

International health regulations and other instruments of global health law

Seminar paper

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030238-1 SE Seminar aus Völkerrecht: Internationale Organisationen und die Corona
Pandemie

Winterterm 2020/21

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Introduction

When a new virus emerged in early 2020 and quickly spread around the world, it alarmed the public and challenged both national and international authorities. This is a case where global health law and its instruments apply. One of the most important tools of global health law are the International Health Regulations (IHR) from 2005, which are the main focus of this paper. Most instruments discussed in this relate to Covid-19, but not all of them. Other instruments of the World Health Organization like the Framework Convention on Tobacco Control (FCTC) are included to give an overview of most of the existing tools of global health law and to show the abilities of the WHO to create health law and how the organization applies it. The WHO is the most prominent organization responsible for establishing international health regulations. As you will see below, this important tool is actually not often used. This text will examine the background of the existing norms to give some insight as to why this tool is barely used and why the very important IHR are hardly ever reformed.

Global health law is a vast legal field and while this paper will try to give an overview over some of the most important tools and treaties it does not cover all of them extensively. Regarding the treaties and tools mentioned and explained in the text, the goal is to give an introduction to their content and their effect on the world. In addition, this paper is meant to give a brief overview and illustrate how some of the instruments of global health law interact with COVID-19. With respect to the information regarding SARS-CoV-2/COVID-19, the information is accurate as of the 31st of December, 2020. Since this is an ongoing crisis, things can and will change as time goes by. Therefore, it is important while reading this to take into account that some of the information might have changed. However, most of the information regarding the virus concerns events that have already happened and therefore will most likely stay accurate.

1. International Health Regulations (IHR)

The International Health Regulations are a legally binding instrument by the World Health Organisation (WHO) designed to help control the international spread of infectious diseases. They are the only global regulations focused on this issue. They try to balance effective measures against the spread of communicable diseases while still not limiting trade and travel extensively. These regulations are passed by the WHO legislative body, the World Health Assembly (WHA). The WHA has the authority to adopt regulations concerning, among other things, requirements and procedures to prevent the international spread of diseases according

to Article 21 of the WHO Constitution. These regulations have to be accepted by a 2/3 majority of all member states present and voting. If the WHA adopts regulations, they are legally binding for all member states unless they notify the Director General (D-G) of the WHO within a stated time period of their rejections or reservations, according to Art. 22 of the WHO Constitution. These norm-creating powers are atypical for an international organization, since usually these organizations pass treaties each country has to sign and ratify to be bound by them. ¹

1.1. History

Infectious diseases have posed a threat to human beings for thousands of years. There used to be confusion about how these diseases are caused and spread. The theories extended from meteorological phenomena to spiritual and/or moral degradation. By the 14th century, people connected the appearance of infectious diseases to trade and travel and Venice ordered the first known quarantine in 1377 against the bubonic plague. All newly arriving ships weren't allowed to unload any cargo and no passengers could disembark for 40 days after arrival and any signs of illness on board had to be reported.²

In 1851, the first International Sanitary Convention was held in Paris and the first attempt to enact cross-border cooperation regarding disease control as a response to cholera outbreaks throughout Europe took place. Twelve European countries were present and the Convention lasted six months. They failed to reach an agreement since they never overcame the difference of opinion about how and by whom cholera was transmitted. In the following years, until 1944, another fourteen international sanitary conventions or conferences were held. They mainly focused on disease outbreaks and their consequences for trade. By 1907, these conventions produced an agreement that an international organization that focused on data collection and the alert of other countries in case of a disease outbreak needed to be established. However, the international community could never agree on the legal framework for the organization. Therefore, an organization like that wasn't established until 1948, when the United Nations Organization (UNO) established the WHO. ³

¹ Armin von Bogdandy, Pedro A. Villarreal, *International Law on Pandemic Response: A First Stocktaking in Light of the Coronavirus Crisis*, (2020) Max Planck Institute for Comparative Public Law & International Law (MPIL), Research Paper No. 2020-07, p.4; Lawrence O. Gosting (1), *International Infectious Disease Law: Revision of the World Health Organization's International Health Regulations*, (2004) 291/21 JAMA, p. 2623, Jan Klabbers, *An Introduction to International Organizations Law*, (3rd, Cambridge University Press, 2015), p.161

² Sara E. Davies, Adam Kamradt-Scott, Simon Rushton, *Disease Diplomacy: International Norms and Global Health Security* (Johns Hopkins University Press, 2015), p.3-4

³ Sara E. Davies, Adam Kamradt-Scott, Simon Rushton, p.4-5,

The WHO was tasked with creating an international legal framework that ensures security against infectious diseases while having minimal interference with international traffic. In 1951, the International Sanitary Regulations (ISR) were adopted by the 4th meeting of the WHA. The ISR named six quarantineable diseases: cholera, plague, epidemic typhus, relapsing fever, smallpox and yellow fever. These highly infectious diseases caused widespread suffering and interfered with trade at the time. Therefore, every member state that had an outbreak of one of these diseases was required to report it to the WHO, so that other states could enforce appropriate measures. In 1969, the ISR were renamed into International Health Regulations (IHR) and two of the named diseases (epidemic typhus and relapsing fever) were eliminated from the regulations. After the eradication of smallpox, it was also taken out of the regulations in 1981. ⁴

1.1.2 Revision of the IHR

After the eradication of smallpox, the IHR only applied to three diseases (cholera, plague, and yellow fever). These diseases affected mostly developing countries and were almost eradicated in high income countries. Newly emerging diseases weren't reportable. By then, most governments also failed to report outbreaks of these diseases because they feared embargoes of people and goods which could severely harm their economy. Moreover, the WHO could not act in regards to outbreaks unless there was an official report by the government of the affected territory. The organization also had no means to sanction countries that didn't comply with the regulations. Therefore, the International Health Regulations failed to fulfil their purpose by the end of the 1980's. New diseases like HIV started to emerge and the threat of human made biological agents grew. ⁵

By the mid 1990's, the secretariat of the WHO started advocating for reforming the IHR and therefore for forming a new international framework that would help prevent the spread of infectious diseases. Additionally, newly emerging diseases, like HIV or the Marburg Virus, the remerging of diseases thought to be eradicated and a new threat of human made biological weapons brought more international attention to the threat of communicable diseases. The scientific community, especially in the US, started calling for updated plans against epidemics and pandemics. A new political consensus emerged that the outdated IHR needed to be revised and the WHO's capabilities in disease outbreak alerting and response needed to be adapted to

⁴ Sara E. Davies, Adam Kamradt-Scott, Simon Rushton, p.5

⁵ Adam Kamradt-Scott, *The International Health Regulations (2005): Strengthening Their Effective Implementation and Utilisation* (2019) 16/2 International Organizations Law Review, p. 244; Sara E. Davies, Adam Kamradt-Scott, Simon Rushton, p.5

the new challenges. In May of 1995, at the 48th WHA in Geneva two resolutions to reform the IHR were passed unanimously. The first resolution called for the “Revision and Updating of the IHR’s” (WHA 48.7). The second was titled “Communicable Disease Prevention and Control: New Emerging and Re-Emerging Infectious Diseases” (WHA 48.13). These decisions gave the D-G the task to begin reforming the Regulations. ⁶

At the time, the most important health security issues could be divided into 3 categories. The first was that through globalization, the frequency and speed of international travel, trade, urbanization and migration increased dramatically. This made the control of infectious diseases at borders and containing a disease within one state increasingly difficult. The issue became even more apparent through the emergence of SARS-CoV-1 in 2002 but also showed in influenza strains which became pandemic and the spreading of drug resistant disease strains. The second problem was the fear of pathogens being used as weapons, like the anthrax letter attacks in the U.S. in 2001. This also led to the creation of new international bodies, i.e. the Global Health Security Initiative. The third issue was the high burdens infectious diseases now had on the stability of social, political and economic systems of states. This was especially shown by the emergence of HIV/AIDS in the 1980’s and is very present at the moment because of the COVID-19 pandemic. All these issues were addressed in the revised IHR with a specific focus on trade and travel. ⁷

After the WHA decided to revise the IHR, the WHO Program on Emerging and other Communicable Diseases was created. It was led at the time by David Heyman, a medical epidemiologist, who was tasked with overseeing the revision process. A small team worked on the projects whose members were picked from different WHO departments. Their main task was to coordinate the revision process between the member states. The team lacked funding and the revision wasn’t a priority for the member states, which made the process difficult. One of the biggest problems the team faced was trying to engage governments in the reform process and convincing them that behavioural changes were going to be necessary. ⁸

The first informed consultation between relevant WHO staff, academic experts and government officials from a range of member states about the revision was held in December of 1995 and brought forth some ideas about first drafts. In January of 1998, the initial provisional draft of revised IHR was shown to the member states. It showed earliest broad outlines of what would be agreed on and passed by the WHA as revised IHR in 2005. One

⁶ Sara E. Davies, Adam Kamradt-Scott, Simon Rushton, p.6-7, 17, 22

⁷ Sara E. Davies, Adam Kamradt-Scott, Simon Rushton, p.20-21

⁸ Sara E. Davies, Adam Kamradt-Scott, Simon Rushton, p.30-31

important change was that the draft moved away from specific diseases that had to be reported to a system of “syndromic reporting”. This system required states to report the outbreaks of syndromes rather than diseases, if they occurred in clusters and were of importance for international public health. The pathogen that caused these symptoms didn’t have to be identified before a state reported it. By taking this approach, the IHR would cover new and unknown diseases. The WHO would also be allowed to receive information about disease outbreaks from non-state sources. These proposed changes lead to a trial of syndromic reporting by the WHO starting in 1998. Additionally, it was proposed that the regulations wouldn’t specify certain measures but wanted evidence-based responses and they thought of a new dispute settlement process.⁹

This provisional draft was supposed to be submitted to the WHO’s executive board in 1999, but they wanted to evaluate the syndromic reporting system for a longer time. The hope was that a syndromic reporting system would lead to a compliance with the IHR but the system turned out to be unmanageable on a global level and therefore the trial was ended. With that and the appointment of a new director general (Dr. Gro Harlem Brundtland) in 1998, the revision process began to fade. It lost the interest of the member states and ceased to be a high priority for the organization. The manager of the project between 1999-2000 (Johan Giesecke) felt that the project was only allocated few resources. The Tobacco Convention (see below) was the priority for most states at the time.¹⁰

In early 2000 there were key personnel changes in the group working on the IHR revision and it got a new director and team leader. Moreover, it was merged with the WHO’s team developing a disease outbreak alert and response system. At this time the combined group restarted the process almost from the beginning and decided to not just update the former IHR from 1969 but revise the entire system with new concepts and methods they had been developing and experimenting with. In April of 2000, the Global Outbreak Alert and Response Network (GOARN) was started and formally endorsed by the WHA in 2001. It was a global collaboration of institutions and networks that is designed to help countries affected by acute public health events with the deployment of staff and resources.¹¹ It was also thought of as a coordination of national and non-state surveillance. With the WHA endorsement, the member states (except for the representative from China) expressed their support for the organization to

⁹ Sara E. Davies, Adam Kamradt-Scott, Simon Rushton, p.32-33

¹⁰ Sara E. Davies, Adam Kamradt-Scott, Simon Rushton, p. 34

¹¹ <https://extranet.who.int/goarn/> (11.12.20)

act on non-state reports, which was an important moment in the IHR revision process. By mid-2001, the revision process moved forward again and a new deadline (May 2004) was set.¹²

In 2002, the secretariat released the proposed changes in a discussion paper that included ten proposals, the reasoning for them and the impact they would have. The main change was still the symptomatic reporting and that the WHO could act on the information from non-state sources, but it also addressed capacity issues the WHO and states could face in implementing the proposed changes. This version wanted to give the WHO not only the power to request more information from states about information about infectious diseases received from non-state sources, but also to send an investigative team and verify the country's ability to control an outbreak. Additionally, they would be able to make any rejection of this assistance by the country public. The proposal didn't focus on measures that prevent diseases from entering a country, but would have obliged countries to contain the outbreak at its source. In exchange countries that weren't affected would have to refrain from any measures that unduly disadvantaged these countries if they complied with the mandate. The WHO would have the power to recommend certain responses and states would have to justify any noncompliance.¹³

The main issues the countries originally couldn't agree on were travel and trade restrictions and the use of non-state sources by the WHO. Developed countries didn't fear infectious diseases as much anymore because they weren't as affected. They wanted to be able to put up trade and travel restrictions as they pleased with no or barely any restrictions, and the WHO to warn them with information from non-state sources. Countries not reporting because of the fear of such restrictions was one of the reasons the IHR did not work anymore. Developing countries, however, still feared these restrictions and didn't want non-state sources to be used. They wanted to limit the possible trade and travel restrictions countries could impose and hold them accountable for unjust restrictions.¹⁴ The discussion paper adhered to some of the wishes of both parties, but some still criticized the need to report all disease outbreaks that might constitute an international risk and not just specific diseases.¹⁵

The emergence of a new Severe Acute Respiratory Syndrome (SARS, the specific virus is now called SARS-CoV-1) in 2002 served as a lesson and wake-up call for the international

¹² Sara E. Davies, Adam Kamradt-Scott, Simon Rushton, p. 34-36

¹³ Sara E. Davies, Adam Kamradt-Scott, Simon Rushton, p. 36-40

¹⁴ Eyal Benvenisti, *The WHO—Destined to Fail?: Political Cooperation and the COVID-19 Pandemic*, (2020) 114/4 AJIL, <https://www.cambridge.org/core/journals/american-journal-of-international-law/article/whodestined-to-fail-political-cooperation-and-the-covid19-pandemic/3E21388DFF4D343F23B1667F44F131CE> (03.11.2020), p. 595

¹⁵ Sara E. Davies, Adam Kamradt-Scott, Simon Rushton, p.44

community. The disease demonstrated that international cooperation is absolutely necessary for health security and that reporting obligations have to include disease outbreaks of unknown and not named diseases. SARS-CoV-1 was a new and unknown virus that spread quickly and easily through international travel and China, where it emerged, wasn't obligated to report the disease to the WHO under the IHR at the time. This threat of a disease that legally nobody had to report lead to a new and vested interest in the revision process. Especially developed countries learned they weren't invincible against infectious diseases. After the outbreak, the D-G allocated an extra ten million US dollars to the revision process of the IHR. This common experience of such a significant threat is what led to the IHR being passed unanimously by the WHA in 2005. It is questionable if the IHR revision process would have ever been successful without the emergence of SARS-CoV-1. ¹⁶

During the SARS-CoV-1 outbreak, most countries complied with the WHO recommendations although there was no formal obligation to do so. With this background, the 2004 drafting process was met with a new seriousness of the matter, states didn't have before. The countries did agree on substantial changes and more restrictive norms, but some room for dodging their responsibility was left. It was obvious that states which did not comply would face substantially more criticism and were more vulnerable to it after SARS-CoV-1. The lessons learned and the collective experience shaped the new norms. The political leaders realized that acting in isolation would not work anymore in the face of globalization and new diseases. It was not feasible any more to just try and stop the disease at the border. Therefore, it was necessary to have a better international detection and containment at the source strategy. ¹⁷

1.3 International Health Regulations 2005

The 58th WHA adopted the revised International Health Regulations on May 23rd, 2005 unanimously (WHA 58.3).¹⁸ They entered into force in June of 2007. They include 66 Articles in ten parts, nine annexes and two appendices. It is among the most widely adopted instruments in the world. All 194 WHO member states, the Holy See and Lichtenstein are legally bound by the IHR. Therefore, 196 countries are bound by these regulations. ¹⁹

¹⁶ Adam Kamradt-Scott, p. 246 Sara E. Davies, Adam Kamradt-Scott, Simon Rushton, p.43-45

¹⁷ Sara E. Davies, Adam Kamradt-Scott, Simon Rushton, p.72-73; Lawrence O. Gostin (2), *Global Health Law* (Harvard University Press, 2014), p.177

¹⁸ The full IHR can be found here: <https://www.who.int/ihr/9789241596664/en/> (13.12.2020)

¹⁹ Gian Luca Burci, Jakob Quirin, *Implementation of the International Health Regulations (2005): Recent Developments at the World Health Organization*, (2018) 22/13 American Society of International Law, <https://www.asil.org/insights/volume/22/issue/13/implementation-international-health-regulations-2005-recent-developments> (25.10.2020); Lawrence O. Gostin (2), p.177, 181

The purpose of the IHR is defined by Art. 2 of the norm as to “prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade.” This shows that the main and original purpose of international health regulations, to balance trade and travel with the protection against the spread of a disease, is still the main purpose. What changed are the tools to do so. Their goal is to do this with an ongoing national and international surveillance and response system. They try to balance the economy as well as, human rights and health, which leads to trade-offs. Art. 1 of the regulations consists of all necessary definitions.²⁰

Art. 3 explains the principles of the IHR, most importantly that the regulations have to be implemented “with full respect for the dignity, human rights and fundamental freedoms of persons.” Art. 4 nominates the establishment of “National IHR Focal Points”. Since the sharing of information regarding diseases is one of the most important goals of the new IHR, these focal points are the instrument through which countries have direct contact between them and the WHO and have to be accessible at all times. The state parties are obligated to build, strengthen, and maintain public health capacities that can detect, assess, notify and report disease events according to Art. 5 and Annex 1. States are supposed to have these capacities built no later than five years after implementation. Additionally, states have to create a response plan for Public Health Emergencies and Pandemics within two years of IHR implementation. Therefore, every member state was supposed to have these systems in place and functioning by 2012 or 2009 for the response plan. It was up to the states parties how they implemented these standards and more importantly how to finance them. The establishment of focal points was possible for almost every country, but by 2010 only half of the countries fulfilled all of the IHR obligations.²¹

One of the most important tools of the IHR is defined in Art. 6. This obliges states to notify the WHO within 24 hours via the Focal Point of all events that may constitute a public health emergency of international concern (PHEIC) within their territory. This would be an unexpected or unusual event of international concern no matter what source it is coming from or what caused it. Therefore, this includes human made pathogens. Annex 2 provides states

²⁰ International Health Regulations (IHR, adopted 23 May 2005, entered into force 15 June 2007); Lawrence O. Gostin (2), p. 182, 184, 186

²¹ IHR (2005); Alexander Hiersche, Kerstin Holzinger, Birgit Eibl, *Handbuch des Epidemierechts: unter besonderer Berücksichtigung der Regelungen betreffend COVID-19*, (MANZ'sche Verlags- und Universitätsbuchhandlung, 2020), p. 75; Lawrence O. Gostin (2), p. 183-184, 186-187; Armin von Bogdandy, Pedro A. Villarreal, p. 7

with a decision instrument to help determine if an event should be reported. Annex 2 still names diseases which have to be reported if a case of them occurs (Smallpox, Poliomyelitis due to wild-type poliovirus, human influenza caused by a new subtype and SARS. There are other named diseases that have to be reported if they have a certain impact, and a general clause that includes diseases of unknown causes or sources and under which circumstances they should be reported. The state has to continue communication with the WHO concerning what they know and learn along the way.²²

Art. 9 allows the WHO to take into account other reports from non-state sources. The organization has to assess these reports and confront the state party of the affected territory in accordance with Art. 10 before taking any action. Art. 9 additionally asks states which have identified evidence of a public health risk that may cause international spread, because of exported or imported goods or people who were diseased or contaminated, to report this to the WHO within 24 hours. Art. 10 gives the WHO the right to request verification from state parties for reports it received from non-state sources. The states have to answer within 24 hours with an initial reply or acknowledgment of the request and have to inform the organization within another 24 hours of all the available public health information of the event. If the WHO receives information that indicates a possible PHEIC, it has to offer the state its collaboration in the assessment of the situation.²³

According to Art. 12, the Director-General has to determine if an event is a PHEIC and declare it as such if that is his or her conclusion. In this decision, the D-G shall confer with the affected states and the Emergency Committee established in accordance with Art. 48. He/ She is not bound by either opinion. The Emergency Committee is established by the D-G. Its members are selected from a roster of experts. The D-G should choose people who have the required expertise for the relevant situation and the affected territories should be somewhat represented by them. The roster itself is also established by the D-G. This Emergency Committee turned out to be an important decision making instrument since the D-G always decided in accordance with their advice. The insight in these committees is only given through one, often short, statement. Therefore, the public doesn't get much information about the exact discussion or the reasoning for differing opinions. The D-G has to end the PHEIC after

²² IHR (2005); Armin von Bogdandy, Pedro A. Villarreal, p.7, Lawrence O. Gostin (2), p. 187;

²³ IHR (2005); Alexander Hiersche, Kerstin Holzinger, Birgit Eibl, p. 75; Armin von Bogdandy, Pedro A. Villarreal, p.8; Lawrence O. Gostin (2), p. 189

consulting with the affected states and the Emergency committee if he/she considers the emergency has ended (Art. 12 (5), Art. 49).²⁴

What constitutes a Public Health Emergency of International Concern is defined by the IHR in Art. 1. It is an “extraordinary event which is determined, as provided in these Regulations: (i) to constitute a public health risk to other States through the international spread of disease and (ii) to potentially require a coordinated international response”. The declaring of a PHEIC in itself does not lead to new obligations for states, but the states are required to establish a response plan in accordance with Art. 13.²⁵

The D-G additionally has to make temporary recommendations (Art. 15) if a PHEIC is declared. In this, the Emergency Committee also has to advise him according to Art. 49. The WHO can also make standing recommendations for health measures for routine or periodic application according to Art. 16, following the procedure of Art. 53. Art. 18 lists measures the WHO may recommend to states. They are split into recommendations concerning people and recommendations concerning cargo, goods, containers, etc. According to Art. 1 and Art. 15, the temporary recommendations may be implemented by member states and therefore non-binding. However, Art. 43 requires state parties who exceed recommended health measures implemented by or through the IHR to inform the WHO of their implementation if they significantly interfere with international traffic. The state has to name the additional health measure and explain why it is scientifically necessary. The WHO can then, after reviewing the information, ask the state to reconsider the measure. The organization has no tool to enforce this Article except for naming and shaming the country.²⁶

Part IV (Art. 19-22) includes norms about designated ports of entry. States have to name ports of entry that have specific capacities named in Annex 1 and 3, i.e. appropriate diagnostic facilities, the equipment and personnel to transport sick travellers to an appropriate medical facility, etc. Part V (Art. 23- 34) deals with possible public health measures. It limits the possible measures countries can put in place against the importation of diseases and always favours the least restrictive measure. This includes gathering information about travellers, i.e. where they are coming from, how they can be contacted, non-invasive medical examinations, etc. and inspection of baggage, cargo, parcels, etc. (Art. 23). States can also not refuse entry for lorries, buses, etc., if they only passed through affected areas, without embarking, disembarking or loading and discharging of goods (Art. 26). Part V also regulates what states can do with

²⁴ IHR (2005); Armin von Bogdandy, Pedro A. Villarreal, p. 11-13, Lawrence O. Gostin (2), p. 191, 195;

²⁵ IHR (2005); Armin von Bogdandy, Pedro A. Villarreal, p. 12; Lawrence O. Gostin (2), p. 185;

²⁶ IHR (2005); Armin von Bogdandy, Pedro A. Villarreal, p. 15; Lawrence O. Gostin (2), p. 195-196;

affected conveyances (Art. 27), if there are signs of infection. Art. 31 defines what health measures are possible for travellers when entering their territory. This includes when medical examinations, vaccines and other prophylaxes are allowed and under which circumstances, as well as how travellers who require treatment have to be handled and treated (Art. 32). Art 33- and 34 have special provisions for cargo, goods etc.²⁷

Part VI (Art. 35-39) consists of norms about what health documents can be requested for entry. Part VII (Art. 40-41) regulates how charges for the health measures are to be handled and who can be charged for what. According to Art. 40, international travellers who don't seek temporary or permanent residency cannot be charged for the cost of measures at the point of entry like medical examinations, vaccinations and other prophylaxes that are not a requirement that was published at least 10 days beforehand, appropriate quarantine or isolation or measures concerning the baggage they are carrying. Art. 41 contains norms for charges for health measures regarding cargo, containers, etc. Part VIII (Art 42-46) regards general provisions about the health measures states should and shouldn't implement. It also includes provisions for collaboration, the treatment of personal data and the transport of biological substances and similar materials.²⁸

Part IX (Art. 47-53) deals with procedures concerning the establishment of the Emergency Committee and Review Committee. The Review Committee is an expert committee that can be established by the D-G to make recommendations on amending the IHR, advise on standing recommendations and if they should be altered or terminated, as well as anything the D-G asks them to look at regarding the functioning of the IHR (Art. 50). Two of these committees have been established before 2020 and written their final reports. One was established during the H1N1 pandemic in 2009 and the second concerned the West African Ebola virus outbreak from 2014-2016. Both committees were tasked with reviewing the functioning of the IHR during these outbreaks. They mostly criticized failing structures to alert the WHO of a possible PHEIC and pointed out that most countries that didn't have them couldn't afford them. They also gave recommendations on how internal structures could be improved. Finally there was, an accusation during the H1N1 pandemic that the alert for this disease was prematurely raised. The Reports of the Review Committees never lead to any substantial changes.²⁹

Part X (Art. 54-66) includes some general provisions, i.e. amendments, the relationship of the IHR with other international agreements, entry into force, etc. and a reviewing system.

²⁷ IHR (2005); Armin von Bogdandy, Pedro A. Villarreal, p. 9; Lawrence O. Gostin (2), p. 196-197

²⁸ IHR (2005); Armin von Bogdandy, Pedro A. Villarreal, p. 9-10; Lawrence O. Gostin (2), p. 195

²⁹ IHR (2005); Armin von Bogdandy, Pedro A. Villarreal, p. 10, 16; Lawrence O. Gostin (2), p. 195

States and the D-G have to regularly report to the WHA on the implementation of the Regulations (Art. 54). The WHA has to repeatedly review the functionality of the Regulations. Since the WHA consists of delegations from the Member States, which are all members of the IHR, they are checking on themselves and each other. Art. 56 provides a possibility of dispute settling between state parties concerning the interpretation or application of the Regulations. States can do this if they tried to settle the conflict themselves beforehand. If that didn't work and all parties agree, they can bring the conflict to the D-G who then has to try and settle the conflict. If all states agree, arbitration is possible. The D-G then has to inform the WHA. A dispute settlement under this regulation has never occurred. If the states have a conflict with the WHO regarding the regulations it has to be submitted to the WHA.³⁰

1.3.1 Covid-19 and the IHR

In December of 2019 a virus that caused an atypical pneumonia was identified. The virus was later named SARS-COV-2. The WHO office in China reported a cluster of a virus in December of 2019. China isolated the virus on January 7th, 2020 and shared its genetic sequence on January 12th. This was necessary so others could diagnose the virus.³¹

On the 22nd of January, 2020, the D-G convened an IHR Emergency Committee in regards to the new virus.³² The Committee didn't conclude anything. The D-G asked them to convene again the next day. At this point, the Committee decided that the outbreak was very serious but that it wasn't a PHEIC. They decided to observe the situation and reconvene soon. The Statements of the Committee however show that there was a divide between the members, as some were for recommending that a PHEIC should be declared. The members who were against it thought that there wasn't enough information yet. At this point, there were first known cases outside of China which could be traced back to travel to the affected region. The Committee reconvened for a third meeting on Jan. 30th, 2020. At this meeting it decided on recommending the declaring of a PHEIC to the D-G which he did that day and made temporary recommendations. At this point there were 19 countries affected by the virus and 4 reported human to human transmission outside of China.³³

³⁰ IHR (2005); Armin von Bogdandy, Pedro A. Villarreal, p. 10; Gian Luca Burci, Jakob Quirin (ASIL); Lawrence O. Gostin (2), p. 197

³¹ Anastasia Telesetsky, *International Governance of Global Health Pandemics*, (2020) 24/3 ASIL insights, <https://www.asil.org/insights/volume/24/issue/3/international-governance-global-health-pandemics> (14.11.2020)

³² The members and statements of the Committee can be found here: <https://www.who.int/groups/covid-19-ihr-emergency-committee> (14.11.2020)

³³ Statement on the first meeting of the International Health Regulations (2005) Emergency Committee regarding the outbreak of novel coronavirus (2019-nCoV), [https://www.who.int/news/item/23-01-2020-statement-on-the-meeting-of-the-international-health-regulations-\(2005\)-emergency-committee-regarding-](https://www.who.int/news/item/23-01-2020-statement-on-the-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-)

The assessment of this and the temporary recommendations continue to be reviewed and updated. As of writing this, the Emergency Committee met the last time at the end of October. The recommendations are mostly general and include things like Contact Tracing, research, sharing of information, reconsidering measures regarding travel regularly in compliance with Art. 43 of the IHR, etc.³⁴ When a new variant of SARS-CoV-2 that could be more infectious emerged in December of 2020 in the UK, multiple countries imposed strict travel bans on passengers and planes from there.³⁵ In light of this, the WHO, while not telling them not to impose these restrictions, reminded them of their obligation under Art. 43, the previous advice of the Emergency Committee and that their travel restrictions have to be “risk-based, evidence-based, coherent, proportionate and time limited” in a statement from 21, December 2020.³⁶

A “Review Committee on the Functioning of the International Health Regulations (2005) during the COVID-19 Response” has been established by the D-G after the WHA asked him to in resolution WHA73.1. It started its work at the beginning of September 2020. In November, the committee gave a Statement at the resumed 73rd WHA. They presented their preliminary findings, though most areas will have to be further examined. In this statement they clearly pointed out that an effective response needs strong public health care systems. Additionally it concluded that the Rapid Response System of the WHO is very important and that official as well as unofficial surveillance information is essential, even if it is only based on rumours. This point needs to be understood completely by member states and other international organizations. The committee regularly hold open meetings and give out statements. The deadline for their final report is May 2021 at the 74th WHA.³⁷

[the-outbreak-of-novel-coronavirus-\(2019-ncov\)](https://www.who.int/emergencies/diseases/novel-coronavirus-2019/interactive-timeline#!) (12.12.2020); Timeline: WHO's COVID-19 response, <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/interactive-timeline#!> (12.12.2020); Mark Eccleston-Turner, *COVID-19 Symposium: The Declaration of a Public Health Emergency of International Concern in International Law* (2020) *Opinio Juris*, <http://opiniojuris.org/2020/03/31/covid-19-symposium-the-declaration-of-a-public-health-emergency-of-international-concern-in-international-law/> (15.11.2020)

³⁴ The full statement can be found here: [https://www.who.int/news/item/30-10-2020-statement-on-the-fifth-meeting-of-the-international-health-regulations-\(2005\)-emergency-committee-regarding-the-coronavirus-disease-\(covid-19\)-pandemic](https://www.who.int/news/item/30-10-2020-statement-on-the-fifth-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-coronavirus-disease-(covid-19)-pandemic) (22.12.2020)

³⁵ *Covid: Nations impose UK travel bans over new variant*, <https://www.bbc.com/news/world-europe-55385768> (22.12.2020); Amy Woodyatt, Taylor Barnes, Tara John, *Canada the latest country to halt travel from UK over new Covid-19 variant concerns*, <https://edition.cnn.com/2020/12/20/uk/uk-coronavirus-variant-intl-gbr/index.html> (22.12.2020)

³⁶ SARS-CoV-2 Variant – United Kingdom, <https://www.who.int/csr/don/21-december-2020-sars-cov-2-variant-united-kingdom/en/> (22.12.2020)

³⁷ Statement to the resumed 73rd World Health Assembly by the Chair of the Review Committee on the Functioning of the International Health Regulations (2005) during the COVID-19 Response, <https://www.who.int/news/item/09-11-2020-statement-73rd-wha-chair-of-the-review-committee-IHR-covid-19> (12.12.2020); Overview of Review Committee, <https://www.who.int/teams/ihr/ihr-review-committees/covid-19> (12.12.2020)

The Chinese authorities have repeatedly been accused of not notifying the WHO and the global community early enough of a possible PHEIC. Some even accused them of purposely not reporting the virus and especially how it gets transmitted. This would strengthen the need for non-state sources to help detect diseases in the revised IHR. The WHO in return has been criticized for not declaring a PHEIC fast enough and for not questioning the information it initially received from the Chinese government.³⁸ The outbreak and spread of the disease might have progressed differently if China had complied with the IHR. Some legal scholars suggested the possibility of taking China to the ICJ (International Court of Justice) for reimbursement for the financial damages caused by them not complying with the Regulations and reporting the virus in due time. This would certainly be difficult to prove. It would also be hard to differentiate how much of the damage was caused by China's not complying and how much by other states' actions themselves.³⁹

The possibility of using non-state sources seems crucial for situations like that, but this instance highlights some problems of that option. The WHO has to consult with the state where the outbreak occurred. The organization can then only share the information received from non-state sources if the state refuses to cooperate and there is a significant public health risk. The main problem in this case is that the WHO is supposed to reveal the source to the affected state. They are allowed to keep the source confidential if it is duly justified. This might be the case if for example a scientist or medical expert inside of China warned the WHO of the outbreak if he or she had a legitimate fear of punishment or severe consequences by the state authorities. Therefore, if they know of the clause it could severely discourage them or other whistle-blowers, as the fear of being found out might increase.⁴⁰

Except for that issue the scientific cooperation in fighting COVID-19 worked quite well. The political cooperation, on the other hand, could have been better. Most countries set out to fight the virus by themselves, cutting off their countries with travel bans and strict quarantines.

³⁸ José E. Alvarez, *The WHO in the Age of the Coronavirus*, (2020) 114/4 AJIL, <https://www-cambridge-org.uaccess.univie.ac.at/core/journals/american-journal-of-international-law/article/who-in-the-age-of-the-coronavirus/93BD64CBE2E5E6557E95E8CAC635BEAD> (01.11.2020), p.579, Julia Belluz, *China hid the severity of its coronavirus outbreak and muzzled whistle blowers — because it can* <https://www.vox.com/2020/2/10/21124881/coronavirus-outbreak-china-li-wenliang-world-health-organization> (16.12.2020); Chris Buckley, Steven Lee Myers, *As New Coronavirus Spread, China's Old Habits Delayed Fight*, <https://www.nytimes.com/2020/02/01/world/asia/china-coronavirus.html> , (16.12.2020)

³⁹ Francisco-José Quintana, Justina Uriburu, *Modest International Law: COVID-19, International Legal Responses, and Depolitization*, (2020) 114/4 AJIL, <https://doi.org/10.1017/ajil.2020.65> (03.11.2020), p.688-689; Peter Tzeng, *Taking China to the International Court of Justice over COVID-19*, (April 2020) <https://www.ejiltalk.org/taking-china-to-the-international-court-of-justice-over-covid-19/> (01.11.2020);

⁴⁰ Eyal Benevenisti, p.595-596

The measures varied from country to country. A consensus on the best measures still do not exist. Most countries do not even recommend the same amount of distance that people should keep between one another to avoid infection. The Center for Disease Control and prevention (CDC) in the US recommends to keep a distance of 6 feet, which is about 1.8 meters. The Austrian Government only requires a distance of one meter, while the UK government requires people to stay two meters apart without a facemask. ⁴¹

2. Framework Convention on Tobacco Control

A global health threat there is more agreement on is the danger of smoking. Tobacco is one of the leading causes of preventable deaths in the world. 100 million people died of tobacco consumption in the 20th century. This legal substance kills about 8 million people every year. Most of the victims live in low and middle income countries and are concentrated among poor, less educated people and racial minorities. Tobacco consumption is also very high among mentally ill people. Use of tobacco leads to high health care costs and contributes to poverty. It is an addiction and often people end up spending money on tobacco rather than basic needs like housing or food and water. ⁴²

Smoking was very popular for at least the first half of the 20th century in the developed world. By the 1950's, half of male adults in the USA used tobacco products, for example. A 1964 report by the then Surgeon General of the U.S., Luther Terry, determined that smoking led to a 70% increase in mortality. This report was discussed broadly in national and international media reports. It led to a shift in the attitude towards smoking and the U.S: started restricting tobacco, with rules about health warnings on the product and banning advertisements for tobacco. Tobacco companies continued to use misinformation and misleading advertising campaigns to keep their business. Some examples of this manipulation was the label "light" on the products so they would appear more healthier or raising the nicotine content in cigarettes with filters so they would be more addictive. The tobacco industry is and was a huge multinational business with big funds and a strong interest in keeping people addicted and willing to do this through false claims and intense lobbying. This combined with a wide-spread

⁴¹ Eyal Benvenisti, p.589; CDC, <https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/social-distancing.html> (22.12.2020); Health ministry of Austria, [https://www.sozialministerium.at/Informationen-zum-Coronavirus/Coronavirus--Haeufig-gestellte-Fragen/FAQ--Mechanische-Schutzvorrichtung-\(MNS\).html](https://www.sozialministerium.at/Informationen-zum-Coronavirus/Coronavirus--Haeufig-gestellte-Fragen/FAQ--Mechanische-Schutzvorrichtung-(MNS).html) (22.12.2020); UK Government, <https://www.gov.uk/coronavirus> (20.12.2020)

⁴² Lawrence O. Gostin (2), p.205, 208; Tobacco Fact Sheet, <https://www.who.int/news-room/fact-sheets/detail/tobacco> (12.12.2020)

belief that the negative effects of tobacco consumption are self-inflicted and therefore not a problem concerning the broad public made regulating tobacco politically challenging.⁴³

In the U.S., the public image of tobacco finally completely changed by the 1990ies for multiple reasons. Leaked documents proved that the tobacco industry knew how harmful its product were, how it tried to conceal this fact and that children and adolescents were specifically targeted with misinformation campaigns. As a result of this leak many lawsuits followed and their extensive media coverage made the topic ever present. This fuelled a wider social movement consisting of professionals, civil society and philanthropists who invested large amounts of money in the cause of stopping or limiting tobacco consumption and holding big tobacco companies accountable. By the late 1990's, most industrialized countries had implemented strict regulatory measures for tobacco and the consumption dropped significantly. This lead the tobacco companies to shift their marketing and attention to the unregulated markets of developing countries.⁴⁴

With the shift of aggressive marketing to poorly regulated countries in Africa, Asia, Eastern Europe and Latin America and an increasing problem of illicit trade which undermined the implemented regulations, where they existed, international cooperation became necessary. Tobacco had become a worldwide problem that had been proven to be harmful and it had become clear that tobacco companies would do whatever they could to market their product. In response to the problem the WHA, in May of 1995 decided to ask the D-G to write a report about the possibility of an international convention concerning tobacco control to be adopted by the UN.⁴⁵

Drafting the Framework convention was still politically challenging. The big civil society movement behind it, consisting of professionals, NGOs, etc., which rigidly lobbied for the cause was one of the reasons an agreement could be reached. The Intergovernmental Negotiation Body (INB) was charged with negotiating the treaty and held 6 formal negations. Over 170 states participated with at least one delegate. Additionally, advocacy networks and scientific expert's attended the negotiations. The Framework Convention on Tobacco Control was adopted by the WHA in 2003 and opened for signature by June of that year. 168 countries signed the convention by the end of the signature period and the document is one of the most

⁴³ Lawrence O. Gostin (2), p. 210-211

⁴⁴ Lawrence O. Gostin (2), p. 212-213, Gian Luca Burci, Claude-Henri Vignes, *World Health Organization*, (Kluwer Law International, 2004), p. 126

⁴⁵ Lawrence O. Gostin (2), p. 213; Gian Luca Burci, Claude-Henri Vignes, p. 126-127

rapidly and widely accepted treaties in UN history. It entered into force in Feb 27th, 2005.⁴⁶ Currently the treaty has 182 parties which make up more than 90% of the world population.⁴⁷ This was possible because tobacco is the only legal but consistently harmful product and by that point the tobacco industry had been discredited for all the things they did as explained above.⁴⁸

The Framework Convention on Tobacco Control (FCTC) is the only treaty adopted by the WHA under Art. 19 and 20 of the WHO Constitution.⁴⁹ These Articles allow the WHA to adopt conventions or agreements within the competence of the organization with a 2/3 majority. This then is binding for every member state that accepts it within its constitutional process. If the state doesn't accept the convention or agreement within 18 months of the decision it has to give a statement to D-G with the reasons for that. It is the only treaty adopted by the WHA under these articles.⁵⁰

The FCTC created binding norms regarding the demand reduction, supply reduction and the sharing of resources and information concerning tobacco (consumption). It also formed a convention secretariat that regularly has to create a report on the progress of the implementation of the FCTC. The convention established a scheme for tobacco control policies. The guiding principles are listed in Art. 4 and include informing the public about the danger of tobacco, promoting international cooperation and civil society engagement, and creating political support. The obligations of the convention entails strategies for achieving the goal of protecting people from the harm tobacco causes, for states to implement tobacco-control plans and regulations, and achieving this in cooperation with each other and the organization.⁵¹

The FCTC accomplished 3 improvements. First, it spurred cooperation concerning problems of cross-border advertisement and illicit trade. Second, it created an international exchange and increased advocacy. Lastly, it managed to create international agreement on social norms, scientific facts and public health concerning tobacco. One of the FCTC's core capacities is to coordinate and promote research and ensure national and international

⁴⁶ Lawrence O. Gostin (2), p. 213-214, Heather L. Wipfli, Kayo Fujimoto, Thomas W. Valente, *Global Tobacco Control Diffusion: The Case of the Framework Convention on Tobacco Control*, (2010) 100/7 American Journal of Public Health, p. 1260

⁴⁷ Parties to the WHO Framework Convention on Tobacco Control, <https://www.who.int/fctc/cop/en/> (13.12.2020)

⁴⁸ L.O.Gostin, D.Sridhar, D.Hougendobler, *The normative authority of the World Health Organization*, (2015) 129/7 Public Health, p. 856

⁴⁹ The full text of the FCTC can be found here: https://www.who.int/fctc/text_download/en/ (13.12.2020)

⁵⁰ Jan Klabbers, *The Normative Gap in International Organizations Law: The Case of the World Health Organization*, (2019) 16/2 International Organizations Law Review, p. 287-288; Lawrence O. Gostin (2), p. 215,

⁵¹ Lawrence O. Gostin (2), p. 214-216, Heather L. Wipfli, Kayo Fujimoto, Thomas W. Valente, p.1260

cooperation, including an exchange on scientific, socioeconomic, technical and legal information. However, it didn't manage to agree on an explicit trade provision. Tobacco companies are still trying to litigate against some regulations in domestic courts arguing that public health should not be treated as more important than economic interests.⁵²

One of the most recent examples for litigation concerning tobacco control measures is Philip Morris v. Uruguay. Uruguay passed new legislation with the aim of limiting tobacco consumption in 2008 and 2009. The tobacco company Philip Morris tried to challenge two of these measures in Uruguay's domestic courts and, when that failed, they requested arbitration by the International Centre for Settlement of Investment Disputes (ICSID), arguing that Uruguay was in breach of the Switzerland - Uruguay bilateral investment treaty (BIT). Philip Morris is a Swiss company. The measures challenged were one that mandated that cigarette packaging by one company had to have the same presentation, therefore the brand could not have different colour or design on their packaging for different kinds, and one that required that 80% of tobacco packaging has to be covered in health warnings. The tribunal decided in 2016 that Uruguay was not in breach of the treaty and referred to the FCTC in the decision which Uruguay is bound to and which explicitly names measures like the ones implemented.⁵³

The FCTC has a governing body called the Conference of the Parties (COP). It is tasked with reviewing and promoting the treaty. To do this, it can and should adopt new protocols, annexes and amendments according to Art. 23 of the Convention. These decisions need a 2/3 majority of the attending state parties, but a consensus should be sought after. The COP additionally has to establish the conventions secretariat (Art. 24). The Convention requires states to implement demand reduction strategies through taxing, prices and other measures. The states have to report the rates of tobacco consumption and its progression to the COP.⁵⁴

The FCTC also requires member states to protect people from environmental smoke in indoor public places and at the work place. (Art. 8). State parties have to warrant that manufacturers and importers make the contents and emissions of the tobacco product known and visible on the packaging. Packaging can not be false, misleading, deceptive or similar. Health warnings should cover at least 30% of the packaging but preferably more than 50%. The

⁵² Lawrence O. Gostin (2), p. 215-216, 229

⁵³ Kate Mitchell, *Philip Morris v Uruguay: an affirmation of 'Police Powers' and 'Regulatory Power in the Public Interest' in International Investment Law*, (July 28, 2016) EJIL <https://www.ejiltalk.org/philip-morris-v-uruguay-an-affirmation-of-police-powers-and-regulatory-power-in-the-public-interest-in-international-investment-law/> (13.12.2020); Cornelia Kirchbach, *Das Recht auf gesundheitliche Regulierung im Investitionsschiedsverfahrensrecht : Dargestellt am Beispiel von Philip Morris v. Uruguay*, (Nomos Verlagsgesellschaft mbH & Co. KG, 2019) p. 43, 48-49

⁵⁴ Lawrence O. Gostin (2), p. 217-219

promotion of tobacco products like advertisements has to be banned if it is in accordance with the state's constitutional principles (Art.13). Cross border advertisements are still a problem, but they also should be restricted according to the FCTC. States should additionally make the public aware of the hazards of tobacco consumption (Art.12). One of the important things to consider in all this is that smokers should not be punished. Smoking is an addiction that often started when tobacco users were very young. Therefore, states should do everything they can to help them reduce their consumption or quit.⁵⁵

The FCTC also expects states to implement measures against illicit trade. These include a tracking and tracing system for tobacco products so the distribution chain can be secured. Therefore, states should monitor trade across borders and gather and share data with one another. Moreover, they should enforce penalties for illicit trade, along with confiscating the goods and prosecuting the organizations behind the trading. The first FCTC protocol focused on illicit trade. The Convention requires states to outlaw tobacco being sold to minors. States are asked to provide and promote alternative work for people whose livelihood depends on the tobacco industry.⁵⁶

3. Other treaties

Human rights generally afford people the right to good health. There are two foundational human rights treaties. Almost all states have ratified at least one of them. One is the International Covenant on Economic, Social and Cultural Rights (ICESCR)⁵⁷, the other is the International Covenant on Civil and Political Rights (ICCPR)⁵⁸. Both were adopted and opened for signature and ratification by the UN General Assembly in resolution 2200A (XXI) on December 16th, 1966. However, there are still vast inequalities in health care and access to it. Human rights are often violated and the enforcement is frail.⁵⁹ Even the richest and most developed countries have obvious shortcomings in their health care in regards to the treatment of women, racial and ethnic minorities, LGBTIQ+ people and other marginalized groups like the homeless.⁶⁰ One current example is that black, indigenous and Latino U.S. Americans were

⁵⁵ Lawrence O. Gostin (2), p.219-220, 222-225; G. Lien, K. DeLand, *Translating the WHO Framework Convention on Tobacco Control (FCTC): Can we use tobacco control as a model for other non-communicable disease control?*, (2011) 125/12 Public Health, p.850-851

⁵⁶ Lawrence O. Gostin (2), p. 226-228

⁵⁷ Full text: <https://www.ohchr.org/en/professionalinterest/pages/cescr.aspx> (13.12.2020)

⁵⁸ Full text: <https://www.ohchr.org/EN/ProfessionalInterest/Pages/CCPR.aspx> (13.12.2020)

⁵⁹ Lawrence O. Gostin (2), p. 244; <https://www.ohchr.org/en/professionalinterest/pages/cescr.aspx> (13.12.2020); <https://www.ohchr.org/EN/ProfessionalInterest/Pages/CCPR.aspx> (13.12.2020)

⁶⁰ i.e. Jennie Jacobs Kronenfeld, *Health and Health Care Concerns Among Women and Racial and Ethnic Minorities*, (Emerald Publishing, 2017); Bernadette Redl, *Wie die Medizin Frauen schadet*, (03.05.2020) <https://www.derstandard.at/story/2000115247755/wie-die-medizin-frauen-schadet> (13.12.2020); Sarah Krill Williston, Jennifer H Martinez, Tahirah Abdullah; *Mental health stigma among people of color: An*

2.6 or 2.8 (depending on the race) times more likely to die from COVID-19 than white people.

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Human rights and health also interact with one another. Strict quarantines and limitations of bigger gatherings, can affect the right of assembly and freedom. Torture obviously leads to health issues and not allowing girls to get educated can lead to an increase in child and maternal mortality. The right to good nutrition, clean drinking water, education and information are also necessary for the health of human beings. Various social movements have led to a greater understanding of human rights and health, like the movement in the 1980ies demanding treatment and research concerning HIV/AIDS or the movement demanding tobacco control. One of the goals of the FCTC, as explored earlier, is information and the stopping of misleading information.⁶²

The Universal Declaration of Human Rights (UDHR) is the standard of human rights the international community agreed on. However, it is not a treaty but a statement by the UN General Assembly in a resolution from 1948 (General Assembly resolution 217 A), which lacks the formal force of law. It is never the less widely agreed on by international lawyers that its key provisions are binding. Art. 25 of the Declaration reads as follows: “(1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control. (2) Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.”⁶³

3.1 International Covenant on Economic, Social and Cultural Rights (ICESCR)

The ICESCR has been ratified by 171 parties and signed by 4 other states.⁶⁴ Art. 11 of the Covenant recognizes everybody’s right to an adequate standard of living. Art. 12 encompasses “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.” To achieve this, necessary measures to control or prevent epidemics have to be taken

examination of the impact of racial discrimination, (2019) International Journal of Social Psychiatry, <https://doi.org/10.1177/0020764019858651> (13.12.2020); Nina Sun, Applying Siracusa: A Call for a General Comment on Public Health Emergencies, (2020) 22/1 Health and Human Rights, <https://www.jstor.org/stable/26923512> (17.12.2020), p. 387-390

⁶¹ COVID-19 Hospitalization and Death by Race/Ethnicity, <https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html> (13.12.2020)

⁶² Lawrence O. Gostin (2), p. 245-246

⁶³ Lawrence O. Gostin (2), p. 247, 250; Universal Declaration of Human Rights, <https://www.un.org/en/universal-declaration-human-rights/index.html> (13.12.2020)

⁶⁴ <https://indicators.ohchr.org/> (13.12.2020)

by the states. Therefore, states have to do what is medically necessary to protect their population from diseases like COVID-19. This could include mass quarantines if less restrictive measures are not available and the threat is immense. Generally it is a difficult task to balance the right to free movement and assembly with the right to health, since they are both equally important human rights.⁶⁵

Additionally, the Covenant guarantees labour rights, social insurance, child protection, education, shared scientific benefits and the participation in cultural rights, all of which are important to attain and retain health. For example, safe working conditions and a fair wage as defined in Art. 7 are key for workers to avoid injuries and being able to afford nutritious foods. All member states have to take all necessary steps, including international assistance and cooperation, to maximize all resources so they can fully realize the Covenant's obligations.⁶⁶

All member states have to report their progress on implementing the Covenant to the UN Secretary General, who has to give copies of the reports to the UN Economic and Social Council (ECOSOC). The ECOSOC established the Committee on Economic, Social and Cultural Rights (CESCR), which has taken over from the ECOSOC in monitoring the progress of the implementation of the Covenant. It reviews the state reports and gives them recommendations for improvement and better and/or further implementation.⁶⁷ The CESCR also issues General Comments on the Covenant. General Comment No. 14 states that the right to health includes measures against infectious diseases and their outbreaks but limits any restrictions caused by them to the least restrictive option.⁶⁸

In June of 2008, the Human Rights Council adopted an Optional Protocol to the ICESCR (resolution 8/2).⁶⁹ It currently has 24 State Parties and additionally 25 states have signed the Protocol.⁷⁰ It has been in force since 2013. It gives individuals or groups of individuals the possibility to submit complaints to the CESCR if their rights granted by the ICESCR have been violated by a state party of the protocol. They can only do so if they have used all possible domestic options and can show that they have been harmed or the complaint concerns a serious

⁶⁵ Armin von Bogdandy, Pedro A. Villarreal, p. 20, Lawrence O. Gostin (2), p. 247, 250

⁶⁶ Lawrence O. Gostin (2), p. 251, International Covenant on Economic, Social and Cultural Rights, <https://www.ohchr.org/en/professionalinterest/pages/cescr.aspx> (13.12.2020)

⁶⁷ Lawrence O. Gostin (2), p. 252

⁶⁸ Diego S. Silva, Maxwell J. Smith, *Limiting Rights and Freedoms in the Context of Ebola and Other Public Health Emergencies: How the Principle of Reciprocity Can Enrich the Application of the Siracusa Principles*, (2015) 17/1 Health and Human Rights, <https://www.jstor.org/stable/healhumarigh.17.1.52> (17.11.2020), p. 52-53

⁶⁹ Optional Protocol to the International Covenant on Economic, Social and Cultural Rights, <https://www.ohchr.org/EN/ProfessionalInterest/Pages/OPCESCR.aspx> (14.12.2020)

⁷⁰ <https://indicators.ohchr.org/> (14.12.2020)

issue of universal significance. The CESCR can conduct its own investigation and the state concerned can submit a report concerning the complaint. The Committee then can make a decision and recommendations to the state on improvements. The state is not bound to fulfil them.⁷¹

3.2 International Covenant on Civil and Political Rights (ICCPR)

The ICCPR has been ratified by 117 States and signed by six.⁷² In contrast to the ICESCR, it does not include an article explicitly granting the right to health. It obliges states to respect and ensure civil and political rights. It protects rights like freedom of expression, opinion, religion, assembly, movement and from slavery, torture and arbitrary imprisonment. Furthermore, it grants the right to privacy, equal protection, asylum from prosecution, free elections, freedom to join labour unions, the right to life and the protection of minorities. In conclusion, it does not specifically mention a right to good health.⁷³

In my opinion, one could argue that besides the obvious health-related topics like protection from torture, slavery and prosecution, labour unions and even the right to privacy, the protection of minorities and equal protections will affect the health and well-being of humans. As discussed in the section on the ICESCR above, labour unions could protect workers from getting hurt or ill from overworking or inhaling toxic fumes, etc. and a right to paid sick leave will decrease the transmission of infectious diseases. Especially, with COVID-19 where symptoms differ vastly and can seem like a common cold, people can and will only stay home if they can afford it and it doesn't threaten their and their family's livelihood.⁷⁴ In my opinion, the protection of minority and equality clause could help in working against discrimination in health care systems and the right for privacy could help protect health related personal data. Moreover, the current pandemic has shown how difficult it can be to project the right to freedom of movement and assembly while trying to protect other human beings from getting infected and/or die.

The treaty's monitoring body is the Human Rights Committee. State Parties have to regularly submit reports on the progress of the Covenant's implementation. The Committee reviews the reports and makes further recommendations to the states. For instance they made a statement concerning health in asking the member states to take all possible actions to reduce

⁷¹ Lawrence O. Gostin (2), p.252

⁷² <https://indicators.ohchr.org/> (14.12.2020)

⁷³ Lawrence O. Gostin (2), p. 252

⁷⁴ Paid sick leave to protect income, health and jobs through the COVID-19 crisis, <https://www.oecd.org/coronavirus/policy-responses/paid-sick-leave-to-protect-income-health-and-jobs-through-the-covid-19-crisis-a9e1a154/> (19.12.2020)

infant mortality and increase life expectancy, particularly by eliminating epidemics and malnutrition. The ICCPR has two optional protocols. The first entered into force in 1976 with the covenant itself, the second was adopted in 1989. The second one involves the abolition of the death penalty and has 88 State Parties. The first optional Protocol has 116 State Parties and another 3 Signatories. The first Protocol concerns a complaint procedure for individuals. They can submit complaints to the Committee if their rights have been violated and they exhausted all domestic options. The Committee has to inform the affected State Party and the State then has to give a statement or explanation. The Committee then gives comments or recommendations. The state does not have to comply with them.⁷⁵

In an emergency that “threatens the life of the nation and the existence of which is officially proclaimed” states can deviate from the obligations of the Covenant, if the state does not discriminate against certain groups of people and some rights have to stay in place. These rights include the right to life, freedom from slavery, torture and arbitrary detention, the right to privacy, the freedom of thought, conscience and religion, etc. (Art.4).⁷⁶ What constitutes an emergency that gives states the permission to limit human rights is interpreted in the Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights. These Principles were established by a colloquium of experts in 1984 and reflect the state of international law. They reflect when emergencies are occurring and countries are therefore allowed to limit the rights guaranteed in the ICCPR. Every limitation has to be based on scientific evidence that proves necessity and efficiency. It has to be the least restrictive measure that is still effective.⁷⁷

The Siracusa Principles explicitly name serious threats to the health of (individual members of) the population as a possible reason for states to limit some rights of the ICCPR according to paragraph 25 of the principle. The measures have to be designed to prevent disease, injury or securing care for the sick or injured. Paragraph 26 exemplifies that for these measures the IHR of the WHO have to be consulted. The COVID-19 Pandemic would most likely be such an emergency that gives the states the power to restrict certain rights if they notify the UN Secretary General. However, one of the most common restrictions, lockdowns and mass quarantine, could not be allowed. The WHO never recommended them and according to Art.

⁷⁵ Lawrence O. Gostin (2), p. 253, <https://indicators.ohchr.org/> (14.12.2020), Optional Protocol, <https://www.ohchr.org/EN/ProfessionalInterest/Pages/OPCCPR1.aspx> (14.12.2020), Second Optional Protocol, <https://www.ohchr.org/EN/ProfessionalInterest/Pages/2ndOPCCPR.aspx> (14.12.2020)

⁷⁶ Lawrence O. Gostin (2), p. 256

⁷⁷ Siracusa Principles on the Limitation and Derogation Provisions in the ICCPR, <https://www.icj.org/wp-content/uploads/1984/07/Siracusa-principles-ICCPR-legal-submission-1985-eng.pdf> (14.12.2020); Nina Sun, p. 387-390, Diego S. Silva, Maxwell J. Smith, p. 54

18 of the IHR it would not be possible to recommend them. Only the isolation of people who have been infected or someone who has been or possibly has been exposed would be allowed. It is questionable that as long as the community spread is not enormous one could claim this for a huge population. Since the Siracusa Principles reference the IHRs and the WHO, some of the strictest measures seen during this pandemic might be in breach of the ICCPR.⁷⁸

3.3 Other tools and treaties

The WHA can issue recommendations and strategies according to Art. 23 of the WHO constitution. This option is the one used most often by the WHA for creating norms. The International Code of Marketing of Breast-Milk Substitutes from 1981 and the Global Code of Practice on the International Recruitment of Health Personnel from 2010 are two very prominent recommendations. The 64th WHA issued such an important recommendation for an infectious disease in 2011 and it has been in effect since then, the Pandemic Influenza Preparedness (PIP) Framework. This happened after the member states urged to implement such a Framework. Additionally, similar strategies have been used often, for example for the control of malaria and AIDS. While they are not legally binding, they do wield some authority.⁷⁹

The main goal of the PIP is to improve the sharing of information on influenza viruses and improve the access to vaccines and other supplies in developing countries. For the sharing of the genetic information of these influenza viruses and assessing their risks, the already established Global Influenza Surveillance and Response System (GISRS) is used. This system was established in 1952 and includes 150 public health laboratories in 122 member states. It is also responsible for the monitoring and surveillance of seasonal and pandemic influenza and alerts in case of novel influenza virus strains. The D-G is responsible for the promotion of the framework, but the WHA is responsible for the oversight, direction and coordination. An Advisory Committee advises the D-G on the implementation. The Committee is made up of 18 experts from all six WHO regions. The PIP framework was last reviewed in 2016.⁸⁰

The Nomenclature with Respect to Diseases and Causes of Death⁸¹ is the only regulation passed by the WHA based on Art. 21 and 22 of the WHO constitution, other than the ISR and

⁷⁸ Armin von Bogdandy, Pedro A. Villarreal, p. 19

⁷⁹ L.O.Gostin, D.Sridhar, D.Hougendobler, p. 855; Anastasia Telesetsky; Jan Klabbbers, p. 289; Pandemic Influenza Preparedness (PIP) Framework, <https://www.who.int/influenza/pip/en/> and <https://www.who.int/news-room/q-a-detail/pandemic-influenza-preparedness-framework> (14.11.2020)

⁸⁰ Anastasia Telesetsky; Pandemic Influenza Preparedness (PIP) Framework, <https://www.who.int/influenza/pip/en/> and <https://www.who.int/news-room/q-a-detail/pandemic-influenza-preparedness-framework> (14.11.2020); Global Influenza Surveillance and Response System, <https://www.who.int/initiatives/global-influenza-surveillance-and-response-system> (14.11.2020)

⁸¹ Full text: <https://www.who.int/classifications/icd/docs/en/NOMREGS.pdf> (20.12.2020)

IHR. Therefore, it is the only regulation based on that currently in force other than the IHR. The Nomenclature was adopted by the first WHA in 1948 and has been revised since then. Its main focus is to norm statistics about mortality, morbidity and death certificates. Member states have to publish these statistics annually. Its most important point however is that states have to use the International Classification of Diseases (ICD) for this. This document norms the global standard for health data, clinical documentation, and statistical collection. It defines disorders, diseases, injuries and so on and therefore it is a crucial tool for the international community to be able to communicate, but especially track health trends and statistics. It is regularly revised and states have to use the current version according to the Nomenclature. As of now the current version is the 11th edition.⁸²

Conclusion

Global health law has multiple instruments which are quite diverse and regard different areas. However, they all have the same goal: to protect the health of the global community. As was shown, the WHO, as the main international organization regarding health, has multiple powerful tools to create global health law. This possibility has been used to create very important norms, especially the IHR and the FCTC. The two of them were enacted on two different legal bases, one as binding regulations and the other one as a binding treaty, but the story of how they came to be highlights the difficulty the WHO has in creating new norms.

The revision of the IHR and the FCTC only occurred because of a prevailing global problem. The FCTC came to be because the international community wanted to be able to better handle big tobacco companies, limit the consumption for the health of the population and a social movement that reminded them constantly of the problem. It was a communal problem everybody could see. The revision of the IHR started with the WHO members agreeing that the regulations were outdated and needed to be revised in the face of newly emerging diseases and possible attacks using human made pathogens. They knew this situation called for a norm that regulated international cooperation. However, the process was slow and difficult and quickly lost the interest of the member states. That only changed when the global community faced a new health threat because of a novel virus, namely SARS-CoV-1. This push was what finally led to the revision. These examples show how difficult revising and creating new norms

⁸² L.O.Gostin, D.Sridhar, D.Hougendobler, p. 856; International Statistical Classification of Diseases and Related Health Problems (ICD), <https://www.who.int/standards/classifications/classification-of-diseases> (20.12.2020)

can be. Although the WHO has powerful tools to create new health regulations the process has to be supported by its member states.

Finally, in 2020, the novel virus SARS-COV-2 took over the world and highlighted the importance of global health law. This event made the global community remember how important the IHR and their tool of obligatory reporting of a PHEIC are. It also showed how much the Human Rights treaties mentioned above have to do with health and how they interact with the measures states imposed against the spread of the virus. Maybe this event will, in hindsight, have acted as a wake-up call for the international community like SARS-CoV-1 did in 2002. If so, maybe for first time it will lead to changes based on the recommendations given by the IHR review committee. As a result they could even add stricter consequences to the IHR if states do not comply with them. Perhaps, the WHO will in the future more often use the possibility of naming and shaming the countries non-conforming. As of now, one can only speculate but time will tell if and how this historical event will shape global health law in the future.

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