

Lodestar in the Time of Coronavirus? Interpreting International Obligations to Realise the Right to Health During the COVID-19 Pandemic

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ABSTRACT

While the right to health has gained significant momentum in international law over the past two years, there is little clarity on what it means for States to comply with this right in times of COVID-19. Taking Articles 2(1) and 12 of the International Covenant on Economic, Social and Cultural Rights as a starting point, our article follows an approach guided by the rules of treaty interpretation under the Vienna Convention on the Law of Treaties to suggest how right to health obligations to prevent, treat and control infectious diseases should be interpreted in relation to COVID-19, and how these obligations interact with general obligations of immediacy, progressive realisation, minimum core and international assistance and cooperation in this context. This article makes a novel contribution to clarifying the right to health during COVID-19, thus enhancing capacity for the oversight of this right; its incorporation in global health law; and the understanding of its corresponding obligations in future global health emergencies.

KEYWORDS: right to health, obligations, COVID-19, Articles 12 and 2(1) International Covenant on Economic Social and Cultural Rights, global health law, epidemics

1. INTRODUCTION

Since the outbreak of COVID-19, multiple international human rights bodies have expressed particular concern about the impact of the pandemic on the realisation of the right to health, calling on States to foreground this human right in their COVID-19 responses.¹ Indeed, Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), the central international human rights obligation on States vis-à-vis infectious diseases, requires

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¹ OHCHR, UN Human Rights Treaty Bodies Call for Human Rights Approach in Fighting COVID-19, 24 March 2020, available at: <https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25742&LangID=E> [last accessed 20 July 2022].

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them to take steps necessary for the ‘prevention, treatment and control of epidemic, endemic, occupational and other diseases’ (Article 12(2)(c)).² However, there has been limited analysis of what this obligation entails by these international human rights bodies, including UN treaty bodies and Special Procedures and regional bodies, and by scholars. Article 12(2)(c) was given cursory attention in General Comment 14 of the UN Committee on Economic, Social and Cultural Rights (CESCR), the most authoritative interpretation of Article 12.³ It was also neglected during other recent public health emergencies of international concern such as Ebola, MERS, SARS, Swine Flu and Zika. Such limited focus meant that there was little existing analysis that could inform the interpretation of States’ Article 12(2)(c) obligations in the context of COVID-19. Since COVID-19 emerged, it has resulted in more than 6 million deaths and half a billion confirmed cases worldwide, yet the requirements of this obligation in relation to COVID-19 remain far from clear.

Furthermore, clarity surrounding States’ obligations is also muddled by ongoing uncertainties in interpreting the general legal nature of obligations under ICESCR Article 2(1), which provides that:

Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realisation of the rights recognised in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.

Whilst the requirements of progressive realisation and international assistance and cooperation frame right to health obligations, their nature and scope have remained contested. Financial resources and international cooperation have been critical for COVID-19 responses, yet many States have fallen short. Challenges to progressive realisation have been experienced during the crisis with States arguably taking retrogressive measures in relation to the right to health and other socio-economic rights and failing to meet so-called ‘minimum core obligations’ (‘core obligations’ hereafter).⁴ Given this context, surprisingly little clarification about these obligations has been provided by international human rights bodies. States have thus been without specific guidance as to how they can comply with the right to health in their COVID-19 responses.

This article utilises a doctrinal interpretation of the right to health to fill these interpretive lacunae. Setting out our interpretive approach in Section 1, we employ this approach to suggest an interpretation of the obligation to ‘prevent, treat and control’ COVID-19 in Section 2. With limited existing clarity surrounding prevention and control obligations, we argue that reading the right to health in light of other international instruments, including those that govern global health emergencies, suggests that Article 12(2)(c) should be interpreted in a holistic way to embrace: environmental and social determinants; as well as pandemic preparedness, treatment and control measures that are necessary, proportionate and based in evidence. The breadth of our reading goes beyond the existing approach of the CESCR, which has particularly focused on biomedical measures such as access to treatment and vaccines, and surveillance and health information, an approach which we argue is too narrow. In Section 3, we use the same interpretative methods to delineate the contours of Article 2(1) ICESCR, when applied

² International Covenant on Economic, Social and Cultural Rights 1966, Treaty Series, 993 UNTS 3 (ICESCR).

³ Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12), 11 August 2000 (GC14).

⁴ Sekalala et al., ‘Health and Human Rights are Inextricably Linked in the COVID-19 Response’ (2020) 5 *BMJ Global Health* 5:e003359.

to the realisation of Article 12(2)(c) in times of COVID-19. While the UN clarified concepts such as immediacy, progressive realisation, core obligations and to a lesser extent international cooperation, by recognising their inherent connection to resource availability, the CESCR seems reluctant to review States' resources in detail and thus to assess how these concepts operate in practice. Our article argues that the CESCR, and UN Treaty Bodies more generally, should explicitly take into account States' levels of income when interpreting States' obligations, to enhance clarity around those concepts.

Interpretative clarity, which we aim to provide in this article, is acutely needed for several reasons. Firstly, it is required to guide States to respect, protect and fulfil the right to health in their COVID-19 responses and to facilitate accountability where they fail to do so. This task is universally and enduringly relevant as COVID-19 has affected populations worldwide and will continue doing so for years to come, making it a key issue in human rights review and implementation. Secondly, we face an ongoing threat from emerging infectious diseases which may play out in similar ways to COVID-19. Clarity about right to health obligations in relation to COVID-19 will help delineate States obligations to prevent, prepare for and respond to future global health emergencies involving epidemics or pandemics and requiring an international response (hereafter 'global health emergencies'). Thirdly, the global COVID-19 response has been primarily framed by global health governance instruments under the auspices of the World Health Organisation, including the International Health Regulations 2005 (IHR).⁵ The IHR creates obligations on States and recognises the right to health in its preamble. However, the relationship between these obligations and the right to health has remained unclear. If the right to health is to play a meaningful role in the COVID-19 global health governance, both in the interpretation of existing instruments and other instruments under development, including a proposed pandemic treaty and the updating of the IHR, it needs clarification.

2. USING THE VIENNA CONVENTION ON THE LAW OF TREATIES TO INTERPRET RIGHT TO HEALTH OBLIGATIONS IN TIMES OF COVID-19

With the ICESCR ratified by 171 States parties, most States worldwide are legally bound by its provisions, including Article 12 which is widely considered to be the central protection of the right to health in international human rights law. Therefore, Article 12 ICESCR as well as its interactions with the general obligations outlined in Article 2(1) are the cornerstone of our analysis. While many international human rights treaty provisions are vaguely worded, Articles 12 and 2(1) are infamously so.⁶ There is no exception to this indeterminacy when it comes to Article 12(2)(c), which recognises States must take measures to 'prevent, treat and control' epidemic and other diseases, an obligation centrally relevant to States' COVID-19 responses. The text of a treaty is its interpretive keystone under the Vienna Convention on the Law of Treaties (VCLT),⁷ yet the broad brushstrokes framing Article 12(2)(c) does little to suggest what actions it requires of States parties.⁸

Beyond treaty text, the VCLT provides a toolbox of rules to support treaty interpretation, under Article 31 on 'General Rules of Interpretation' and Article 32 on 'Supplementary Means of Interpretation'. Tobin reflects that due to the range of rules in these articles and an ambiguity in their weighting, the VCLT cannot be used to provide a definitive interpretation of the right to health.⁹ We accept this proposition;⁹ nevertheless, when it comes to interpreting ICESCR

⁵ International Health Regulations (2005) World Health Organisation, 2006 (IHR).

⁶ Ruger, 'Toward a Theory of a Right to Health: Capability and Incompletely Theorized Agreements' (2006), 18 *Yale Journal of Law & the Humanities* 273; Tobin, *The Right to Health in International Law* (2011) at 75.

⁷ Article 31(1), Vienna Convention on the Law of Treaties 1969, Treaty Series, 1155 UNTS 331 (VCLT).

⁸ Chapman, *Global Health, Human Rights and the Challenge of Neoliberal Politics* (2016) at 15.

Articles 12(2)(c) and 2(1), it is striking that many of the VCLT interpretive rules provide little additional clarification. Limited insights are shed by the ICESCR's preamble, Optional Protocol and *travaux préparatoires*, all interpretive sources under Articles 31(1) VCLT (objects and purposes of the treaty), 31(2) (context) and 32 (supplementary rules of interpretation), respectively. This process of elimination leads us to focus on two rules that can be applied more successfully to enhance clarity.

Under Article 31(2)(b) VCLT, 'any subsequent practice in the application of the treaty that establishes the agreement of the parties regarding its interpretation' shall be taken into account. Developed on the basis of experience overseeing international human rights treaties, General Comments adopted by UN Treaty Bodies are considered reflective of this subsequent practice.¹⁰ Indeed, General Comments adopted by the CESCR have been widely used as a first point of interpretation of the ICESCR. Whilst a soft law standard, they are considered to be 'authoritative',¹¹ to possess 'significant legal weight',¹² and to add interpretive detail to treaty provisions.¹³ They have served to delineate the contours of individual rights, as well as the general legal nature of obligations under Article 2(1). General Comment 14 on the right to health has been pivotal in clarifying Article 12,¹⁴ and is widely considered to be its most authoritative interpretation.¹⁵ Its influence has extended to many international and regional human rights bodies', academics' and civil society analyses of the right to health.¹⁶ While General Comment 3 on the nature of States parties' obligations contributes to clarifying the general legal nature of obligations that applies to Article 12, General Comment 14 provides complementary illustrative details that specify how this provision interacts with Article 2(1).¹⁷ With this in mind, General Comment 14 is our first interpretive point of call.

Nevertheless, General Comment 14 has some shortcomings for interpreting right to health obligations in times of COVID-19. Firstly, it devotes limited attention to unpacking the obligations to 'prevent, treat and control' infectious diseases. This lack of granularity is consistent with the overall approach of General Comment 14, whose analysis of the right to health remains at a general level of abstraction. Secondly, its biomedical slanting with a particular focus on healthcare minimises attention to other types of population health measures,¹⁸ which are central to prevention and control of COVID-19, including for populations lacking access to healthcare and vaccines. At the same time, General Comment 14 embraces a teleological approach for interpreting Article 12(2)(c), recognising that 'formerly unknown diseases . . . have created new obstacles for the realisation of the right to health, which need to be taken into account when interpreting Article 12'.¹⁹ This allows an evolving interpretation that is responsive to emerging situations, such as new infectious diseases.²⁰ However, more than two years into the COVID-19 pandemic and despite other global health emergencies, no significant analysis of Article

⁹ Tobin, *supra* n 6 at 77.

¹⁰ Keller and Grover, 'General Comments of the Human Rights Committee and their Legitimacy' in Keller and Grover (eds), *UN Human Rights Treaty Bodies* (2012) 116 at 127.

¹¹ Steiner and Alston, *International Human Rights in Context: Law, Politics, Morals*, 2nd ed (2000) at 265.

¹² Craven, *The International Covenant on Economic, Social, and Cultural Rights: A Perspective on Its Development* (1998) at 91.

¹³ Shelton, 'Human Rights' in Shelton (ed), *Commitment and Compliance: The Role of Non-Binding Norms in the International Legal System* (2003) 345 at 451.

¹⁴ GC14, *supra* n 3.

¹⁵ Chapman, *supra* n 8 at 16.

¹⁶ Hunt and Leader, 'Developing and Applying the Right to the Highest Attainable Standard of Health: The Role of the UN Special Rapporteur' in Harrington and Stuttaford (eds.), *Global Health and Human Rights: Legal and Philosophical Perspectives* (2010) at 30.

¹⁷ Committee on Economic, Social and Cultural Rights, General Comment No. 3: The Nature of States Parties' Obligations (Art. 2(1)), 14 December 1990 (GC3).

¹⁸ Chapman, *supra* n 8 at 256–7.

¹⁹ GC14, *supra* n 3 at para 10.

²⁰ Chapman, *supra* n 8 at 29.

12(2)(c) obligations has been carried out.²¹ Furthermore, the legal frameworks developed by General Comment 14 to connect Articles 12 and 2(1) have not received much clarification during the pandemic, since the CESCR rarely refers to them in recent documents and thus fails to refine them.

The CESCR and other UN Treaty Bodies have adopted a practice of issuing ‘Statements’, the purpose of which is to assist states parties by ‘clarify[ing] and confirm[ing] its position with respect to major international developments and issues bearing upon implementation of the Covenant.’²² Since the outbreak of COVID-19, the CESCR has adopted three Statements on COVID-19, which can also be considered as authoritative interpretations of Article 12 under Article 31(2)(b) VCLT,²³ and support our interpretation of Article 12(2)(c) to a certain extent. While recently the CESCR has devoted more attention to a broader range of health determinants, these three Statements revert to a more biomedical bias. The same is true in respect of the CESCR’s 12 Concluding Observations adopted since the beginning of the pandemic (it has not adopted any Views yet dealing with alleged violations of Article 12 during the pandemic).²⁴ This limits clarity of public health prevention and control obligations under Article 12(2)(c), as discussed in Section 2. Furthermore, these Statements and Concluding Observations provide limited clarification about how the CESCR interprets Article 2(1) obligations in the context of COVID-19 (i.e. immediacy, progression, non-retrogression, core obligations), with the exception of ‘international assistance and cooperation’, which is interpreted in unprecedented detail, as discussed in Section 3.

We thus turn our attention to relevant international and regional treaties and soft law instruments, which can be drawn on to provide interpretive clarity to Article 12(2)(c) in particular, and its relationship with Article 2(1). The VCLT provides that international standards may be interpreted in the light of ‘any relevant rules of international law applicable in the relations between the parties’ (Article 31(3)(c)). Other international treaties, including on human rights and global health, can be scrutinised to provide significant normative clarity to interpretive lacunae in Article 12(2)(c) ICESCR. Notably, the IHR, a treaty binding on the 196 Members of the WHO, establishes highly relevant and dedicated standards for public health emergencies that we argue should be drawn on. Our approach is situated in a broader body of scholarship that has analysed and called for systemic integration of currently fragmented global health and international human rights law. It is argued that this will clarify international human rights standards and bring them to bear in global health governance, including in the interpretation and implementation of the IHR where human rights have been neglected, despite being protected as a cross-cutting principle under the treaty.²⁵ We also draw on other international soft law standards, including those developed to guide public health responses, to suggest an interpretive pathway through remaining ambiguities under Article 12(2)(c) and Article 2(1) where clarification is not provided by CESCR’s General Comments, Statements and Concluding Observations or by other treaties.

²¹ Villarreal, ‘Infectious Diseases’ in Binder et al., *Elgar Encyclopedia of Human Rights* (2022) at 50.

²² CESCR, Report on the forty-fourth and forty-fifth sessions, 3–21 May 2010, 1–19 November 2010, E/2011/22, at para 59.

²³ CESCR, Statement on the coronavirus disease (COVID-19) pandemic and economic, social and cultural rights, 17 April 2020, E/C.12/2020/1 (Statement COVID-19); CESCR, Statement on universal and equitable access to vaccines for COVID-19, 27 November 2020, E/C.12/2020/2 at para 4. (Statement COVID-19 vaccines); CESCR, Statement on universal affordable vaccination against coronavirus disease (COVID-19), international cooperation and intellectual property, 23 April 2021, E/C.12/2021/1 (Statement universal COVID-19 vaccination). Khaliq and Churchill, ‘The Protection of Economic, Social and Cultural Rights: A Particular Challenge?’ in Keller and Grover, supra n 10, 199 at 208.

²⁴ OHCHR, ‘Jurisprudence: Document Search’, available at: <https://juris.ohchr.org/search/documents>; CESCR, ‘Table of Pending Cases’, available at: <https://www.ohchr.org/en/treaty-bodies/cescr/table-pending-cases> [both last accessed 20 July 2022].

²⁵ Toebes, Forman and Bartolini, ‘Toward Human Rights-Consistent Responses to Health Emergencies: What Is the Overlap between Core Right to Health Obligations and Core International Health Regulation Capacities?’ (2020) 22 *Health and Human Rights* 99.

3. OUT OF THE SHADOWS? INTERPRETING ARTICLE 12(2)(C) OBLIGATIONS TO PREVENT, TREAT AND CONTROL INFECTIOUS DISEASES IN TIMES OF COVID-19

ICESCR Article 12(1) establishes a right to the highest attainable standard of physical and mental health, whilst 12(2)(a)–(d) lists illustrative corresponding obligations on States to address wide-ranging health issues, including the prevention, treatment and control of diseases. These obligations are unpacked in General Comment 14, which clarifies that the broad scope of this human right encompasses: healthcare and underlying determinants of health such as water, sanitation and adequate housing; an obligation to implement a 'national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population'; the participation of the population in health decision making; and remedies and accountability for violations. In recent years, international human rights bodies have significantly clarified the application of the right to health to certain health issues such as sexual and reproductive health, mental health, neglected diseases and HIV/AIDS. Yet, with the exception of HIV, limited focus has been given to 'the prevention, treatment and control of epidemic, endemic, occupational and other diseases' obligation under Article 12(2)(c).

The CESCR's recent Statements and Concluding Observations have begun to shed some light in how we should interpret this obligation in the context of COVID-19. Yet this analysis has been biased towards treatment and vaccination and has given limited attention to other population health measures, leaving many aspects of prevention and control obligations in the shadows. This biomedical slanting, which goes against a trend of giving more weight to social and other determinants in interpreting the right to health,²⁶ precludes a necessary holistic interpretation of Article 12(2)(c). In particular, the CESCR has yet to clarify whether Article 12(2)(c) extends to underlying social and environmental determinants of infectious diseases; pandemic preparedness; and control measures ranging from public mask mandates to lockdowns, which have been widely deployed by States in COVID-19 responses. We argue that Article 12(2)(c) should be read in the light of other international human rights and global health law instruments on public health emergencies to structure a more holistic interpretation of prevention and control obligations to embrace necessary, evidence-based and proportionate prevention and control measures, which are conducive to the realisation of the right to health.

A. Prevention

The text of the ICESCR does not specify what 'prevention' obligations require of States. General Comment 14 highlights that States should establish 'prevention and education programmes for behaviour-related health concerns' in fields of sexually transmitted infections, and the 'promotion of social determinants of health, such as environmental safety, education, economic development and gender equity.'²⁷ Little clarity is found about prevention from Concluding Observations relating to other epidemics including those also classified as public health emergencies of international concern, such as Zika and Ebola.

CESCR's focus on prevention obligations in its COVID-19 Statements has gravitated towards downstream, proximate measures to limit the spread of COVID-19 between individuals and within vulnerable communities. It highlighted the obligation to provide accurate and accessible information necessary to 'reduce the risk of transmission of the virus, and to protect the population against dangerous disinformation';²⁸ such information must be tailored to contexts of vulnerable populations by using accessible formats and translation to local and indigenous

²⁶ Chapman, *supra* n 8 at 251.

²⁷ GC14, *supra* n 3 at para 16.

²⁸ Statement COVID-19, *supra* n 23.

languages.²⁹ Broadening General Comment 14's focus on underlying determinants to a more integrated analysis of social determinants ('the conditions in which people are born, live in, work and age and the underlying systems that impact them'),³⁰ the CESCR highlighted that States must protect against the spread of COVID-19 among communities and groups 'subject to structural discrimination and disadvantage, including through providing water, soap and sanitiser to communities who lack them.'³¹ The CESCR likewise drew attention to an obligation to prevent infection at work,³² which also has structural discrimination implications considering the disproportionate COVID-19 risks faced by women and particular racial/ethnic groups at work.³³ Further interpretive insights can be gained from other UN Treaty Bodies, which have applied such obligations to other marginalised population groups, for example recommending that States accelerate the deinstitutionalisation of persons with disabilities,³⁴ and provide systematic COVID-19 testing in refugees and internally displaced person camps.³⁵ These interpretations can provide more granularity to interpreting Article 12(2)(c) in contexts experienced by these vulnerable groups.

While clarifying these practical, affirmative obligations that are important for protecting vulnerable groups, the CESCR's focus on social determinants of COVID-19 has been limited to what Solar and Irwin refer to as 'intermediary' social determinants, i.e. downstream determinants such as water, sanitation and housing,³⁶ rather than specifically addressing upstream structural drivers of COVID-19 risk,³⁷ such as racism, patriarchy, ableism, coloniality and the systemic structures and power imbalances, which render communities vulnerable in the first place. The limited attention to root causes by the international human rights community, and its tendency to dwell on 'technical problems and solutions', has been recognised by authors including Marks.³⁸ This interpretive limitation is particularly stark in the COVID-19 context given the patterning of infection and death rates by race, socio-economic status, disability and a country's global north/south status.³⁹ Nevertheless, addressing root causes of discrimination is considered part of cross-cutting obligations to guarantee all rights on the basis of equality and non-discrimination under ICESCR Article 2(2),⁴⁰ and is increasingly recognised in the context of the right to health by UN Special Rapporteur on the right to health ('Special Rapporteur' hereafter), and by the UN Committee on the Elimination of All Forms of Racial Discrimination in the context of COVID-19.⁴¹

²⁹ Ibid.

³⁰ WHO, 'Social Determinants of Health', available at: https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1 [last accessed 20 July 2022].

³¹ Statement COVID-19, supra n 23, at para 15.

³² Statement COVID-19, supra n 23, at para 16.

³³ Kapilashrami et al., 'Ethnic Disparities in Health and Social Care Workers' Exposure, Protection, and Clinical management of the COVID-19 Pandemic in the UK' (2022) 32 *Critical Public Health* 68.

³⁴ Chair of the United Nations Committee on the Rights of Persons with Disabilities, Statement, 1 April 2020.

³⁵ Committee on the Elimination of All Forms of Discrimination Against Women (CEDAW), Guidance Note on CEDAW and COVID-19, 22 April 2020.

³⁶ Solar and Irwin, Conceptual Framework for Action on the Social Determinants of Health (2010), available at: http://apps.who.int/iris/bitstream/handle/10665/44489/9789241500852_eng.pdf;jsessionid=7EE16CBEDD028938D4745A290E8AB325?sequence=1 [last accessed 20 July 2022].

³⁷ Commission on Social Determinants of Health, *Closing the Gap in a Generation* (2008) at 42, available at: https://apps.who.int/iris/bitstream/handle/10665/43943/9789241563703_eng.pdf [last accessed 20 July 2022].

³⁸ Marks, 'Human Rights and Root Causes' (2011) 71 *Modern Law Review* 57 at 71.

³⁹ Levin et al., 'Assessing the Burden of COVID-19 in Developing Countries: Systematic Review, Meta-analysis and Public Policy Implications' (2022) 7 *British Medical Journal Global Health* 7:e008477.

⁴⁰ CESCR, General Comment No 20: Non-discrimination in economic, social and cultural rights (art. 2, para 2), 2 July 2009, at para 12.

⁴¹ UN Special Rapporteur on the right to health, Report to the General Assembly, 16 July 2020, A/75/163, at para 2; Committee on the Elimination of All Forms of Racial Discrimination, Statement on the coronavirus (COVID-19) pandemic and its implications under the International Convention on the Elimination of All Forms of Racial Discrimination, 7 August 2020.

Other ‘upstream’ deep prevention measures for emerging infectious diseases, including at the animal/human/environment interface and preparedness for global health emergencies, are also noticeably absent from the CESCR’s interpretation of prevention obligations. General Comment 14 mentions ‘environmental safety’ as an obligation, but it is unclear if this could be interpreted to include reducing zoonoses risks through addressing root causes such as deforestation, biodiversity collapse, climate change, the wildlife trade and risky farming methods.⁴² Certainly, the Human Rights Council’s 2021 resolution recognising a right to a healthy environment links the right to health to ecosystem management.⁴³ However, the relevance of such measures to COVID-19 and other zoonotic diseases has been overlooked by most international human rights bodies. However, this issue has been recognised by the Special Rapporteur (on the right to health), while the Special Rapporteur on Toxics has gone further, calling on States to ‘recognise their obligation to prevent exposure to hazardous substances, including zoonotic viruses, as part of their obligation to protect human rights, including the rights to life, health and bodily integrity’.⁴⁴

The dearth of attention to zoonoses and human rights is located in a broader context of limited and fragmented international law at the environment/animal/human interface of prevention.⁴⁵ Even so, the right to health can be interpreted in the light of other pertinent treaties such as the UN Framework Convention on Climate Change,⁴⁶ the Convention on Biological Diversity,⁴⁷ and the Convention on International Trade in Endangered Species,⁴⁸ which obligate States to address climate change, biodiversity loss and endangered wildlife trade—all zoonoses risks—respectively.⁴⁹ The IHR does not explicitly extend to environmental determinants, but includes obligations to develop capacities to detect, assess, notify and respond to events that pose risk to human health.⁵⁰ The IHR reporting guidelines elaborate that these risks include animal health risks. The guidelines require States to report on mechanisms and procedures related to ‘preparedness, planning, surveillance and response for zoonotic diseases and other health events existing or emerging at the human–animal–environmental interface’, and on the ‘ability of the country to prepare for, prevent, identify, conduct risk assessment for and report’ potential zoonoses risks.⁵¹ Turning to soft law standards, the International Law Commission’s Draft Articles on Disaster Risk Reduction (2016), whose definition of disasters has been argued to extend to public health emergencies of international concern,⁵² sets out in Article 9 that States shall ‘reduce the risk of disasters by taking appropriate measures, including through legislation and regulations, to prevent, mitigate and prepare for disasters.’⁵³ The 2015–2030 Sendai Framework for Disaster Risk Reduction, the central international policy instrument for disaster risk reduction and which is referred to in the International Law Commission’s

⁴² Lawler et al., ‘The COVID-19 Pandemic is Intricately Linked to Biodiversity Loss and Ecosystem Health’ (2021) 5 *Lancet Planet Health* 840.

⁴³ Res 48/13, 8 October 2021, A/HRC/RES/48/13.

⁴⁴ UN Special Rapporteur on the Implications for Human Rights of the Environmentally Sound Management and Disposal of Hazardous Substances and Wastes, Report to the General Assembly, 13 October 2020, A/HRC/45/12 at para 97; Special Rapporteur 2020, *supra* n 41 at para 47.

⁴⁵ Negri and Eccleston-Turner ‘One Health and Pathogen Sharing: Filling the Gap in the International Health Regulations to Strengthen Global Pandemic Preparedness and Response’ (2022) 19 *International Organizations Law Review* 188.

⁴⁶ United Nations Framework Convention on Climate Change 1992, General Assembly Res 48/189.

⁴⁷ Convention on Biological Diversity 1992, 1760 UNTS 69.

⁴⁸ Convention on International Trade in Endangered Species of Wild Fauna and Flora 1973, 993 UNTS 243.

⁴⁹ Phelan and Carlson, ‘A Treaty to Break the Pandemic Cycle’ (2022) 377 *Science*, available at: <https://www.science.org/doi/full/10.1126/science.abq5917> [last accessed 20 July 2022].

⁵⁰ IHR, *supra* n 5 at Articles 5 and 13.

⁵¹ WHO, *State Party Self-Assessment Annual Reporting Tool* (2021), available at: <https://www.who.int/publications/i/item/9789240040120> [last accessed 9 January 2023].

⁵² Coco and de Souza Dias, ‘Prevent, Respond, Cooperate’ (2020) 11 *Journal of International Humanitarian Legal Studies* 218.

⁵³ International Law Commission, Draft Articles on the Protection of Persons in the Event of Disasters, 26 May 2016, A/CN.4/L.871.

draft commentary on Article 9, provides potential interpretive guidance for Article 12(2)(c), setting out that States should prevent new and reduce existing disaster risk including through health and environmental measures.⁵⁴ These obligations and responsibilities should inform the interpretation of Article 12(2)(c) prevention obligations.

This fragmented legal picture has been highlighted in ongoing discussions on a new pandemic treaty with several States advocating that a treaty should adopt a multisectoral ‘onehealth’ approach establishing preventive obligations at this human-animal-ecosystem interface, and indeed this approach is embraced in the ‘conceptual zero draft’ of the treaty prepared for the International Negotiating Board in November 2022.⁵⁵ This approach is also advocated by the Bangkok Principles for the Implementation of the Health Aspects of the Sendai Framework (2016)⁵⁶ and the World Health Assembly,⁵⁷ which have called for all-hazards multisectoral coordinated approach in preparedness for health emergencies and disasters. This emerging holistic approach should be considered in interpreting Article 12(2)(c).

The IHR also establishes public health emergency preparedness obligations, which should structure interpretation of prevention obligations under Article 12(2)(c). These obligations include a set of ‘core capacities’ under IHR Annex 1, and unpacked in IHR reporting guidelines addressing, amongst others, preparedness obligations relating to health infrastructure, legal and policy frameworks, finance, surveillance, health workforce, a national health emergency framework including surge capacity to respond to threats, health service provision and information. As noted by Toebes, Forman and Bartolini, these core capacities significantly overlap with right to health obligations under ICESCR Article 12, including ‘core obligations’ which include a duty to adopt national public health strategy and plan of action to address population’s health concerns, leading those authors to advocate a more integrated reading of the IHR and the right to health.⁵⁸

B. Treatment

Significant limitations in accessing COVID-19 treatment have been experienced due to demand exceeding supply for hospital beds, ventilators and oxygen; hoarding of supplies; corruption at government and local levels; inequalities and discrimination experienced by some population groups; and weak, underfunded health systems.⁵⁹ ICESCR Article 12(2)(c) requires that States parties take steps that are necessary for the treatment of epidemic and endemic diseases, while Article 12(2)(d) establishes an interlinked obligation to create ‘conditions which would assure to all medical service and medical attention in the event of sickness.’ General Comment 14 requires States to provide for a system of ‘urgent medical care’ in case of epidemics,⁶⁰ a pertinent interpretation given the urgent nature of COVID-19 treatment for people experiencing severe disease. This obligation should also be interpreted in light of IHR reporting guidelines, which provide health services should assure capacity for case management (e.g. triage, referral procedures and facilities) in emergencies.⁶¹

⁵⁴ Res 69/283, 23 June 2015, A/Res/69/283.

⁵⁵ Balcazar Moreno, Burci and Strobejko, *Taxonomy of Substantive Proposals for a New Instrument on Pandemic Prevention, Preparedness and Response* (Graduate Institute Geneva, 2022); WHO, Conceptual Zero Draft for the consideration of the Intergovernmental Negotiating Body at its Third Meeting (November, 2022).

⁵⁶ Bangkok Principles for the Implementation of the Health Aspects of the Sendai Framework for Disaster Risk Reduction 2015–2030, International Conference on the Implementation of the Health Aspect of Sendai Framework, 2016.

⁵⁷ WHA Resolution 74.7, 31 May 2021.

⁵⁸ Toebes, Forman and Bartolini, *supra* n 25 at 100.

⁵⁹ Bueno de Mesquita, Kapilashrami and Meier, *Human Rights Dimensions of the COVID-19 Pandemic* (Independent Panel on Pandemic Preparedness and Response, 2021), available at: <https://theindependentpanel.org/wp-content/uploads/2021/05/Background-paper-11-Human-rights.pdf> [last accessed 20 July 2022].

⁶⁰ GC14, *supra* n 3 at para 16.

⁶¹ WHO, *supra* n 51.

General Comment 14 clarifies that health care facilities, goods and services must be: *available* in adequate numbers; *accessible* financially, geographically and on the basis of non-discrimination; *acceptable* including in terms of being respectful of gender and medical ethics; and of good *quality*.⁶² This overarching conceptual framework, which embraces treatment (goods) and services, has been applied to COVID-19.⁶³ The CESCR has also specified that to ensure accessibility of care, the State should adopt regulatory measures to mobilise healthcare resources in the public and private sectors.⁶⁴ Further, the CESCR has highlighted the importance of longer-term investment in public health systems to support effective responses to COVID-19,⁶⁵ whilst the IHR reporting guidelines point to a similar obligation that can inform interpretation of ICESCR Article 12(2)(c) to develop resilient public health systems.

General Comment 14 clarifies that health goods and services must be accessible on the basis of equality and non-discrimination. This obligation has been interpreted, amongst others, to require elimination of discrimination on grounds of race in access to health, including against migrants and undocumented persons;⁶⁶ and to provide healthcare on the basis of equality and non-discrimination to those in detention during COVID-19.⁶⁷ Non-discriminatory access has important implications in the context of triage protocols for COVID-19 healthcare, some of which have discriminated by age or disability.⁶⁸ Others, which are underpinned by goals such as saving more lives or more life years, are not neutral, and indirectly discriminate insofar as determinants of survival may coincide with protected characteristics such as age or disability.⁶⁹ Though not addressed by the CESCR, the UN Special Rapporteur on disabilities has clarified that treatment prioritisation decisions should be made on the basis of 'medical needs, the best scientific evidence available and not on non-medical criteria such as age or disability'.⁷⁰ A transparent and participatory process for priority setting processes,⁷¹ which is rooted in General Comment 14's emphasis participation in all health-related decision making⁷² and linked to participation rights under other treaties, such as the CPRD, is essential to protect equality and non-discrimination in this context.

The CESCR has not interpreted Article 12(2)(c) as providing a specific entitlement to any type of COVID-19 treatment. Rather, with its Statements being adopted early in the pandemic when there was a lack of clarity on effective treatment, it has focused on obligations to create conditions for available treatment, through the sharing of scientific knowledge to expedite effective treatment; and international assistance and cooperation in sharing research, medical equipment and supplies. This contrasts with its more detailed approach to COVID-19 vaccines, as well as to goods and services for matters such as sexual and reproductive health, with the CESCR having identified entitlements to condoms, emergency contraception, medical abortion and post-abortion care, medicines for HIV and assisted reproductive technologies.⁷³ This

⁶² GC14, supra n 3 at para 12.

⁶³ Pūras et al., 'The right to health must guide responses to COVID-19' (2020) 395 *The Lancet* 1888.

⁶⁴ CESCR, Concluding observations regarding Latvia, 30 March 2021, E/C.12/LVA/CO/2 at para 41.

⁶⁵ Ibid at para 40.

⁶⁶ Committee on the Elimination of Racial Discrimination, Statement 3: The Coronavirus (COVID-19) Pandemic and its Implications under the International Convention on the Elimination of All Forms of Racial Discrimination, 7 August 2020, para 4.

⁶⁷ Committee against Torture et al., COVID-19 Exacerbates the Risk of Ill-treatment and Torture Worldwide, 26 June 2020.

⁶⁸ Michalowski, 'The Use of Age as a Triage Criterion' in Ferstman and Fagan (eds), *Covid-19, Law and Human Rights: Essex Dialogues* (2020).

⁶⁹ Bhatt et al., 'Human rights and COVID-19 Triage: A Comment on the Bath Protocol' (2021) 47 *Journal of Medical Ethics* 464.

⁷⁰ UN Special Rapporteur on the rights of persons with disabilities, COVID-19: Who is Protecting the People with Disabilities? 17 March 2020.

⁷¹ Rumbold et al., 'Universal Health Coverage, Priority Setting and the Human Right to Health' (2017) 390 *The Lancet* 712.

⁷² GC14, supra n 3 at para 11.

⁷³ CESCR, General Comment No 22: The right to sexual and reproductive health (art. 12), 2 May 2016, at para 13.

suggests that over time, it may highlight more specific measures, including those identified by other international human rights bodies such as diagnostic tests, ventilators and oxygen,⁷⁴ or relevant facilities such as hospital beds, intensive care units and equipment.⁷⁵ The CESCR's previous Concluding Observations in which it recommended States to provide post-Ebola care,⁷⁶ as well as clarification of obligations regarding post-abortion care,⁷⁷ suggests treatment obligations should be interpreted to extend to long-COVID care.

Whilst the CESCR expects States to provide COVID-19 treatment, its responses to both previous public health emergencies and COVID-19 clarify that treatment for other health conditions must not be sacrificed. Following the Ebola outbreak in West Africa, the CESCR expressed concern about its 'devastating effect' on Guinea's health system and expressed concerns over insufficient medical facilities and personnel, as well as high healthcare costs for low-income households.⁷⁸ In Concluding Observations addressing COVID-19, the CESCR follows this reasoning by recommending Latvia to 'take measures to ensure that constraints on health-care resources owing to the COVID-19 pandemic do not significantly hinder the provision of other health care and services, including for pre-existing conditions, for mental health care and for sexual and reproductive health-care services.'⁷⁹ The IHR reporting guidelines are instructive in this matter, providing that 'particularly in emergencies, health services provision for both event-related case management and routine health services are ... equally as important'⁸⁰ While highlighting that other right to health obligations should not be neglected, the CESCR has provided limited guidance on balancing different right to health entitlements in a context of limited capacity, including the position of core obligations as we explore in Section 3, though the cross cutting principles of equality, non-discrimination and participation which—as described above—frame priority setting in COVID-19 treatment are equally relevant to frame prioritisation across health issues and conditions.

C. Control Measures

General Comment 14 clarifies that control obligations include 'mak[ing] available relevant technologies, using and improving epidemiological surveillance and data collection on a disaggregated basis, the implementation or enhancement of immunisation programmes and other strategies.'⁸¹ With a significant focus on COVID-19 vaccines, CESCR has unpacked obligations regarding vaccines and epidemiological surveillance of COVID-19.⁸² However, less attention has been given to interpreting what 'other strategies' could mean in the context of COVID-19, including the relationship of isolation, quarantine, 'social' distancing, lockdown and travel restrictions with the right to health.

(i). Vaccines

General Comment 14 casts 'immunisation programs against the major infectious diseases' as a core obligation.⁸³ Deriving from interconnections with the right to 'enjoy the benefits of

⁷⁴ Special Rapporteur 2020, supra n 41 at paras 37–41; European Committee of Social Rights, Statement on the right to protection of health in times of pandemic crisis, 22 April 2020.

⁷⁵ European Committee on Social Rights, *ibid*.

⁷⁶ CESCR, Concluding observations regarding Guinea, 30 March 2020, E/C.12/GIN/CO/1.

⁷⁷ General Comment 22, supra n 73.

⁷⁸ CESCR, Concluding observations regarding Guinea, supra n 76.

⁷⁹ CESCR, Concluding observations Latvia, supra n 64.

⁸⁰ WHO, supra n 51.

⁸¹ GC14, supra n 3 at para 16.

⁸² CESCR, Concluding observations regarding Bolivia, 5 November 2021, E/C.12/BOL/CO/3 at para 51(b); CESCR, Concluding observations regarding Nicaragua, 11 November 2021, E/C.12/NIC/CO/5 at para 54.

⁸³ GC14, supra n 3 at para 44(b).

scientific progress' (ICESCR art 15.1),⁸⁴ the CESCR's Statement on Universal and Equitable Access to Vaccines for COVID-19 clarified that 'every person has a right to access a vaccine for COVID-19, which is safe, effective and based on the application of the best scientific developments',⁸⁵ and that States must give 'maximum priority to the provision of vaccines for COVID-19 to all persons.'⁸⁶ Despite these pronouncements, the CESCR recognised that at the time it drafted this Statement, shortly after vaccines were first approved, it would be impossible to make the vaccine available to all due to limited supply. This led it to use the concept of accessibility to frame distribution of vaccine supply: vaccines must be made economically accessible through providing them free of charge, especially to poorer population groups; States must provide accessible information on vaccines; and vaccines must be accessible on the basis of equality and non-discrimination, including for marginalised groups such as health workers, older persons, refugees, migrants and indigenous populations.⁸⁷

The CESCR's vaccine Statement argued that national prioritisation policies must be guided by medical need and public health grounds, taking into account equality and non-discrimination, to prioritise 'those most exposed and vulnerable to the virus owing to social determinants of health, such as people living in informal settlements or other forms of dense or instable housing, people living in poverty, indigenous peoples, racialised minorities, migrants, refugees, displaced persons, incarcerated people and other marginalised and disadvantaged population.'⁸⁸ Though the CESCR has embraced an intersectional approach to equality and non-discrimination for the right to health in the past,⁸⁹ it has not explicitly extended this to its analysis of vaccine allocation in the COVID-19 context. However, an intersectional approach should be adopted, informed by WHO's COVID-19 vaccination technical guidance, which uses an intersectional lens to leave no-one behind.⁹⁰ This requires embedding prioritisation in a matrix of reinforcing vulnerabilities including individual health risks (e.g. age, disability, comorbidities), social vulnerabilities (e.g. housing conditions, gender, race and other factors that limit access to healthcare) and vulnerability arising from financial and social effects of ill-health (e.g. catastrophic health expenditure, caring responsibilities).⁹¹

(ii). Surveillance and data collection

Public health surveillance provides an early warning system for emerging health threats; helps track progress; supports evaluation of interventions; and helps guide policy responses. As such, surveillance is an important strategy in both prevention and control, though it is discussed as a control obligation in General Comment 14. The CESCR's COVID-19 Statements do not clarify surveillance obligations in the context of COVID-19. However, under Articles 5, 13 and Annex 1, the IHR establishes public health event surveillance obligations on States as a core capacity, which should inform interpretation of Article 12(2)(c). Testing and contact tracing obligations have also been highlighted by regional human rights bodies,⁹² as well as under the IHR as part of disease surveillance,⁹³ an interpretation that should inform interpretation of Article 12(2)(c).

⁸⁴ CESCR, General Comment No. 25: Science and economic, social and cultural rights (article 15 (1) (b), (2), (3) and (4)), 30 April 2020, para 7.

⁸⁵ Statement COVID-19 vaccines, supra n 23 at para 4.

⁸⁶ Ibid.

⁸⁷ Ibid at para 6.

⁸⁸ Ibid at para 5.

⁸⁹ General Comment 22, supra n 77.

⁹⁰ WHO, *SAGE Values Framework for the Allocation and Prioritization of COVID-19 Vaccination*, 14 September 2020.

⁹¹ Sekalala et al., 'An Intersectional Human Rights Approach to Prioritising Access to COVID-19 Vaccines' (2021) 6 *British Medical Journal Global Health* 6:e004462.

⁹² African Commission on Human and Peoples' Rights, Press Statement on human rights based effective response to the novel COVID-19 virus in Africa 24 March 2020; European Committee on Social Rights, supra n 74.

⁹³ E.g., IHR, supra n 5 at Article 18.

In recent years, surveillance methods have significantly evolved, utilising new technologies such as phone apps, global positioning systems and artificial intelligence to forecast or model the spread of infectious diseases.⁹⁴ Many States have embraced this technology that can bring new insights for public health surveillance, yet it can also pose human rights risks. Drawing on the example of contact tracing apps, McGregor illustrates risks including to privacy and confidentiality given adequate safeguards are not in place in most contexts; equality and non-discrimination insofar as an over-reliance on digital surveillance techniques can marginalise communities without connectivity in pandemic responses; and longer-term risks beyond the pandemic.⁹⁵ There is no international guidance on the use of digital technologies during global health emergencies, to inform interpretation of Article 12(2)(c). Nevertheless, the Human Rights Council has recognised the right to privacy in the context of the digital age,⁹⁶ while the Special Rapporteur has clarified that COVID-19 surveillance technology must abide by strict protections of human rights law with safeguards in place, and must be ‘limited in use, in purpose and time.’⁹⁷

(iii). *Other strategies of infectious disease control*

Governments have deployed a wide spectrum of measures with the stated purpose of controlling the spread of COVID-19 including isolation, quarantine, mask wearing, ventilation, testing and contact tracing, surveillance, social distancing, lockdown and international travel restrictions. The ICESCR requires States to take ‘steps’ to realise the right to health, but States have some discretion in determining the most ‘appropriate means’.⁹⁸ Nevertheless, the relationship (if any) of each of these measures with the Article 12(2)(c) obligation to adopt ‘other strategies of infectious disease control’ has remained ambiguous. This is partly because neither General Comment 14 nor the CESCR’s Statements on COVID-19 illustrate what measures may comprise the ‘other strategies of infectious disease control’ it refers to. Indeed, the CESCR’s first Statement on COVID-19 chooses to frame measures to ‘combat’ COVID-19, including emergency measures and those which restrict other rights, as ‘public health’ rather than ‘right to health’ measures. This seems to frame such measures as having a relationship with human rights primarily insofar as they may entail limitations on other rights to ‘protect public health’, without recognising that some measures may also contribute to the realisation of the right to health.

Indeed, reading Article 12(2)(c) in light of interpretive statements by other international human rights bodies suggests some of these measures should be considered ‘other strategies of infectious disease control’, at least in some contexts. For example, in interpreting ‘the right to protection of health’ under the European Social Charter in times of pandemic, the European Committee of Social Rights declared that States should take ‘all necessary emergency measures [which may include] . . . testing and tracing, physical distancing and self-isolation, the provision of adequate masks and disinfectant, as well as the imposition of quarantine and “lockdown” arrangements [and must be] with regard to the current state of scientific knowledge and in accordance with relevant human rights standards’.⁹⁹ The Special Rapporteur further highlighted restrictions on movement insofar as they are necessary, proportionate, time-bound and non-discriminatory in the pandemic response.¹⁰⁰ This reading of the right to health is significant as it

⁹⁴ Sarfaty, ‘Can Big Data Revolutionize International Human Rights Law?’ (2017) 39 *University of Pennsylvania Journal of International Law* 73.

⁹⁵ McGregor, ‘Regulating Digital and AI Technologies: Lessons from the Digitisation of Contact Tracing during the Covid-19 Pandemic’ (2022) 3 *Yearbook of International Disaster Law Online* 35.

⁹⁶ Res 42/15, 24 September 2019, A/HRC/RES/42/15.

⁹⁷ Statement by UN Special Rapporteur on right to health, Informal conversation of the Human Rights Council, 30 April 2020.

⁹⁸ GC3, supra n 17 at para 3.

⁹⁹ European Committee on Social Rights, supra n 74.

¹⁰⁰ Special Rapporteur 2020, supra n 41 at para 93.

casts such measures as potential legal human rights entitlements with corresponding obligations. Yet some of these measures may be poorly designed or inappropriately implemented to control COVID-19, whilst they may undermine human rights including other right to health norms or other minimum essential levels of economic and social rights.

International human rights law establishes various principles that can help navigate these difficult questions. Firstly, as the CESCR highlights, measures to combat COVID-19 must be based on the ‘best available scientific evidence to protect public health’, a framing principle also deployed by the European Committee of Social Rights in the citation above. This insistence on scientific evidence resonates with General Comment 14’s affirmation that health interventions for the right to health must be ‘scientifically appropriate’,¹⁰¹ suggesting that the right to health can embrace obligations vis-à-vis those control measures that have a robust basis in the best available scientific evidence, such as indoor ventilation.¹⁰² For some measures, such as travel restrictions, there was variation between countries in terms of the design of such restrictions, with some following a scientific basis and being effective in containing or slowing the spread of virus, whilst more often such restrictions were epidemiologically ineffective and discriminatory.¹⁰³ This suggests such strategies cannot be categorised in a binary way as right to health or non-right to health measures, instead requiring a case-by-case analysis.

Secondly, General Comment 14 and CESCR’s first COVID-19 Statement draw on the Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights (1984) to highlight that public health measures should be proportionate, necessary and in accordance with the law.¹⁰⁴ These Principles have become an influential framework to navigate the protection of human rights in emergencies including public health emergencies such as COVID-19. Though developed with civil and political rights in mind, General Comment 14 suggests their relevance to interpreting permissible limitations to economic, social and cultural rights under the ICESCR’s limitations clause (article 4), which also states that any limitations must ‘promote general welfare.’ To keep with the example of travel restrictions, those restrictions based on scientific evidence could be considered an appropriate measure under the right to health if there were proportionate to achieving their ends, and if they are necessary to control COVID-19 and promote general welfare.¹⁰⁵

Even so, these principles have often been ignored or proven difficult to apply: States’ responses have largely neglected human rights protection,¹⁰⁶ proportionality assessments at a time of scientific uncertainty have been challenging;¹⁰⁷ and the limitation of other parts of the right to health (and other social and economic rights) to control COVID-19 has also been challenged.¹⁰⁸ Scholars are working on proposals for rethinking these parameters of necessity and proportionality and conceptualising new approaches to protecting economic, social and cultural

¹⁰¹ GC14, supra n 3 at para 12.

¹⁰² Morawska and Milton, ‘It is Time to Address Airborne Transmission of Coronavirus Disease 2019 (COVID-19)’ (2020) 71 *Clinical Infectious Disease* 2311.

¹⁰³ Meier et al., ‘Travel Restrictions and Variants of Concern: Global Health Laws Need to Reflect Evidence’ (2022) 100 *Bulletin of the World Health Organisation* 178.

¹⁰⁴ GC14, supra n 3 at para 28; Statement COVID-19, supra n 23 at para 3; International Commission of Jurists, *Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights*. (1984), available at: <https://www.icj.org/wp-content/uploads/1984/07/Siracusa-principles-ICCPR-legal-submission-1985-eng.pdf> [last accessed 20 July 2020].

¹⁰⁵ *Ibid.*

¹⁰⁶ Bueno de Mesquita, Kapilashrami and Meier, supra n 59.

¹⁰⁷ Habibi et al., Harmonizing global health law and human rights law to develop rights-based approaches to global health emergencies, *OpinioJuris*, 24 February 2021, available at: <http://opiniojuris.org/2021/02/24/harmonizing-global-health-law-and-human-rights-law-to-develop-rights-based-approaches-to-global-health-emergencies> [last accessed 20 July 2020].

¹⁰⁸ Forman and Kohler, ‘Global Health and Human Rights in the Time of COVID-19: Response, Restrictions and Legitimacy’ (2020) 19 *Journal of Human Rights* 547.

rights in public health emergencies,¹⁰⁹ which may provide new interpretive insights in the years to come.

4. IN THE SHADOWS? INTERPRETING ARTICLE 2(1) OBLIGATIONS TOWARDS THE RIGHT TO HEALTH IN TIMES OF COVID-19

Article 2(1) is a foundational provision setting out the general legal nature of obligations under the ICESCR, including its Article 12(2)(c). It obliges States to progressively realise the right to health by using the maximum of their available resources, both individually and through international assistance and co-operation with other States.¹¹⁰ However, the flexibility offered by this provision, which the CESCR deems ‘necessary’,¹¹¹ has not always been compensated by sufficient clarification of what it entails in practice, including during the pandemic. Indeed, the CESCR recognises useful legal frameworks relevant to Article 2(1) in its General Comments 3 (on the nature of States parties’ obligations) and 14 (on the right to health), but it rarely uses them when monitoring States’ compliance with the right to health in times of COVID-19, thereby failing to specify how Articles 2(1) and 12 interact in practice.

The pandemic, nonetheless, raises key questions—explored in the following sections—on immediacy, progressive realisation (including non-retrogression), core obligations and extra-territoriality, calling for a clarification of States’ obligations to realise the right to health under Article 2(1) ICESCR. How should such concepts be understood when unprecedented shortages of resources, health nationalism and arbitrary decisions to prioritise certain treatments or certain groups over others, worsen health outcomes for vulnerable groups and populations, especially in poor- and middle-income countries? Our doctrinal approach, informed by Articles 31 and 32 VCLT, highlights that while extra-territorial obligations have been refined in unprecedented details, thorny concepts such as immediacy, progressive realisation, non-retrogression and core obligations remain blurry. The CESCR’s inability to adopt consistent approaches to interpreting these obligations and its unwillingness to review budgetary data in detail, impede significantly the clarification of the relationship between Articles 2(1) and 12 ICESCR in times of COVID-19, since global health law instruments are of limited assistance in its interpretation.

A. Progressive Realisation Versus Immediacy in Times of COVID-19

Drawing the contours of States’ obligation to progressively realise Article 12(2)(c) in times of COVID-19 first entails appreciating what it does *not* include: i.e. immediate obligations, which General Comment 14 specifies to encompass: non-discrimination; and taking deliberate, concrete and targeted steps towards the realisation of the right to health.¹¹² Arguably, the obligation to take steps presumes an immediate obligation to not take retrogressive measures (discussed in Section 3.B). Furthermore, key human rights UN agencies and scholars have also identified core obligations (discussed in Section 3.C) as being of immediate nature,¹¹³ for General Comment 14 declares they are ‘non-derogable’.¹¹⁴ However, the relationship between immediate obligations and Article 2(1) is under-explored in practice and the scope of these obligations remains unclear.

Indeed, immediacy is not explicitly discussed in the text of Article 2(1), its *travaux préparatoires* or its context.¹¹⁵ It is not clarified in the relevant rules of international law applicable

¹⁰⁹ Ibid.

¹¹⁰ ICESCR, *supra* n 2 at Article 2(1).

¹¹¹ GC3, *supra* n 17, at para 9.

¹¹² GC14, *supra* n 3 at para 30.

¹¹³ E.g., Courtis, ‘Standards to Make ESC Rights Justiciable: A Summary Exploration’ (2009), 2 *Erasmus Law Review* 379, at 382–390.

¹¹⁴ GC14, *supra* n 3 at para 47.

¹¹⁵ Saul et al., ‘Article 2(1): Progressive Realization of ICESCR Rights’ in Saul, Kinley and Mowbray, *The International Covenant on Economic, Social and Cultural Rights: Commentary, Cases and Materials* (2014).

between parties to the ICESCR either. The CESCR, UN Treaty Bodies and the Special Rapporteur have rarely referred to ‘immediate obligations’ during the COVID-19 pandemic or during past global health emergencies.¹¹⁶ In the three Statements and the 12 Concluding Observations it adopted during the pandemic, the CESCR only once referred to immediacy, when reminding States that ‘it is impossible to guarantee that everyone will have immediate access to a vaccine for COVID-19’ (although vaccines represent a ‘core obligation’, as per General Comment 14).¹¹⁷ Instead, the CESCR used a time-specific terminology (e.g. urgency, expeditiousness) highlighting two particular aspects of the right to health which States ought to prioritise: the principle of non-discrimination (an ‘immediate obligation’, as per General Comment 14);¹¹⁸ and access to essential medicines (a ‘core obligation’, as per General Comment 14).¹¹⁹ In its COVID-19 Statements, the CESCR contemplated the need to protect vulnerable groups from discrimination as a matter of ‘urgency’, rather than immediately. This included ‘prioritising’ the allocation of resources to prevent or mitigate the disproportionate impact of the pandemic on vulnerable groups,¹²⁰ and taking ‘urgent’ international measures to scale up production and distribution of vaccines worldwide and achieve universal access (including in the Global South).¹²¹ Furthermore, the CESCR reminded States that they ought to take swift steps towards the realisation of the right to health, by ‘expedit(ing)’ the discovery of COVID-19 treatments and by ‘guarantee(ing), as expeditiously as possible’ universal equitable access to COVID-19 vaccines.¹²²

The CESCR’s (arbitrary) decision to embrace obligations to ‘prioritise’ certain aspects of the right to health, instead of explicitly recognising their immediate nature, indirectly suggests that immediate obligations are derogable and not absolute in practice. This seeming confusion between immediate and progressive obligations casts doubts about whether States that discriminated against vulnerable groups in pandemic responses will be *presumed* in violation of the right to health or whether their resources will be assessed first. Though there is limited in-depth analysis of immediacy in human rights scholarship,¹²³ we argue that immediate obligations represent a valuable monitoring tool to assess States’ compliance against Article 12. This is especially true during pandemics, where widespread shortages of resources could be used as an excuse to justify inaction or discrimination. A more assertive approach to immediate obligations to prevent, treat and control COVID-19 under Article 12(2)(c) would allow the CESCR to clarify what immediate obligations entail in this context, to differentiate them more explicitly from the general requirement of progressive realisation, and to hold States to account for failures to realise the right to health during the pandemic through findings of *prima facie* violations.

B. Progressive Realisation, Retrogression and the Right to Health

(i). *Progressive realisation in times of COVID-19: pace and resources*

In General Comment 14, the CESCR outlines that States’ obligation to progressively realise the right to health implies expeditious and effective steps towards its full realisation.¹²⁴ However, the

¹¹⁶ See rare requests for ‘immediate’ measures: CESCR, Concluding Observations on Ukraine, 4 January 2008, E/C.12/UKR/COS at para 49; Concluding observations Latvia, supra n 64 at para 33(b); Special Rapporteur 2020, supra n 41 at paras 16, 20, 74, 98.

¹¹⁷ Statement universal COVID-19 vaccination, supra n 23 at para 5; GC14, supra n 3 at para 44(b).

¹¹⁸ GC14, supra n 3 at para 30.

¹¹⁹ Ibid at para 43(d).

¹²⁰ Statement COVID-19, supra n 23 at paras 14–15.

¹²¹ Statement universal COVID-19 vaccination, supra n 23 at paras 6, 11 and 12.

¹²² Statement COVID-19, supra n 23 at para 23; Statement COVID-19 vaccines, supra n 23 at paras 7 and 12; Statement universal COVID-19 vaccination, supra n 23 at para 6.

¹²³ Katharine G Young, ‘The Immediacy of Economic and Social Rights’ (Boston College Law School Faculty Papers, 2018) available at: <https://lawdigitalcommons.bc.edu/cgi/viewcontent.cgi?article=2223&context=lsfp> [last accessed 20 July 2020].

¹²⁴ GC14, supra n 3 at para 31; Statement COVID-19, supra n 23 at paras 14–15.

pace at which States are expected to take steps to prevent, treat and control COVID-19 depends heavily on their resources, a parameter that varies from one country to the next and renders the interpretation of the ICESCR difficult.

Two aspects of this pace-resources relationship have been interpreted comprehensively, thereby clarifying States' obligation to progressively realise the right to health in times of COVID-19. Firstly, the resources States must deploy to protect the right to health are interpreted broadly, which means that States must take steps in different areas and can less easily justify slow progress. Article 2(1) declares that States must realise rights 'by all appropriate means' and its *travaux préparatoires* call for an extensive interpretation of the concept of resources,¹²⁵ an approach supported by scholars such as Robertson.¹²⁶ This interpretation remains relevant, since recent CESCR's Statements and Concluding Observations understood resources required to fight COVID-19 as including health expenditures, medical equipment, human resources and scientific knowledge, highlighting that States should draw on resources from the public or the private sector (e.g. private hospitals and laboratories) to cope with demand.¹²⁷ Furthermore, the CESCR recognised that resources required to fight COVID-19 should be deployed during the pandemic as well as in advance, through pandemic preparedness and adequate investment in public health systems.¹²⁸ Finally, a broad interpretation of States' resources is also supported by the IHR, relevant to the reading of Article 12(2)(c), since it considers that States' capacities to fight infectious diseases rely on 'human, financial, material or technical resources'.¹²⁹ A comprehensive interpretation of 'resources availability' allows the UN to widen the net for potential violations of States' obligation to expeditiously prevent, treat and control COVID-19, and to successfully hold States to account for poor COVID-19 responses.

Secondly, States' overall level of domestic resources tends to be taken into consideration to assess their ability to speedily prevent, treat and control COVID-19, including their ability to provide or access international resources through international cooperation, as per Article 2(1). The CESCR often connects obligations arising from Article 2(1) ICESCR to countries' 'level of development' and to their 'current economic situation', including during global shortages of resources such as the 2007–2008 financial crisis.¹³⁰ It continued doing so during the COVID-19 pandemic since its three Statements and 12 Concluding Observations reflect different expectations depending on States' incomes. Furthermore, the CESCR often refers to 'developed' countries' obligation to provide international assistance and cooperation to 'developing' countries (which will be discussed in further details in Section 3.D).¹³¹ A targeted interpretation of 'resources availability' taking into account States' overall level of income allows the UN to fairly assess potential violations of States' obligation to expeditiously prevent, treat and control COVID-19, and to hold States to account based on their capacity.

¹²⁵ ECOSOC Commission on Human Rights, Summary Record of the 271st Meeting' (1952), E/CN.4/SR.271 at 5 (Mr Azkoul, Lebanon) and at 6 (Mr Cassin, France): 'The resources of a state should be interpreted broadly to include budgetary appropriations and also technical assistance, international co-operation and other elements'.

¹²⁶ Robert E Robertson, 'Measuring State Compliance with the Obligation to Devote the "Maximum Available Resources" to Realizing Economic, Social and Cultural Rights' (1994) 4 *Human Rights Quarterly* 693 at 697.

¹²⁷ GC14, supra n 3 at paras 12 and 17; Statement COVID-19, supra n 23 at paras 6, 9, 18, 20, 23; Statement on COVID-19 vaccines, supra n 23, at paras 2, 4 and 11; Statement universal COVID-19 vaccination, supra n 23 at paras 3 and 9; see also Special Rapporteur 2020, supra n 41 at para 32.

¹²⁸ Statement COVID-19, supra n 23 at para 4; Concluding observations Latvia, supra n 64 at para 40.

¹²⁹ IHR, supra n 5 at Annex 2.

¹³⁰ CESCR, Statement: An Evaluation of the Obligations to Take Steps to the 'Maximum of Available Resources' under an Optional Protocol to the Covenant (2007), E/C12/2007/1 at para 10; Eitan Felner, 'Closing the "Escape Hatch": A Toolkit to Monitor the Progressive Realization of Economic, Social and Cultural Rights' (2009) 1 *Journal of Human Rights Practice* 402 at 406.

¹³¹ See all CESCR COVID-19 Statements, supra n 23; as well as Concluding observations Latvia, supra n 64 at paras 38–45; CESCR, 'Concluding Observations on Finland, 30 March 2021, E/C.12/FIN/CO/7 at paras 8–9, 41–45; CESCR, Concluding Observations on Kuwait, 3 November 2021, E/C.12/KWT/CO/3 at para 40.

However, two aspects of the synergy of pace and resources remain opaque and ought to be interpreted in more depth to clarify States' obligation to progressively realise the right to health in times of COVID-19. First, since most technical and human resources can only be available if funded, financial resources should consistently and explicitly be taken into consideration when assessing compliance with the right to health. However, the CESCR and the Special Rapporteur never mentioned States' respective levels of income when assessing compliance with the right to health at the domestic level but rather, expressed concerns over the lack of resources deployed to fight COVID-19.¹³² The same can be said when analysing the comments formulated by UN Treaty Bodies (including the CESCR) during past global health emergencies, comments exclusively addressed to low- and middle-income countries since they were the most affected by Ebola, Tuberculosis, Poliomyelitis and Zika. Whilst UN Treaty Bodies recognised the impact of epidemics on States' resources and health systems,¹³³ they expected all States (including those with low resources) to progressively realise the right to health and deploy adequate resources to fight against or recover from virus outbreaks.¹³⁴ By contrast, when it comes to assessing obligations of international cooperation, the CESCR takes account of resource levels, requiring 'developed states' to avoid decisions that would obstruct access to necessary supplies to the world's 'poorest victims of the pandemic.'¹³⁵ We contend that Article 2(1) requires that the CESCR consider more consistently budgetary data and gross national income across States' domestic and extraterritorial responses to COVID-19. This would enable the CESCR to adjust its expectations regarding the timeframe in which each State should fulfil its obligations to prevent, treat and control COVID-19 and whether it should seek international cooperation.

Second, since the aim of Article 2(1) is to oblige States to realise economic, social and cultural rights, failures to do so due to insufficient resources should be narrowly interpreted and when relevant, violations should be found. However, that is rarely the case since UN Treaty Bodies, including the CESCR, often fail to use a clear terminology or engage with systematic benchmarks to hold violations of the right to health in their Statements and Concluding Observations addressing global virus outbreaks, including COVID-19. Whilst this approach traditionally reflects a focus on constructive dialogue (and perhaps a deference to States' sovereignty),¹³⁶ it fails to set a clear legal framework under Article 2(1). Corkery and Saiz argue that the austerity era that ensued from the 2007 economic crisis, as well as the targets set by the 2030 Agenda for Sustainable Development, have encouraged UN Treaty Bodies (including the CESCR) to sharpen their interpretation of what constitute 'maximum available resources' into jurisprudential trends.¹³⁷ However, the materials they adopted during the COVID-19 pandemic or during past global health emergencies do not capture such trends with enough precision or consistency. Therefore, the CESCR should adopt a more assertive violations approach when States fail to speedily prevent, treat and control COVID-19. This would enable the CESCR to justify what might (or might not) represent a violation of the right to health, and thus, to clarify how it interprets States' obligations under Article 2(1) in practice, in light of a pandemic that reduced States' 'maximum available resources'.

¹³² E.g., CESCR, Concluding Observations on Bolivia, 5 November 2021, E/C.12/BOL/CO/3 at paras 50–51.

¹³³ E.g., CEDAW, Concluding observations Liberia, 24 November 2015, CEDAW/C/LBR/CO/7–8 at para 39; CEDAW, Concluding Observations on Guinea, 14 November 2014, CEDAW/C/GIN/CO/7–8 at para. 8.

¹³⁴ E.g., *Ibid* (Liberia) at paras 17 and 39 and (Guinea) at para 127; CRC, Concluding Observations on Sierra Leone, 1 November 2016, CRC/C/SLE/CO/3–5 at para. 29(c); CESCR, Concluding Observations on Tajikistan, 25 March 2015, E/C.12/TJK/CO/2–3.

¹³⁵ Statement COVID-19, *supra* n 23, at para 20.

¹³⁶ Statement on maximum resources, *supra* n 130 at para 12: States have the discretion 'to determine the optimum use of [their] resources and to [...] prioritize certain resource demands over others'.

¹³⁷ Corkery and Saiz, 'Progressive realization using maximum available resources: the accountability challenge' in Dugard et al. (eds), *Research Handbook on Economic, Social and Cultural Rights as Human Rights* (2020).

(ii). *Progressive realisation and non-retrogression in times of COVID-19*

In General Comments 3 and 14, the CESCR declares that States' obligation to progressively realise the right to health presumes an impermissibility of retrogressive measures.¹³⁸ It also declares that retrogressive measures are allowed if States can prove they carefully considered all alternatives and can justify such measures by reference to all the other rights protected in the ICESCR, in light of their maximum available resources.¹³⁹ However, the COVID-19 context renders the interpretation of non-retrogression difficult, given some measures to progressively prevent, treat and control COVID-19 entailed in practice retrogressive measures for other right to health entitlements, e.g. pausing cancer screening or interruptions to sexual and reproductive healthcare.

The presumption of non-retrogression is well-established under international human rights law, including in times of COVID-19. The CESCR expressed concerns regarding retrogressive measures taken during the COVID-19 pandemic, including the disastrous impact of decades of underinvestment in health services and decreasing levels of health expenditures;¹⁴⁰ while the Special Rapporteur recently expressed concerns about reduced access to sexual and reproductive healthcare.¹⁴¹ The CESCR further suggested that States should monitor poverty levels and mitigate the impact of COVID-19, for instance through income redistribution.¹⁴² The Special Rapporteur stressed that the prioritisation of public health should not be used to curtail human rights;¹⁴³ and that '(o)ver a year into the COVID-19 pandemic, retrogressive measures that are still being applied and maintained must be repealed'.¹⁴⁴ Upholding the presumed impermissibility of retrogressive measures during the pandemic thus enables the UN to assert *prima facie* violations of the ICESCR when States curtail access to rights such as health in the name of COVID-19 prevention, treatment and control.

However, the UN recognises exceptions to this presumption by designing criteria determining the lawfulness of retrogressive measures. The Statements adopted by the CESCR in response to austerity measures introduced by States following the 2007–2008 economic crisis, declare that retrogressive measures are impermissible unless States can prove they are temporary, legitimate, necessary, reasonable, proportionate and non-discriminatory,¹⁴⁵ criteria used since in the CESCR's jurisprudence on evictions.¹⁴⁶ In these documents, the CESCR also highlights that it would consider: (i) the State's level of development, current economic situation or other serious parameters affecting its resources; (ii) the severity of the breach (i.e. whether it affects core obligations); and (iii) the State's attempts to identify low-cost options and to seek international assistance and cooperation.¹⁴⁷ However, neither the CESCR nor the Special Rapporteur have applied this legal framework (or any, for that matter), to examine retrogression under Article 12, in the context of the COVID-19 pandemic. Since 2020, the Concluding Observations of the CESCR and the thematic reports of the Special Rapporteur fail to use explicit terminology to identify 'retrogression' and are limited to expressing concerns. The same can be said when analysing the comments of the CESCR and other UN Treaty Bodies

¹³⁸ GC 14, *supra* n 3 at para 32; GC 3, *supra* n 17 at para 9.

¹³⁹ *Ibid.*

¹⁴⁰ Statement COVID-19, *supra* n 23 at para 4; Concluding observations Latvia, *supra* n 64 at para 38.

¹⁴¹ UN Special Rapporteur on the right to health, Report on sexual and reproductive health rights: challenges and opportunities during the COVID-19 pandemic, 16 July 2021, A/76/172.

¹⁴² Concluding Observations Finland, *supra* n 131 at paras 36–37; Concluding observations Latvia, *supra* n 64 at para 33(b).

¹⁴³ Special Rapporteur 2020, *supra* n 41 at para 92.

¹⁴⁴ Special Rapporteur 2021, *supra* n 141 at para 13.

¹⁴⁵ CESCR, Statement on Public Debt, Austerity Measures and the International Covenant on Economic, Social and Cultural Rights, 22 July 2016, E/C.12/2016/1 at para 4.

¹⁴⁶ E.g., CESCR, *Ben Djazia et al v Spain* (S/2015), Views, E/C.12/61/D/5/2015 at para 17.6; CESCR, *Lorne Joseph Walters v Belgium* (61/2018), Views, E/C.12/70/D/61/2018 at para 9.2.

¹⁴⁷ Statement on maximum resources, *supra* n 130 at para 10.

that assessed States' compliance with the right to health during recent global virus outbreaks: references to retrogression, cuts, decrease, reduction (or even 'backwardness') are scarce.¹⁴⁸ Given the nature of the reporting procedure and the mandate of the Special Rapporteur (i.e. identifying broad, widespread right to health barriers rather than deciding if a particular action or omission infringes its content), this is perhaps unsurprising. Therefore, the CESCR should draw on the criteria it developed post-2007 and refer to budgetary data, to positively clarify States' obligation to progressively realise the right to health in times of COVID-19. We are yet to witness this in action.

C. Minimum Core Obligations and the Right to Health in Times of COVID-19

The CESCR recognised the concept of core obligations for the first time in General Comment 3, where it declared that States ought to ensure 'minimum essential levels' for each right, including 'essential primary healthcare'.¹⁴⁹ In General Comment 14, it translated this concept into a non-exhaustive list of 'minimum core obligations' to realise the right to health.¹⁵⁰

Core obligations are highly relevant in the context of the COVID-19 pandemic.¹⁵¹ However, more clarity is needed regarding their immediate and absolute nature. General Comment 14, in paragraphs 43 and 44, lists various core obligations to realise the right to health that are particularly relevant to COVID-19:

- providing access to health facilities, goods and services on a non-discriminatory basis and distributing them equitably;
- providing essential medicines;
- adopting and implementing a national public health strategy and plan of action based on epidemiological evidence to address the population's health concerns;
- providing immunisation against major infectious diseases in the community;
- taking measures to prevent, treat and control epidemic and endemic diseases;
- providing education and information on the main health problems in the community, including on prevention and control;
- training appropriately health personnel, including on health and human rights.¹⁵²

It is worth noting that the obligations to prevent, treat and control epidemic and endemic diseases, enshrined in Article 12(2)(c), are considered as core obligations.¹⁵³ This emphasises how crucial they are to the right to health. This also echoes the concept of States' core capacities recognised in the IHR, according to which States should, as a minimum, detect, assess and respond adequately to relevant health threats.¹⁵⁴ Therefore, both core capacities and core obligations converge towards placing States' response to COVID-19 as a focal point of compliance with international law.

¹⁴⁸ This phenomenon has also been observed during the post-2008 global recession: e.g. Warwick, 'Unwinding Retrogression: Examining the Practice of the Committee on Economic, Social and Cultural Rights' (2019) 19 *Human Rights Law Review* 467 at 470.

¹⁴⁹ GC3, supra n 17 at para 10.

¹⁵⁰ GC14, supra n 3 at paras 43–44.

¹⁵¹ Toebes, Forman and Bartolini, supra n 25 at 104. See also Lisa Montel and Anuj Kapilashrami, 'The Right to Health in Times of Pandemic: What Can We Learn from the UK's Response to the COVID-19 Outbreak?' (2020) 22 *Health and Human Rights Journal* 227.

¹⁵² GC14, supra n 3 at paras 43–44.

¹⁵³ Ibid at para 44(c).

¹⁵⁴ IHR, supra n 5 at Annexes 1 and 2; Giulio Bartolini, 'Are You Ready for a Pandemic? The International Health Regulations Put to the Test of Their "Core Capacity Requirements"', *EJIL: Talk!*, 1 June 2020, available at: <https://www.ejiltalk.org/are-you-ready-for-a-pandemic-the-international-health-regulations-put-to-the-test-of-their-core-capacity-requirements/> [last accessed 20 July 2022].

Before and during the COVID-19 crisis, the CESCR repeatedly interpreted core obligations as having to be prioritised over other requirements.¹⁵⁵ The CESCR recently declared that ‘the minimum core obligations imposed by the Covenant (thus including those imposed by Article 12) should be prioritised (. . .) (i)n responding to the pandemic.’¹⁵⁶ More precisely, by using terminology akin to ‘urgency’ and ‘speed’ (see Section 3.B.(i)), the CESCR and the Special Rapporteur acknowledged that States ought to prioritise the protection of vulnerable groups in the fight against COVID-19, as well as universal access to COVID-19 vaccines and treatments, both of which are core obligations.

Nevertheless, significant legal uncertainty persists regarding the immediate and absolute nature of core obligations under Article 12 ICESCR, which could be detrimental to the CESCR’s assessment of States’ responses to COVID-19. Indeed, by interpreting core obligations through a prioritisation exercise and by failing to use terminology akin to immediacy, the CESCR implies that the realisation of these obligations is subject to resources and thus, that they merge into progressive realisation requirements. This leaves two crucial questions open, in the COVID-19 context.

Firstly, how can States comply with the right to health when they cannot prioritise two core obligations at the same time, for instance, if the realisation of one conflicts with the realisation of another? This question becomes even more problematic when reading the obligation ‘to take measures to prevent, treat and control epidemic and endemic diseases’ as core.¹⁵⁷ This would imply that States ought to prioritise *all* measures required to fight COVID-19, but what about when it conflicts with competing aspects of the right to health or with other rights, for instance when restrictions on individuals’ freedom of movement to prevent the spread of COVID-19 results in reducing women’s access to essential maternal healthcare.¹⁵⁸ In response, the CESCR declared that States’ measures to combat COVID-19 should be ‘reasonable and proportionate to ensure protection of all human rights’,¹⁵⁹ presumably including other aspects of the right to health such as core obligations. However, no further guidance can be drawn from the CESCR’s jurisprudence on core obligations (or lack thereof), given its failure to use ‘core’ terminology or to engage with budgetary data and findings of non-conformity. No guidance can be found either from UN Treaty Bodies’ right to health jurisprudence during past global health emergencies or from annual reports drafted by the Special Rapporteur. Answers may be found instead in the CESCR’s approach to the ‘non-derogable’ or absolute nature of core obligations to realise the right to health, discussed below.

Secondly, the prioritisation exercise suggested by the CESCR raises another question on the derogable and absolute nature of core obligations to realise the right to health in the context of resource scarcity during the pandemic. Unlike other human rights treaties, the ICESCR does not contain a derogations clause allowing States to suspend their obligations in times of emergency. The Office of the United Nations High Commissioner for Human Rights specifies that ‘State obligations associated with the core content of the right to (. . .) health (. . .) remain in effect even during situations of emergency, including in times of COVID-19’.¹⁶⁰ The CESCR, nonetheless, keeps sending confusing messages regarding the absolute nature of such obligations, i.e. the possibility to restrict them at any given time. In General Comment 3, it declared that States could justify failures to meet core obligations on the basis of a lack of available resources

¹⁵⁵ GC3, *supra* n 17 at para 10; GC14, *supra* n 3 at paras 43–44.

¹⁵⁶ Statement COVID-19, *supra* n 23 at para 12.

¹⁵⁷ GC14, *supra* n 3 at para 44(c).

¹⁵⁸ Special Rapporteur 2021, *supra* n 141 at para 29.

¹⁵⁹ Statement COVID-19, *supra* n 23 at paras 3 and 11.

¹⁶⁰ OHCHR, Emergency Measures and COVID-19: Guidance, 27 April 2020, at 1, available at: https://www.ohchr.org/sites/default/files/Documents/Events/EmergencyMeasures_COVID19.pdf [last accessed 20 July 2022].

and as long as they could demonstrate that ‘every effort’ had been made to use ‘all resources’ at their disposition, in an attempt to ‘prioritise’ core obligations.¹⁶¹ In General Comment 14, the CESCR affirmed the contrary: States ‘cannot under any circumstances whatsoever, justify (. . .) non-compliance with the core obligations (to realise the right to health), which are non-derogable’.¹⁶²

Recent General Comments have since reverted to General Comment 3’s approach,¹⁶³ possibly as a response to criticisms raised against the inadequacy of the non-derogable and absolute approach to core obligations for low- and middle-income countries.¹⁶⁴ However, nothing indicates how the CESCR will interpret this in the COVID-19 context, since core obligations are not mentioned in the Statements, Concluding Observations and Views adopted by the CESCR since the beginning of the pandemic or in response to other significant virus outbreaks.

By failing to recognise the absolute/non-derogable (and thus, immediate) nature of core obligations in times of COVID-19, including under Article 12(2)(c), the CESCR has declined to set universal standards applying to all States regardless of their income. Furthermore, the CESCR does not compensate for this by providing guidance on how the prioritisation exercise (which it suggests instead) ought to be monitored during the pandemic, since it does not use budgetary data when assessing States’ compliance with Article 12. While scholars such as Chapman or Tobin may not agree,¹⁶⁵ Müller rightly argues that adjusting core obligations to States’ income would undermine the function of the right to health (and human rights in general) as ‘egalitarian limits on democracy’.¹⁶⁶ This is particularly relevant for individuals living in low- and middle-income countries, given the significant shortage of resources these countries have experienced during the COVID-19 pandemic. She also argues that such adjustments would dismiss consensus across domestic and regional human rights jurisprudence to hold certain norms absolute.¹⁶⁷ Therefore, we contend that the CESCR should recognise more assertively the absolute and non-derogable nature of core obligations to realise the right to health in times of COVID-19. This would enable it to hold States to account in their COVID-19 responses as well as in future global health emergencies; and to encourage international endeavours harmonising human rights and health governance to integrate this right, including through a pandemic treaty.

D. International Assistance and Cooperation Obligations towards the Right to Health

Article 2(1) of the ICESCR contrasts with the traditional (though increasingly challenged) understanding that treaty obligations under international human rights treaties have a domestic scope, since it requires that States take steps individually and ‘through international assistance and cooperation’. The CESCR has clarified since that international assistance and cooperation represents a legally binding obligation and that it is particularly relevant to States’ obligation to prevent, treat and control epidemic and endemic diseases during the COVID-19 pandemic.

In General Comment 3, the CESCR declared that this obligation was ‘particularly incumbent’ upon States able to assist other States, since Article 2(1) drafters intended to view ‘available resources’ as those existing within and across borders.¹⁶⁸ In General Comment 14, the CESCR

¹⁶¹ GC3, supra n 17 at para 10.

¹⁶² GC14, supra n 3 at para 47. See also Statement on Public Debt, supra n 145 at para 4 in the context of non-retrogression.

¹⁶³ E.g., General Comment 25, supra n 84 at para 51; CESCR, General Comment No. 19 on The Right to Social Security (art. 9), 4 February 2008 at para. 60.

¹⁶⁴ Toebe, Forman and Bartolini, supra n 25 at 103.

¹⁶⁵ Chapman, supra n 8 at 50–55; Tobin, supra n 6 at 240.

¹⁶⁶ Müller, ‘The Minimum Core Approach to the Right to Health. Progress and Remaining Challenges’ in Klotz et al., *Healthcare as a Human Rights Issue: Normative Profile, Conflicts and Implementation* (2017) at 74–75.

¹⁶⁷ *Ibid* at 67–75 (however, some national jurisdictions continue to resist such trends, e.g. the *South African Constitutional Court in Minister of Health v Treatment Action Campaign (TAC)*, Judgment of 5 July 2002).

¹⁶⁸ GC3, supra n 17 at paras 13–14.

continued to acknowledge States' 'responsibility' and 'obligations' to provide international assistance and cooperation towards the right to health,¹⁶⁹ including for 'diseases (that) are easily transmissible beyond the frontiers of a State'.¹⁷⁰ The CESCR has since made multiple references to the 'obligation' of international cooperation and assistance,¹⁷¹ including in past global virus outbreaks and during the COVID-19 pandemic, leaving little doubt on its legally binding nature and instrumentality in global health. In fact, the CESCR has become unusually assertive on this aspect of States' obligations over the past two years. In its Statements, it declared that the global nature of the pandemic 'highlights the crucial importance of international assistance and cooperation',¹⁷² and 'reinforces this obligation of States' in the context of COVID-19 vaccines,¹⁷³ since these are primarily manufactured in high income countries and are unavailable in many low-income countries.¹⁷⁴ Furthermore, the CESCR has recognised the essential role of the WHO in responding to pandemics and called on all States to support this organisation, as well as mechanisms supporting international cooperation and solidarity in the face of future public health threats,¹⁷⁵ alluding to the notion of global obligations of 'forward looking' character when considering 'who can assist' rights-holders.¹⁷⁶ This approach, supported by the Special Rapporteur,¹⁷⁷ highlights that right to health obligations extend to global governance arrangements, axiomatic for the prevention, treatment and control of COVID-19,¹⁷⁸ yet often undermined by nationalist, isolationist responses to COVID-19.

On one hand, the CESCR recognised strong obligations upon States with higher resources, by being increasingly specific in illustrative measures to respect, protect and fulfil the right to health across borders. Sepúlveda has argued that in practice, the CESCR usually asserts obligations to respect and protect with more clarity than the obligation to fulfil.¹⁷⁹ However, this is not necessarily true in the COVID-19 context, since the CESCR adopted a detailed analysis across all three layers of obligations.

The CESCR reiterated the relevance of the obligation to respect during the pandemic, by affirming that States should not obstruct access to medical supplies needed by individuals living in poorer States, both directly (e.g. export limits) or indirectly (e.g. unilateral economic sanctions).¹⁸⁰ When commenting upon vaccine hoarding, it even elevated the prohibition of discrimination—a respect bound obligation—to a global scale.¹⁸¹

The CESCR also reaffirmed the importance of the obligation to protect, by highlighting States' obligation to ensure that corporations domiciled in their territory or within their jurisdiction do not invoke intellectual property law in a way preventing universal and equitable access to COVID-19 vaccines.¹⁸² In its first Statement on COVID, the CESCR suggested a test of proportionality taking into account the 'urgent needs of other countries',¹⁸³ but it is unclear to what extent richer States can justify failures to comply with obligations to respect and

¹⁶⁹ GC14, supra n 3 at para 38–42.

¹⁷⁰ Ibid at para 40.

¹⁷¹ Magdalena Sepúlveda Carmona, 'The Obligations of "International Assistance and Cooperation" under the International Covenant on Economic, Social and Cultural Rights. A Possible Entry Point to a Human Rights Based Approach to Millennium Development Goal 8' (2009) 13 *International Journal of Human Rights* 86 at 89.

¹⁷² Statement COVID-19, supra n 23 at para 19.

¹⁷³ Statement COVID-19 vaccines, supra n 23 at para 9.

¹⁷⁴ Statement universal COVID-19 vaccination, supra n 23.

¹⁷⁵ Statement COVID-19, supra n 23 at paras 23–24.

¹⁷⁶ Elena Pribytokva, 'What Global Human Rights Obligations Do We Have?' (2020) 20 *Chicago Journal of International Law* 339.

¹⁷⁷ Special Rapporteur 2020, supra n 41 at paras 9–14.

¹⁷⁸ Meier, de Mesquita and Williams, 'Global Obligations to Ensure the Right to Health' (2022) 3 *Yearbook of International Disaster Law Online* 3.

¹⁷⁹ Sepúlveda, supra n 171 at 90–94.

¹⁸⁰ Statement COVID-19, supra n 23 at paras 20 and 22.

¹⁸¹ Statement universal COVID-19 vaccination, supra n 23 at paras 1 and 3.

¹⁸² Statement COVID-19 vaccines, supra n 23 at para 8.

¹⁸³ Statement COVID-19, supra n 23 at para 20.

protect, based on the shortages of resources experienced during the pandemic, bringing back unanswered questions on budgetary data and prioritisation.

The CESCR, nonetheless, placed significant emphasis on the obligation to fulfil during the pandemic. In its three recent Statements, the CESCR asserted that the obligation to provide international assistance and cooperation entailed: sharing medical equipment and supplies, as well as benefits of scientific progress and its applications; providing financial and technical support; and temporarily waving provisions of the TRIPS agreement, in order to facilitate universal distribution of COVID-19 vaccines.¹⁸⁴ The CESCR even gave life to these obligations in practice, by pointing towards an obligation for high-income countries such as Latvia, Finland and Czech Republic to actively ‘advocat(e) for universal, equitable and affordable access to COVID-19 vaccines and drugs in regional and international organisations’.¹⁸⁵ This trend could announce a clearer legal framework for international cooperation and positively influence other human rights bodies to follow suit. Furthermore, this interpretation of Article 2(1) is reinforced by Article 44(1)(c) IHR, according to which ‘States Parties shall undertake to collaborate with each other, to the extent possible, in (. . .) the mobilisation of financial resources to facilitate implementation of their obligations under these Regulations’.¹⁸⁶ However, some necessary international cooperative activities, e.g. sharing of pathogen samples or genomic sequence data, and enhancing research and development and pharmaceutical manufacturing capacity in Global South countries, remain underexplored both under the right to health and the IHR, a legal lacuna that may be addressed by a pandemic treaty.¹⁸⁷

On the other hand, the CESCR has been more reserved in its approach when it comes to the obligation for States with lower resources to seek international assistance and cooperation where necessary to support right to health realisation. Despite Sepúlveda identifying the existence of this obligation in past CESCR’s jurisprudence,¹⁸⁸ the CESCR has not formulated any comments clarifying it during the COVID-19 pandemic. So far, it limits its assessment to the ‘effective mobilisation of domestic resources’.¹⁸⁹ Other UN Treaty Bodies, nonetheless, have given it some context during previous global health emergencies. For instance, the Committee on the Elimination of Discrimination Against Women urged States to seek international support to overcome the practical and budgetary disruptions caused by the Ebola crisis in areas such as health, education, employment, food security and social protection.¹⁹⁰ It is unclear, nonetheless, how this obligation would be monitored in times of COVID-19. Who should the CESCR find in violation of the right to health: States with fewer resources not able to contain the virus due to PPE shortages; and/or States with more resources unwilling to share or fund PPE in other States, and if so which ones in particular?

5. CONCLUSION

In order to interpret right to health obligations under the ICESCR in times of COVID-19, our article adopted a doctrinal approach inspired by the rules of treaty interpretation outlined by Articles 31 and 32 VCLT. In doing so, we concluded that little clarification could be obtained through the text, *travaux préparatoires* and context of Articles 12 and 2(1) ICESCR, but that

¹⁸⁴ Ibid at para 19; Statement COVID-19 vaccines, supra n 23 at para 11; Statement universal COVID-19 vaccination, supra n 23 at paras 5, 6 and 13.

¹⁸⁵ Concluding observations Latvia, supra n 64 at para 40; Concluding Observations Finland, supra n 131 at para 9; CESCR, Concluding Observations on Czech Republic, 28 March 2022, E/C.12/CZE/CO/3 at para. 44.

¹⁸⁶ IHR, supra n 5 at Article 44(1)(c).

¹⁸⁷ Phelan and Carlson, supra n 49; WHO, supra n 55.

¹⁸⁸ Sepúlveda, supra n 171 at 94–95.

¹⁸⁹ CESCR, Concluding Observations on Democratic Republic of the Congo, 28 March 2022, E/C.12/COD/CO/6 at paras 24–25.

¹⁹⁰ CEDAW, Concluding observations Liberia, supra n 133 at paras 10 and 28; CEDAW, Concluding Observation Guinea, supra n 133 at para 9.

more precision could be achieved by analysing the ‘relevant rules of international law applicable in the relations between the parties’, suggested by Article 31(3)(c) VCLT. Indeed, piecing together insights provided by the CESCR in General Comments, as well as in recent Statements and Concluding Observations, and supporting such statements by instruments governing pandemic responses, including the International Health Regulations (2005), enabled us to clarify a number of right to health obligations such as guaranteeing access to COVID-19 treatment and vaccines, as well as extra-territorial obligations. While the CESCR’s interpretations contained in its General Comments, Statements and Concluding Observations tend towards an analysis of biomedical interventions, health systems and the legal nature of obligations under Article 2(1), other international treaties and soft-law instruments suggest scope for a more holistic interpretation of Article 12(2)(c) to encompass population-based pandemic prevention, preparedness and control obligations. They also help refine the scope of the right to health and balance it with other rights to ensure a holistic approach to human rights realisation during global health emergencies. As an authority on the ICESCR, the CESCR should further clarify elements of States’ obligations to prevent and control epidemic diseases by reference to the IHR and the Siracusa Principles, and it should refine in practice aspects of progressive realisation and core obligations by using budgetary data.

In providing this clarity, the CESCR would establish a clearer set of expectations regarding how States can comply with the right to health in COVID-19 responses and enhance accountability where they fail to do so. Such an exercise would also serve other purposes. Clarifying the content of social rights such as health is crucial to improve their monitoring and, ultimately, their realisation. This is particularly important in the face of a global health threat such as the COVID-19 pandemic, with devastating human rights impacts on populations worldwide, especially vulnerable groups, and given States’ inability or lack of interest in adopting human rights-based approaches to pandemic preparedness and response to date.¹⁹¹ Though not all infectious diseases give rise to exactly the same prevention, treatment and control strategies, clarifying the content of the right to health in relation to COVID-19 will enhance the precision through which the nature and scope of State obligations are understood in future global health emergencies. Furthermore, applying rules of treaty interpretation to human rights treaties contributes towards emphasising the importance of such treaties and the rights they protect in the international arena and therefore, highlighting the relevance of the right to health in other disciplines such as global health law. Such endeavours are crucial in the context of current processes to reform the IHR and draft a pandemic treaty, with calls for enhanced attention to human rights in these discussions.¹⁹² Finally, focusing on the use of ‘relevant rules of international law applicable in the relations between the parties’ to clarify Article 12 ICESCR contributes towards attempts to mitigate the impact of the fragmentation of international law. This embeds our research in current attempts to bridge the gap between human rights law and global health law.

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¹⁹¹ Habibi et al., ‘Reshaping Global Health Law in the Wake of COVID-19 to Uphold Human Rights’ *Health and Human Rights Journal Blog*, 1 June 2021, available at: <https://www.hhrjournal.org/2021/06/reshaping-global-health-law-in-the-wake-of-covid-19-to-uphold-human-rights/> [last accessed 20 July 2022].

¹⁹² Statement from UN Special Procedures, Negotiations for a Pandemic Treaty Must be Guided by Human Rights, 20 May 2022.