Combining the WHO's International Health Regulations (2005) with the UN Security Council's Powers: Does it Make Sense for Health Governance?

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Abstract

Does it make sense to modify and adapt the International Health Regulations (2005) (IHR) in light of the recent crises? Does it make sense to create legally binding effect for the World Health Organization's (WHO) temporary recommendations? Does it make sense to engage the United Nations Security Council? How can both be combined?

This article attempts to answer these questions. It addresses the pluriverse of actors in health governance with an emphasis on the WHO and the UN Security Council.

The assessment by the WHO's internal review may lead one to assume that it simply does not matter. During the Ebola-outbreak 2014, states disregarded the WHO's non-binding temporary recommendations. This article suggests that creating binding effects may not matter as much as lawyers would hope: Other issues are more pressing in times of crises. Creating legal effect may be theoretically possible, but it would probably not matter much during the next epidemic. A more sophisticated approach may be found in the WHO's IHR 2005, if states are prepared to re-interpret the existing law.

Engaging the Security Council is a good idea only for epidemics with negative impacts on a region's security. This is due to the mandate of the Security Council. In addition, legitimacy concerns with regard to the Security Council could be raised.

In contrast, it makes sense to focus on human rights law, which protects against the exercise of international public authority. It could lead to comprehensive international health governance, with the WHO at its core and the Security Council providing support where needed. Keeping the human

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right to the highest attainable standard of health care at the heart of health governance highlights for whom health governance works: the individuals affected by a pandemic.

I Introduction: The Ebola-Outbreak 2015 as a Global Health Crisis

Globalization exacerbates domestic health problems:[1] Diseases spread more easily to other parts of the world. Most recently, the outbreak of the Zika-virus in Latin America and the Caribbean, suspected to be connected to an observed increase in neurological disorders and neonatal malformations (2016),[2] caused worldwide fears.

The one example that stands out, however, is the Ebola-crisis starting in 2014. Starting with "patient zero", a two-year-old toddler, in a small village in Guinea,[3] the virus spread quickly through a region where Ebola was previously unknown. After affecting Guinea, Sierra Leone and Liberia and other states throughout the world, more than 11.323 lives were lost and more than 28.600 persons were infected.[4] Eventually, it turned out to be the biggest Ebola-outbreak in history by far.

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1 Instructive Aginam, O, "Mission (Im)possible? The WHO as a 'Norm Entrepreneur' in Global Health Governance", in Freeman, M, Hawkes, S & Bennett, B (eds.), *Law and Global Health*, 2014, 559 (564 et seq.), who explains the shift from "international" to "global" health. Meier, B M & Mori, L M, "The Highest Attainable Standard: Advancing a Collective Human Right to Public Health" (2005), 37 *Columbia Human Rights Law Review*, 101 (105 et seq.) and UN High-level Panel on the Global Response to Health Crises, *Protecting Humanity from Future Health Crises*, January 25, 2016, para. 40.

2 On February 1, 2016 the WHO determined the Zika-outbreak a public health emergency of international concern, see WHO, *Statement on the first meeting of the International Health Regulations (2005) (IHR 2005) Emergency Committee on Zika virus and observed increase in neurological disorders and neonatal malformations*, available at http://bit.ly/1STUtYL.

3 UN High-level Panel on the Global Response to Health Crises, *Protecting Humanity from Future Health Crises*, above Fn. 1, para. 9.

4 Data up to March 27, 2016 taken from the World Health Organization, available at http://apps.who.int/ebola/ebola-situation-reports. For a historic overview see Gostin, L O & Friedman, E, "A Retrospective and Prospective Analysis of the West African Ebola Virus Disease Epidemic: Robust National Health Systems at the Foundation and an Empowered WHO at the Apex" (2015), 385 *The Lancet*, 1902 (1902 et seq.).

Notwithstanding its severity, the number of victims, the region affected by the outbreak, and not the least the media's fear-mongering coverage regarding Ebola being a threat to Europe,[5] the international response has not been speedy and comprehensive.[6] Even while the outbreak continued, several review processes were initiated and tasked to look at how international health governance could be improved.[7] This paper attempts to review two contributions to the fight: Temporary recommendations by the WHO and Resolution 2177 (2015) by the UN Security Council. After stocktaking, improvements are suggested for the respective instrument. As a third way forward, the paper proposes to utilize human rights law as catalyst for health governance and health law.

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5 This holds true even for respectable news sources, see Elger, K, Hackenbroch, V & Knaup, H et al., "Gateway to Hell: The Threat of Ebola grows Worse" (September 8, 2014), *Spiegel Online International*, available at http://bit.ly/2lB67K0; Walker, T & Schmidt-Chanasit, J, "Is Europe taking the Ebola Threat seriously?" (Oktober 7, 2014), *Deutsche Welle*, available at http://www.dw.de/is-europe-taking-the-ebola-threat-seriously/a-17980662; "WHO warns of Ebola health care risks" (October 8, 2014), *BBC*, available at http://www.bbc.com/news/world-europe-29531671.

6 See Médecins Sans Frontières, *Ebola: Pushed to the limit and beyond. A critical analysis of the global Ebola response one year into the deadliest outbreak in history*, 2015, available at http://bit.ly/1OrjgQ8; Meier & Mori, "The Highest Attainable Standard", above Fn. 1, 101 (105 et seq.) as well as internal WHO documents published by The Associated Press dealing with the WHO's flawed attempts to combat the outbreak, available at http://apne.ws/1bGeijD. Criticism was also raised within the UN Security Council, Record of the 7502nd meeting of the Security Council, UN Doc. S/PV.7502 of August 13, 2015. The motifs for delaying response were already forecast by Davies, S & Youde, J, "The IHR (2005), Disease Surveillance, and the Individual in Global Health Politics" (2013), 17 *The International Journal of Human Rights*, 133 (134 et seq.); Silver, A, "Obstacles to Complying with the World Health Organization's 2005 International Health Regulations" (2009), 26 *Wisconsin International Law Journal*, 229 (235 et seq.).

7 See for example the UN Secretary General's High-Level Panel on Global Response to Health Crises or the WHO's own Ebola Interim Assessment Panel and Review Committee on the Role of the IHR (2005) in the Ebola Outbreak and Response.

II Pluriverse of Actors (1): The World Health Organization

1 Stocktaking

In international health governance, a pluriverse of actors undertakes the task of improving health: states, International Organizations as well as non-state actors work alone or together to combat diseases. Most prominently, the World Health Organization is tasked to attain for all peoples the highest possible level of health (Article 1 WHO Constitution).[8]

In order to do so, it has several possibilities at hand. In addition to the rather traditional and common possibilities to adopt conventions or agreements (Article 19 WHO Constitution) and to make recommendations (Article 23 WHO Constitution) there is a unique feature in WHO law: The authority of the WHO to issue legally binding regulations under Article 21 WHO Constitution.[9] This provision empowers the organization to adopt regulations concerning aspects specified in literae a-e. The key aspect is the entry-into-force: A convention or agreement adopted under this provision enters into force for all members after due notice has been given of its adoption (Article 22 WHO Constitution) – explicit consent is not required. As consequence, regulations adopted under Article 21 WHO Constitution are binding for Member States.[10] The only way to opt out of such an agreement for the state is to notify the Director-General of the rejection or a reservation by that state.

This is the legal ground for the International Health Regulations of 2005, or IHR (2005), which entered into force in 2007.[11] The IHR (2005) were the result of a reform process after the outbreak of the Severe Acute Respiratory Syndrome (SARS) in 2003 that affected more than 8.000 people

8 See Acconci, P, "The Reaction to the Ebola Epidemic within the United Nations framework: What Next for the World Health Organization?" in Lachmann, F, Röder, T J & Wolfrum, R (eds.), *Max Planck Yearbook of United Nations Law* 2014, 405 (406 et seq.).

9 Gostin, L O, *Global Health Law*, 2014, 111; Aginam, O, "Mission (Im)possible?", above Fn. 1, 559 (561).

10 Ruger, J, "Toward a Theory of a Right to Health: Capability and Incompletely Theorized Agreements" (2006), 18 *Yale Journal of Law & the Humanities*, 273 (312).

11 WHO, *International Health Regulations*, 2005, 2509 UNTS 179, thereinafter IHR (2005).

and killed 774 persons in 27 countries.[12] The preceding instruments were the IHR (1969),[13] which, as the name suggests, were adopted in 1969. After two modifications in 1973[14] and 1981[15] the scope of the IHR (1969) was limited to cholera, yellow fever and the plague. Before that, the WHO adopted the International Sanitary Regulations in 1951.[16] The current version is not limited to specific diseases.

In "Public Health Emergencies of International Concern", as defined in Article 1 IHR (2005), the WHO's Director-General has the power to issue temporary recommendations. These recommendations are non-binding in nature (Article 1 IHR [2005]). As a preparatory measure for further health crises, it may be useful to give the IHR (2005) and temporary recommendations more teeth.[17] This may be achieved by either creating explicit legal effect or by re-interpreting the law.[18]

2 No Case for a Binding Nature of Temporary Recommendations

De lege lata, temporary recommendations are non-binding, as stated in Article 1 (1) IHR (2005).[19] This does not lead to conclude that those recommendations are automatically without effect. On the contrary, due to the authority of the WHO, its aggregated expertise and the risk faced by states for defiance ensure compliance with emergency recommendations[20] – or at least *should* ensure compliance. In this sense, the WHO is supposed to work through its expertise. Theoretically, the mechanism regarding public health emergencies of international concern is an essential tool to address global

12 See WHO, *Summary of probable SARS cases with onset of illness from 1 November 2002 to 31 July 2003,* 2003, available at http://bit.ly/2lljjaE.
13 International Health Regulations, 1969, 764 UNTS 3, thereinafter IHR (1969).
14 WHO, *Health Assembly Resulution WHA26.55*, May 23, 1973.
15 WHO, *Health Assembly Doc. WHA34/1981/REC/I. at 10 (Resolution WHA34.13)*; see WHO, *Official Records, No. 217*, 1974, at 21, 71, and 81.
16 International Sanitary Regulations, 1951, 175 UNTS 215, thereinafter ISR (1951).
17 Villarreal, P A, "Reforms of the World Health Organization in light of the Ebola crisis in West Africa: More delegation, more teeth?" (August 26, 2015), *voelkerrechtsblog.com*, available at http://bit.ly/2m2NIYj.
18 See section II.4. The Way forward for the IHR (2005)?
19 Likewise Vierheilig, M, *Die rechtliche Einordnung der von der Weltgesundheitsorganisation beschlossenen regulations*, 1984, 34.
20 Burci, G L & Quirin, J, "Ebola, WHO, and the United Nations: Convergence of Global Public Health and International Peace and Security" (2014), 18 *ASIL Insights*, available at http://bit.ly/2m5AFIF.

threats that utilizes international law without creating new obligations on the actors involved.

3 Evaluation within WHO

Despite the idea behind a non-binding character of temporary recommendations and its benefits, in fact many states ignored temporary recommendations during the Ebola-crisis 2014.[21] As stated earlier, there may be two solutions to this problem at hand.

Within the WHO two bodies identified Member States, whose lack of understanding of the IHR (2005) and respect for temporary recommendations, provided major obstacles.

a Ebola Interim Assessment Panel

Foremost, the Ebola Interim Assessment Panel was of the opinion that significant changes throughout the WHO were needed to re-establish the WHO's authority:[22] The panel found that the WHO lacked both, the capacity as well as the "organizational culture to deliver a full emergency public health response".[23] This went so far as to discuss a proposal to either establish a new health emergency organization or confer the lead in such cases to another UN agency.[24] As both would certainly have meant the end of the WHO as such, the panel urged the WHO to invest in its emergency operational capacity. In doing so, improvements were needed in governance and leadership, financing, organizational culture and procedures, as well as the work force and regional and international collaboration. In addition, research and development should be focused. The panel recalled that Member States of the WHO were responsible for raising the funds of the WHO. Without increased funding, all attempts of reform and improvement would

21 See WHO, *Report of the First Meeting of the Review Committee on the Role of the IHR (2005) in the Ebola Outbreak and Response*, August 25, 2015, para. 13.
22 WHO, *Report of the Ebola Interim Assessment Panel*, July 2015, 5.
23 Ibid., para. 26.
24 Ibid., para. 27.

be futile.[25] The Ebola Interim Assessment Panel also found shortcomings within the IHR (2005), which were implemented not strongly enough. First, the declaration of a public health emergency of international concern was too late. The panel highlighted that to declare a situation a public health emergency of international concern, the Director-General and her staff need to be independent and courageous.[26] However, this was absent during the first months of the crisis.[27] In addition, neither the Director-General nor the Member States took the IHR (2005) serious enough.[28] For example, Member States have failed to fulfill their obligations under the IHR (2005) to develop a preparedness strategy that could be independently evaluated.[29] As under the current IHR (2005), States will be penalized in practice by other countries if they report outbreaks quickly and transparently. Even though the IHR (2005) oblige States to act responsibly in case of an outbreak, the closing of borders and travel and trade restrictions hurt the countries affected by the crisis without benefiting anyone.[30] Here, the weakness of the IHR (2005) became very visible: Without any means to enforce its recommendations, States will most likely continue to defy temporary measures in situations of a public health emergency of international concern.[31] The panel proposed possible sanctions "for inappropriate and unjustified actions".[32] It also introduced the idea of calling on the Security Council in such cases.[33]

To summarize, the panel found shortcomings in leadership, organization and the behaviour of Member States. The IHR (2005) are, in the view of the panel, too soft and without any necessary enforcement mechanism.

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25 WHO Ebola Response Team, "Ebola Virus Disease in West Africa — The First 9 Months of the Epidemic and Forward Projections" (2014), 371 *New England Journal of Medicine*, 1481 (1482).
26 WHO, *Report of the Ebola Interim Assessment Panel*, above Fn. 22, para. 8.
27 See also ibid., para. 20 et seq.
28 Ibid., para. 10.
29 Ibid., para. 11 et seq.
30 Ibid., para. 16.
31 Gostin & Friedman, "A Retrospective and Prospective Analysis of the West African Ebola Virus Disease Epidemic", above Fn. 4, 1902 (1904).
32 WHO, *Report of the Ebola Interim Assessment Panel*, above Fn. 22, para. 19.
33 Ibid., para. 19.

The Secretariat responded with an official paper.[34] With regard to the IHR (2005) the Secretariat announced a review process, albeit without going into detail on what changes could be imagined. It envisaged an intermediate stage before declaring a public health emergency of international concern.[35] With regard to possible disincentives or even sanctions for ignoring either the IHR (2005) or the temporary recommendations, the Secretariat kept rather quiet. It referred to its internal review process of the IHR (2005), which did focus on these issues.[36] Still, it is unfortunate that the Secretariat did not take a stand on such a crucial issue. For example, it could have envisaged a role of the Security Council, as recommended by the Ebola Interim Assessment Panel and the African Union.[37] In essence, it promised to work more efficiently and signalized institutional reforms to be prepared by several advisory bodies.

The Ebola Interim Assessment Panel has raised several important factors. From a legal perspective, the effectiveness of both, the IHR (2005) and the temporary recommendations issued in a concrete public health emergency of international concern needs to be increased. This could happen first through making the recommendations legally binding or by introducing a sanctions mechanism. Given that there is no such mechanism currently in place, even a soft one would be an improvement. Here, the Security Council could play a pivotal role. However, given that already the recommendations of 2011[38] to adapt the IHR (2005) in response to the swine flu pandemic of 2009 were ignored by the WHO and its Member States, it is not very likely that those regulations will be updated soon.

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34 WHO, *Secretariat response to the Report of the Ebola Interim Assessment Panel*, August 2015, available at http://bit.ly/25dvmaA.

35 Ibid., para. 10. Likewise WHO, *Review Committee on the Role of the IHR (2005) in the Ebola Outbreak and Response, Implementation of the International Health Regulations (2005), A69/21*, May 13, 2016, recommendation 6, 64.

36 WHO, *Secretariat response to the Report of the Ebola Interim Assessment Panel*, above Fn. 34, para. 8; WHO, *Review Committee on the Role of the IHR (2005)*, above Fn. 35.

37 WHO, *Report of the Ebola Interim Assessment Panel*, above Fn. 22, para. 19; Statement of the representative of the AU, *Record of the 7502nd meeting of the Security Council*, UN Doc. S/PV.7502 of August 13, 2015, 8.

38 WHO, *Implementation of the International Health Regulations (2005) – Report of the Review Committee on the Functioning of the International Health Regulations (2005) in relation to Pandemic (H1N1) 2009, A64/10*, 2011.

b Review Committee on the Role of the IHR (2005) in the Ebola Outbreak and Response

Similar to the findings by the Ebola Interim Assessment Panel, the WHO's Review Committee on the Role of the IHR (2005) in the Ebola Outbreak and Response identified the lack of knowledge or understanding of the IHR (2005) and the need for further implementation (and not amendment) of the regulations as key issues for future reform.[39] Among others, it recommended to "incentivize compliance"[40] by supporting countries more which adhere to the IHR (2005) and to increase transparency and publicity about compliance with IHR (2005) and temporary recommendations.[41]

4 The Way forward for the IHR (2005)?

As stated earlier, there are two possibilities to enhance compliance with the IHR (2005) and temporary recommendations.

a Updating the IHR (2005)

First and most obvious, the WHO may modify the IHR (2005) in light of the recent defiance by states. If states are not ready to follow temporary recommendations, it may help if these recommendations became binding.

This would be a rather ingenuous way: Just a small modification is needed. In detail, Article 1 IHR (2005) could be modified to the extent that temporary recommendations are defined as "binding" measures. It would make sense to update the IHR (2005) in other ways as well. Most importantly, temporary recommendations should be relabelled as "temporary regulations" to make the binding nature transparent. By letting them expire after three months (as is today the case with temporary recommendations), states may be convinced not to opt-out of the modified IHR (2005). The binding nature would come with a price, in essence an expiration date. A

39 WHO, *Review Committee on the Role of the IHR (2005)*, above Fn. 35, para. 4 et seq., 154 et seq.
40 Ibid., para. 78.
41 Ibid., para. 66.

further vigorous addition would be a sanction mechanism for non-compliance with temporary recommendations. Of course, this would only make sense if the recommendations became binding.

However, the WHO's own review committee on the IHR (2005) advises against any modification of the existing law but suggests to better implement the existing law.[42] Especially a sanctions mechanism is highly unlikely. Given the WHO's reluctance to even name the states that have ignored past temporary recommendations,[43] an even more vigorous approach than under existing law is improbable.[44] It seems as if even the small obliteration of "non" in "non-binding" could not be achieved politically.

This questions the importance of law as in instrument in health governance: Legal tools are not the most important tools available in the fight against diseases.[45] What matters most are public health measures such as the improvement of hygiene, distribution of medication, development of antidotes. Whether or not an act is equipped with legal consequences is rather unimportant in the international arena and in the fight against a disease. Health governance relies on other mechanisms. Still, international law is not without any relevance and lawyers may nevertheless contribute in this effort. A purely source-based approach may stop short of the possibilities that international law and legal scholarship have to offer. In the end, rather than a change of the existing law, a new approach to the existing law is advisable and more likely. This more sophisticated approach is addressed in the following.

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42 Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response, Progress Report, January 25, 2016, 15; WHO, *Review Committee on the Role of the IHR (2005)*, above Fn. 35, para. 4 et seq., 154 et seq.

43 Kamradt-Scott, A, "WHO's to blame? The World Health Organization and the 2014 Ebola outbreak in West Africa" (2016), 37 *Third World Quarterly*, 1 (11).

44 As a somewhat lesser modification, the IHR (2005) could envisage a role for the UN Security Council. Currently, the IHR (2005) do not reference the Council overall. A modification could be made which entitles the Security Council to render those measures binding. In essence, this would not be needed, for the Security Council may do so already today: It is not a question of WHO-law, but of the UN Charter, more specifically of Article 41 UN Charter. It will be dealt with infra.

45 See Frau, R, "Law as an Antidote? Assessing the Potential of International Health Law Based on the Ebola-Outbreak 2014" (2016), 7 *Göttingen Journal of International Law*, 225 (228 et seq.).

b Article 43 IHR (2005) as a Means to Ensure Compliance

A smarter possibility to bring temporary recommendations to full effect may be to utilize Article 43 IHR (2005). This provision stipulates a very sophisticated process for additional health measures by states. In general, State Parties are not precluded from implementing additional health measures (Article 43 [1] IHR [2005]). However, the IHR (2005) are clear and repetitive on one thing: those additional measures may not be more restrictive on international traffic and not more intrusive on persons than reasonably available alternatives which achieve the appropriate level of health protection. If a state wants to adopt additional measures, this state shall provide the WHO with information. The WHO, in turn, assesses these measures and may request the state to reconsider its plans (Article 43 [4] IHR [2005]). In other words, additional measures must be justified by a State Party. If a state plans to adopt measures contrary to temporary recommendations already in place, those measures would contravene the conditions set at the end of Article 43 (1). If the WHO, for example, recommends to not restrict trade and travel, any trade and travel restrictions by states are more restrictive on international traffic and are more intrusive on persons. Thus, they fail to meet the threshold. Nevertheless, under international law, those national measures remain in force; the IHR (2005) cannot void any national measure. Still, the state is under the treaty obligation to report such measures (Article 43 [3], [5], [6] IHR [2005]). Thus, this requirement may push the state to adhere to the temporary recommendation and at least nudge him to refrain from contravening them. To be perfectly clear: This is in no way a legal enforcement mechanism, it may work for policy reasons only. From a public relations standpoint, it may sell well with local constituencies to adhere to the WHO's recommendation. If the WHO is recognized as an important and trustworthy actor, following its advice makes sense. But yet again, even though Article 43 IHR (2005) does not change the law, it may be advantageous for states to comply with the WHO's statement, thus, the WHO exercises public authority also in this field.[46]

46 Bogdandy, A von, Dann, P & Goldmann, M, "Developing the Publicness of International Law: Towards a Legal Framework for Global Governance Activities" (2008), 9 *German Law Journal*, 1375 (1382).

c Human Rights Law as Catalyst

Yet another possibility would be to interpret a state's obligation to progressively realize the human right to health in line with the temporary recommendations. In order to assess this possibility, a closer look at the human rights dimension is indispensable.

5 Changing Role of the WHO as a Price to Pay

Before addressing the human rights dimension, however, one further aspect needs to be emphasized: Be it the straightforward approach of changing the existing law or the more sophisticated approach of re-interpreting current law, both come with a price-tag. The WHO is supposed to function through its expertise. This organization is tasked to convince, not coerce by legal means. Conferring legally binding effects on acts (i.e. temporary recommendations) changes the perception of this organization. The WHO ceases to be seen as a health actor and takes the role of a norm-creator. Already existing legitimacy concerns towards the WHO would increase. Similar concerns exist towards the UN Security Council, the second actor which is analysed by this paper.

III Pluriverse of Actors (2): The UN Security Council

1 The UN and UNMEER

The UN were actively involved in the fight against Ebola with rather innovative measures. The Secretary General as well as the Security Council took unprecedented steps to counter the threat posed by Ebola. UNMEER, the United Nations Mission for Ebola Emergency Response, will be left out of the present analysis.[47]

47 See Frau, R, "Law as an Antidote?", above Fn. 45, 225 (253).

2 The UN Security Council and Resolution 2177 (2014)

a Article 41 UN Charter

In one astonishing move, the Security Council addressed the Ebola-outbreak in a resolution under chapter VII. In Resolution 2177 (2014) the Security Council highlighted the severity of the Ebola-outbreak. Taking note of the different actors, i.e. the countries affected, neighbouring states, UN-organs and organizations, Non-Governmental Organizations as well as first-line responders, the Security Council called upon them to collectively address the threat posed by the epidemic. In the operative part of said resolution, the Council commended the actors for their contributions but also "encouraged", "called" and "urged" these actors to do even more. Noteworthy is not the fact that the Council was not satisfied with the efforts to date, but that the Council did not "decide" on a common strategy, nor did it "demand" specific measures or "requested" concrete actions. It could have done so in regard to travel and trade restrictions, border management or access of health care workers to affected countries or regions – issues that are addressed by the WHO as well as by the Council, but only as recommendations.[48] Also, the recommendations by the WHO were not transformed into legally binding obligations by virtue of Security Council actions under chapter VII UN Charter. The Council could have easily demanded from Member States that they keep open their borders to affected countries, cooperate with them with regard to border management (exit and entry screenings that is) or address domestic actors to continue travel and transport to and from West Africa.[49] In essence, the Council refrained from addressing the epidemic by legal means and issued mere recommendations.

b Article 39 UN Charter

Audaciously the Council determined "that the unprecedented extent of the Ebola outbreak in Africa constitutes a threat to international peace and security", thus opening its powers under chapter VII. This is an innovative approach. Given, there is a large discussion about the scope of the notion

48 See preambular para. 9 and 17 of Resolution 2177 (2014).
49 Similar Gostin & Friedman, "A Retrospective and Prospective Analysis of the West African Ebola Virus Disease Epidemic", above Fn. 4, 1902 (1906).

"threat to international peace and security" under Article 39 UN Charter. As is well known, scholarship is divided on the interpretation of "peace" in Article 39 UN Charter. Some[50] argue for a wide understanding of "peace", which includes aspects of positive peace, for example "broader conditions of social development".[51] Others take a more cautious approach, understanding the term to cover only negative peace, in other words the absence of armed violence between states.[52]

With the Security Council understanding the Ebola-outbreak as a "threat to international peace and security", one could assume that the Council now opts for a wider interpretation of that notion as before. Is there any merit to this claim? Is that the way forward for the Security Council?

3 The Way forward for the Security Council?

a Article 39 UN Charter (1): Health Crises as a Threat to the Peace

First of all, the Security Council has never before understood Article 39 UN Charter as to include health aspects. While the Council prudently hinted that HIV/AIDS "may pose a risk to stability and security",[53] the Council did not dare to make that recommendation in the decades that followed this suggestion.[54] In addition, the human right to health is not closely related to negative peace, it is a part of positive peace. Also, the Council highlights the vast challenges, which are posed by the Ebola-outbreak, beginning with care for infected persons, safe burials of victims, misinformation about the virus and its transmission, food insecurity, a functioning domestic health care system and other. Contrary to its usual practice, the Council did not address the question of refugees explicitly as constituting a threat. This could be understood as a move away from the fear of refugees as a destabilizing factor. More than 130 States co-sponsored the draftresolution, mak-

50 See ibid.
51 Akehurst, M & Malanczuk, P, *A modern introduction to international law*, 1987, 219.
52 See only Tomuschat, C, "Obligations arising for States without or against their will" (1993), 241 *Recueil des Cours de l'Academie de droit international de la Haye*, 195 (334 et seq.).
53 Security Council Resolution 1308 (2000).
54 Security Council Resolution 1983 (2011), which repeats the phrasing of Resolution 1308 (2000).

ing it the most supported chapter VII resolution ever. This seems to demonstrate a unanimous understanding between Member States of the UNO as authorized interpreters of Article 39 UN Charter to include positive peace aspects in this notion.

Interpreting Resolution 2177 (2014) in this way, however, ignores the wording of the resolution. First of all, the Council clearly states that the "unprecedented extent" of the outbreak constitutes the threat and not the mere existence of an epidemic. Granted, the claim that something is unique may be made quite easily and is not decisive. Second, and most importantly, the Council relates the Ebola-outbreak to international peace and security in a rather traditional way: its preambular paragraphs emphasize such aspects repeatedly. The Council not only reiterates the international dimension of the disease, affecting several countries in the region, but links the disease directly to international security issues: The Security Council recognizes

> "that the peacebuilding and development gains of the most affected countries concerned could be reversed in light of the Ebola outbreak and underlining that the outbreak is undermining the stability of the most affected countries concerned and, unless contained, may lead to further instances of civil unrest, social tensions and a deterioration of the political and security climate."[55]

The meeting record is affluent with references to the instable situation in the most affected countries and the region.[56] Voices that based Resolution 2177 (2014) on the health crisis alone are minor.[57]

In this sense, the members of the Security Council did not interpret Article 39 UN Charter in an innovative way, Resolution 2177 (2014) keeps in line with the conservative understanding of the notion "threat to inter-

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55 Preambular para. 4 Resolution 2177 (2014).

56 See for example the statements by the representatives of the Security Council Member States Argentina (20), Australia (16), Chad (19), Chile (22), China (16), France (10), Jordan (21), Lithuania (14), Luxembourg (18), Republic of Korea (13), Rwanda (12) and United Kingdom (17), as well as participating States under rule 37 of the Security Council's provisional rules of procedure Brazil (29), Canada (32), Colombia (45), Estonia (41), Germany (44), Guinea (24), Guyana (47), Italy (39), Japan (33), Morocco (29), Netherlands (35), Norway (42), Sierra Leone (26), Spain (38), Switzerland (30), Turkey (32) and International Organizations as the African Union (37), all in UN Doc.S/PV/7268. As a side note, the traditional aspects were already highlighted in Annex to the Letter dated September 15, 2014 from the Secretary-General addressed to the President of the Security Council, UN Doc. S/2014/669.

57 Statement by the representative of the United States, UN Doc. S/PV/7268, 7. See also the statement by the representative of France, UN Doc. S/PV/7268, 30.

national peace and security".[58] Ultimately, it is not Ebola that led the Security Council to act, but the anticipated instability of the region due to Ebola.

In addition, if states ignore the temporary recommendations issued by the Director-General, this may pose a threat to international peace and security. Thus, the Security Council may determine defiance as such and is at least in theory able to take measures under chapter VII UN Charter.

b Article 39 UN Charter (2): Safeguarding the Human Right to Health

Even if health crises per se do not fall under the notion of peace as intended by Article 39 UN Charter, the danger to the human right to the highest attainable standard of health, Article 12 ICESCR, could enable the Security Council to act. Precondition, however, is the existence of a threat to international peace and security. If, and only if, a danger to Article 12 ICESCR has some cross-border effects (or is feared to have such effects), Article 39 UN Charter is fulfilled and the Security Council may act.

c Article 41 UN Charter: Possible Measures by the Security Council

If the Security Council determines a situation to be a threat to peace and security, it opens the doors to chapter VII measures. These measures may include peaceful and coercive measures.

In the case of Ebola, however, the Security Council missed an opportunity to act swiftly and effectively and re-shape international health law or at least facilitate its development. Once the Council had determined that the unprecedented extent of the Ebola outbreak in Africa constituted a threat to international peace and security,[59] it could have issued binding decisions under Article 41 and 42 UN Charter and not mere recommendations under Article 40 UN Charter. The need for effective action was evident, at least by the repeated calls of the Emergency Committee regarding Ebola to address border management, exit and entry screening as well as a lift to trade and travel bans. Given the fact that the majority among the UN Member States was willing to deal with the crisis under chapter VII UN Charter,

58 See Acconci, "The Reaction to the Ebola Epidemic within the United Nations framework", above Fn. 8, 405 (419 et seq.) for a different approach.

59 Preambular para. 5 of Resolution 2177 (2014).

including all permanent and elected members of the Security Council, binding measures seemed to be a viable option.

The Council could have used its far-reaching powers under Article 41, 42 UN Charter in the following ways: For example, it could have authorized the deployment of troops in order to provide much needed staff for safe burials of victims or border management, i.e. to conduct exit or entry screenings. Furthermore, it could have elevated the WHO's temporary recommendations as proposed by the Emergency Committee regarding Ebola to legally binding obligations, where applicable. Surprisingly, the IHR (2005) do not reference the Security Council in any way and neither did the Security Council establish any relations to the WHO.[60] Also, it could have decided that borders to the three most affected countries had to stay open in order to halt the isolation of these countries and communities and subsequent protests and violence, which challenged the three states. After all, all the factors that the members of the Security Council feared contributed to the likelihood of new civil wars in the region.[61]

In the aftermath of the Ebola-crisis, experts suggested to install a permanent Global Health Committee.[62] This commission should be established by the Security Council and should be a subsidiary organ. As such, it could monitor health situations all over the world and advice the council on dangers and possible counter measures. The UN Charter would allow for that. It is up to the Security Council to organize its own work. If its members find it smart to establish such a supervising health commission, nothing stops the council from establishing it. The only limit is that the Security Council itself needs to act: The Charter confers rights to the Council, not to a subsidiary organ.

4 The Role of the Security Council

The UN Security Council has a mandate to maintain international peace and security (Article 24 [1] UN Charter); it is not an international Health Council. If the Security Council becomes an actor in health governance by way

60 Statement, *Record of the 7502nd meeting of the Security Council*, above Fn. 37, 8.
61 See above Fn. 56.
62 Moon, S, Sridhar, D & Pate, M A et al., "Will Ebola change the game? Ten essential reforms before the next pandemic. The report of the Harvard-LSHTM Independent Panel on the Global Response to Ebola" (2015), 386 *The Lancet*, 2204 (2216).

of states relying on its powers, health governance shifts into the direction of security. Resolution 2177 (2014) may be seen as a first step towards a securitization of health.[63] Yet securitization of health only makes sense in cases of worldwide pandemics or similar cases where the stability of an entire region is at stake. For health issues without a security implication, the Security Council is not competent to act.

Even in cases comparable to Ebola 2014, any increased importance of the Security Council comes with a price as well. Ownership of health governance is taken away from local actors or even specialized such as the WHO and conferred to the most powerful organ of the international community in New York City. In the regions concerned, however, ownership and legitimacy matter. Relying on the Security Council would increase concerns with regard to both issues.

IV The Human Right to Health as Catalyst

1 The Human Right to Health

Bringing all together is the human right to health. Despite the difficulties surrounding this right – after all, being healthy does not solely or primarily depend on state's behaviour, but on one's physical and mental preconditions[64] and due to the scope of the human right being limited – its importance can hardly be overstated. Nevertheless, when states drafted the International Covenant on Economic, Social and Cultural Rights (ICESCR)[65] and its Article 12, States were aware of the broad definition of health as well as the impossibility to safeguard a perfect health for everyone.[66] Consequently, Article 12 ICESCR guarantees a human right to the "enjoyment of the highest attainable standard of physical and mental health" (Article 12 [1] ICESCR).

Article 12 (2) ICESCR insinuates several steps that State Parties shall take to achieve the full realization of the right enshrined in Article 12 (1). Among those steps are the "prevention, treatment and control of epidemic,

63 See the contribution of *Ilja Richard Pavone*, "Ebola and Securitization of Health: UN Security Council Resolution 2177/2014 and its Limits" in this volume.

64 Wolff, J, *The Human Right to Health*, 2012, 27.

65 International Covenant on Economic, Social and Cultural Rights, 1966, 993 UNTS 3, thereinafter ICESCR.

66 Gostin, *Global Health Law*, above Fn. 9, 251.

endemic, occupational and other diseases" and the "creation of conditions which would assure to all medical service and medical attention in the event of sickness". However, under Article 2 (1) ICESCR it has to be taken into account that a State is obliged to undertake steps to "progressively [achieve] the full realization of the rights recognized" by the ICESCR. Hence, Article 12 (2) ICESCR complements[67] the individual human right to health with obligations of State Parties.[68]

In this sense, Article 2 (1) ICESCR "limits" the human right to health to a relatively weak and abstract obligation of progressive realization.[69] States may thus differ in their approach to the full realization due to specific domestic factors.[70] To shape the substantial obligations, some specific areas of concern have been identified in the General Comment. Among them are not, however, substantial obligations regarding emergency situations.

2 Obligations to Respect, Protect and Fulfil

State Parties to the ICESCR are under an obligation to ensure the human right to the highest attainable standard of health. The General Comment has interpreted Article 12 ICESCR to include obligations to respect, protect and fulfil.[71] In particular, a state is under the obligation to refrain from interfering directly or indirectly with this right, to protect individuals from interference by other actors and to adopt appropriate measures towards the full realization of the human right to health.[72] Of outmost importance is international assistance and cooperation, as laid out in Article 2 (1) ICESCR.

In addition to bilateral cooperation and multilateral cooperation through the WHO, the UN General Assembly is also tasked with promoting international cooperation in the field of health (Article 13 [1][b] UN Charter). In doing so, each state is expected to contribute to the maximum of its capacities.[73] How international cooperation can be achieved is, of course, a matter for each specific case.

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67 Meier & Mori, "The Highest Attainable Standard", above Fn. 1, 101 (113).
68 See Tobin, J, *The Right to Health in International Law*, 2012, 75, 225 et seq.
69 Critical Meier & Mori, "The Highest Attainable Standard", above Fn. 1, 101 (115).
70 Ibid.
71 General Comment No. 14 (2000), *The right to the highest attainable standard of health*, UN Doc. E/C.12/2000/4, August 11, 2000, para. 33.
72 Ibid., para. 33.
73 Ibid., para. 40.

3 States Obligations Ratione Loci

The ICESCR does not provide an explicit threshold of application, unlike the International Covenant on Civil and Political Rights (ICCPR), where Article 2 [1] ICCPR obliges State Parties to undertake to "respect and to ensure to all individuals within its territory and subject to its jurisdiction the rights recognized in the present Covenant". A comparable provision is found in Article 2 [1] ICESCR where states agree to undertake to take

> "steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of [their] available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures".

Any reference to the applicability ratione loci is missing.[74]

One can make the case and argue for applicability only in a State Party's territory. If the "right to health" is correctly the somehow weaker human right to the enjoyment of the highest attainable standard of physical and mental health (Article 12 [1] ICESCR), it could follow that it has no international dimension. Moreover, if a state cannot provide perfect health to everyone on its territory, how can a state than achieve this goal abroad? Providing health care is a domestic matter and states are under no obligation to provide healthcare abroad.

This view has its merits. However, interpreting the human right to the mere supply of hospitals, doctors, medicine and the like falls short of treaty law.[75] After all, Article 2 [1] ICESCR includes an undertaking of international assistance and cooperation. International assistance and cooperation has naturally an international dimension. By being under the treaty obligation to render assistance, states may not hamper efforts by other states to achieve health. One needs to keep in mind that international assistance may be rendered on the state's own territory.

4 The Role of Human Rights Law

Taken all together, human rights law may act as a catalyst in health law as part of health governance. The present author proposes to put the human

74 See the contribution of *Elif Askin*, "Extraterritorial Human Rights Obligations of States in the Event of Disease Outbreaks" in this volume regarding the extraterritorial applicability of the ICESCR.

75 *Elif Askin* is making a more straightforward approach in the present volume.

right to health at the very heart of health governance, which may lead to improved interaction between different branches of law. This may be achieved by the following reasoning.

If one takes into account, first, that travel and trade restrictions are detrimental to the fight against Ebola, second, that the Director-General repeatedly recommended to lift travel and trade restrictions, and third, that such measures are taken by a state on its territory, then Article 12 (1), (2) ICESCR is affected by such measures. In short, the obligation to progressively realize the rights enshrined in the ICESCR in cooperation with other states as well as the obligation to assist other states in their endeavour to provide the human right to health is violated by restrictions taken despite a temporary recommendations to the opposite.[76] Even if states are not under an obligation to render assistance without being asked for it,[77] impeding assistance is not in the ambit of the ICESCR.[78]

The Security Council should embrace the human right to health. It is unfortunate that the Council ignored this right during the recent Ebola-outbreak. If taken seriously, human rights may lead the WHO and the Security Council to cooperate more closely and combat outbreaks more effectively and efficiently.

V Conclusion

Does it make sense to modify and adapt the IHR (2005) in light of the recent crises? Does it make sense to create legally binding effects for the WHO's temporary recommendations? Does it make sense to engage the Security Council?

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76 An international dimension of Article 12 (2) ICESCR is also identified by General Comment No. 14 (2000), *The right to the highest attainable standard of health*, above Fn. 71, para. 38 et seq.; and General Comment No. 3 (1990), *The Nature of States Parties' Obligations*, UN Doc. E/1991/23, December 14, 1990, para. 13. Critical to the General Comment Saul, B, Kinley, D & Mowbray, J, *The International Covenant on Economic, Social and Cultural Rights: Commentary, Cases, and Materials*, 2014, 139 et seq. Others identify this international dimension also, see Wolff, *The Human Right to Health*, above Fn. 64, 32; Tobin, *The Right to Health in International Law*, above Fn. 68, 325 et seq.

77 Saul, Kinley & Mowbray, *The International Covenant on Economic, Social and Cultural Rights*, above Fn. 76, 139.

78 Likewise Tobin, *The Right to Health in International Law*, above Fn. 68, 331 et seq. See also General Comment No. 14 (2000), *The right to the highest attainable standard of health*, above Fn. 71, para. 39, 41.

The assessment by the WHO's internal review may lead one to assume that it simply does not matter. Law does not cure anyone. The non-binding nature of temporary recommendations may not have had any impact on the Member States unwillingness to adhere to them. In this way, creating legal effect may be theoretically possible but would probably not matter much during the next epidemic. A more sophisticated approach may be better suitable to enforce compliance, i.e. a re-interpretation of the law. Also, engaging the Security Council is a good idea only for epidemics with negative impacts on a region's security. Relying on the Security Council would take ownership of health governance from the actors in the field and confer it to the powerful actor in New York City. Thus, legitimacy concerns with regard to the Security Council are well founded. It makes sense to focus on human rights law, which protects against the exercise of international public authority and which would lead the WHO and the Security Council to cooperate more closely.