater review over IHR recommendations and

77 *Ibid.* (identifying state obligations to protect medical facilities including those engaged in vaccine research during conflicts, negative and positive obligations on states vis-à-vis other states to the same end, relevant civil and political rights, and social, cultural and economic rights).

78 ‘Human Mobility and human rights in the COVID-19 pandemic: Principles of protection for migrants, refugees, and other displaced persons’ (2020) 32 Int’l J. Refugee L, at <<https://academic.oup.com/ijrl/article/32/3/549/5954392>>.

79 *Institut de Droit International*, Resolution on Epidemics, Pandemics and International Law, 12th Commission, 4 Sept. 2021, arts. 4, 9, 10, 12 (all mentioning the need to respect particular or general human rights); also Art. 15 (affirming the international responsibility of states and international organisations for failing to prevent, reduce or control pandemics).

80 The nexus between health outcomes and the violation of rights, particularly of those who are socially marginalized, have received considerable attention from journalists and health experts. See, e.g., Alan Nicol, ‘The Pandemic is Laying Bare a Global Water Crisis’ (Foreign Policy, 12 May 2020); Nina L. Hall, ‘Australian Indigenous remote communities and water, sanitation and hygiene: A Scan of needs’ (2018) 3 Water, 1; Sujata Gupta, ‘Why African-Americans may be especially vulnerable to COVID-19’ (Science News, 10 April 2020); Maanvi Singh and Mario Koran, ‘The virus doesn’t discriminate but governments do’ (The Guardian, 18 April 2020); American Medical Association, ‘Racism is a threat to public health’, Statement 16 November 2020, at <<https://www.ama-assn.org/delivering-care/health-equity/ama-racism-threat-public-health>>. Of course, human rights bodies have also focused on COVID’s impact on human rights. See, e.g., ICESCR Committee, ‘Statement on the coronavirus disease (COVID-19) pandemic and economic, social and cultural rights’ (17 April 2020) UN Doc E/C.12/2020/1.

81 WHO, ‘Strengthening WHO preparedness for and response to health emergencies’ (12 April 2022) Doc A75/18. These proposals to amend the IHR rather than negotiate a new treaty may be motivated, at least in part, by the political difficulties of securing the approval of a wholly new treaty by the US Congress.

their implementation, and revisions to PHEIC decision-making. While the US amendments would result in something of a departure from the IHR's deferential approach to compliance and could improve the WHO's response to future pandemics, they do not seek to fill the IHR's multiple human rights gaps. Whether the leading proposal for more comprehensive change – for a “Pandemic Prevention Treaty” originally advanced by the EU and described in this Yearbook by Gian Luca Burci – will come closer to embracing a human rights framework remains to be seen.⁸²

There are many reasons why WHO reformers may choose not to take human rights or the right to health seriously. The WHO is dominated by an institutional culture of scientists and health professionals who demarcate their intellectual authority, professional goals, and career opportunities from those who deal with the political, the subjective, the normative.⁸³ Those charged with reforming the current IHR, like those involved in the 2005 revisions, may choose to avoid a fuller embrace of a human rights framework intentionally – out of a possibly misplaced desire to protect the IHR's (and the WHO's) epistemic “scientific” authority or credibility. WHO insiders – including the health ministries that represent members to the organisation – may fear that a full-throated embrace of human rights would draw them – and the organisation – into a maelstrom of political controversies over “culturally relative” human rights values that have only increased amid a renewed backlash to human rights regimes.⁸⁴ There is probable fear that pressures for human rights “accountability” would compel the organisation to deploy the binding dispute settlement modes that it has to date resisted and that health professionals would waste precious time in “litigating” human rights compliance. As with other organisations that are said to resist human rights, many reformers probably fear the prospect that the WHO's will lose its scientific legitimacy by turning into yet another “human rights cop”.⁸⁵ Others, in *realpolitik* mode, may believe that enabling the organisation to send a more coherent human rights message is not worth undermining reform efforts that face formidable challenges on their own terms.

82 Compare Gostin (n 73) describing the proposed Framework Convention on Global Health.

83 See generally, Thomas F. Gieryn, ‘Boundary-Work and the Demarcation of Science from Non-Science: Strains and Interests in Professional Ideologies of Scientists’ (1983) 48 *American Sociological Review*, 781. This may explain the WHO's historic aversion to deploying its considerable powers to adopt legally binding regulations or treaties. Alvarez (n 58) 585–87.

84 See, e.g., Zagor (n 67).

85 See Alston (n 25) 387–89 (discussing and rebutting such fears with respect to the World Bank).

Those inclined, nonetheless, to resist the tide in favor of “apolitical” or technocratic WHO/IHR reforms might consider the following five arguments for taking human rights seriously.

4.1 *Acknowledging Legal Obligation Does Not Mean Turning into a Human Rights Enforcer*

As Philip Alston has argued in responding to comparable concerns that have been expressed concerning the World Bank, institutions that genuinely embrace a human rights framework need not become human rights “enforcers” or “cops”.⁸⁶ Mechanisms to encourage acceptance of human rights as legal obligations come in all shapes and sizes. Only rarely – as under regional human rights conventions – do human rights “enforcement” mechanisms include judicially binding supranational judgments issued in the wake of a time-consuming dispute. Securing compliance with international law, particularly for human rights, is a many-splendored – albeit much delayed – thing.⁸⁷ The methods of “managerial” or “experimentalist” compliance include, for example, ombudspersons procedures, periodic State reports subject to view, or specialized expert reports.⁸⁸ If even these soft processes seem a step too far for the WHO, it may be possible to incorporate human rights into the procedural IHR amendments proposed by the US. All or most of the US proposed changes – establishing Universal Health Periodic Reviews, early warning criteria, enhanced WHO annual reports to its Health Assembly, a Compliance Committee, modifications to the creation and implementation of WHO temporary recommendations, or new modes of consultation with other UN agencies – could include human rights elements. IHR reforms intended to enhance scrutiny over States’ pandemic response could incorporate, for example, consideration of how a particular State is doing in terms of complying with the components of the right to health.⁸⁹

86 *Ibid.*, 389.

87 See generally Robert Howse and Ruti Teitel, ‘Beyond Compliance: Rethinking Why International Law Really Matters’ (2010) 1 *Global Policy*, 127.

88 *Ibid.*; see also Gráinne de Búrca, ‘Human Rights Experimentalism’ (2017) 111 *AJIL*, 277.

89 See, e.g., US proposed amendments (n 81) art. 5 (surveillance), art. 6 (notification), art. 11 (provision of information by WHO), or arts. 15 and 18 (enabling expert implementation teams and greater consultation in developing temporary recommendations). The US proposal to permit the WHO to consult with enumerated UN agencies or other relevant entities in arts. 6(1) or art. 18(3), could be extended to include, for example, authority to examine state notifications alongside a state’s reports to the ICESCR on what it has done or failed to do to implement that treaty’s right to health or other relevant rights. States’ human rights reports, including under the CERD, might also be useful additional sources of information to supplement a state’s self-reporting in connection with arts. 9 or

It matters that the international community speaks with one voice on the need to comply with fundamental human rights. It matters that the leading global health does not send mixed signals on human rights. Changing the language of key IHR provisions or public-facing COVID Strategic Plans to acknowledge the underlying legally binding obligations at stake does not commit the Organization to enforce those obligations itself. But it may still make a significant difference to how national health ministries behave if the IHR clearly affirm, for example, that WHO surveillance and notification requirements or States' offers of vaccines to other States implicate myriad human rights treaty obligations. Were the IHR to be changed throughout to make reference to relevant human rights obligations, *qua obligations*, those unwilling to comply with the IHR would need to consider the more direct impact on their reputations as human rights compliers, amid a chorus of human rights defenders emboldened to protest.⁹⁰

4.2 *Human Rights Underpin the Systemic Causes of Disease and Pandemic Failures*

Human rights and public health professionals share common ground. Both agree that diseases, particularly zoonotic ones, have many drivers: economic, geo-political, social, cultural, and economic. Both see the successful prevention and mitigation of transnational transmission of disease as multi-dimensional. Both assume that access to basic health care is essential to the successful prevention and mitigation of pandemics. Disease prevention and mitigation can benefit from the application of both disciplines.

Those committed to defending boundary-demarcations between medical and "less scientific" forms of expertise are ignoring trends in the other direction. Recently, in response to the probable fact that COVID-19, like more than half of the known pathogens infectious to humans, may have spread from an animal to infect humans, the WHO entered into a collaboration with the

10 (verification), to enable the WHO to inform other states of how to respond to a public health risk announced by a state under art. 11, or to enable more accurate annual reports by the WHO secretariat to the Health Assembly under the US's new art. 11(5).

90 See generally, Cosette D. Creamer and Beth A. Simmons, 'The Proof is in the Process: Self-Reporting under International Human Rights Regimes' (2019) 114 *AJIL*, 1. Apart from emulating the processes now used to mobilize shame against human rights violators under UN human rights regimes, the WHO could, for example, authorise its lawyers to issue, in response to questions posed by members or the Secretary-General, public interpretations of global health law and its connections to human rights – even if their views were not to be deemed authoritative. Some UN system organisations, such as the ILO, have adopted comparable practices.

FAO, the World Organization for Animal Health, and the UNEP.⁹¹ Under a new Memorandum of Understanding, those diverse organisations with differing goals – to improve global health, to raise the standing of living including levels of nutrition worldwide, to improve animal health and welfare, or to set environmental agendas consistent with sustainable development respectively – have entered into an accord that would enable each to puncture existing silos between international and national bureaucrats, distinct national stakeholders, and experts. The new arrangement reflects a realization that diseases that emerge because of a “jump” between species require jumping over disciplinary and organisational hurdles. As the title of the new accord indicates, its goal is to encourage multi-sectoral approaches to respond to the complex health challenges posed by zoonotic diseases and antimicrobial resistance that spread among animal and human pathogens.⁹² Comparable openings to other disciplines have started to appear in the WHO’s bureaucratic response to COVID.⁹³

The WHO’s Memorandum of Understanding specifically adopts the framework generated by the ‘One Health High Level Expert Panel’ and its draft ‘Global Plan of Action for Health’.⁹⁴ The ‘One Health’ framework is a highly touted approach that has been widely adopted, including within the US’s Center for Disease Control (CDC). Although a number of definitions exist, One Health is generally described as a ‘collaborative effort of multiple health science professions, together with related disciplines and institutions working locally, nationally, and globally – to attain optimal health for people, domestic animals, wildlife, plants, and our environment’.⁹⁵ ‘One Health’ emphasises the ‘inextricable interconnectedness of animal, environmental, human, plant and planet health’.⁹⁶ Its key goal is to break down professional segregation and data separation in the relevant scientific communities that delimit the scrutiny of environmental and other determinants of diseases. A second objective is to

91 Memorandum of Understanding Between the Food and Agriculture Organization of the United Nations, and the World Organisation for Animal Health and The World Health Organization and The United Nations Environmental Programme Regarding Cooperation to Combat Health Risks at the animal-Human-Ecosystems Interface in the Context of the “One Health” Approach and Including Antimicrobial Resistance (17 March 2022), henceforth “Memorandum of Understanding”.

92 *Ibid.*; see also its preamble, para. 1 and art. 2 (Purpose).

93 See, e.g., WHO, ‘A Coordinated Global Research Roadmap: 2019 Novel Coronavirus’ (March 2020). This Roadmap includes perspectives from multiple social science disciplines, including anthropology, psychology, social epidemiology, and political science. *Ibid.*, 61.

94 Memorandum of Understanding, preamble, para. 7.

95 See One Health Commission, World Health Through Collaboration, at 2, <https://www.onehealthcommission.org/en/why_one_health/what_is_one_health/>.

96 *Ibid.*

combat the tendency of governments and health experts to mobilize attention only in the wake of emergencies and ignore preventive strategies frequently blocked by significant barriers across fragmented State and federal agencies and public agencies engaged in zero-sum games to protect their respective bureaucratic turf.⁹⁷ 'One Health' is defined by its interdisciplinary reach to encompass environmental contamination, habitat use conflicts, biodiversity loss, as well as 'the social determinants of health'.⁹⁸

And yet, depending on the meaning given to the "social determinants" of health under 'One Health', it is not clear that the WHO's recognition of the need for multidisciplinary collaboration to prevent and respond to zoonotic diseases will encompass the underlying human rights determinants of such diseases. This worthy effort to enable greater WHO boundary crossings may fall short of its goals should it succumb to the WHO's stunted human rights agenda. 'One Health' is most often defined (as noted above) in terms of exchanges among "scientific forms" of expertise. The 'One Health' literature does not commonly address the need to incorporate insights from human rights experts who examine the underlying social determinants of disease, including NGOs devoted to documenting and correcting discriminatory denials of access to health care, to essential medicines, or to accurate information. It is not altogether surprising, therefore, that human rights institutions are not mentioned as collaborators in the new 'One Health' inspired Memorandum of Understanding.

This is a perverse omission for an organisation that has acknowledged that 'neglected diseases' common to 'poor and marginalized populations in low-income countries' are a 'right to health issue with many faces'.⁹⁹ The WHO itself accepts that such diseases, in which discrimination is both a 'cause and a consequence' require attention to the underlying determinants of the right to health as well as human rights violations associated with inequality and poverty.¹⁰⁰ Those who study zoonotic diseases, such as the determinants of HIV-1 which emerged from bushmeat hunting and whose spread was exacerbated by increased levels of urbanization and road expansion in central Africa

97 See, e.g., American Public Health Association, 'Advancing a 'One Health' Approach to Promote Health at the Human-Animal-Environment Interface', 7 November 2017, abstract at <<https://apha.org/policies-and-advocacy/public-health-policy-statements/policy-data-base/2018/01/18/advancing-a-one-health-approach>>.

98 One Health Commission (n 95). The Commission has identified 23 areas of urgent concern, from agricultural production and land use to the well-being of animals, humans, ecosystems and the planet.

99 Fact Sheet (n 14) at 8.

100 *Ibid.*

combined with relatively little regulation, would agree.¹⁰¹ The zoonotic diseases that explain many current pandemics emerge and are transmitted at the borderlines between the developed and less developed worlds and are caused by the actions of both groups of States. The shift in production of meat and milk products to places characterized by “inadequate governance” (defined as ‘the absence of needed regulatory authority, antiquated rules, uncoordinated policy and governmental capacities, lack of resources to devote to addressing difficult health, social, and economic problems, and the speed and scale of globalization’) helps to explain a phenomenon also associated with food insecurity, cultural preferences for “fresh” products found in “wet” markets, and population displacements caused by natural disasters or zones of conflict.¹⁰² These determinants implicate indivisible and interrelated human rights – such as rights to food, culture, and migration.

Zoonotic diseases also arise among, and victimize, those made vulnerable by longstanding discriminatory denials of rights, such as marginalized groups. They include some living in rural areas, stateless persons, the internally displaced, and refugees. The connections between lack of access to basic civil or political rights and, of course, to basic health care – within and among nations – and the emergence and spread of zoonotic diseases is hard to deny.¹⁰³ Addressing the underlying human rights violations would appear to be as essential to preventing the spread of zoonotic disease as other factors now embraced under ‘One Health’. There are, in short, highly pragmatic, scientific reasons for examining the human rights determinants of disease and pandemics.

4.3 *The Right to Health Should Not Be Left to Human Rights Experts*

The interconnectedness of zoonotic diseases generates a wider insight: the human right to health and what it means requires interpretative help from those most familiar with the determinants of good health and the spread of disease. The right to health, like many others, evolves in line with technological as well as political developments. Its meaning should not be left to

101 See, e.g., National Research Council, *Sustaining Global Surveillance and Response to Emerging Zoonotic Diseases*, at 77–78 (2009), henceforth “Zoonotic Disease Study”.

102 *Ibid.*, discussing various determinants of zoonotic disease, including “inadequate governance” (106–107), population mobility (84–86), and food preferences and other factors (87–89).

103 Routine infectious disease diagnosis in animals – including wild animals treated as pets – is said to be virtually ‘nonexistent in sub-Saharan Africa’ whereas biological testing (as in living cells) for zoonotic diseases such as brucellosis, are much more readily available in developed countries – to mention but two examples. *Ibid.*, at 101–102.

traditional human rights experts or bodies. What it means for a State to have the capacity to detect and promptly notify to the WHO a threat with potential to be transmitted transnationally depends on scientific advances and medical expertise. The meaning of “core capacities” for surveillance, what it takes for a State to satisfy “minimum standards for essential health”, or the kind or extent of information that might be expected from a State when a seemingly new risk to health emerges – all vary over time. The interpretations of such key terms in the IHR in light of human rights would benefit from the views of health care professionals.¹⁰⁴ The same holds true with respect to the extra-territorial human rights obligations that human rights proponents defend but that governments (and the WHO) tend to resist.¹⁰⁵ Serious consideration of what exactly human rights treaties demand of States with respect to the development and free distribution of vaccines, for example, would benefit from the views of those involved in vaccine production and not only experts on human rights.¹⁰⁶

The meanings of the right to health and other interdependent, indivisible, and inevitably interrelated rights require the joint, symbiotic efforts of human rights and global health regimes. The right to health is not a one-way ratchet to be downloaded in places like the ICESCR Committee and exported, unchanged, to the WHO. Adopting a human rights framework within the WHO should not be seen as a concession to human rights regimes. The argument in favor of a full-throated embrace of human rights by the WHO is not just about enhancing the legitimacy of the WHO or buttressing the challenged authority of human rights regimes. Having continuous and serious interactions between human rights, public health, and other relevant regimes is a precondition for generating useful, realistic, and appropriate interpretations of the complex human rights challenges posed by, and underlying, pandemics.

4.4 *Accountability Is Not a Luxury and Need Not Be Supranational*

For proponents of human rights, taking them seriously entails accountability. As Alston argues with respect to the World Bank, ‘where rights are ignored or violated, there must be accountability’.¹⁰⁷ As he indicates, the human right

104 The anthropologist, Sally Engle Merry, described comparable processes as “vernacularization”. Peggy Levitt and Sally Engle Merry, ‘The Vernacularization of Women’s Human Rights’ in Leslie Vinjamuri, Jack Snyder and Stephen Hopgood (eds), *Human Rights Futures* (CUP 2016).

105 See Meier, Mesquita and Williams (n 22).

106 As is suggested by debates over the need for waivers of intellectual property rights as part of the response to vaccine nationalism.

107 Alston (n 25) 395.

to food or essential health care does not guarantee anyone food or care, but recognizing these as genuine rights requires accepting that individuals are owed, at a minimum, the dignity and agency to access remedies for violations of them.¹⁰⁸ The WHO's Fact Sheet on the right to health, consistent with the ICESCR's General Comment No. 14, agrees.¹⁰⁹

As the emerging number of COVID claims directed against governments and some private enterprises suggest, accountability in some form is likely to come unevenly – in some rule of law States and within some specialized regimes.¹¹⁰ Over time, particularly as the facts underlying the “color of COVID” emerge, there will be growing political pressures to recognize who was complicit in death by skin color. As students of transitional justice can attest, those victimized by COVID are likely to demand preservation of the evidence of what occurred and recognition of their own or their families' losses – in the form of eventual monuments, commemorations, apologies, law reforms, and yes, financial recompense when feasible.¹¹¹

As with respect to compliance and enforcement, there are many forms of accountability (political, social, legal) at the local, regional, or supranational levels.¹¹² As many have pointed out, there is little prospect that any government, alone or with others, will attempt a contentious case before the International Court of Justice (ICJ) against China for the initial emergence of COVID or against any number of States for not containing its transnational spread.¹¹³ It is also unlikely that anyone will deploy the WHO's largely unused dispute settlement mechanisms to blame the organisation for its COVID failures. But, as shown by the *Institut de Droit International's* affirmation that both States and organisations like the WHO are, in principle, legally accountable for

108 *Ibid.*

109 Fact Sheet (n 14), 31–39 (affirming the need for accountability at the national, regional, and international levels).

110 See, e.g., European Court of Human Rights, Factsheet – COVID-19 health crisis, Oct. 2021 (containing summaries of claims directed at governments under the European Convention on Human Rights resulting from government actions during the pandemic); Raphael Minder, ‘Spain's Court, Already Strained, Face Crisis as Lockdown Lifts’ (NY Times, 26 May 2020). See generally Sarah Heathcote, ‘State Responsibility, International Law and the Covid-19 Crisis’, ANU College of Law, Legal Studies Research Paper Series, No 21.22.

111 Compare Articles of State Responsibility, Articles 28–31, 34–38. States' responsibility to cease internationally wrongful acts (under Art. 30) – which would entail, for example, lifting immigration restrictions not justified by legitimate health concerns – has a particular relevance with respect to COVID.

112 See, e.g., Ruth W. Grant and Robert O. Keohane, ‘Accountability and Abuses of Power in World Politics’ (2005) 99 *American Political Science Review*. See generally Alvarez (n 67).

113 The problems go beyond the difficulties of grounding jurisdiction in forums like the ICJ. See, e.g., Alvarez (n 67); Sebastián Guidi and Nahuel Maisley, ‘Who Should Pay for COVID-19? The Inescapable Normativity of International Law’ (2021) 96 *NYU L. Rev.*, 375.

breaches of international law to prevent, reduce or control epidemics,¹¹⁴ some form of accountability is necessary to human rights and the right to health – as to any rule of international law worth having.

Millions have died or faced catastrophic economic losses due to international discrimination or other internationally wrongful acts during the age of the coronavirus. Accountability for these actions or omissions need not take the form of unlikely inter-State claims before bodies like the ICJ. More politically viable methods include claims before specialized tribunals with jurisdiction, such as investor-State arbitrations or regional human rights courts or suits for tort damages in national courts where these are feasible under national law or where international law is incorporated into national law. Even more likely are specially designed claims commissions – akin to truth commissions used in transitional justice – which may be limited to particular type of claims (e.g., for the particularly egregious acts leading to the “color of COVID”) and charged with finding the truth of what occurred, listening to those victimized by government actions or inactions, and pronouncing suitable remedies. Such commissions could be established at the national, State or provincial, or even municipal level.¹¹⁵ They may or may not authorise financial damages. Accountability, as this suggests, is likely to start at the local level – where all of us live (and die).

Accountability mechanisms, akin to transitional justice measures adopted after mass atrocities, are not only morally and legally justified under human rights treaties, they are pragmatically desirable. Governments that do not eventually accept a measure of accountability for unnecessary COVID deaths, not to mention millions who survive with long term COVID, are less likely to take the measures needed to mitigate the spread of future pandemics. Governments that do not come to terms with the structural inequalities that deny basic access to health care to many of their own nationals will come to haunt all of us during the next pandemic. The failure to take the right to health – and related rights – seriously enough to make those who violate them accountable may doom generations to COVID variants.¹¹⁶

¹¹⁴ See (n 79).

¹¹⁵ See, e.g., Resolution of the NYC Board of Health Declaring Racism a Public Health Crisis (adopted on 18 October 2021), recommending that, given the documented racial inequities in health both before and after the current pandemic and the structural racism underpinning them, the NYC Health Department ‘participate in a truth and reconciliation process with the communities harmed by these actions’. See, generally, Alvarez (n 67) proposing claims commissions at various levels of government to respond to the harms caused by the “color of COVID”.

¹¹⁶ According to one study by epidemiologists who examined the US state of Louisiana, had the US undertaken reparations to Black descendants of persons enslaved in the US COVID transmission rates in that state would have been reduced by between 31 to 68

Accountability, as this suggests, is backed by pragmatism, science, morality, and law. Recognizing the responsibility of States and of the WHO for ensuring everyone's right to health and health care should be an essential element of any future "pandemic prevention" treaty worthy of the name. By word (and at least some deeds), States have long accepted responsibility for respecting and ensuring the human rights of their own peoples. It is past time that they accept their legal responsibilities for evident failures to respect and ensure the human right to health care, starting with their own nationals. It is also time for States to accept their collective responsibilities when they delegate their authority to organisations like the WHO and these fail to uphold human rights.¹¹⁷ A truly comprehensive Pandemic Prevention Treaty would, at a minimum, endorse the need for accountability mechanisms at the national level. And though these mechanisms need not involve the WHO or its venues, that future treaty could even go further – and enable the organisation to cooperate with such efforts by providing access to its abundant sources of information, network of connections, and technocratic expertise.

4.5 *Human Rights Is Critical to Involving and Recruiting Non-state Allies*

A WHO astute enough to cooperate with efforts to promote some measure of accountability for the horrors of COVID (as discussed above) might do so because such efforts would gain it considerable goodwill among members of international civil society. As even the limited proposals by the US for changes to the IHR indicate, the WHO would be a far more effective and credible organization if it became a less State-centric place that could, for example, rely more on non-State sources of information to detect and monitor pandemics. Adopting a genuine human rights frame and actually mainstreaming human rights throughout its operations would widen the appeal of the WHO – both within States and among them.

Democratizing the organization through greater involvement of international civil society, including private enterprises now involved in disease prevention and vaccine production and distribution, is consistent with the "participation" demands made by proponents of the right to health. Like the other reasons offered here to incorporate human rights, the reach for non-State

percent among all Louisiana residents, black and white alike. Eugene T. Richardson, et al, 'Reparations for black American descendants of persons enslaved in the U.S. and their potential impact on SARS-CoV-2 transmission', (2021) 276 *Social Science & Medicine*, 113741 at <<https://www.sciencedirect.com/science/article/pii/S0277953621000733>>.

¹¹⁷ See, e.g., Draft Articles on the Responsibility of International Organizations, arts. 3 and 58–61, contained in UNGA Res 66/100 (9 December 2011) UN Doc A/RES/66/100.

allies implicit in a human rights turn is supported by pragmatism as well as positive law.

5 Conclusion

The WHO is not the human rights organization that it pretends to be. The WHO's Constitution has not become the "Magna Carta for health" that those present at its creation sought. The Organization remains the heir of global and regional State-centric health regimes that, both before the WHO's establishment and now, seek principally to balance States' interests in preventing the entry of foreign diseases with States' interest in not hindering free trade.

The right to health has not been operationalized within the WHO in the ways that it and the ICESCR Committee have jointly proclaimed. The Organization originally designed to protect individuals' right to health has not done so. As the COVID pandemic tragically illustrates, this needs to change – for the sake of the organization and for the health of us all.