From Principles to Practice: Human Rights and Public Health Emergencies

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About

From October - December 2023, the Petrie-Flom Center for Health Law, Policy, Biotechnology and Bioethics, at Harvard Law School, together with the Global Health Law Consortium, the International Commission of Jurists, and the University of Ottawa Center for Health Law, Policy and Ethics, published a digital symposium on the 2023 Principles and Guidelines on Human Rights and Public Health Emergencies (the Principles). Featuring guest editors Timothy Fish Hodgson, Roojin Habibi, and Alicia Ely Yamin, this Symposium gathered critique and reflections from leading scholars, activists, jurists and others from around the world on the contribution of the Principles in clarifying legal imperatives for rights-based approaches to public health emergency prevention, preparedness, and response.

The Symposium featured a concluding webinar which is available for viewing here:

> "From Principles to Practice: Critical Reflections on Human Rights Advocacy in Public Health Emergencies" (January 18, 2024)
>
> Chair: Alicia Ely Yamin; Speakers: Luisa Cabal, A. Kayum Ahmed, Paul Hunt, and Zione Ntaba

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Introduction to the Symposium: From Principles to Practice: Human Rights and Public Health Emergencies

By Roojin Habibi, Timothy Fish Hodgson, and Alicia Ely Yamin

Today, as the world transitions from living in the grips of a novel coronavirus to living *with* an entrenched, widespread infectious disease known as COVID-19, global appreciation for the human rights implications of public health crises are once again rapidly fading from view.

Against the backdrop of this burgeoning collective amnesia, a project to articulate the human rights norms relevant to public health emergencies led to the development of the 2023 *Principles and Guidelines on Human Rights and Public Health Emergencies* (the Principles).

This symposium gathers reflections from leading scholars, activists, jurists, and others from around the world with respect to the recently issued Principles.

Launched by the Global Health Law Consortium and the International Commission of Jurists during the 76th World Health Assembly, the Principles were developed through a three-year deliberative process between more than 150 individuals from around the world, including international legal scholars and practitioners, human rights defenders, civil society advocates, public health researchers, health workers, and others bearing relevant insights and expertise.

Recalling the increasing recurrence of public health emergencies over the past century and contemplating the possibility of the continued proliferation of emergencies, the Principles clarify human rights law obligations and standards applicable in prevention of, preparation for, response to, and recovery from, such emergencies. In so doing, the Principles take a broad view of what might constitute a "public health emergency," recognizing that while such crises may vary in scope and in nature, safeguarding human rights remains not only a legal obligation, but vital to an effective and equitable public health emergency response.

Historically, Global Health Law has been permeated with colonialism and concerned with preserving travel and trade rather than protecting human dignity, health and life. Despite more than a century-long existence, for instance, the World Health Organization's (WHO's) *International Health Regulations* only began to incorporate references to human rights in their text as recently as their 2005 iteration and even then engaged with the subject matter in broad strokes.

As recently as the 2023 UN High Level meetings, the adopted text of the political declaration on pandemic preparedness shied away from a mainstreaming of human rights considerations, and instead, steadfastly affirmed the moral equivalence between corporate interests, incentives, and intellectual property rights and *human* rights in pandemic preparedness.

Experience should have impressed on State representatives — and indeed individuals throughout the world more generally — a different understanding of what is at stake when human rights are neglected in public health emergency planning. More than four decades ago, the HIV pandemic triggered a global reckoning with the inextricable ways that health and human rights are linked. When public health measures are designed and implemented with human dignity, rights and the rule of law at their core, they stand a greater chance of succeeding. In turn, public health measures that are grounded in the best available evidence are more likely to

secure the protection of human rights, including the rights to life and to the highest attainable standard of physical and mental health.

The Principles are firmly grounded in legally binding sources of international law and supplemented by authoritative sources, which, while not yet necessarily reflecting binding obligations for all States carry increasing weight in determining States obligations. They moreover build on existing interpretations of international law in times of emergency and exception, such as the Siracusa Principles on Limitations and Derogations Rights Provisions of the International Covenant on Civil and Political Rights (Siracusa Principles), developed by the International Commission of Jurists more than 35 years ago.

Importantly, however, the Principles go beyond a crisis frame. Spanning 28 interrelated provisions, they acknowledge that the impact of a public health emergency depends on how ready and resilient health systems are in "ordinary" times — at international, regional, and national levels. In other words, we must think of preparedness for (inevitable) future emergencies in terms of human rights. Without efforts to prevent and prepare, drastic measures to respond to public health threats — measures that are more likely to restrict human rights — may become necessary.

Some of the key areas of ambiguity and tension in international human rights law that the Principles engage with include:

- Further delineating obligations of private actors in the context of public health emergencies, especially private health care providers and insurers, and manufacturers of health goods, facilities, and technologies;
- Obligations to realize economic, social, and cultural rights in ordinary times to mitigate the occurrence and effects of crisis, as well as sustaining protections for those rights during emergencies;
- The crucial roles of social deliberation, participation, and trust in the design and uptake of public health policies and measures that inevitably require balancing and trade-offs; and
- The nuances of assessing necessity and proportionality during a rapidly evolving emergency triggered by novel pathogens.

The Principles come at an important time, as we mark the 75th anniversary of WHO's Constitution and of the Universal Declaration of Human Rights. We value these instruments more than ever, as they established the international recognition of the right to health and health-related rights that have set the foundation of so many struggles for rights and dignity in past public health crises.

Building on that 75-year history, the Principles can serve as a basis for developing and improving policies and guidelines that will make future responses to public health emergencies more rights-based. Moreover, the Principles can equip civil society, jurists, and others with the tools to hold their governments and powerful corporate entities accountable to the standards set by human rights. The current reforms of global health law — including amendments to the IHR and negotiations for a new pandemic accord — are an immediate entry point. But the Principles bear

relevance and were developed for all levels of governance in mind. Indeed they have already found their way in a resolution of the Council of Europe's Parliamentary Assembly.

Ultimately, the Principles provide a roadmap to a world where human rights and public health are aligned and mutually reinforcing. They present an opportunity for robust discussions from a diverse array of perspectives, breathing life into the notion of "rights-based approaches to public health emergencies." We hope that this Symposium brings together the first in a series of such conversations, and that many more take place in the future. The full text of the Principles and Guidelines on Human Rights and Public Health Emergencies can be accessed here.

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COVID-19 Showcased Failed Global Cooperation

By Kayum Ahmed, Julia Bleckner, and Kyle Knight

In mid-May, the World Health Organization officially declared the "emergency" phase of the COVID-19 pandemic over. However, the deep wounds of the pandemic remain, compelling those concerned about this pandemic and future health emergencies to account for catastrophic failures by those in power. These reflections suggest that the public health crisis could have been addressed differently, both reducing COVID-19's unprecedented magnitude of illness and death, and preserving human dignity.

The COVID-19 pandemic isn't over, and the end of this pandemic's emergency phase certainly doesn't mean we accept the widely abysmal response as the model for the world's reaction to the next one. Public health emergencies aren't entirely preventable. We live in a complex world where health is increasingly affected by a changing climate, extraordinary levels of pollution, and inadequate preventive and responsive health services. Emergencies will happen. But when they do, responses that uphold human rights need to be the norm.

Drawing on the lessons from these failures, the Principles and Guidelines on Human Rights and Health Emergencies offer an important framework for centering human rights in preventing, preparing, and responding to health emergencies. More specifically, the development of "solidarity" as an emerging principle of international human rights law creates a duty for states to achieve common goals in the context of public health emergencies, as well as to prevent non-state actors from frustrating solidarity efforts.

Solidarity operates at two intersecting levels. Global solidarity requires cooperation between governments, while national solidarity involves cooperation within a state to address common challenges and achieve shared goals. During the height of the COVID-19 pandemic, we noted that governments around the world scrambled to coordinate responses to the novel virus, while often trampling on basic rights domestically.

As reasonable and evidence-based adjustments to prevent transmission and protect health became the norm, authorities continued to fail on equity. In some cases they weaponized public health measures to target activists and opponents and consolidate power. Internationally, rich countries hoarded vaccines, letting them expire in warehouses, and blocked a proposal to share the vaccine recipe, while those in poorer countries died waiting for a first dose.

The Principles also significantly recognize the role of non-state actors in using intellectual property and trade protections to advance a profit-centered approach to health. By noting that non-state actors, such as the pharmaceutical industry, have a "duty to respect human rights in the context of a public health emergency," the Principles acknowledge the outsized power of non-state actors in global health, and the ways in which they undermine solidarity in the face of a global health emergency.

In fact, the most important global policy debate of the COVID-19 pandemic – over intellectual property as it related to vaccines, testing, and treatment – took place inside a commerce body, the World Trade Organization (WTO), with no health or human rights mandate. The WTO's promotion of trade and protection of intellectual property has historically taken priority over

health, environment, and human wellbeing. This pattern has had lethal consequences during the COVID-19 pandemic, harming efforts to advance global solidarity.

It is already well-established in international human rights law that states should not frustrate the efforts of other states to fulfill their human rights obligations, including when negotiating international agreements or participating in decisions as members of international organizations, such as by invoking intellectual property protections to slow vaccine distribution or production.

The pandemic has laid bare the dangers of having manufacturing capacity for life-saving vaccines concentrated in a few countries where governments have refused to prioritize and mandate intellectual property waivers and technology transfers for rapid, diversified, and global production. That has created deep inequities in access to health products that can save lives. The Principles therefore lay the foundations for holding non-state actors accountable when they fail to respect human rights by exacerbating inequities in access to health products.

Cementing solidarity as part of international law will be an important step in the right direction. Beyond that high-level shift that should influence global health diplomacy, the Principles also offer critical guidance on how to support people most affected by health crises with a call to "take into account the health needs and rights of the whole population, including marginalized, disadvantaged and disproportionately affected individuals and groups, as well as health and frontline workers."

As the post-emergency phase of the COVID-19 pandemic so far shows the predictable fallout of infections and severe illness among marginalized groups, the Principles should reinvigorate a global health system in dire need of reform toward equity. Solidarity doesn't have to remain relegated to platitudes and lamentations if we enshrine it in the legal thinking that guides our next response.

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Making Explicit a Rights-Based Approach to Infodemic in a Public Health Emergency

By Calvin Wai-Loon Ho

With the mainstreaming of digital technology across many spheres of social life, infodemic management must be an integral part of public health emergency prevention, preparedness, response, and recovery.

While the Principles and Guidelines on Human Rights and Public Health Emergencies (the Principles) do not make explicit reference to infodemics, the application of digital technologies in response to a public health emergency is a clear concern. This article provides further elaboration and critique of the Principles and their treatment of this emergent phenomenon.

The World Health Organization (WHO) defines an infodemic as having "too much information including false or misleading information in digital and physical environments during a disease outbreak." Over the course of the COVID-19 pandemic, the accompanying infodemic gained visibility through the widespread use of digital resources, platforms and tools to support a range of social interactions, activities, and pandemic countermeasures. False and misleading information was rapidly disseminated on the nature of SARS-CoV-2, hidden political agenda linked to public health countermeasures, serious safety concerns over vaccines, vaccination and treatment options, and the risks of infection posed by health care providers and people and communities of particular ethnicity.

WHO has been pivotal in framing and operationalizing COVID-19 infodemic countermeasures through initiatives that monitor harmful information, and counter false information. More recently, it launched "infodemic management" as a public health program, comprising practices underpinned by the science of infodemiology – a relatively new specialty in epidemiology – that seek to listen to community concerns and questions, promote understanding of risk and authoritative health information, build information resilience and empower (through engagement with) communities to take positive action.

From a systems perspective, infodemic management may be seen as falling within WHO's wider mandate under the International Health Regulations (IHR) of supporting its Member States in developing informational capabilities (for disease surveillance, for instance). In the months ahead, targeted amendments may be made to the IHR to render infodemic an explicit concern.

Meanwhile, in previous drafts of the the pandemic treaty under negotiation, certain provisions made limited reference to "combat[ing] the infodemic, and tackl[ing]false, misleading, misinformation or disinformation" through measures that include promoting and facilitating the development and implementation of risk communication strategies, conduct regular community outreach and consultations with civil society organizations and media outlets, promoting communications on technical advances, and taking effective measures to increase digital health literacy among the public and within the health sector.

These measures put forward in the pandemic treaty are largely technical in nature, and hence do not adequately account for human rights or ethical concerns. In this respect, they fail to adequately account for the complexity of an infodemic, which is often, if not always, interlinked with other information disorders that may be driven by political, economic, or other motivation that have no direct connection to health. The UN system's response to the COVID-19 infodemic

reflects this complexity in the participation of other UN agencies like the UN Department of Global Communications, UNESCO (with a mandate to protect and promote freedom of expression), and UNICEF (in its focus on vaccination and immunization) in countering different types of harmful information, including misinformation, disinformation and hate speech. However, effective collaboration across the different UN agencies and their external partners was hampered by the lack of a common understanding, as a review of the UN system reports. Other challenges encountered include inadequate capacity to analyze and manage the infodemic, inability to conduct impact assessments in different contexts, and difficulty to work effectively with large technology platforms. Although largely technical in focus, these challenges have a normative dimension, as well as concerns that relate to appropriate governance, which the pandemic treaty is largely silent on.

Read with the pandemic treaty, the Principles and Guidelines on Human Rights and Public Health Emergencies (the Principles) constitute a critical framework for forging a common and more holistic understanding of infodemic-related harm. In Section V, the rights-based approach is not confined to a single human right obligation, but takes into account limitations and derogations to human rights (e.g., the right to freedom of expression, the right to freedom of association, and the right to peaceful assembly), as well as underscores the importance of having strict regard for the principles of legality, necessity, proportionality and non-discrimination. Given that UN agencies have mandates that give differential emphasis to one or more human right obligations, the Principles' framework could foster common understanding that may be both epistemic and applied.

The Principles' explication of what a participatory approach should look like from a human rights perspective could also help to address the other challenges that hampered the UN's response to the COVID-19 infodemic. For instance, Article 7 instructively highlights that states must "consult and take into account the self-expressed needs, knowledge, expertise and perspectives of rights holders," and "guarantee effective and institutionalized public participation and deliberation mechanisms which are accessible to everyone, in order to meet its human rights obligation of respecting and ensuring meaningful and effective participation." Just as crucial is the explication (in Article 5) of the human rights duties relating to non-State actors, such as social media companies where infodemic is concerned. Non-state actors, particularly business enterprises, have a duty to respect and, where applicable, to contribute to the fulfillment of human rights. They should, where relevant, "proactively engage, collaborate and coordinate with States, individually and collectively, to ensure the full realization of health and human rights" (Article 5(b)(ii)). This statement is especially pertinent in the light of the challenges that UN agencies faced in the lack of resources to pay full-price to social media platforms for advertising UN messages about COVID-19, and to customize social listening tools (initially developed for marketing) for public health purposes. More recently, the announcement by Twitter to charge a substantial data access fee is likely to have a profound impact on infodemic management, unless exceptional arrangements are put in place for public health emergencies.

In sum, a number of key concerns that infodemic management seeks to address are implicitly considered in the Principles. Moving forward, these considerations could be made more explicit in subsequent versions of the framework or possibly in an addendum directed at more applied objectives. It is less clear to what extent the Principles, and for that matter the pandemic treaty,

apply to serious health threats like antimicrobial resistance (AMR), despite their relevance and potential utility.

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Non-State Actors and Public Health Emergencies

By Rossella De Falco

Strong, well-coordinated and resilient public health care services play a vital role in preventing and responding to public health crises. Under international human rights law, States have a positive, primary obligation to ensure that such health care services are of the highest possible quality and accessible to everyone, everywhere, and without discrimination.

States maintain these obligations even when non-State actors are involved in health care financing, provision, and governance, albeit further normative development in this area is still urgently needed. The Guiding Principles on Business and Human Rights, unanimously endorsed by the United Nations (UN) Human Rights Council in 2011, were one of the first steps in this direction, as they recognize States' duty *to protect* against human rights abuses by third parties as well as corporate *responsibility* to respect human rights.

A range of UN Human Rights Treaty Bodies have further contributed to interpret the human rights implications of private actors' involvement in health care. As shown in an analysis of their concluding observations over 2006-2020, UN Treaty Bodies have called on States to strictly monitor and regulate private health care actors; to ensure that any private sector involvement do not result in discrimination in accessing health care services; and to assess public-private partnerships in light of the duty to use their maximum available resources (Art. 3 ICESCR) for the full realization of the right to health.

What are, however, the specific legal and ethical implications of involving private actors in health care vis-à-vis public health emergencies? The recent ***Principles and Guidelines on Human Rights and Public Health Emergencies*** *(the Principles)* provide a first answer to this pressing question. The Principles emphasize that States, as part of their duty to prevent, respond to, and remedy public health emergencies: "*must ensure that non-State actors do not, whether by their acts or omissions, impair the enjoyment of human rights*"; and *"must regulate and monitor engaged non-State actors to prevent them from impairing the enjoyment of human rights and provide for redress and accountability"* (para. 5.1). This applies in the case of private actors operating both nationally and cross-nationally (para 5.2). Importantly, the Principles emphasize that non-State actors of particular relevance to this discourse are: "*corporate entities such as private healthcare providers and insurers, and manufacturers of health goods, facilities and technologies*" (p. 4, Introduction).

Further, non-State actors also have a responsibility to respect human rights (5.4.b), as well as to *"contribute to the fulfilment of human rights"*"(5.3. b) and "*to refrain from impeding international solidarity efforts"* (2.4.) in the context of public health emergencies. The Principles thus respond to the urgent need to foreground human rights in prevention and responses to public health emergencies, particularly at a time when corporations exercise ever-growing influence in both global health and domestic health systems. In fact, government-backed involvement of commercial actors in health care often acts as a catalyst for discrimination and inequality in accessing health care services, which are magnified at times of disease outbreak.

In low- and middle-income countries like Kenya and Nigeria, individuals living in urban informal settlements tend to use low-cost private health care services, especially when public health care services are unavailable. These private facilities are often unsafe, unlicensed, and offer sub-

standard medical care, including by using expired drugs, misdiagnosing, overcharging, employing untrained staff or detaining patients over unpaid bills. Relatively higher quality, registered private health care services, by contrast, serve higher income groups in well-off areas.

Reports by the Global Initiative for Economic, Social and Cultural Rights (GI-ESCR) and partners showed that this situation was a breeding ground for discrimination and inequality in accessing health care services during COVID-19. People living in poverty in marginalized urban areas experienced socioeconomic, information, and geographical barriers to accessing health care amid the health emergency. GI-ESCR's investigations further highlight how women, the elderly, and the chronically ill suffered the most. Given the gravity of this situation and mounting civil society pressure, the UN Committee on Economic, Social and Cultural Rights recently asked Kenya to report on measures taken to monitor private actors' involvement in health care.

Notably, the Principles underline that States must take effective measures to protect the right to health when third parties are involved *before*, *during,* and *in the recovery from* public health emergencies (para 5.2). This is especially instructive in cases where overreliance on private health care providers infiltrates health system governance, with consequences on the health system's resilience to public health emergencies. In Lombardy, Italy, for instance, one of the richest areas in Europe, decades of market-based health reforms were accompanied by underinvestment in general practice, urgent care, and prevention – all of which are fundamental in responding to disease outbreaks. As showed in a policy-brief by GI-ESCR, this situation might amount to a violation of the right to health under domestic constitutional and international law.

Read together with the World Health Organization's International Health Regulation (IHR) and the 1984 *Siracusa Principles on the Limitations and Derogations Provisions in the International Covenant for Civil and Political Rights* (Siracusa Principles), the Principles are a fundamental piece in the normative puzzle regarding human rights and private health care actors' in the context of public health emergencies. Thanks to their special emphasis on non-State actors, their overarching *pro homine approach* as well as the meaningfully participatory process through which they were developed, the Principles represent a genuinely progressive effort to advance human rights norms and standards against the new challenges of a changing global health landscape.

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Human Rights Principles in Public Health Emergencies: From the Siracusa Principles to COVID-19 and Beyond

By Eric A. Friedman and Lawrence O. Gostin

In 1984, the United Nations Economic and Social Council (ECOSOC) adopted the Siracusa Principles, which state that restrictions on human rights must meet standards of legality, necessity, and proportionality. States must use the least restrictive means available when putting in place rights-restricting measures.

One of us (LG) was involved in the drafting of the Siracusa Principles, which have become the chief international instrument governing permissible human rights limitations during national emergencies. Yet when COVID-19 – the greatest health emergency in a century – devastated the world, the Siracusa Principles seemed unequal to the task – too narrow, including with their remit limited to civil and political rights, not sufficiently specific, and above all, without sufficient accountability.

During the pandemic phase of COVID-19, human rights violations were widespread and spanned the full gamut of rights: from arbitrary detentions and suppression of free expression, to violations of the right to health, failure to ensure sufficient food and other necessities during lockdowns, quarantines, and isolations, and woefully inadequate international cooperation and assistance, including discriminatory travel and trade restrictions.

Extensive abuses of human rights during the pandemic led international experts to draft the Principles and Guidelines on Human Rights and Public Health Emergencies (HR Principles). Firmly embedding these principles in international law and creating accountability will be critical for realizing the HR Principles' potential.

The International Covenant on Civil and Political Rights (ICCPR) and the Siracusa Principles recognize that emergency situations may require governments to temporarily limit certain rights. The ICCPR recognizes that "a public emergency which threatens the life of the nation" may require derogating from certain rights obligations. States may do so only "to the extent strictly required by the exigencies of the situation," subject to non-discrimination and other international law requirements. Certain rights – such as the right to life, freedom from torture, and freedom from slavery – are non-derogable, even in emergency contexts such as the ones brought on by a pandemic.

The Siracusa Principles were developed in 1984 by 31 independent experts, co-sponsored by the International Commission of Jurists (ICJ), as a reaction to regular abuse of the ICCPR's derogation provisions. The Siracusa Principles intended to provide interpretative principles for the ICCPR. Key elements include that rights restrictions must be necessary and proportionate, pursue a legitimate aim, and of limited duration, subject to challenge, and neither arbitrary nor discriminatory.

Though developed by independent experts, the Siracusa Principles quickly assumed authoritative status through United Nations processes, with the ECOSOC adopting them. The UN Human Rights Committee, which monitors the ICCPR, has also referenced the Siracusa Principles, which are widely recognized as the "leading approach to understanding" ICCPR derogations. Courts have referenced and drawn on the Siracusa Principles. Constitutions developed today commonly

include provisions on derogations and limitations that draw on the standards clarified by the Siracusa Principles.

The inadequacy of Siracusa in the the context of public health emergencies

Then came COVID-19. The pandemic quickly proved the inadequacy of the Siracusa Principles in the specific context of public health emergencies. There are many reasons, but a few examples will suffice for the present context.

First, with the Siracusa Principles' focus on human rights limitations, and civil and political rights in particular, they did not speak to the most pervasive rights shortfalls during the pandemic – inequalities in people's ability to realize their right to health and a full range of other economic and social rights. Deep inequities and discrimination were manifested across the board. From national disparities across populations, to global inequalities in access, to scarce medical technologies, from ventilators to vaccines, inequalities have been an overriding feature of this pandemic. Nor do the Siracusa Principles address measures to mitigate other human rights consequences, such as people's need for food, water, housing, income, medicines, and other basic necessities during lockdowns.

Second, being applicable to all national emergencies, the Siracusa Principles are general, and thus unable to speak in any significant detail to the particular concerns of public health crises, from surveillance and timely access to accurate health information, to investing in preparedness, to international assistance and cooperation, including barriers imposed by intellectual property laws.

Third, states that exceeded permissible derogations from the ICCPR, as elucidated by the Siracusa Principles, faced precious little accountability for their actions whether on domestic or international levels. The contrast between rights violations during COVID-19 and states' impunity for them has been as striking as it is tragic. To take only several examples, China's government manipulated its surveillance app to limit the freedom of movement of activists, governments including in Egypt, Russia, Bangladesh, Pakistan, and Venezuela arrested health workers and journalists for daring to criticize the government's COVID-19 response and to contradict government data on COVID-19 cases, and governments in Zambia and elsewhere banned political protests or rallies under the guise of controlling COVID-19.

Building on Siracusa to develop new human rights principles for public health emergencies

Once again, the ICJ played a leading role in collaboration with the Global Health Law Consortium in drafting the PH Principles—released alongside the World Health Assembly in May 2023. The HR Principles build on the Siracusa Principles. Ultimately, they address the first two major shortcomings of the Siracusa Principles and present some potential for assisting in responding to the accountability problem.

The HR Principles encompass both civil and political rights and economic, social, and cultural rights — the right to health above all, but also others, such as the need to compensate for the impact of public health measures on people's livelihood (think lockdowns) and on gender-based violence (think increased domestic violence during lockdowns).

The HR Principles offer a detailed approach to proactively addressing human rights concerns, such as access to information. They address a host of other matters as well, such ensuring access to judicial and administrative remedies for rights violations, meaningful participation in all public health emergency decision-making processes, and ensuring that limitations on freedoms of expression, association, and assembly are not used "to silence disfavoured views." Throughout, they focus on non-discrimination and protecting the rights of marginalized populations. While drawing heavily on COVID-19 experiences (but also, notably, drawing on those of other recent epidemics, like Ebola), the vast scope of rights violations addressed ensures that these principles have a comprehensiveness that will enable them to provide extensive guidance during future health emergencies.

Developed outside of official channels, there is little that the HR Principles do, or can do, on accountability. However, their detailed, public health emergency-specific guidance provide powerful potential for accountability through other mechanisms. And that is what needs to happen – for mechanisms, especially through the United Nations and WHO, along with states in their individual capacity, to create accountability where the Principles alone cannot.

Towards accountability for human rights violations in public health emergencies

First and foremost, the two legally binding instruments that the World Health Assembly is expected to adopt next May, a pandemic treaty and a revised International Health Regulations (2005), should incorporate the Principles. At the very least, both instruments should, in their embrace of human rights, expressly recognize these principles as a key interpretative instrument and take their content seriously as a clear reflection of international law and standards. Better still would be for both these instruments to include separate articles that directly address human rights, incorporating and stating states' express commitment to the Principles – though a human rights article included in the pandemic treaty's initial draft was since removed.

Relatedly, the pandemic treaty's Implementation and Compliance Committee, a subsidiary body of the Conference of the Parties, should fully include the HR Principles within its mandate. While the Committee's powers are limited – conceived as "non-adversarial and non-punitive," making sanctions unlikely – it can ensure governments focus on rights violations and respond accordingly. WHO Member States are similarly negotiating "implementation" or "compliance" mechanisms under a revised IHR.

Crucially, the United Nations and WHO must also vehemently promote accountability. UN bodies and the World Health Assembly should endorse the Principles, much as the ECOSOC did vis-à-vis the Siracusa Principles. This autumn, the UN General Assembly had an opportunity to reference the HR Principles in its political declaration on pandemic preparedness. Unfortunately, the approved declaration failed to do so.

The UN Secretary-General could appoint special envoys to review and facilitate compliance with the HR Principles whenever a health emergency emerges. Both the United Nations and WHO should call out instances of non-compliance at the highest institutional levels, while also facilitating civil society engagement to develop and implement pathways towards compliance. Governments should also reach into their diplomatic toolbox to encourage compliance.

The HR Principles provide a firm foundation for far better adherence to human rights in future public health emergencies – including responses that place equity at the center. Yet their value is only as good as State compliance, individually and collectively. Establishing effective compliance mechanism is our task now.

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Reflections on the United States Health Care System and the Right to Health

By Brianna da Silva Bhatia, Michele Heisler, and Christian De Vos

American health care too often fails to protect the right to health or promote health-related rights. Despite efforts to increase access to health care and to better incentivize high-quality, value-based care, the United States' health care system remains fragmented, largely profit-based, and predominantly disease-focused rather than prevention-focused.

To design systems and policies that promote the right to health, a holistic and proactive approach is needed, one in which people, institutions, and corporations have a shared responsibility in promoting physical, mental, and social well-being. The Principles and Guidelines on Human Rights and Public Health Emergencies (the Principles), allow us to imagine a new future and help outline a path for how to get there. In this piece, we discuss how the Principles might be applied in a rights-based approach to address some of the core problems in the U.S. health care system.

The dire state of the U.S. health system

In considering how the Principles can contribute to a new vision for America's health care system, we must face several harsh realities. First, while the U.S. has some of the world's leading medical facilities and research institutions, and the ability to deliver the highest available quality of care, it ranks last among rich nations in providing equitable, accessible, affordable, and high-quality health care. America is the only wealthy nation to lack universal health coverage. Despite the important enactment in 2010 of the Patient Protection and Affordable Care Act (ACA), which increases access to care by expanding Medicaid eligibility and protecting insurance coverage of people with pre-existing health conditions and disabilities, more than 25 million people remain uninsured. This burden falls most heavily on individuals of color and low-income communities.

Another reality is that even for those who have health insurance, the high costs associated with health care in the U.S. impede the right to health and contribute to disparities. The U.S. spends far more than other developed nations on health care more than double the average of other wealthy countries- yet our life expectancy, child mortality, among other outcomes, lag well behind. Americans spend more on pharmaceuticals compared to peer nations, with generic and brand name drugs costing consumers 2.5 to 4 times more in the U.S. This high financial burden forces people to perform cost-saving measures at the expense of their health and wellbeing. Further, access to health care is only one of multiple equally important social determinants of health. These determinants, such as economic stability through universal services like unemployment benefits, paid parental leave, paid sick leave, or social support systems, like family-friendly policies and child care, remain mostly unavailable. Under-investment in social determinants of health are major drivers of inequitable health outcomes in the United States.

Finally, racism and other forms of discrimination in the U.S. health system continue to exacerbate poor health and disparities. Uninsured people in the U.S. are primarily Black, Latine, Indigenous, and low-income individuals. Non-citizens and undocumented people are more likely to be uninsured and face many barriers to assistance programs. When compared to white people, Black, Latine, American Indian, and Alaska Native communities have significantly

worse health outcomes. The U.S. has criminalized addiction and other social problems, and created additional barriers for justice-involved individuals to meet basic needs.

COVID-19 and the U.S. health system

The COVID-19 pandemic had devastating effects on the United States, and brought these long standing health inequities and policy failures – from resource allocation to public health coordination – into the view of the general American public.

The U.S. experienced a high number of COVID-19-related deaths, more than 1.1 million. The health care system struggled to handle the surge of COVID-19 patients leading to shortages of critical supplies, and overcrowded emergency rooms and hospitals. The overwhelming amount of COVID-19 patients coupled with fear of the disease resulted in poor access to routine or preventative care, less people seeking care, and delayed evaluation and treatment of other acute and chronic medical conditions. Health care worker burnout has only worsened after the extreme stresses of caring for COVID-19 patients and the resultant backlog of people seeking care. Many areas have also faced critical staff shortages, which impacted the delivery of safe care and safety net services. Ultimately, COVID-19 caused an unprecedented loss in U.S. life expectancy, including a rise in "deaths of despair." By the end of 2022, nearly 1.7 million more Americans died than what would have been expected, representing the highest excess mortality rate among peer wealthy nations.

Throughout the pandemic, Black, Latine, people of other minority racial or ethnic backgrounds, people with disabilities, and other socially vulnerable people, were disproportionately impacted by COVID-19 with higher rates of infection, higher risk of hospitalization and death, and lower use of outpatient medications important for prevention of severe disease. Further, health insurance coverage varies substantially between racial and ethnic groups in the United States, with low-income people of minority groups having lower odds of being insured. Unsurprisingly, a lack of health insurance coverage during the pandemic was associated with more deaths; while excess mortality rates varied widely between states, they strongly correlated with uninsurance.

The ACA and temporary pandemic-era policies such as the Families First Coronavirus Response Act of 2020, which allowed continuous Medicaid enrollment during the public health emergency (PHE), has helped to reduce racial and ethnic disparities in health care coverage – and proved to be important during COVID-19 to increase health care access. Unfortunately, the unprecedented low rate of uninsurance in 2022, has proved temporary. At the end of the PHE, states began Medicaid disenrollment, and more than 7 million people have already lost health insurance this year.

In short, the pandemic underscored the need for a rights-based approach to health in the U.S., the need for health care system reform, and greater preparedness for future public health crises.

Applying the Principles in the U.S. health care context

There are many fruitful applications of the Principles to the U.S. health care system, but the most aspirational includes utilizing principles 9 (strengthen and develop sustainable health systems), 10 (measures to prioritize and mobilize resources for public health emergency prevention and preparedness), 11 (ensure access to health goods, facilities, services and technologies), and 12

(refrain from retrogressive measures), as a blueprint for a minimum standard of health and financial reform. Adaptation to the health care sector could include:

1. access to health care without discrimination or exclusion regardless of income, ability to pay, employment, location, medical history, criminal history, or citizenship;
2. inability to take away or lose access to health care;
3. equality and equity in health care availability and services.

Universal health coverage is the best way to fulfill these principles, work to eliminate disparities, increase the health of the population, and cement a minimum standard of health.

The ability to apply and use the Principles more broadly also requires attention to principle 13 (legal and policy preparedness for public health emergencies). The U.S. must enshrine in laws and policies specific shared human rights duties and enforcement mechanisms for any individual, corporation, or institution, private or public, whose decisions or business-dealings impact: 1) access to or the delivery of health care; or 2) and the creation and distribution of health-related goods. This should include specific obligations for: fair access to goods, technologies, and services; strengthening and developing health systems; and refraining from regressive measures or causing harm to the fulfillment of other human rights. If the U.S. already had such policies in place during the pandemic, the scale of suffering would likely have been far less. For example, investing in public vaccines, therapeutics, and technologies that were not limited in speed or availability due to cost and intellectual property, may have saved lives.

Prioritizing well-being

The pandemic revealed significant weaknesses in the U.S. health system, from resource allocation and public health coordination to health care access and infrastructure. It demonstrated why health care system reform is essential for preparedness, response and recovery from any health crisis. The U.S. urgently needs a rights-based approach to health. The Principles help draw a line in the sand between how the U.S. functions currently and what health care could look like if people were prioritized over profit, if transparency and accountability were strengthened, and if fundamental human rights were upheld through the enforcement of minimum essential standards for well-being.

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Reviewing Solidarity in the Principles and Guidelines on Human Rights and Public Health Emergencies

By Eduardo Arenas Catalán

The Principles and Guidelines on Human Rights and Public Health Emergencies (the Principles), entail a notable attempt to consolidate lessons learned from the COVID-19 pandemic. After the largely non-solidaristic international response to COVID-19, the Principles outline the advantages and limitations of embedding human rights discourse within the global public health machinery.

One key element that will test the Principles will be their ability to influence the measures taken, including by States, in preparing for, preventing, and responding to future public health emergencies with increased solidarity. That uncertain future aside, by incorporating critical elements of solidarity, which so far have been largely absent in the human rights corpus, these Principles strengthen the protection of human rights in international law.

Acknowledging solidarity as a legal principle

The Principles provide more than sufficient acknowledgement of solidarity as an "emerging principle of international law," stressing the idea of shared responsibility, actions, and goals irrespective of territory. The Principles aptly characterize solidarity by paraphrasing, in Principle 2.1, Article 28 of the Universal Declaration of Human Rights: States must work individually and collectively to ensure a social and international order where human rights can be enjoyed by everyone. A formal, albeit still significant aspect, is that the Principles appropriately place solidarity in a high position on the list of the applicable human rights principles – second only after the universal enjoyment of human rights, notably ahead of fundamental principles like the rule of law, non-discrimination, and access to justice.

Having set the emphasis and the normative framework of solidarity in the right way, the question is whether the form and functionality of these Principles allow for the attainment of solidaristic commitments. In other words, States should not be able to merely pay lip service to solidarity while at the same time remaining free to privatize knowledge or infrastructure critical to the satisfaction of human needs.

In my view, despite one critical shortcoming, the Principles largely embrace solidarity and, as such, provide a meaningful road ahead for future global health crises.

Do the Principles promote solidarity sufficiently?

It is clear that the Principles significantly improve the protections available in human rights law. For example, Principle 10.4 indicates that the obligation to contribute resources to the prevention and preparedness of public health emergencies at global and regional levels should be commensurate with States' resources. The critical notion of shared but differentiated responsibilities is thus strengthened within global public health.

Moreover, Section VI includes a set of ambitious obligations. Principle 24 consolidates the prohibition of general sanctions because of their deleterious effects over human rights. Another important set of principles expound on the tension between commercial interests and human rights, examples include: Principle 25.3, by requiring barriers like intellectual property to be

human rights compliant; Principle 27.2(a), by claiming a superior normative hierarchy for human rights in comparison to commercial interests and Principle 28.2, by requiring intergovernmental organizations to refrain from impairing States in the fulfilment of their human rights obligations. This language, sadly absent from the WTO negotiations on a potential patent waiver for COVID-19 vaccines and treatments, will provide a new accountability against wealthy nations seeking to privilege business at the expense of access to medicines.

On a more critical note, the Principles reproduce a traditional problem in the protection of social rights internationally, namely, the difficulty of dominant interpretations of human rights to take power as a more central unit of analysis in law (Britton-Purdy et al. 2020). The Principles follow the path of the foundational General Comment 14 of the United Nations Committee on Economic, Social and Cultural Rights on the human right to health, whereby the private provision of healthcare services is not presented as something that is intrinsically associated with inequitable provision and human rights harm. In following this approach, the Principles miss an opportunity to counter the normalization of private health markets under international human rights law.

Moreover, while it is evident that the drafters who developed these Principles sought to consider economic, social and cultural rights, it is unclear whether the dominant – *thin* – interpretations of these rights, will succeed in providing a sufficiently robust legal framework in preparing for, preventing and responding to future public health emergencies given the conventional focus on individualized judicial review. Principle 19.1, for example, contemplates the review of public health measures on the basis of classical civil and political rights (least restrictive means, legality, necessity, proportionality, and non-discrimination). Yet, a logical consideration flowing from Principle 2 would have been to enlarge such judicial review so that it could incorporate collective considerations of equity in order to allow state authorities to tighten the control and regulations over private actors. What the COVID-19 pandemic corroborated is that such interference might be justified, even when less restrictive measures are available, if the former does more to ensure equity.

An opportunity to discipline the neoliberal order in the name of human rights

Despite the criticisms above in relation to privatization of health services and the protection of social and economic rights, the Principles nevertheless embody a substantial step forward in the contemporary protection afforded by international human rights law in the context of public health emergencies. Principle 28.1, which imposes an obligation over intergovernmental organizations to facilitate the sharing of information and technology, nurtures what might be seen as the greatest promise yet in terms of setting a concrete and effectual solidarity-based legal obligation regarding public health emergency preparedness. The challenges to guaranteeing human security in the face of such emergencies will not be met unless States develop the ability to invest in research, develop national and regional biomedical industries, and protect these commons from the constantly renewed winds of neoliberal privatization.

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Old Dogs and New Tricks: A Case for the Principles and Guidelines on Human Rights & Public Health Emergencies

By Nerima Were and Allan Maleche

Taking into account our experiences as human rights lawyers working in Kenya during the COVID-19 pandemic, in this article we briefly analyze the Principles and Guidelines on Human Rights and Public Health Emergencies (the Principles) and make a case for their utility in guiding State measures to prepare for, prevent, and respond to future pandemics consistently with international human rights law and standards.

Explaining the failure: dated laws, lack of knowledge about human rights standards

Kenya has grappled with HIV and TB epidemics in its recent past and continues to do so. From these experiences, the continuous call for action from civil society and affected communities has been to center human rights in epidemic responses and ensure that rights-based approaches remain the focal point. Despite these experiences, Kenya failed take a human rights-based approach to responding to COVID-19, as was also the case in many other countries.

One of the most glaring reasons for this failure was that the Kenyan government simply did not know how to do so. Though the government has learnt lessons in the past, and though it has codified some aspects of these lessons into our laws and policies relating to public health, it has always used a disease lens in the application of the lessons learned as opposed to a human rights lens. Therefore, when faced with an overwhelming emergency, the default mechanisms available to the State in crafting its responses were decades old laws such as the Public Health Act (1921) and Public Order Act (1950) that can be traced back to colonial Kenya. Plainly, these laws were not fit for purpose — having been passed before Kenya took on international legal obligations relating to the right to health, before Kenya was a Republic, and well before Kenya adopted its Constitution in 2010 — they were what was available.

Deepening this challenge, the enactment of new legislation during the COVID-19 pandemic — and especially in its early stages — was near impossible. Parliament suspended its operations and was unable to urgently convene and pass the necessary laws, instead it abdicated this duty to the executive. The Kenyan executive, for its part, therefore relied on these antiquated Acts to enforce measures that failed to center human rights or even to consider its human rights obligations in terms of either domestic or international law. Going forward, the Principles may help to prevent some of these failures.

Looking back to move forward: why the Principles may help in future pandemics

Crystalizing the applicable international law and standards in public health emergencies

First, the Principles bridge a much-needed gap in our understanding of public health emergencies. They crystalize existing international human rights law and standards, but they do not simply restate them. They clarify these obligations within the context of public health emergencies and provide clear guidance for States and members of society on how to navigate these emergencies. This is critical given the immediacy of responses that may be needed in the face of emergencies. In Kenya, for example, we experienced a scrambling of multiple state and

non-state actors who individually and collectively failed to understand — or sometimes even consider — what their human rights obligations were. This was, in part, because they would be required to rely on multiple varying — sometimes vague — articulations of both domestic and international human rights obligations to reach this understanding. This is difficult at the best of times, and near impossible during an emergency. Because of this, many states fell back to public order policing of the pandemic and/or states of emergencies, using security tactics, techniques, and legislation as a public health tool to the obvious detriment to both human rights and public health outcomes.

Taking a systems approach to public health emergencies

Second, the scope of the Principles is broad, spanning prevention, preparedness, response, and recovery measures relating to public health emergencies. This broad temporal scope is useful in that it considers previous pandemics and lessons learned from them and obliges states to put systems — health care systems, economic systems, and social systems — in place that can both prevent and effectively respond to public health emergencies. This could help address the continued global concern that pandemic measures are limited only to addressing a disease/outbreak (HIV, Zika, TB), and not the directly related problems with existing health care, economic and social systems that help produce pandemics and/or deepen their impact.

Importantly, the Principles define a public health emergency broadly enough to capture existing pandemics and epidemics, as well as to provide guidance for how to address future epidemics/pandemics. The Principles take this view to advance States' international obligations to develop and maintain sustainable health systems, moving each state beyond any one emergency and towards the fulfilment of the right to health for all.

Taking the responsibilities of non-State actors seriously

Third, the Principles look at the role of both State and non-state actors, including with respect to international cooperation (extra-territorial obligations), appreciating the important role that other states, companies, and inter-governmental organizations have in pandemic responses across the globe. Particularly significant, in this regard, is the clarification of the State's oversight obligation to ensure that the actions of non-state actors are human rights compliant. While in terms of international law and standards non-state actors carry a limited range of human rights responsibilities, in light of the use of the *pro homine* principle in human rights, where a non-state actor is acting on behalf of the State — or performing a state function directly — their obligations are not limited to respecting human rights, but also fulfilling them. Some of our experiences in Kenya make clear the importance of this obligation. For example, some health services (such as mandatory isolation facilities) were outsourced to private actors who did not act in a human rights complaint manner (and who have yet to face any repercussions for such failures).

Further, a range of Principles address problems experienced during the COVID-19 pandemic in relation to vaccine inequity — and inequity in access to health goods and services necessary to respond to the pandemic more generally. These include: the overarching Principle of international solidarity (Principle 2); the obligation to mobilize resources (Principle 10); the obligation to ensure access to health goods, facilities, services, and technologies; the obligation to ensure legal and policy preparedness (Principle 13); and Chapter V on extra-territorial

obligations. Read together, these Principles make clear that international law and standards require coordinated, collaborative, and equitable responses to public health emergencies instead of the approaches we witnessed that left Kenyans (like people in many other countries in the Global South) without access to vaccines and other health technologies for long periods of time.

These realities are consequences of an inequitable global health and economic system that is rooted in a history of colonialism and extractivism. The content of the Principles therefore represents a step forward in the application of human rights law to confront these deep-seated injustices.

Teaching an old dog new tricks

Can you teach an old dog (in this instance, States and state public health apparatus) new tricks? In our view, with the right tools you can. These Principles represent a starting point in articulating how States can build systems — health care, economic, and social systems — which, if adhered to, will allow them to prepare for, prevent, and respond to public health emergencies in a manner that is human rights-compliant.

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Judging in the Pandemic – A Malawian Perspective

By Zione Ntaba

Malawi is not a stranger to public health crises in the last number of years, having faced a severe HIV epidemic and several cholera outbreaks continuing into 2023. Nevertheless, the onset of the COVID-19 pandemic caused a major panic in the country's legal system and judiciary. COVID-19 brought to fruition a major ethical dilemma in ensuring the justice system's continued functioning, while also protecting the lives of all those involved, and simultaneously ensuring the promotion and protection of human rights.

The constitutional mandate of ensuring access to justice in Malawi, a country which already struggles with effective and efficient justice delivery at the best of times, required urgent resolution, especially noting the potential of human rights violations arising from State responses to COVID-19 worldwide. Interestingly, in addition to the general need to safeguard the justice system as a whole, the pandemic itself brought before the courts issues relating to public health and human rights.

The prevailing principle in Malawi, as it is internationally, is for the judicial system to ensure that there exists an equal balance between the protection and promotion of human rights and the fair and just administration of justice. The courts in Malawi were called upon to rise above the political bureaucracy, to ensure judicial impartiality when dealing with pandemic-related issues. This was crucial in a context in which political responses to the pandemic sometimes remained unquestioned or unchallenged. However, unless these principles — of human rights and fair administration of justice — were properly upheld by the courts, sadly they may have remained in the world of the metaphysical.

It is with this context in mind that I turn to reflecting on the Principles and Guidelines on Human Rights and Public Health Emergencies ("Principles").

The Principles and Guidelines on Human Rights and Public Health Emergencies

The Principles would have greatly assisted the Malawian judiciary if they had been available at the onset of the pandemic. This is because, from my perspective, they are an authoritative text, representing an international, consensus-based expert opinion on the most pressing human rights issues in public health emergencies.

The Principles therefore form and provide a benchmark by which the courts in Malawi should, in the future, consider whether State (and sometimes non-state) actors comply with their human rights obligations to prevent, prepare for, and respond to pandemics. The Principles do so by emphasizing the wide range of rights protections for all individuals and not just select groups.

Judgments of Malawian courts in the context of COVID-19

In exploring the potential usefulness of the Principles, it is helpful to consider Malawian judgments that arise from cases dealing with the pandemic and the Malawian government's response to it.

Kathumba case: separation of powers, social security, and lockdowns

The *Khatumba* case involved an order made by the Minister of Health for a temporary, national 3-week lockdown from April 18, 2020 to May 2020 due an increase in COVID-19 cases. The order was on the basis of two presidential declarations that declared a state of national disaster under section 32(1) of the Disaster Preparedness and Relief Act.

Additionally, the Government declared COVID-19 a "formidable disease" under the Public Health Act on April 1, 2020. The Minister of Health duly issued Rules aimed at the control or suppression of COVID-19, in terms of his powers under this Act. Despite there being various occupations that were exempted from the lockdown given effect to by the Rules, the restrictions were far reaching and adversely affected the lives and livelihoods of millions of people in Malawi.

In this context, four applicants approached the High Court to review the Minister's decision to declare a lockdown and enact the Rules. The applicants sought both a declaration of invalidity and a temporary injunction preventing the government from implementing a lockdown, which they argued could only lawfully be put in place simultaneously with sufficient social security relief for poor persons.

Notably, the *Kathumba* case was initially a leave application for judicial review; handed down on April 28, 2020, the High Court awarded the interim order sought by the applicants pending full judicial review to determine the constitutional challenges to the lockdown regime. In the related constitutional judgment handed down on September 3, 2020, the Court responded more fully to the substance of the applicants' challenges.

Ultimately, the Court upheld the applicants' challenges for a range of reasons. First, it found that the Rules were enacted without providing for checks and balances because such subsidiary legislation must be subject to "mandatory scrutiny by Parliament." Second, the Court found that the manner in which the executive sought to implement the lockdown in terms of the Rules was "over-broad" and displayed "over-concentration of power in one authority."

Finally, and of central concern to the Court, was the lockdown's effect on Malawians living in poverty, who would struggle to survive under lockdown, as they would lack access to basic necessities such as food and water if they were prevented from leaving their homes. It noted that existing social assistance programs that the Government identified for reducing poverty and vulnerability were denounced as failures. Emphasizing the extent of poverty in the country, with 51% living below the national poverty line and 73% below the international poverty line of US$1.90 per day, the Court therefore found the right to social security to be implicitly guaranteed under sections 19 (human dignity) and 16 (right to life) of the Constitution, as read with section 13 of the Constitution on principles of national policy. The Court therefore declared the Rules invalid and indicated that any measures to implement lockdowns should thus be taken with caution and after full consideration of the lives and livelihoods of marginalized Malawians living in poverty.

These judgments are consistent with the Principles which assert the universal enjoyment of human rights, including economic and social rights, separation of powers, and the rule of law as "overarching principles and obligations" of states in relation to public health emergencies. Importantly, the Principles also affirm the need for States to "provide for the potential

deployment of social protection measures to mitigate and compensate for the impact of public health emergencies on livelihoods [and] welfare…" (Principle 12(2)(f)).

Nyirenda case: mandatory vaccinations and human rights

Both judgments in *Khatumba* were delivered and decided before effective COVID-19 vaccines were yet available in Malawi or worldwide.

After COVID-19 vaccines subsequently became available in Malawi, some statements were made by government officials suggesting that vaccination may be made mandatory for all public servants, frontline workers, and those working in the social sector, including journalists.

In *Nyirenda v Ministry of Health*, the applicants sought to review the of the imposition of mandatory vaccination, arguing that it amounted to a violation of human rights including the right of bodily integrity, as part of the right to private life and the right to free and informed consent. The applicants also challenged the decision to deny one of them entry into the parliamentary building on December 23, 2021 due to a failure to produce a vaccination certificate.

In deciding the case, the Court noted that there should be a clear examination of the issues. However, the Court denied the application on a procedural basis, highlighting that the applicants had misrepresented statements made by government officials to suggest a decision had been made to implement a policy of mandatory vaccination. Therefore, no matter how extreme it may seem to pursue such a policy, such a decision had not been illustrated to have been made.

Interestingly, the Principles, only refer to "informed consent" in the context of institutionalization (Principle 20.1), though protection of the right to informed consent is well established in international human rights law. The Principles, while detailing States' obligations with respect to provision of vaccines, also remain — perhaps deliberately — silent on the topic of mandatory vaccination.

Conclusion: Thoughts from the bench

The Malawian courts have, in essence and to a large degree, embraced the human rights obligations within the context of public health emergencies as detailed in the Principles. Despite this, the courts would, in my view, have benefited from the detailed and specific guidance provided by the Principles. It remains essential to emphasize that, even though the Principles would not strictly be considered "law" under the Malawian Constitution, their strong foundation in international human rights makes them both relevant and important in the interpretation and application of Malawian laws and the Malawian Constitution. The Principles therefore hold substantial persuasive power for any judge, including myself, when determining a case involving public health emergencies.

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Securing a Place for Children's Rights in Public Health Emergencies

By Sheila Varadan, Ton Liefaard, and Jaap Doek

The *Principles and Guidelines on Human Rights and Public Health Emergencies* (Principles) make a significant contribution towards clarifying the scope of States' legal obligations under international human rights law during public health emergencies. What is missing, however, is a specific and detailed discussion on the rights obligations and principles owed to children during public health emergencies. This leaves open the question of how States will guarantee respect for and protection of children's rights in future public health emergencies, and what measures, if any, will be taken to ensure children are actively listened to and engaged with in the prevention of, preparedness for, and response to public health emergencies (PPRR).

The vulnerability of the child in global health emergencies

At the height of the COVID-19 pandemic, 194 countries and territories shut their schools nationally, affecting the right to education of more than a billion children. The UN Committee on the Rights of the Child highlighted the "grave physical, emotional and psychological effects of the COVID-19 pandemic on children" while the UN Special Rapporteur on the Right to Education warned of the impact that such an unprecedented school closure would have on already existing structural barriers in the implementation of the right to education.

It goes without saying that human rights are enjoyed by all persons, and as such general measures for the protection of human rights should apply equally to children in a public health emergency. However, we would argue that the unique dimensions of childhood warrant a different set of considerations both in how children's rights are respected and how a child's rights are recognized and protected during a public health emergency. A child's relative maturity and dependency on parents and family member renders them uniquely vulnerable to rights abuses, often at the hands of the very persons entrusted to protect their rights. This vulnerability is exacerbated by a presumption of incompetence attributed to children under the age-threshold of adulthood ("legal age of majority"), which often leads to their exclusion from formal decision-making processes both at the policy level or in a legal setting. Children are also generally not granted legal standing in most jurisdictions, making it difficult, if not impracticable for an individual child to seek redress for rights violations, particularly where rights abuses or violations are perpetrated or facilitated by the adults entrusted to their care.

That the media cast children as the "hidden" or "silent" victims of COVID-19 further reinforces an imagery of the child as "unseen" and "unheard," robbing children of their voice and agency in the prevention of, preparedness for, and response to public health emergencies (PPRR).

The children's rights legal framework

The United Nations Convention on the Rights of the Child ("CRC") is an almost universally ratified human rights instrument dedicated to upholding the human rights of children. It provides a rights-based framework that not only ensures children are recognized as rights-holders, but also that States take measures to enable and empower children's agency in the exercise of their own rights.

What relevance does the CRC framework hold for the interpretation and implementation of the *Principles*?

As a starting point, we would suggest that the *Principles* be interpreted and implemented in compliance with States' obligations under the CRC, specifically its four general principles:

- the right to non-discrimination (Article 2(1));
- the best interests of the child (Article 3(1));
- the right to life, survival and development (Article 6); and
- the right to be heard (Article 12(1)).

In practical terms, this will mean that, *inter alia*, PPRR measures limiting or derogating against human rights (pursuant to Principles 16.1, 16.2 and 16.3) should account for the best interests of the child as a primary consideration. Taking the example of school closures during the COVID-19 pandemic, this would require balancing immediate public health concerns, (i.e., containing the infectious disease outbreak), against the short-, medium- and long-term impact of such measures on children's enjoyment and realization of rights, namely the right to development (Article 6(2)), the right to education (Article 28) and the right to play (Article 31). Moreover, it will require actively including children in the decision-making process, and ensuring that due consideration is given to their perspectives in the implementation of PPRR measures. Furthermore, particular measures will need to be taken to ensure disadvantaged or marginalized groups of children do not face discrimination in accessing their rights or barriers from participating in PPRR decision-making processes.

In some instances, a deeper elaboration on the content of the *Principles* will be needed to ensure compliance with the CRC. For example, Principle 7 requires that States "respect and ensure the right to meaningful and effective public participation in decision-making processes relating to PPRR" (Principle 7.1). However, there is no mention of children nor is there any guidance on what measures will be needed to ensure children are able to actively and meaningfully participate in decision-making processes (Principle 7.2). The CRC and related guidance provided by the UN Committee on the Rights of the Child ("Committee") may be useful here. The Committee enumerates specific measures that both ensure children receive guidance and support to enable their participation, and create a space for children to be listened to on the matters affecting their everyday lives.

Similarly, Principle 6.1 calls on States to "guarantee access to information, including health-related information and information concerning State policies to address public health emergencies…" However, again there is no mention of children, nor is there any guidance on how such information should be made accessible to children during a public health emergency (Principle 6.2). Articles 13 and 17 of the CRC expressly set out rights to freedom of information and access to information with the CRC Committee enumerating specific measures to guarantee children's access to information that is age-appropriate and consistent with their evolving capacities.

Finally, it may be necessary to broaden the scope of the *Principles* to take into account the interdependence and indivisibility of children's rights in the context of public health emergencies. Principle 12 addresses retrogressive measures in respect of the right to health and health-related rights. We would argue that more consideration should be given to economic, social, and cultural rights specific to children, such as the right to development (Article 6(2)) and the right to leisure and play (Article 31 CRC).

Securing a place for children's rights in public health emergencies

The *Principles* are an important first step towards clarifying the scope of States' rights obligations during public health emergencies; as such, it is not unreasonable that their scope should be framed broadly without a detailed discussion on the rights of specific vulnerable populations. At the same time, without a deeper reflection on how to recognize and enable children as rights-holders, and importantly practical guidance to States on what measures will be needed to secure for children the enjoyment of their rights, the *Principles* will do little more than pay lip service to children's human rights in times of public health emergencies. If we are to secure a place for children's rights in future public health emergencies, a more deliberate and detailed discussion will be needed – one that actively engages and empowers children, both as individuals and a collective, in the protection and promotion of their own rights.

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Public Health Emergencies and Human Rights Principles: A Solidarity Approach

By Anne Kjersti Befring and Cecilia Marcela Bailliet

1. Introduction

The COVID-19 pandemic posed a grave threat to humanity and revealed the need for a new approach to improve transnational cooperation within the global health system and new perspectives on solidarity addressing the cross-border spread of infection and distribution of vaccines.

The Principles and Guidelines on Human Rights and Public Health Emergencies ("the Principles"), developed by the Global Health Law Consortium and the International Commission of Jurists, set forth a human rights-based solidarity approach that can provide a basis for implementing the obligations of States and responsibilities of Non-State actors to achieve the goal of limiting the harmful effects of serious health crises.

2. Human Rights and Solidarity: The Case of COVID Vaccines

The Principles and Guidelines refer to the principle of solidarity as applying individually and collectively to both state and non-state actors (see article 2). In the context of a public health emergency, States have the duty to ensure that all individuals can, on the basis of equality and non-discrimination, participate meaningfully in, contribute to, and enjoy a social and international order in which their human rights can be fully realized.

During the COVID-19 pandemic, vaccine production and distribution provided a particularly stark example of the challenges to solidarity. Global financing for low-income and middle-income countries (LMICs), as classified by the World Bank, and equitable distribution of vaccines, global supplies and equitable distribution of key commodities – including protective equipment, diagnostics, medicines, medical equipment, proved to be a major challenge. Pharmaceutical companies were able to develop pandemic vaccines at a faster pace than before, but the distribution of vaccines between countries was not based on actual needs.

3. Solidarity in the Principles

Experience from the COVID-19 pandemic and previous pandemics demonstrate the inter-dependence between countries and the increased risk of failure of the international community to act in solidarity. The mutual dependence between countries to fulfill human rights is reflected in the Principles.

For example, in Article 2.2, the principles encourage international cooperation, "including measures for technical and economic cooperation, and equitable access to health goods, facilities, services and technologies." The ability to limit the spread of epidemics and other health threats requires cooperation between countries to monitor and report on health threats. The World Health Organizations (WHO) agreements are central in this context." Moreover, Article 2.4 of the Principles indicates that "Non-State actors, including those whose activities have extraterritorial effects, have a responsibility to refrain from impeding international solidarity efforts." This can apply to both the fair distribution of vaccines and protective equipment.

Article 25. 2 articulates a positive obligation for States to: "remove or limit, through appropriate temporary or permanent measures, legal or non-legal barriers to the equitable access to health goods, facilities, services and technologies that are necessary for PPRR. . . Such measures may include: a. the adoption of technology transfer agreements; b. emergency use agreements; c. other information sharing agreements and other arrangements for the just and equitable sharing of data and health goods, facilities, services and technologies; and d. by collaboratively setting up capacities and infrastructure for PPRR."

4. The Draft Declaration on the Right to International Solidarity and its Added Normative Value in Relation to the Principles

In harmony with the Principles is the recently revised Draft Declaration on the Right to International Solidarity from the UN Independent Expert on the Right to International Solidarity. This Declaration aims to provide a framework for network solidarity policies and actions among States, International Organizations, NGOs, Companies, and civil society actors in order to prevent and respond to global challenges, including health emergencies (see A/HRC/53/32: Revised draft declaration on human rights and international solidarity – Report of the Independent Expert on human rights and international solidarity, Obiora Chinedu Okafo, Article 2).

Article 6 sets forth the duty of States to respect, protect, and fulfill the right to international solidarity, while International Organizations and Non-State Actors have the duty to respect the right to international solidarity. According to Article 8: "States may give full effect to the right to international solidarity by adopting legislative, administrative, budgetary or other measures. States and non-State actors can pursue solidarity agreements to facilitate access to technology, financing and infrastructure. States and international organizations should create indicators to measure the impact of transnational solidarity actions and deliver reports to the universal periodic review." The Independent Expert on Human Rights and International Solidarity issued a report on Global Vaccine Solidarity and Human Rights in the Context of the Coronavirus disease (COVID-19) pandemic in which he recommended that States and other relevant actors "urgently develop legislative and/or administrative solutions to end the monetization of COVID-19 disinformation, to refrain from taking any measures (such as export bans) that impose a disproportionately negative impact on equitable access to vaccines around the world, and to prioritize the protective coordination, support, and reinforcement of WHO-led global vaccine solidarity initiatives, such as COVAX facility, and fully support the proposal before the to allow all states that are able, especially lower-income countries to manufacture and use already developed COVID-19 vaccines without being subject to restrictions within intellectual property. (See here.) States would be able to file best practices reports to the UPR.

Hence, the Draft Declaration on the Right to Solidarity and the Principles are complementary and may provide a strengthened framework to promote implementation of solidarity strategies in the realm of health emergencies.

5. Global Health Solidarity Through the Rule of Law – Filling the Gaps

A rule of law approach involves the protection of human rights and public health through legality and legal certainty. An essential part of the law in a modern society consists of legislation passed

by democratically elected authorities (laws) and delegated legislation by the administration (regulations). EU legislation has gradually become more important in the field of health for member states and has recently adopted a regulation that obliges countries to help limit cross-border health crises but are limited in these contexts as they only regulate EU countries (see *Helseretten*, ch. 2.2.4 and *Tradisjonelle smitteverntiltak*, ch. 4,5.).

In line with this type of approach, it is clear that a global health crisis must be handled with global standards. WHO is working on a separate treaty that will oblige countries to handle more effectively health crises and also supports a revision of the international health regulations. However, strong tensions between China, Russia and the Western world about the war in Ukraine and also about blame for the COVID-19 pandemic may weaken the possibility of further developing legal instruments in this context.

Common understanding of the seriousness of the crisis brought on by COVID-19 and threatened by future public health emergencies and agreement on principles and standards can be a basis for countries striving to establish common practices. Critically, the Principles operationalize key human rights into concrete duties for states in connection with a pandemic.

The need for learning and continuity in the realization of positive human rights obligations in connection with public health crises is emphasized in the Principles. In doing so, they expand the focus beyond public health as a permissible reason for human rights derogation or limitation in emergency situations. Global innovation and the spread of new therapies should be supported and disseminated in a fair and efficient way. The experience of the COVID-19 pandemic in terms of the transmission of infection between countries and challenges in achieving a fair distribution of vaccines should be used in further work to develop common driving rules.

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Scarcity Is Not an Excuse to Discriminate: Age and Disability in Health Care Rationing

By Silvia Serrano Guzmán

On July 4, 2023 the Constitutional Court of Colombia handed down a landmark decision on one of the most difficult dilemmas faced during the COVID-19 pandemic: the rationing of intensive care in situations of scarcity. Although the need for prioritization was a reality almost globally, many countries had no such regulation in place, which frequently led to the adoption of fragmented and discriminatory triage protocols.

The Colombian case reinforces that human rights and public health are not mutually exclusive. Importantly, this is reflected in the Principles and Guidelines on Human Rights & Public Health Emergencies (2023). Though the Principles did not exist during the litigation of the case, they will be of use in similar instances going forward, both for States working to develop human rights-compliant public health measures, as well as for courts reviewing such measures.

The "who," the "when," and the "how"

This is what happened in Colombia: by the third peak of the pandemic in April 2021, the Ministry of Health had adopted general, non-binding recommendations that allowed triage decisions on the basis of age and disability. Hence, both regional health authorities as well as private hospitals in a number of cities had in place protocols using age and disability as criteria for rationing intensive care.

This situation motivated 26 persons – some older persons and some persons with disabilities – to file a lawsuit[1]. After two unfavorable lower court decisions, the case made its way to the Constitutional Court, which decided in favor of the petitioners and ordered the Ministry of Health to issue a binding and uniform regulation regarding prioritization of scarce medical resources in the context of an emergency.

The Constitutional Court answers the three main questions that were left without clear response during the pandemic: *who* should regulate, *when* prioritization is acceptable, and *how* to prioritize. It is worth mentioning from the outset when addressing the *who, when, and how* questions, the Constitutional Court took into consideration international human rights law, including the guidance provided by different international bodies during the pandemic at the universal and regional level (the I-A Commission and Court, the United Nations Treaty Bodies and the Special Procedures).

Participation, accountability, transparency, and non-discrimination, essential in the Court's reasoning, are also reflected in the Principles and Guidelines on Human Rights & Public Health Emergencies. In particular, Principles 6, 7, and 8 focus in detail on what procedural safeguards – applicable to government decisions and policies in public health emergency contexts – should look like in order to facilitate compliance with human rights, as well as to ensure legitimacy and public support on those decisions and policies.

First, with respect to the *who,* the Court concludes that it was the State (through its Ministry of Health) that bore responsibility for adopting a binding and uniform regulation providing the criteria for providers to use in determining who (and who not) to treat in the face of scarce resources. This also means that healthcare providers' autonomy – the main argument offered by

the Ministry of Health to avoid regulating – is not absolute and cannot escape human rights scrutiny.

Second, the question of *when* has two components, and the Court dealt with both. The Court explicitly clarifies the States' obligation to *anticipate* future health emergencies and scenarios of scarcity. Anticipation would allow for an assessment of the availability of goods and services and the adoption of measures to improve, to a maximum extent, such availability and to avoid the need of prioritization in the form of triage. It also prevents improvising criteria in the heat of the moment, when rationing is unescapable. The Court also emphasizes the obligation to exhaust any and all possible means before resorting to rationing (for example, the remission of patients to other facilities). Principle 10 of the Principles and Guidelines on Human Rights & Public Health Emergencies is consistent with this preventive component of the judgment. Insufficient anticipation, prevention, and preparedness should not be commonplace in future public health emergencies.

Third, the issue of *how* was addressed by the Court on two levels. The Court clarified that need for procedural safeguards, such as public debate and the development of regulations with full public participation (including the participation of persons with disabilities, older persons, civil society organizations, and other relevant public and private actors). Another procedural safeguard discussed by the Court is the creation of effective mechanisms to ensure transparency and accountability in triage decisions in the context of public health emergencies.

Can age and disability be considered in triage decisions in the face of public health emergencies?

However, the most difficult to answer question addressed by the Court is the more substantive aspect of the *how*, namely: whether age and disability were acceptable criteria in triage decisions at all. Applying a proportionality test and using strict scrutiny, the Constitutional Court concluded that the consideration of age and disability in prioritization protocols and decisions amounts to discrimination in terms of domestic and international law. The Court correctly understood the prohibition of discrimination as complex and multilayered, including direct and explicit, as well as indirect or implicit, discrimination. In this matter, part of the discrimination alleged on both grounds was implicit and covert, with some of the relevant protocols including considerations such as: "long term survival"; "social functionality"; "the need for supports in the future"; "survival free from illness"; and other forms of conscious and unconscious assumptions regarding age and disability. In addition, the Court correctly considered that discrimination continues to exist even when the grounds of age or disability are not the exclusive factors of the decision. On this matter, the decision is also connected to the Principles and Guidelines on Human Rights & Public Health Emergencies, especially principle 4.

Conclusion: the role of courts in the context of public health emergencies

The Court's decision constitutes a good example of the role of courts in reviewing acts or omissions of other branches of government in the context of public health emergencies. While it was not for the Court to act in place of the relevant authorities, the Court reviewed the actions and omissions of the Ministry of Health against domestic and international human rights standards, leading to procedural and substantive minimum requirements that the Ministry is now required to comply with.

This case invites us to reflect on the pandemic, what we did wrong, and how to anticipate and face the next public health emergency. The Principles and Guidelines on Human Rights & Public Health Emergencies show that public health and human rights protected in international treaties are not exclusive nor necessarily in tension. On the contrary, human rights-compliant responses lead to better public health outcomes.

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[1] The Health and Human Rights Initiative from the O'Neill Institute for National and Health Law at Georgetown University and PAIIS from the *Universidad de Los Andes* in Colombia, acted as legal advisors of the plaintiffs.

The Parliamentary Assembly of the Council of Europe: Responding to Public Health Emergencies by Upholding Human Rights, Democracy, and the Rule of Law

By Anita Gholami

The Parliamentary Assembly of the Council of Europe, which brings together parliamentarians from 46 member States, has been a vigilant guardian of respect for the European Convention on Human Rights and other international standards throughout the COVID-19 pandemic. The Assembly has adopted a number of resolutions and recommendations seeking to equip parliaments in our European member States and beyond with the relevant tools and expertise to uphold human rights, democracy and the rule of law. It has been an important forum for enabling States to address the fault lines in national public health systems, bridge gaps in global health security and policy, and strengthen collective efforts to build back better.

In June 2023, the Assembly adopted Resolution 2500 (2023) on "Public health emergency: the need for a holistic approach to multilateralism and health care." The report supports the ongoing processes taking place at the international level to transform global health governance. It considers that States must build on the principles of equity and the protection of human rights and fundamental freedoms during public health emergencies, and thus makes specific and productive reference to the *Principles and Guidelines on Human Rights and Public Health Emergencies* ("the Principles").

The Assembly's report came in response to States' failed preparation for, prevention of, and responses to the COVID-19 pandemic. Of particular concern for the Assembly is the lack of civil society participation and consideration for human rights in the ongoing drafting process of a new pandemic treaty. As cornerstone institutions of democracy, parliaments play a crucial role in moving the global health agenda forward. As such, an active role must be defined for parliamentarians to implement and oversee the much-needed consultative processes, taking into account the proposals of civil society, non-governmental- and human rights organizations, in line with PHE Principle 7 on the right to meaningful and effective public participation in decision-making processes.

Against this backdrop, the Assembly's report underlines the critical importance of mainstreaming human rights in this treaty drafting process, as well as in potential amendments to the International Health Regulations. As reaffirmed by both the report and the Principles, it is a fundamental tenet of international law that all human rights are indivisible and interrelated. Of particular concern to the Assembly in the context of public health emergencies are economic, social, and environmental rights (such as housing, social protection, adequate nutrition and a safe, clean, healthy, and sustainable environment), which are essential to the enjoyment of the right to health. These critical global health law reform processes must be grounded in human rights and, in doing so, would do well to draw substantially on the comprehensive Principles.

Indeed, many global bodies, including the Assembly, had warned of the world being woefully ill-prepared to handle international public health emergencies. In 2016, the Assembly adopted a resolution calling for the existing worldwide health-system architecture to be strengthened with an empowered, well-governed, sustainably financed, and accountable World Health Organization at its apex, and efficient, equitable, and resilient national health systems at its foundation.

Unfortunately, the pandemic hit the world largely unprepared and laid bare the fault lines in our national health systems, as well as our global health policy and security. The Principles clarify the obligation of states to strengthen and develop sustainable health systems – in general and in anticipation of inevitable future public health emergencies. The two Assembly reports on "Lessons for the future from an effective and rights-based response to Covid-19" and "Public health emergency: the need for a holistic approach to multilateralism and health care" provide states with policy recommendations in this regard. With threats from infectious diseases linked to climate change, coupled with dwindling biodiversity and the consequences of armed conflicts presenting one of the primary international health challenges of our times, states must accelerate efforts to ensure universal health coverage for all and commit to realizing the right to a safe, clean, healthy, and sustainable environment.

Moreover, the Principles reaffirm the critical notion of international solidarity. The pandemic demonstrated, once again, that viruses know no borders, and that it is in our collective interest to ensure equitable access to public goods, facilities, services, and technologies for all. Regrettably, this has been one of the major failures of the response to the pandemic – calls from the Assembly and other stakeholders to ensure equity, not only within member States, but also at the global level, were ignored. Instead, rich countries stockpiled vaccines and undermined multilateral efforts to ensure global equitable distribution through the COVAX mechanism by outbidding poorer countries and entering into bilateral agreements with vaccine developers.

The Assembly supports a reform of international trade agreements with the aim of correcting and preventing inequities in accessing health goods, facilities, services, and technologies that are critical to preventing, preparing for, responding to, and recovering from public health emergencies. Supply chains must be strengthened, diversified, and kept open during public health emergencies. These imperatives flow from States' obligation to regulate activities, monitor, and protect against abuses by non-state actors and companies operating within their jurisdiction (including extraterritorial activities), in line with the UN Guiding Principles on Business and Human Rights, the Council of Europe CM Recommendation on Human Rights and business, and PHE Principle 5.

COVID-19 has demonstrated the devastating impact of public health emergencies, in particular on vulnerable groups such as refugees and migrants, children, young people, and the elderly. The pandemic has been a major setback to the UN Sustainable Development Goals, gender, equality, and non-discrimination, as well as to the global economy, deepening already-existing socioeconomic inequalities. During times of public health emergencies, democracies are put to test. In order to mitigate the damage, states must respond with prompt and effective measures. Any measure which interferes with fundamental rights and freedoms must be foreseen by law, strictly necessary, proportionate, and limited in time. The decision-making must be transparent and subject to parliamentary and judicial oversight. Far from being an afterthought, human rights, democracy, and the rule of law must always be respected and upheld.

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The Case for Procurement Transparency

By Tara Davis and Nicola Soekoe

In January 2021, the Director General of the World Health Organization (WHO) observed that the world was on the brink of a "catastrophic moral failure" if wealthier nations did not ensure the equitable distribution of COVID-19 vaccines. Global health activists and civil society organizations who worked transnationally to curtail what came to be referred to as "vaccine apartheid" faced a pharmaceutical industry that globally relied on secrecy, capital-friendly trade laws, and brute economic force to shirk considerations of human rights. In many ways, pharmaceutical companies and the states that protected them, including by failing to achieve consensus at the World Trade Organization (WTO) for a waiver of intellectual property rights with respect to vaccines, seemed impenetrable.

Unsurprisingly, given the extreme position of power from which pharmaceutical companies were negotiating contracts, there were widespread reports and allegations of inequitable contractual terms and a culture of bullying in the development of contracts. This was an issue of global concern for a long period during the pandemic. In South Africa, the Health Justice Initiative (HJI), a local advocacy organization, joined the global calls for greater procurement transparency.

However, when the South African Department of Health refused to disclose even the names of the entities with which it had entered into vaccine-related agreements, the HJI was forced to turn to the courts for relief.

HJI's case in the High Court

In *Health Justice Initiative v Minister of Health*, a matter brought before the High Court of South Africa, the HJI relied on South Africa's access to information law – the Promotion of Access to Information Act 2 of 2000 (PAIA) – to seek access to two categories of information: 1) the vaccine procurement contracts entered into between the South African Government and vaccine manufactures or licensees; and 2) the minutes, correspondence, and negotiation meeting outcomes with any vaccine manufacturer or licensee.

The relevant provisions of PAIA are cast in peremptory terms: the requester must be given access to the information held by the state, regardless of the reasons for which access is sought, so long as the request complies with the procedures outlined in the Act and the information requested is not protected from disclosure by the "limited and specific" exemptions provided.

Despite what appeared to be a clear duty to provide the information in terms of PAIA, the Department of Health refused access to the records, contending that it was bound by confidentiality agreements that precluded disclosure and that disclosing the records would prejudice the Department of Health and the vaccine manufacturers in future engagements. It argued, in addition, that there was no public interest in the disclosure of the contracts and other requested documents. The state therefore sought to justify the opaque procurement process primarily by hiding behind confidentiality clauses – the content of which themselves were not even disclosed. This, again, was in keeping with the position of many States at the time with respect to COVID-19 vaccine procurement.

Rejecting the government's position, the High Court held that "[i]t is not open to the respondents to conclude agreements which include a confidentiality clause and then seek to rely

on the confidentiality clause to circumvent their obligations of accountability and transparency" (para 33). It noted that it was "self-evident, that there is a public interest in the disclosure of the records." Crucially, the Court held that the state's obligation of disclosure in the public interest persists even in emergency situations (para 48). Ultimately, the Court found no merit in the Department of Health's arguments and ordered the disclosure of all the records requested.

Impact of the judgment: what have records disclosed shown?

The disclosure of the records, and subsequent analysis thereof led by the HJI have revealed that not only was South Africa charged more for COVID-19 vaccines than countries in the Global North, but also that the terms and conditions that the state had to agree to were overwhelmingly one-sided, favouring multinational pharmaceutical companies (including Janssen Pharmaceuticals, which produces the J&J vaccine, as well as with Pfizer, and the Serum Institute of India) and preserving their intellectual property empires. Commenting on these revelations, the Deputy Director-General of South Africa's Department of Health has conceded that South Africa was "screwed" by the global Covid-19 vaccine procurement process and that the government is "very unhappy with the way in which this all happened".

While the HJI's victory comes too late for the changes that might have prevented the so-called "excess deaths" resulting from the inequitable distribution of vaccines – estimated at 670,000 deaths worldwide – or the large-scale suffering that the pandemic brought about, it nevertheless offers a sobering reminder of the role that transparency must play in a human rights-centered response to the next pandemic.

The importance of transparency in responses to pandemics

Transparency is also a founding value of the South African Constitution, and central to the rule of law. Transparency and access to information is also recognized as one of the overarching "principles and obligations" contained in the Principles and Guidelines on Human Rights and Public Heath Emergencies (the Principles). Specifically, the Principles indicate that international law places an obligation on states to "ensure widespread, meaningful, and timely access to accurate and quality information" (Principle s 6.2(a)). Notably, during a public health emergency this clearly is intended to apply to public procurement contracts (s 6.2(a)(iii)).

The Health Justice Initiative's litigation was launched before the publication of the Principles, but their existence would, in our view, have bolstered the case for the importance of transparency during a global emergency. First, the Principles might have bolstered global solidarity efforts by civil society actors across the world by giving them a central source from which to draw their demands. Second, in some countries where, unlike South Africa, comprehensive constitutional rights to access public information and legislation giving effect to them do not exist, the Principles could have been relied on for human rights-based arguments in Court. Finally, if the Principles had been followed by States at the time of the COVID-19 Pandemic, which, in our view, they should have been, proactive disclosure by the South African government would have vitiated the need for protracted court processes in South Africa and elsewhere. This, critically, could have helped save lives.

The COVID-19 pandemic placed extraordinary demands on governments across the world – requiring them to maximize the use of scarce human, financial, technological, and other resources in the face of great global demand and unequal bargaining power with major

multinational companies, not least in the pharmaceutical industries. This is no easy feat, as the UN Committee on Economic, Social and Cultural Rights noted from the outset of the pandemic, States are obliged to ensure the "extraordinary mobilization of resources" in response to public health emergencies. Principle 10 recognizes this obligation in international law and, moreover, interestingly indicates that the resources available to states should be understood to include resources that are privately held, whether obtained or controlled through "effective measures to direct or otherwise regulate the use of privately held, owned or operated resources" or through "coordinat[ion] with private actors" (Principle 10.3).

Further, the context of public health emergencies more generally makes the need for transparency and accountability greater, particularly when the usual checks and balances have been relaxed as occurred in many situations during the COVID-19 pandemic. One of the lessons from the HJI judgment is that in times of public health emergencies, States and the public cannot rely on the goodwill of pharmaceutical companies to ensure equitable and comprehensive vaccine rollout, which is critical to the protection of a wide range of human rights. Lives literally depend on transparent procurement contracts and lives can actually be saved by ensuring that their contents are publicly known during future public health emergencies. States can no longer pretend not to know this.

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Conclusion to the Symposium: From Principles to Practice: Human Rights and Public Health Emergencies

By Timothy Fish Hodgson, Roojin Habibi, and Alicia Ely Yamin

In developing the digital symposium, *From Principles to Practice: Human Rights and Public Health Emergencies* (which ran from October – December 2023), as editors we endeavored to get scholars, human rights advocates, judges, and policy makers to engage critically with the expert *Principles and Guidelines on Human Rights and Public Health Emergencies* (the PHE Principles), published by the International Commission of Jurists and the Global Health Law Consortium in May 2023. In doing so, we encouraged contributors to comment on the Principles' potential usefulness as guidance in addressing real emergency situations, as well as any possible gaps and weaknesses.

While summarizing the entire content of the 13 blogs comprising this symposium in any depth is not possible here, this concluding post will attempt to synthesize some of the major inputs from the contributions. We also provide some of our own observations, as participants in the drafting of the Principles, with the aim of pushing the discussion prompted by the posts forward.

The Purpose of the Principles

In their contribution, Gostin and Friedman provide some context for the development of the PHE Principles by explaining the deficiencies in the *Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights* (Siracusa Principles). While receiving significant global traction and acceptance since their publication in 1985, the Siracusa Principles, the authors argue, proved to be simply "unequal to the task" of guiding States' conduct in the context of COVID-19 because they are "unable to speak in any significant detail to the particular concerns of public health crises." Without adequate guidance for how to comply with human rights in the context of public health emergencies, the authors therefore noted that States commonly "exceeded permissible derogations from the ICCPR" and faced "little accountability for their actions whether on domestic or international levels."

The inadequacy of the Siracusa Principles in addressing the wide ranging issues arising in the specific context of public health emergencies was indeed a key motivation to the drafters of the Principles in undertaking their development. To be fair, the Siracusa Principles were aimed at narrowly addressing the permissible scope of measures limiting or derogating from human rights obligations under the ICCPR. They also were intended to be of application to a wide range of emergencies, not public health emergencies specifically. To that purpose, they have stood the test of time. However, this notwithstanding, the very brief treatment of public health emergencies in Siracusa (paragraph 25) simply does not provide sufficient guidance to States on how to deal with a range of issues emerging as critical during the COVID-19 pandemic, including, as examples: health system preparedness pandemic prevention; widescale responses such as lockdowns and quarantines; application of new technologies including for surveillance purposes; social safety nets and provision for the social determinants of health; and effective regulation of private actor involvement in emergency contexts.

Therefore, and building on the Siracusa Principles, the PHE Principles, overall, can be seen as an effort to "harmonize" global health law and international human rights law, drawing, as they do, from both fields.

Global Solidarity and Private Actor Involvement in PHE

Given the catastrophic failure of States to effectively coordinate global responses to the COVID-19 pandemic, clarifying global solidarity and international cooperation standards were at the center of the drafters' discussions during the development of the Principles.

The duty of states to realize human rights through international cooperation and assistance is a clearly articulated legal obligation in international law. The Principles affirm States' obligations to cooperate towards measures that prepare for, prevent and respond to public health emergencies. They therefore reiterate that all human rights must realized through "international cooperation" having regard to the varied "capacities, resources and influence" of different States. In addition, the Principles also include "international solidarity" as one of eight "overarching principles and obligations" in the context of public health emergencies. The Principles embody throughout the legal imperatives of international cooperation and solidarity – which is described as an "emerging principle of international law."

Several contributions to the symposium unpack the PHE Principles' treatment of solidarity further.

Gostin and Friedman bemoan the "woefully inadequate international cooperation and assistance" during COVID-19 and call for improved accountability for States "individually and collectively" in the future.

Ahmed et al. emphasize solidarity both at the national level (within States) and the international level (between States), and note that the Principles sharply express States' duties to "prevent non-State actors from frustrating solidarity efforts." The authors warn, however, that, if global health reform is going to produce sorely needed equity in health access that solidarity must not be "relegated to platitudes and lamentations." They therefore endorse including it in the "legal thinking that guides our next response."

Gholami highlights the fact that the pandemic illustrated that "viruses know no borders" and asserts that "it is in our collective interest to ensure equitable access to public goods, facilities, services, and technologies for all". She notes that, in the context of Europe, that despite calls from the Parliamentary Assembly of the Council of Europe, "rich countries stockpiled vaccines and undermined multilateral efforts to ensure global equitable distribution through the COVAX mechanism by outbidding poorer countries and entering into bilateral agreements with vaccine developers."

Arenas Catalan notes that a key test for the Principles will be their "ability to influence the measures taken, including by States, in preparing for, preventing, and responding to future public health emergencies with increased solidarity." Such a solidaristic approach would, in his view, prevent States from "remaining free to privatize knowledge or infrastructure critical to the satisfaction of human needs," with significant implications for the role of private actors in health care.

Ho commends the Principles' explication of the duties of non-State actors, which he notes are critical in the context of much-needed interaction and cooperation between States and social media companies in the wake of public health emergencies.

De Falco, like Arenas Catalan, expresses skepticism about the role of private actors in health care, both within the public health emergency context, and also more generally, by drawing on examples from Nigeria, Kenya, and Italy. She emphasizes the importance of Principle 5, pertaining to "human rights duties relating to non-State actors," thereby focusing more on State *regulation* of private actors than State *coordination and cooperation* with private actors. Emphasizing that the Principles indicate that non-State actors must "respect rights," "contribute to their fulfilment," and "refrain from impeding international solidarity efforts," De Falco stresses that "corporations exercise ever-growing influence in both global health and domestic health systems." She concludes that "strong, well-coordinated and resilient public health care services play a vital role in preventing and responding to public health crises."

Country-Specific Applications

Though the COVID-19 pandemic exposed in stark terms the interconnectedness of health between countries and across the world, it also served to underline the glaring inequities that resulted in particular countries and/or particular groups of marginalized persons within countries bearing a disproportionate burden of the pandemic's worst effects. Several authors made contributions to the symposium that were country specific, honing in on such impacts and efforts to secure accountability domestically.

The Jurisprudence of COVID-19

Substantial databases of jurisprudence relating to COVID-19 show that judicial decisions continued to proliferate on a range of issues and deep into 2023. Blog contributions from Malawi, South Africa, and Colombia are illustrative of the important role of courts in ensuring accountability in the context of public health emergencies, as is emphasized by the PHE Principles (Principle 8).

Judge Zione Ntaba's contribution highlights how courts in Malawi decided cases relating to the Government's responses to the COVID-19 pandemic, including, in particular, the provision of social security measures in parallel with lockdown measures, and the policy proposals relating to mandatory COVID-19 vaccinations. Judge Ntaba indicates that "the Principles would have greatly assisted the Malawian judiciary if they had been available at the onset of the pandemic." For her, "they are an authoritative text, representing an international, consensus-based expert opinion on the most pressing human rights issues in public health emergencies."

Judge Ntaba draws attention to the consistency with and relevance to the Malawian Court's judgments on lockdowns of Principle 12(2)(f) pertaining to the obligation that States provide for "social protection measures to mitigate and compensate for the impact of public health emergencies on livelihoods [and] welfare…" As alluded to above, the need to include a sufficient focus on the protection of economic and social rights – lacking entirely in the Siracusa Principles – was one of the key reasons for the development of the PHE Principles, which address all human rights as "universal, indivisible, interdependent, interrelated and mutually reinforcing" (Principle 1).

Soekoe and Davis, both South African lawyers involved in litigation relating to transparency in vaccine contracts between the Government and pharmaceutical companies, detail the successful vindication of the right to access to information, entrenched in the South African Constitution and legislation. The South African Court ultimately ordered disclosure of such contracts despite the government's reliance on confidentiality clauses.

In analyzing the impact of the judgment, Soekoe and Davis argue that the PHE Principles would have "bolstered the case for the importance of transparency during a global emergency" and would improve the prospects of success in future similar cases in South Africa and elsewhere. First, they note that "global solidarity efforts," key in vaccine access advocacy, could draw on the Principles as a strong source. Second, they note that countries with less comprehensive information rights/laws could draw on the Principles to bring similar cases to court. Finally, they remind us that had governments simply proactively disclosed contracts, the need for such litigation would have been obviated and this could have helped to save lives.

Writing on a decision of the Colombian Constitutional Court, Silvia Serrano describes the Court's approach to protocols adopted in health care institutions relating to triage in the face of scarce health resources in the face of the COVID-19 pandemic. As Serrano notes, many countries did not have regulations in place, and the result was often "the adoption of fragmented and discriminatory triage protocols" resulting in age and disability discrimination.

The Court indicated that the Colombian government had failed in its obligation to adopt a "binding and uniform regulation providing the criteria for providers to use in determining who (and who not) to treat in the face of scarce resources." Crucially, Serrano notes that the Court also clarifies the State's obligation "to anticipate future health emergencies and scenarios of scarcity" to "exhaust any and all possible means before resorting to rationing." In order to ensure rights protection in situations where triage may become necessary, the Court also highlights the need for public participation in development of such regulations, including the involvement of those most at risk, such as persons with disabilities and older persons. It also affirms and the necessity of "effective mechanisms to ensure transparency and accountability in triage decisions in the context of public health emergencies."

Serrano acknowledges that the Principles' articulation of transparency, accountability, and non-discrimination as overarching principles (Principles 6, 8 and 4 respectively) could have assisted the Court in coming to its decision in this matter and bolstered its reasoning.

Health Systems

By design, the PHE Principles depart from the Siracusa Principles which address emergencies as events that require human rights consideration only on the level of response measures. The PHE Principles therefore focus throughout also on prevention and preparedness and emphatically affirm States' obligations to "strengthen and develop sustainable health systems" (Principle 9) as arguably the most critical means of preventing and/or mitigating the impact of future pandemics.

Were and Maleche decry the failure of the Kenyan government to "take a human rights-based approach to in response to COVID-19," arguing that the "Kenyan government simply did not know how to do so." Instead, the government applied archaic and outdated laws that were not fit for purpose, with dire consequences for human rights. In addition, Parliament, unable to

enact new laws at the beginning of the pandemic, "abdicated" its duties to the executive. Noting that this was a common problem across the world, Were and Maleche welcome the Principles. They express the hope that they will "bridge a much-needed gap in our understanding of public health emergencies."

They commend their "broad temporal scope" – focusing on prevention, preparation, response, and recovery – and their emphasis on the improvement of health care, economic and social systems that are human rights-compliant. Aiming to address the problem succinctly identified by Were and Maleche, the Principles emphasize the State "obligation to ensure legal and policy preparedness for public health emergencies" (Principle 13). They also affirm that States must produce a "coordinated, effective and human rights compliant legal framework which operationalizes" their human rights obligation in respect of public health emergencies.

Similarly, Da Silva Bhatia et al. focus on the generally poor state of the United States health care system, which they describe as "fragmented, largely profit-based, and predominantly disease-focused rather than prevention-focused." While COVID-19 resulted directly in the deaths of over 1.1 million people in the U.S., with 1.7 million "excess" deaths by the end of 2022, the pandemic impacted "Black, Latine, people of other minority racial or ethnic backgrounds, people with disabilities, and other socially vulnerable people" disproportionately. Advocating for an overhauling of the existing approach to health care in the United States, the authors argue that the Principles "help draw a line in the sand between how the U.S. functions currently and what health care could look like if people were prioritized over profit, if transparency and accountability were strengthened, and if fundamental human rights were upheld through the enforcement of minimum essential standards for well-being." They correctly emphasize that the Principles call for a human rights-based approach to both health care in general and in public health emergencies in particular (Principle 13).

The problems are obviously not particular to Kenya and the United States. In her contribution, Gholami for instance, notes that "the pandemic hit the world largely unprepared and laid bare the fault lines in our national health systems" and welcomes the Principles affirmation of the "obligation of states to strengthen and develop sustainable health systems" ahead of future public health emergencies.

Gaps in the Principles: Room for Future Evolution

Several authors provide constructive criticism of the PHE Principles in their analysis, creating important incentive for the drafters of the Principles to consider future normative development and for external stakeholders to conduct further research. This is fitting given the Principles' provision that they "provide a foundation upon which future human rights norms in public health emergency prevention, preparedness, response and recovery emerge and evolve."

Ho, for example, focuses on the Principles' failure to cover "infodemics," a phenomenon described by the WHO as the availability of "too much information including false or misleading information in digital and physical environments during a disease outbreak." He notes that infodemics, such as the one that accompanied the COVID-19 pandemic, warn of the need to include "infodemic management" as an "integral part of public health emergency prevention, preparedness, response, and recovery." While criticizing the Principles for failing to address infodemics directly, he concedes that they contain provisions that will form the basis for the

"forging [of] a common and more holistic understanding of infodemic-related harm," and applauds their emphasis on a "participatory approach" (Principle 7).

Varadan et al. focus their contribution on the Principles' failure to include a "specific and detailed discussion on the rights obligations and principles owed to children during public health emergencies." The principles, the authors argue, fail to identify measures States can take to "ensure children are actively listened to and engaged with in the prevention of, preparedness for, and response to public health emergencies."

Nonetheless, the authors consider the Principles to be "an important first step towards clarifying the scope of States' rights obligations during public health emergencies" and stress that "it is not unreasonable that their scope should be framed broadly without a detailed discussion on the rights of specific vulnerable populations." They argue that children should not be cast as merely "hidden" or "silent" victims of pandemics and emphasize the need for "a deeper elaboration on the content of the Principles will be needed to ensure compliance with the CRC" as the product of a "more deliberate and detailed discussion" which "actively engages and empowers children."

Finally, Catalan expresses reservation about the Principles' failure – in keeping with General Comment 14 of the CESCR Committee – to more strongly acknowledge what he argues is the "instrinsic[] assocati[on]" between private provision of health services and inequitable health provision. Nevertheless, Catalan describes Principle 28 (which imposes an obligation over intergovernmental organizations to facilitate the sharing of information and technology) as "the greatest promise yet in terms of setting a concrete and effectual solidarity-based legal obligation regarding public health emergency preparedness."

Looking Forward: What's next for the PHE Principles

As with any legal drafting processes, multiple versions of the Principles were developed, debated, amended, and refined during the nearly three-year process of their drafting.

In our view, the Principles are better off for such robust engagements, but, inevitably, this resulted in the repeated refinement and modification of the content of the Principles to achieve full consensus of the experts who, after all, were attempting to draft a consensus position of the requirements of international law and standards – not merely state their own opinions.

As individuals who contributed to the drafting process, we thank the authors of the blogs in this symposium for their thorough engagement, and invite more commentary about the Principles in the future.

As is already evident, the COVID-19 pandemic, much like pandemics of the past, have resulted in significant social change. According to historian of medicine Frank M. Snowden this is because "epidemics are a category of disease that seem to hold up the mirror to human beings as to who we really are."

For us, one of our major points of learning from the COVID-19 pandemic is that international law's prescriptions with respect to public health emergency preparedness, prevention, response, and recovery were insufficiently clear to State and non-State actors alike.

We hope that, alongside important developments such as the elaboration of a Pandemic Treaty and the review of the International Health Regulations, the PHE Principles will make a small

contribution to legal change that inevitably runs alongside the social change stemming from COVID-19. If that legal change is grounded in existing human rights law and standards, we retain some hope that the next pandemic will not be as catastrophic as COVID-19.

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