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Law as an Antidote? Assessing the Potential of International Health Law Based on the Ebola-Outbreak 2014

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> "And, indeed, as he listened to the cries of joy rising from the town, Rieux remembered that such joy is always imperilled. He knew what those jubilant crowds did not know but could have learned from books: that the plague bacillus never dies or disappears for good; that it can lie dormant for years and years in furniture and linen-chests; that it bides its time in bedrooms, cellars, trunks, and bookshelves; and that perhaps the day would come when, for the bane and enlightening of men, it roused up its rats again and sent them forth to die in a happy city."
>
> *A.Camus, The Plague*

Abstract

The Ebola-Outbreak of 2014 has put international health law in the limelight. This contribution assesses the measures taken by the international community with regard to the outbreak of 2014 with a special focus on the World Health Organization and the UN Security Council. International law provides different actors with means to cooperate in order to fight the outbreak. The list of actors does not include the UN Security Council, which has addressed the outbreak in one resolution under chapter VII without taking any effective legal remedies. In addition, the relevant human right to health has not been addressed by actors, creating leeway in further emergencies.

A. Introduction

The worldwide spread of severe diseases seems more common today than in the past. The most recent epidemics and pandemics[1] include the 2002/2003 outbreak of the severe acute respiratory syndrome (SARS), the 2009 H1N1-swine-origin influenza virus or *swine flu* pandemic, cholera since 2010 in Haiti, the Chikungunya-fever in the Americas (2013) and most recently the Middle East respiratory syndrome coronavirus (MERS) in the Republic of Korea (2015) or the outbreak of the Zika-virus in Latin America and the Caribbean suspected

[1] An outbreak is considered an epidemic in cases where cases are clearly in excess of normal expectancy within a community or region while a pandemic is an epidemic that "has spread over several countries or continents", UN High-level Panel on the Global Response to Health Crises, *Protecting Humanity from Future Health Crises*, 25 January 2016, 74, 77 [High-level Panel].

to be connected to an observed increase in neurological disorders and neonatal malformations (2016).[2] Even the plague resurfaces regularly, most recently at the end of 2014 in Madagascar.[3] In 2014, the Ebola-virus broke out in western Africa. First, it was contained in a small village in Guinea where a two-year-old toddler was infected and died after four days.[4] After his family and inhabitants of surrounding villages were infected, the disease quickly spread to other countries. It turned out to be by far the biggest Ebola-outbreak in history. In January 2016, when the WHO declared the outbreak to be over,[5] more than 28,600 people were infected and 11,316 lives were lost. Ultimately, when the Director General terminated the public health emergency of international concern, 11,323 people died and 28,646 cases were counted.[6]

The Ebola-Outbreak of 2014 has put international health law in the limelight. As a rather *niche* field of law, legal aspects of health are often overlooked or even ignored.[7] In the case of health emergencies, such as the 2014 Ebola-outbreak, factors other than legal ones matter more and are considered to

2 On 1 February 2016 the WHO determined the Zika-outbreak a public health emergency of international concern, cf. *WHO statement on the first meeting of the International Health Regulations (2005) (IHR 2005) Emergency Committee on Zika virus and observed increase in neurological disorders and neonatal malformations*, 1 February 2016, available at http://www.who.int/mediacentre/news/statements/2016/1st-emergency-committee-zika/en/ (last visited 1 August 2016).

3 WHO, 'Plague – Madagascar', 21 November 2014, available at http://www.who.int/csr/don/21-november-2014-plague/en/ (last visited 1 August 2016).

4 H. Yan & E. Smith, 'Ebola: Who is patient zero? Disease traced back to 2-year-old in Guinea', *Cable News Network* (21 January 2014), available at http://edition.cnn.com/2014/10/28/health/ebola-patient-zero/index.html (last visited 1 August 2016); *High-level Panel*, *supra* note 1, 21, para. 9.

5 WHO, 'Latest Ebola outbreak over in Liberia; West Africa is at zero, but new flare-ups are likely to occur', 14 January 2016, available at http://www.who.int/mediacentre/news/releases/2016/ebola-zero-liberia/en/ (last visited 1 August 2016).

6 WHO, Data up to 27 March 2016, available at http://apps.who.int/ebola/ebola-situation-reports (last visited 1 August 2016). For a historic overview cf. L. Gostin & E. Friedman, 'A Retrospective and Prospective Analysis of the West African Ebola Virus Disease Epidemic: Robust National Health Systems at the Foundation and an Empowered WHO at the Apex', 385 *The Lancet* (2015) 9980, 1902 *et seq.*[Gostin & Friedmann, Retrospective and Prospective Analysis]; O. Aginam, 'Mission (Im) possible? The WHO as a 'Norm Entrepreneur' in Global Health Governance', in M. Freeman, S. Hawkes & B. Bennett (eds), Law and Global Health (2014), 559, 562 *et seq.*

7 B. Meier & L. Mori, 'The Highest Attainable Standard: Advancing a Collective Human Right to Public Health', 37 *Columbia Human Rights Law Review* (2005) 3, 101, 103; Aginam, *supra* note 6, 559. This holds especially true for German scholarship of international law.

be more urgent. When States are eager to cooperate and stop a further spread of a disease, there seems to be no need for international law. Medical, social and other aspects are more pressing. Also, traditional challenges to health usually require continuous and permanent efforts – maternal and childhood health, issues arising from disabilities or HIV/AIDS as well as poverty are all long-term-challenges and need to be addressed accordingly. Even then, the applicable legal framework is not easy to identify. One has to take into account, among others, human rights, environmental and intellectual property law as well as domestic law: in the end a concoction of various legal orders. Nevertheless, law is not irrelevant. While it will not cure a single disease or sickness, it may provide a framework in which experts counter sicknesses and diseases and law may facilitate the solution. It may also provide factors that help to lead a healthy life.

In stark contrast to aforementioned traditional challenges, viruses like the Ebola virus disease, or short Ebola, need to be addressed expeditiously. Fighting an outbreak is, first and foremost, a question of time.[8] The Ebola-crisis 2014 has demonstrated the need for swift global[9] action. Despite its severity, the number of victims, the region affected by the outbreak, and not the least the media's fear-mongering coverage regarding Ebola being a threat to Europe,[10] the international response has not been speedy and comprehensive.[11] In 2014,

8 Statement by the Special Representative of the Secretary General and Head of the United Nations Mission for Emergency Ebola Response A. Banbury, *Record of the 7279th meeting of the Security Council*, UN Doc. S/PV.7279, 14 October 2014, 3.

9 Globalization as an additional challenge has been described extensively by Meier & Mori, *supra* note 7, 105; *High-level Panel*, *supra* note 1, 25, para. 40.

10 This holds true even for respectable news sources, cf. K. Elger *et. al.*, 'Gateway to Hell: The Threat of Ebola grows Worse', *Spiegel Online International* (8 September 2014), available at http://www.spiegel.de/international/world/how-the-ebola-outbreak-in-africa-could-become-a-threat-to-europe-a-990445.html (last visited 1 August 2016); T. Walker, 'Is Europe taking the Ebola Threat seriously?', *Deutsche Welle* (7 October 2014), available at http://www.dw.de/is-europe-taking-the-ebola-threat-seriously/a-17980662 (last visited 1 August 2016); 'WHO warns of Ebola health care risks', *British Broadcasting Corporation* (8 October 2014), available at http://www.bbc.com/news/world-europe-29531671 (last visited 1 August 2016); cf. also *High-level Panel*, *supra* note 1, 23, para. 23.

11 Cf. Médecins Sans Frontières, 'Ebola: Pushed to the Limit and Beyond. A Year Into the Largest Ever Ebola Outbreak', 23 March 2015, available at http://www.msf.org/sites/msf.org/files/msf1yearebolareport_en_230315.pdf (last visited 1 August 2016); Meier & Mori, *supra* note 7, 105 *et seq*.; cf. also internal WHO documents 'Bungling Ebola Documents', *The Associated Press*, available at http://interactives.ap.org/specials/interactives/_documents/who-ebola/ (last visited 2 August 2016) dealing with the WHO's flawed attempts to combat the outbreak [Bungling Ebola Documents]; Criticism was also raised within *Record of the 7502nd meeting of the Security Council*, UN Doc. S/PV.7502,

the international community attempted to address the recent outbreak by a vast array of measures.

These measures will be addressed in the following. The underlying assumption is that the recent outbreak has shaped some aspects of international health law, which now provides for better measures against similar outbreaks. The article will first identify the different notions of *health* and the applicable legal framework before the specific measures in regard to the Ebola-outbreak 2014 are analyzed. The concluding remarks will summarize the findings and assess the potential of international health law based on the Ebola-outbreak 2014. As stated in the introductory quote, even if a specific outbreak of a disease was halted successfully, chances are that other diseases or another outbreak will occur. Thus, it is crucial to adapt international health law with regard to future threats.

B. Identifying the Legal Framework

I. What is *Health*?

The legal framework surrounding aspects of health depends on, naturally, the understanding of *health*.[12]

The preamble to the *Constitution of the World Health Organization* (WHO) defines *health* as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity."[13] Thus, *health* refers to the condition of an individual.[14] *Public health*, in contrast, is neither defined in the *WHO-Constitution*, nor in the current program of work[15] nor

13 August 2015 [7502nd Meeting] and in *High-level Panel*, *supra* note 1, 6. The motifs for delaying response were already laid out by S. Davies & J. Youde, 'The IHR (2005), Disease Surveillance, and the Individual in Global Health Politics', 17 *The International Journal of Human Rights* (2013) 1, 133, 134; A. Silver, 'Obstacles to Complying with the World Health Organization's 2005 International Health Regulations', 26 *Wisconsin International Law Journal* (2008) 1, 229, 235 *et seq*.

12 Cf. also C. Foster & J. Herring, 'What is Health?', in Freeman, Hawkes & Bennett, *supra* note 6, 23.

13 *Constitution of the World Health Organization*, 22 July 1946, 14 UNTS 185, [WHO-Constitution]; Cf. *Declaration of Alma Ata*, 12 September 1978, Article 1, available at http://www.who.int/publications/almaata_declaration_en.pdf (last visited 1 August 2016).

14 Cf. J. Wolff, *The Human Right to Health* (2012), 27.

15 L.O. Gostin & E.A. Friedman, 'Ebola: a Crisis in Global Health Leadership', 384 *The Lancet* (2014) 9951, 1323 [Gostin & Friedmann, Ebola: a Crisis].

the most recent *International Health Regulations (2005)* [IHR (2005)]. One can find a definition on the WHO's website, stating that "public health refers to all organized measures (whether public or private) to prevent disease, promote health, and prolong life among the population as a whole". The WHO aims at creating conditions in which people can be healthy. The organization focuses on entire populations, not on individual patients or diseases. One may define public health as referring to all organized measures (whether public or private) to prevent disease, promote health, and prolong life among the population as a whole.[16] This is supported by the fact that the *International Covenant on Civil and Political Rights*[17] (*ICCPR*) and the *European Convention of Human Rights*[18] (*ECHR*) recognize public health as a limitation of specific human rights (Articles 12 (3), 18 (3), 19 (3)(b), 21 and 22 (2) *ICCPR*, Articles 2 (2), 8 (2), 9 (2), 10 (2), 11 (2) *ECHR*). Thus, public health is a matter of public interest.

Inherent in that terminology is an international dimension, given that

> "forces that affect public health can and do come from outside State boundaries and that responding to public health issues now requires attention to cross-border health risks, including access to dangerous products and environmental change."[19]

Primarily, measures of *public health* are population based and focused on preventive measures.[20]

II. The World Health Organization

Admittedly, the definition of health is very broad – after all, the term *well-being* is so vague that it constitutes an unreasonable standard for human rights law, as will be shown below.[21] Nevertheless, the definition sets the objective for the WHO. According to Article 1 *WHO-Constitution*, the WHO shall attain the highest possible level of health for all peoples. In order to achieve this

16 WHO, *Health Promotion Glossary* (1998), 3.

17 *International Covenant on Civil and Political Rights*, 999 UNTS 171, 16 December 1966 [ICCPR].

18 *European Convention on Human Rights*, 213 UNTS 221, 11 April 1950.

19 WHO*, Health Promotion Glossary* (1998), 3.

20 WHO, *Twelfth General Programme of Work. Not Merely the Absense of Disease* (2014).

21 B. Toebes, 'Introduction: Health and Human Rights in Europe', in B. Toebes *et al*. (eds), *Health and Human Rights in Europe* (2012), 5.

goal, Article 2 WHO-Constitution outlines the functions of the organization. According to its own understanding the

> "WHO is the directing and coordinating authority for health within the United Nations system. It is responsible for providing leadership on global health matters, shaping the health research agenda, setting norms and standards, articulating evidence-based policy options, providing technical support to countries and monitoring and assessing health trends."[22]

1. The WHO's Powers Under International Law

While the mandate of the WHO seems to be all encompassing,[23] its powers under international law are limited.

Under Article 19 of its Constitution, the Health Assembly of the WHO may adopt conventions or agreements with respect to any matter within the WHO's competencies.[24] Such conventions or agreements enter into force for each member State the moment the State accepted the treaty in accordance with its constitutional law. Subsequently, a State has to take action relative to the acceptance of that treaty (Article 20 *WHO-Constitution*). The first treaty adopted under this provision is the *Framework Convention on Tobacco Control*.[25]

Also, the Health Assembly has the authority to make recommendations with respect to any matter within its competencies (Article 23 *WHO-Constitution*). Finally, State parties are under an obligation to report on a regular basis to the WHO (Articles 61-65 *WHO-Constitution*).

More important than these conventional measures is, however, the authority of the WHO to issue legally binding regulations. In this sense, the *WHO-Constitution* offers some unique features.[26]

22 WHO, 'About WHO', available at http://www.who.int/about/en/ (last visited 1 August 2016).

23 For a possible limitation cf. *Legality of the Use by a State of Nuclear Weapons in Armed Conflict*, Advisory Opinion, ICJ Reports 1996, 66, 74, paras 19 *et seq*.

24 Cf. also L. O. Gostin, *Global Health Law* (2014), 110.

25 *WHO Framework Convention on Tobacco Control*, 2302 UNTS 166, 21 May 2003. For a comprehensive overview cf. G. B. Cockerham & W. C. Cockerham, 'International Law and Global Health', in Freeman, Hawkes & Bennett, *supra* note 6, 492, 495 *et seq*.

26 Gostin, *supra* note 24, 111.

2. The WHO's International Health Regulations (2005)

Article 21 *WHO-Constitution* grants the organization the power to adopt regulations concerning specific aspects, including sanitary and quarantine requirements and other procedures designed to prevent the international spread of diseases; nomenclatures with respect to diseases, causes of death and public health practices; standards with respect to diagnostic procedures for international use; advertising and labelling of biological, pharmaceutical and similar products moving in international commerce and similar.

A convention or agreement adopted under this provision enters into force for all members after due notice has been given of its adoption (Article 22 *WHO-Constitution*). As consequence, regulations adopted under Article 21 *WHO-Constitution* are binding for member States.[27] This is the legal ground for the *International Health Regulations* (IHR).

The power granted by this provision came to life at a very early stage. In 1951, the WHO adopted the *International Sanitary Regulations* (ISR).[28] In 1969, the need for an update led to the adoption of the *International Health Regulations*,[29] which "represent a revised and consolidated version"[30] of the *ISR* (1951). The *IHR* (1969) were amended in 1973[31] and 1981[32]. After these changes, the scope of the *IHR* (1969) was limited to cholera, yellow fever and the plague. Despite the Health Assembly being aware of the fact that

> "there is a continuous evolution in the public health threat posed by infectious diseases related to the agents themselves, the facilitation of their transmission in changing physical and social environments and to diagnostic and treatment capacities"[33]

27 J. P. Ruger, 'Toward a Theory of a Right to Health: Capability and Incompletely Theorized Agreements', 18 *Yale Journal of Law & the Humanities* (2006) 2, 273, 312.

28 *International Sanitary Regulations*, 25 May 1951, 175 UNTS 215, [ISR (1951)].

29 *International Health Regulations*, 25 July 1969, 764 UNTS 3, [IHR (1969)].

30 WHO, *International Health Regulations* (1969), 3rd. ed. (1983), 5.

31 WHO, *Additional Regulations of 23 May 1973 Amending the International Health Regulations (1969), in Particular with Respect to Articles 1, 21, 63-71 and 92*, Health Assembly Res. WHA26.55, 23 May 1973.

32 WHO, Health Assembly Doc. WHA34/1981/REC/I., 22 May 1981, 10; cf. WHO, *Official Records of the World Health Organization No. 217* (1974), 21, 71, 81.

33 WHO, Health Assembly, Res. WHA48.7, 12 May 1995, Preamble para. 5.

already in 1995 as well as the (re)emergence of old and new threats, States lacked political will to update the *IHR* (1969).[34] This changed after the outbreak of Severe Acute Respiratory Syndrome (SARS) in 2003, which affected more than 8,000 people and killed 774 persons in 27 countries.[35] This pandemic ultimately led to the new *International Health Regulations* (2005)[36], which entered into force in 2007.

3. Public Health Emergencies of International Concern

Purpose of the *IHR (2005)* is to "prevent, protect against, control and provide" a response to any "public health emergency of international concern" (Article 2 *IHR (2005)*). The *IHR (2005)* are guided by the thought to "avoid unnecessary interference with international traffic and trade" – States fear negative economic implications without any scientific justification for such measures.[37] In stark contrast to the *IHR (1969)*, there is no focus on specific diseases.[38] A *public health emergency of international concern* is to be understood as

> "an extraordinary event which is determined, as provided in these Regulations: (i) to constitute a public health risk to other States through the international spread of disease and (ii) to potentially require a coordinated international response" (Article 1 *IHR (2005)*).

A *public health risk* means

> "a likelihood of an event that may affect adversely the health of human populations, with an emphasis on one which may spread internationally or may present a serious and direct danger" (Article 1 *IHR (2005)*).

34 M. Frenzel, *Sekundärrechtsetzungsakte internationaler Organisationen: völkerrechtliche Konzeption und verfassungsrechtliche Voraussetzungen* (2011), 136; R. Katz & A. Muldoon, 'Negotiating the Revised International Health Regulations (IHR)', in E. Rosskam & I. Kickbusch (eds), *Negotiating and Navigating Global Health* (2012), 77, 80.

35 WHO, Summary of Probable SARS Cases With Onset of Illness from 1 November 2002 to 31 July 2003, 21 April 2004, available at http://www.who.int/entity/csr/sars/country/table2004_04_21/en/index.html (last visited 1 August 2016).

36 *International Health Regulations*, 23 May 2005, 2509 UNTS 79, [IHR (2005)].

37 B. Condon & T. Sinha, 'The Effectiveness of Pandemic Preparations: Legal Lessons from the 2009 Influenza Epidemic', 22 *Florida Journal of International Law* (2010) 1, 1, 2.

38 Gostin, *supra* note 24, 184.

The *IHR (2005)* focus on containing threats in their place of origin – in contrast to the *IHR (1969)* – which were focused on preventing the spread of the mentioned diseases across international borders through controlling ports and borders.

According to Articles 6, 7 *IHR (2005)*, States must notify the WHO of any unexpected or unusual event that may constitute a *public health emergency of international concern*. It is then up to the Director General of the WHO to determine whether or not such a *public health emergency of international concern* is occurring (Article 12 *IHR (2005)*). Subsequently, an elaborate mechanisms comes into play by which the WHO and State parties in the affected area attempt to counter the threat. It is important to note that an Emergency Committee may be established with regard to a specific *public health emergency of international concern* to propose measures to be taken which, in turn, may be endorsed by the Director General subsequently be issued as temporary recommendations (Article 15 *IHR (2005)*).

A case could be made for a binding character of temporary recommendations: The language of Article 15 *WHO-Constitution* sounds rather as if the recommendations under Article 15 *IHR (2005)* are binding. For one, Article 15 *IHR (2005)* is rather explicit about the procedure to adopt recommendations and their modification. Also, recommendations may be terminated and automatically expire after three months if there is no extension. Such sophisticated provisions are not necessary for mere suggestions. Finally, interpreting these provisions in light of object and purpose of the instrument,[39] a binding character would be beneficiary to combat a *public health emergency of international concern*.

Making this case, however, is futile. The most obvious reason is found in Article 1 *IHR (2005)* where temporary recommendations are defined as "non-binding advice". In support, *recommendations* are usually not binding under any circumstances. Being recommendations, the content of such regulations is rather vague and better compared to suggestions than to permissions or prohibitions. For example, recommendations under Article 40 *Charter of the United Nations* (UN-Charter) are very different from measures under Articles 41 and 42 *UN-Charter*. Those recommendations are "without prejudice to the rights, claims, or position of the parties concerned" and ultimately, the Security Council may "call upon the parties concerned to comply with such provisional measures"

[39] Even though the *IHR (2005)* are not an international treaty as defined in *Vienna Convention on the Law of Treaties*, 23 May 1969, Article 2 (1) (a), 1155 UNTS 331, 3, for the purpose of this article the rules on treaty interpretation are applied here.

(Article 40 *UN-Charter*). Also, recommendations under Article 36 (3) *UN-Charter* are non-binding by nature.[40] In contrast to the obligation to report on the implementation of *IHR (2005)* by State parties (Article 54 (2) *IHR (2005)*) or the obligation to report incidents that may constitute a *public health emergency of international concern* (Article 7 *IHR (2005)*), such clear language is missing in regard to recommendations. Also, the Director General has no legislative power under the *WHO-Constitution*.[41] Other recommendations, which are made by the Health Assembly under Article 23 *WHO-Constitution*, are not binding.[42] To ensure compliance with such recommendations, States are obliged to report on an annual basis to the WHO (Article 62 *WHO-Constitution*).

A closer look at the recent practice of the Director General supports this conclusion. For example, in the Ebola-outbreak she recommended, first, measures usually regulated by domestic law and not international law, for example that the heads of State should declare national emergencies; affected States should activate their national disaster/emergency management mechanisms; and, second, soft measures, for example that heads of State should personally address the nations to provide information on the situation or health ministers and other health leaders should assume a prominent leadership role in coordinating and implementing emergency Ebola response measures.[43]

Ultimately, recommendations issued by the Director General under the regime of *public health emergency of international concern* provided for in the *IHR (2005)* are not of a binding nature.[44] This does not lead to the conclusion that those recommendations are without effect. On the contrary, due to the authority of the WHO, its aggregated expertise and the risk faced by States

40 Cf. Separate Opinion by Judges J. Basdevant, M.Alvarez, B. Winiarski, M. Zoricic, C. De Visscher, A.H. Badawi K. Pasha, B. Krylov, *Corfu Channel (United Kingdom of Great Britain and Northern Ireland v. Albania)*, Preliminary Objection, ICJ Reports 1948, 31, 32.

41 R. Katz & J. Fischer, 'The Revised International Health Regulations: A Framework for Global Pandemic Response', 3 *Global Health Governance* (2010) 2, 1, 2 [Revised IHR].

42 M. Vierheilig, *Die Rechtliche Einordnung der von der Weltgesundheitsorganisation Beschlossenen Regulations* (1984), 38.

43 WHO, 'Statement on the 1st meeting of the IHR Emergency Committee on the 2014 Ebola outbreak in West Africa', 8 August 2014, available at http://www.who.int/mediacentre/news/statements/2014/ebola-20140808/en/. [Statement on the 1st meeting] (last visited 1 August 2016). The content of the recommendation may be due to the fact that among the Emergency Committee members, none has a legal background.

44 Cf., Vierheilig, *supra* note 42, 34.

for defiance ensure compliance with emergency recommendations[45] – or at least *should* ensure compliance. In this sense, the WHO is supposed to work through its expertise. Hence, the mechanism regarding *public health emergencies of international concern* is an essential tool to address global threats that utilizes international law without creating new obligations on the actors involved.

A further possibility is to bring temporary recommendations to take full effect, which may be done by utilizing Article 43 *IHR (2005)*. This provision stipulates a very sophisticated process for additional health measures by States. In general, State parties are not precluded from implementing additional health measures (Article 43 (1) *IHR (2005)*). However, the *IHR (2005)* are clear (and repetitive) on one thing: those additional measures may not be more restrictive on international traffic and not more intrusive on persons than reasonably available alternatives, which achieve the appropriate level of health protection. If a State wants to adopt additional measures, it shall provide the WHO with information. The WHO, in turn, assesses these measures and may request the State to reconsider its plans (Article 43 (4) *IHR (2005)*). In other words, additional measures must be justified by a State party. If a State plans to adopt measures contrary to temporary recommendations already in place, those measures would contravene the condition set at the end of Article 43 (1). If the WHO, for example, recommends to not restrict trade and travel, restrictions by States are more restrictive on international traffic and are more intrusive on persons. Thus, they fail to meet the threshold. Nevertheless, under international law, those national measures remain in force – the *IHR (2005)* cannot void any national measure. Still, the State is under the treaty obligation to report such measures (Article 43 (3), (5), (6) *IHR (2005)*). Thus, this requirement may nudge the State to adhere to the temporary recommendation and at least nudge them to refrain from contravening the provisions. To be perfectly clear: This is in no way a legal enforcement mechanism should work – although it may work for policy reasons.

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

45 G. Burci & J. Quirin, 'Ebola, WHO, and the United Nations: Convergence of Global Public Health and International Peace and Security', 18 *American Society of International Law Insights* (2014) 25, available at http://www.asil.org/insights/volume/18/issue/25/ebola-who-and-united-nations-convergence-global-public-health-and (last visited 4 October 2016).

III. The Human Right Dimension

1. The Human Right

Next to the aim of *health* in international law and the institutional aspects, there is a human rights dimension to *health*. After all, being healthy does not solely or primarily depend on State's behaviour, but on one's physical and mental preconditions.[46] When drafting the human right to health, States were aware of the broad definition of *health* as well as the impossibility to safeguard a perfect health for everyone.[47] Despite the scope of the human right being limited, its importance can hardly be overstated. As the General Comment on Article 12 *ICESCR* states, "health is a fundamental human right indispensable for the exercise of other human rights."[48]

To reconcile the above mentioned practical difficulties, the *International Covenant on Economic, Social and Cultural Rights* (ICESCR)[49] stipulates a somewhat lesser goal when it guarantees a human right to the "enjoyment of the highest attainable standard of physical and mental health" (Article 12 (1) *ICESCR*). In the same vein, the *WHO-Constitution* specifies that the "enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being." Other human rights instruments include the same content for the human right to health. Notwithstanding these provisions as well as the right to health being included in several other human rights instruments, including the non-binding *UN Declaration of Human Rights*[50] and binding regional instruments,[51] in this case particularly the *African Charter on Human and Peoples' Rights*[52] (or *Banjul-Charter*), as well as instruments focusing on

46 Wolff, *supra* note 14, 27.

47 Gostin, *supra* note 24, 251.

48 Human Rights Committee, *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Article 12)*, UN Doc. E/C.12/2000/4, 11 August 2000, 1, para. 1 [Right to Highest Standard].

49 *International Covenant on Economic, Social and Cultural Rights*, 993 UNTS 3, 16 December 1966 [ICESCR].

50 *Universal Declaration of Human Rights*, GA Res, 217 A (III), Article 25 (1), 10 December 1948.

51 *Charter of Fundamental Rights of the European Union*, 50 Official Journal of the European Union C 303, Article 35, 14 December 2007, 389; *Arab Charter on Human Rights*, translated English version for example in 24 *Boston University International Law Journal* (2006) 2, 147, Article 39, 23 May 2004.

52 *African Charter on Human and Peoples' Rights*, 1520 UNTS 217, Article 16, 27 June 1981.

specific groups or topics,[53] the meaning of the right to health remains difficult to establish.[54]

Article 12 (2) *ICESCR* insinuates several steps that State parties shall take to achieve the full realization of the right enshrined in Article 12 (1). Among those steps are the "prevention, treatment and control of epidemic, endemic, occupational and other diseases" and the "creation of conditions which would assure to all medical service and medical attention in the event of sickness." However, under Article 2 (1) *ICESCR* it has to be taken into account that a State is obliged to undertake steps to "progressively [achieve] the full realization of the rights recognized" by the *ICESCR*. Hence, Article 12 (2) *ICESCR* complements[55] the individual human right to health with obligations of State parties.[56]

The Committee's General Comment No. 14 separates the freedoms to control one's health and body and to be free from interference by non-consensual treatment from the entitlements such as the right to a health care system, which provides the opportunity to enjoy the highest attainable standard of health.[57]

A major factor in the highest attainable standard of health is the State's available resources.[58] Here, major elements to be taken into consideration are availability, accessibility, and acceptability of quality of a health care system.[59] In this sense, Article 2 (1) *ICESCR* limits the human right to health to a relatively weak and abstract obligation of progressive realization.[60] States may thus differ in their approach to the full realization due to specific domestic factors.[61]

To shape the substantial obligations, some specific areas of concern have been identified. Among those are women's and mothers health, children and

53 *Convention on the Elimination of All Forms of Racial Discrimination*, Article 5 (e) (iv), 660 UNTS 195, 21 December 1965; *Convention on the Elimination of All Forms of Discrimination against Women*, 1249 UNTS 13, Article 12, 18 December 1979; *Convention on the Rights of the Child*, 1577 UNTS 3, Article 24, 20 November 1989; *Convention on the Rights of Persons with Disabilities*, 2515 UNTS 3, Article 25, 30 March 2006; *United Nations Principles of Older Persons*, GA Res. 46/91, 16 December 1991, Principle 1. A comprehensive overview over the different applicable treaties and provisions is available at http://www.ohchr.org/EN/Issues/Health/Pages/InternationalStandards.aspx (last visited 1 August 2016).

54 Katz & Fischer, 'Revised IHR', *supra* note 41, 13; Ruger, *supra* note 25, 273.

55 Meier & Mori, *supra* note 7, 113.

56 Cf. J. Tobin, *The Right to Health in International Law* (2012), 75, 225 *et seq*.

57 *Right to Highest Standard*, *supra* note 48, para. 8.

58 *Ibid*., para. 9.

59 *Ibid*., para. 12.

60 Criticial Meier & Mori, *supra* note 7, 115.

61 *Ibid*.

adolescents, older persons, persons living with disabilities, workers, migrants, and indigenous people. Mainly, binding treaties as well as non-binding guidelines exist to improve the health situation of these groups. Missing are substantial obligations regarding emergency situations. As will be seen later on, the Ebola-outbreak of 2014 had hardly an impact on the development of such substantial obligations.

Some of the rights enshrined in the *ICCPR* cover health aspects as well.[62] The health aspects of Article 6 (right to life), Article 7 (prohibition of torture), and Article 9 (liberty and security) are evident, even though they are focused on other aspect and are not framed as to include a right to being healthy. The European Court of Human Rights shares this view.[63]

2. No Derogation in Times of Emergency

In contrast to the *ICCPR*, the *ICESCR* does not contain a provision comparable to Article 4 *ICCPR*, allowing State parties to derogate from their treaty obligations in *time of public emergency* and under further preconditions. Nonetheless, it does not mean that the rights of the *ICESCR* are granted unlimited. Article 4 *ICESCR* allows for limitations to the rights enshrined in the covenant by law if this is compatible with nature of these rights and solely for the purpose of promoting the general welfare in a democratic society. This provision, however, applies at all times and not solely in times of emergency. In the end, the *ICESCR* is equally applicable in calmer times as well as in times of emergency. *Mutatis mutandis*, the finding by the Human Rights Committee that the *ICCPR* is "generally sufficient during such situations and no derogation from the provisions in question would be justified by the exigencies of the situation"[64] holds true to the *ICESCR* as well.[65] In addition, State parties are obliged to progressively realize the rights under the Covenant (Article 2 (1) *ICESCR*). As stated previously, in this sense Article 2 (1) *ICESCR limits* the human right to health.

If the *ICESCR* contained a provision like Article 4 *ICCPR* and provided a derogation clause, the Ebola-outbreak might have constituted such a situation, especially given the fact that the WHO declared a *public health emergency of*

62 Gostin, *supra* note 24, 252 *et seq*.

63 *Pentiacova v. Moldova*, ECtHR Application No. 14462/03, Judgment of 4 January 2005.

64 Human Rights Committee, *General Comment No. 29: States of Emergency (Article 4)*, UN Doc. CCPR/C/21/Rev.1/Add.11, 31 August 2001, para. 5.

65 B. Saul, D. Kinley & J. Mowbray, *The International Covenant on Economic, Social and Cultural Rights: Commentary, Cases, and Materials* (2014), 979.

international concern. This scenario, however, does not fit under *lex lata*. Given the fact that no such provision exists, the outbreak did not shape international human rights law with regard to a derogation-clause or to emergency provisions. Moreover, in times of health emergencies, a derogation from Article 12 *ICESCR* would not make any sense. In times like these, it is the primary goal to uphold the highest attainable standard of health and defeat the disease.[66]

3. Possible Limitation in Times of Emergency

Nevertheless, in the case at hand there have been instances where a restriction of the rights under the *ICESCR* made sense. Such a restriction is possible under Article 4 *ICESCR* if such a limitation is provided by law and only in so far as a limitation may be compatible with the nature of these rights and solely for the purpose of promoting the general welfare in a democratic society.

In the case of Sierra Leone, for example, the State closed down hospitals.[67] This was not only due to the fact that not adequate staff was present to help – sometimes because they were sick themselves. In some cases, hospitals contributed to spread the disease.[68] In fact, some of the Ebola cases that have occurred in countries far away from West Africa were helpers from abroad who returned home sick.[69] In such a situation in would be counterproductive to oblige a State party to keep hospitals open. Such an obligation may lead to a further spread of the disease and ultimately to self-defeat.

In this sense, the Ebola-outbreak refined Article 4 *ICESCR* as it illustrated that pursuing a short-term goal such as keeping hospitals open may have in turn (and after just a few days) a devastating effect on the rights enshrined in the Covenant.

66 Cf. *ibid*.

67 D. Koroma, 'Government Hospitals Close Down – Executive Director Health Alert', *Awareness Time* (27 August 2014), available at http://news.sl/drwebsite/publish/article_200526067.shtml (last visited 4 October 2016).

68 M. Fox, 'Are Hospitals Part of the Ebola Problem? Charity Wants New Strategy', *National Broadcasting Company News* (15 September 2014), available at http://www.nbcnews.com/storyline/ebola-virus-outbreak/are-hospitals-part-ebola-problem-charity-wants-new-strategy-n202486 (last visited 1. August 2016).

69 Cf. Saul, Kinley & Mowbray, *supra* note 65.

IV. The Obligations of States

1. Obligations to Respect, Protect and Fulfil

State parties to the *ICESCR* are under an obligation to ensure the human right to the highest attainable standard of health. The General Comment No.14 has interpreted Article 12 *ICESCR* to include obligations to respect, protect and fulfil.[70] In particular, a State is under the obligation to refrain from interfering directly or indirectly with this right, to protect individuals from interference by other actors and to adopt appropriate measures towards the full realization of the human right to health.[71] Of outmost importance is international assistance and cooperation, as already laid out in Article 2 (1) *ICESCR* and Article 2 (a) *WHO-Constitution* as well as section IX of the *Alma Ata Declaration on Primary Health Care*, which was adopted at the International Conference on Primary Health Care in 1978,[72] expressing the need for urgent action to protect and promote the health of all people.

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

2. States' Obligations *Ratione Loci*

The *ICESCR* does not provide an explicit threshold of application, unlike the *ICCPR*, where Article 2 (1) *ICCPR* obliges State parties to undertake to "respect and to ensure to all individuals within its territory and subject to its jurisdiction the rights recognized in the present Covenant." A comparable provision is found in Article 2 (1) *ICESCR* where States agree to undertake

> "steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of [their] available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant

70 *Right to Highest Standard*, *supra* note 48, para. 33.
71 *Ibid*.
72 Cf. Gostin, *supra* note 24, 97 *et seq*.
73 *Right to Highest Standard*, *supra* note 48, para. 40.

> by all appropriate means, including particularly the adoption of legislative measures."

Any reference to the applicability *ratione loci* is missing.

One can make the case and argue for applicability only in a State party's territory. After all, it is difficult enough to provide health care within a State alone. If the *right to health* is correctly the somehow weaker human right to the enjoyment of the highest attainable standard of physical and mental health (Article 12 (1) *ICESCR*), it could follow that it has no international dimension. Moreover, if a State cannot provide perfect health to everyone on its territory (due to individual preconditions), how can a State than achieve this goal abroad? Providing health care is a domestic matter and States are under no obligation to provide healthcare abroad.

This view has its merits. However, interpreting the human right to the mere supply of hospitals, doctors, medicine and the like falls short of treat law. After all, Article 2 (1) *ICESCR* includes an undertaking of international assistance and cooperation. International assistance and cooperation has naturally an international dimension. By being under the treaty obligation to render assistance, States may not hamper efforts by other States to achieve health.

In addition, the human rights approach may counter a problem that became evident yet again in the Ebola-case 2014: States ignore the temporary recommendations issued by the WHO's Director General. If one takes into account, first, that travel and trade restrictions are detrimental to the fight against Ebola, second that the Director General recommended repeatedly to lift travel and trade restrictions, and third, that such measures are taken by a State on its territory, Article 12 (1), (2) *ICESCR* is affected by such measures. In short, the obligation to progressively realize the rights enshrined in the *ICESCR* in cooperation with other States as well as the obligation to assist other States in their endeavour to provide the human right to health is violated by restrictions taken despite a temporary recommendation to the opposite.[74] Even if States

[74] An international dimension of Article 12 (2) ICESCR is also identified by *Right to Highest Standard*, *supra* note 48, para. 38 *et seq*.; cf. Human Rights Committee, *General Comment No. 3: The Nature of States Parties' Obligations (Article 2 para. 1)*, UN Doc. E/1991/23, 14 December 1990, para. 13. Critical to the General Comment Saul, Kinley & Mowbray, *supra* note 65, 139 *et seq*. Others identify this international dimension also, cf. Wolff, *supra* note 14, 32; Tobin, *supra* note 56, 325 *et seq*.

are not under an obligation to render assistance without being asked for it,[75] impeding assistance is not in the ambit of the *ICESCR*.[76]

To summarize, the obligation to render assistance to other States amounts an obligation not to interfere with measures taken by other States or the international community.

V. The Legal Framework of International Health

In brief, the international law framework for public health is characterized by a broad understanding of the term *health*. Its core meaning covers the absence of disease or infirmity and a broader understanding may entail a State of complete physical, mental, and social wellbeing.

International organizations take the broader approach, with the WHO leading the way. This organization's *IHR (2005)* provide a framework to address *public health emergencies of international concern* on a global scale, however, not granting the WHO any legal powers. There is a practical need to cooperate internationally and to assist weaker States. However, international law does not provide for specific forms of cooperation in regard to international health. Thus, cooperation is regulated by general international law.

In addition to institutionalized efforts, States are under an obligation to achieve the highest attainable level of health. This corresponds to the human right to health, benefiting individuals.

Largely, international law relies on States and their domestic law to counter health issues and emergencies. It further attempts to regulate international health by way of recommendations by the WHO and this forum to cooperate. The human right to health obliges States to take steps in order to bring this right to life.

C. The Measures Taken by the International Community During the Ebola-Outbreak 2014

I. The Ebola-Outbreak 2014

The aforementioned framework was challenged during the Ebola-outbreak 2014 in West Africa. In December 2013 first cases were reported in Guinea

75 Saul, Kinley & Mowbray, *supra* note 65, 139.

76 Cf. Tobin, *supra* note 56, 331 *et seq*. Cf. also *Right to Highest Standard*, *supra* note 46, paras 39, 41.

before the WHO was officially notified on 23 March 2014.[77] Still in March 2014, Ebola spread to Liberia[78] and in May to Sierra Leone.[79] In the following months, Ebola spread to the West African States of Mali and Senegal as well as to Nigeria and as far as USA and Spain. By mid-September, nearly 5,000 cases were reported and more than 2,500 people had died.[80] Two months later, on 14 November, the numbers mounted to over 14,000 cases and more than 5,100 deaths.[81] Just one week later, there were 1,000 more cases and nearly 300 more people had died.[82] By mid-August 2015, nearly 28,000 people have been infected and 11,299 persons lost their lives.[83] Seven months later, at the end of the outbreak, 11,323 people died and 28,646 cases were counted.[84]

II. The IHR Emergency Committee Regarding Ebola

1. The IHR Emergency Committee's Recommendations

In the beginning of August 2014, when 1,711 cases including 932 deaths had been reported[85] the WHO's Director General declared the situation a *public*

77 WHO, 'Ebola virus disease in Guinea', 23 March 2014, available at http://www.afro.who.int/en/clusters-a-programmes/dpc/epidemic-a-pandemic-alert-and-response/outbreak-news/4063-ebola-virus-disease-in-guinea.html (last visited 4 October 2016); Fox, *supra* note 68.

78 WHO, 'Ebola virus disease, Liberia (Situation as of 30 March 2014)', 30 March 2014, available at http://www.afro.who.int/en/clusters-a-programmes/dpc/epidemic-a-pandemic-alert-and-response/outbreak-news/4072-ebola-virus-disease-liberia.html (last visited 1 August 2016).

79 WHO, 'Ebola virus disease, West Africa (Update of 26 May 2014)', 26 May 2014, available at http://www.afro.who.int/en/clusters-a-programmes/dpc/epidemic-a-pandemic-alert-and-response/outbreak-news/4143-ebola-virus-disease-west-africa-26-may-2014.html (last visited 1 August 2016).

80 The Secretary-General, *Identical Letters Dated 17 September 2014 from the Secretary-General Addressed to the President of the General Assembly and the President of the Security Council*, UN Docs A/69/389-S/214/679, 18 September 2014 [Identical Letters].

81 WHO, 'Ebola Response Roadmap–Situation Report Update', 14 November 2014, available at http://apps.who.int/iris/bitstream/10665/143216/1/roadmapsitrep_14Nov2014_eng.pdf?ua=1 (last visited 1 August 2016).

82 WHO, 'Ebola Response Roadmap–Situation Report Update', 21 November 2014, available at http://apps.who.int/iris/bitstream/10665/144117/1/roadmapsitrep_21Nov2014_eng.pdf?ua=1 (last visited 1 August 2016).

83 Cf. Yan & Smith, *supra* note 4; *High-level Panel*, *supra* note 1, 21, para 9.

84 Data up to 27 March 2016 taken from the WHO's website, available at http://apps.who.int/ebola/ebola-situation-reports (last visited 4 October 2016).

85 [Statement on the 1st meeting], *supra* note 43.

health emergency of international concern according to Articles 12(4)(c), 48(1)(a), 49(5) *IHR (2005)*.[86] This came after the advice of the IHR Emergency Committee regarding Ebola that the situation constituted an extraordinary event, given the fact that this outbreak constitutes the largest Ebola-outbreak ever recorded. In its assessment, the Emergency Committee regarding Ebola identified major challenges for the affected countries: As their health systems were fragile and inexperienced in dealing with Ebola outbreaks, and given a high mobility of populations as well as the speed at which the disease was spreading, the fight against the outbreak required a joint effort. Among the measures that could be taken the Emergency Committee recommended to States with Ebola transmission that their competent national authorities declare a national emergency and ensure that all necessary measures to stop the outbreak may be taken; the activation of national disaster/emergency management mechanisms; health ministers and other leaders to assume leadership roles in coordination and implementing response measures; provide sufficient medical commodities; conduct exit screenings and prohibit travel by persons confirmed to suffer from Ebola; monitor probable and suspected cases closely; and that funerals and burials are conducted by trained personnel. To States with a potential or confirmed case and to States with land borders with affected States, the Emergency Committee regarding Ebola recommended to closely monitor clusters of unexplained fever of deaths and treating any suspected or confirmed case as an emergency. There is no recommendation, even for non-affected States with land borders to affected States, to close their borders to those affected States. In the same vein, all States should not ban travel or trade from and to affected States, but be prepared to detect, investigate and manage Ebola cases. In addition, all States, affected or not, should provide the public with accurate and relevant information on the outbreak and the transmission of as well as measures against Ebola.[87] The Director General followed the Emergency Committee's findings and issued these recommendations as temporary recommendations under Article 15 *IHR (2005)*.

In its second meeting in September 2014, the Emergency Committee regarding Ebola regretted flight cancelations and other travel restrictions to and from affected countries, which result in detrimental economic consequences, hinder relief and support and ultimately result in an increased risk of international spread of Ebola. In addition, health-care workers should be provided with adequate means to counter Ebola as well as to protect themselves from the

86 *Ibid*.
87 *Ibid*.

disease. As consequence of the Emergency Committee's findings, the Director General extended the temporary recommendations already in place.[88]

Owing to the increase in cases, the Emergency Committee regarding Ebola met in advance of the expiration date of the temporary recommendations. In its third meeting, the Emergency Committee regarding Ebola identified as lessons learned the importance of leadership, community engagement, bringing in more partners, paying staff on time and accountability. Primary emphasis must continue to be the stop of the disease in the three most affected countries Liberia, Sierra Leone and Guinea. Here, the Emergency Committee regarding Ebola recommended exit screenings. Nevertheless, the Emergency Committee regarding Ebola reiterated that there should not be a general ban on travel or trade, which is likely to cause hardship, increase uncontrolled migration and isolate or stigmatize affected countries and their populations. Entry screenings, however, were viewed critically by the Emergency Committee regarding Ebola. With regard to international meetings and mass gatherings, a risk-based approach on a case-by-case basis should be followed. Again, the Director General extended the temporary recommendations already in place.[89]

In contrast to the situation in October the number of cases decreased at the time of the Emergency Committee's fourth meeting in January 2015. Nonetheless, the Emergency Committee regarding Ebola still determined the situation to be a *public health emergency of international concern*. It was concerned with the fact that more than 40 States established travel restrictions that went beyond what the WHO had recommended earlier. In substance, the earlier recommendations were repeated. For the first time countries sharing borders with Guinea, Liberia and Sierra Leone were advised to conduct border surveillance as well as to cooperate internationally. Other States were reminded of Article 2 *IHR (2005)*, which emphasizes the need to avoid unnecessary interference with international travel and trade. The travel restrictions put in place by States were harmful to local populations, increase stigma and isolation, disrupt livelihoods

88 WHO, 'Statement on the 2nd meeting of the IHR Emergency Committee on the 2014 Ebola outbreak in West Africa', 22 September 2014, available at http://www.who.int/mediacentre/news/statements/2014/ebola-2nd-ihr-meeting/en/ (last visited 1 August 2016).

89 WHO, 'Statement on the 3rd meeting of the IHR Emergency Committee on the 2014 Ebola outbreak in West Africa', 23 October 2014, available at http://www.who.int/mediacentre/news/statements/2014/ebola-3rd-ihr-meeting/en/ (last visited 1 August 2016).

and economies as well as impede recruitment of health-care workers. Again, the Director General extended the temporary recommendations already in place.[90]

When the fifth meeting of the Emergency Committee took place in April 2015, the situation improved further. Fewer cases were reported and the overall risk of spread appeared to had been further reduced, especially in the three most affected countries.[91] Still, the Emergency Committee regarding Ebola felt compelled to warn against complacency. It remained essential to reach a *global zero* with not a single new case worldwide for a time span of 42 days. In this line of reasoning, the Emergency Committee maintained that the Ebola-outbreak constituted a *public health emergency of international concern* and recommended that all temporary recommendations should be extended. In addition, the Emergency Committee repeated its call to conduct exit screenings in the three most affected countries, reinforce border surveillance and avoid unnecessary interference with international travel and transport. As before, the Director General extended the temporary recommendations already in place.

The Emergency Committee regarding Ebola maintained at its sixth meeting in July 2015 that the outbreak still constituted a *public health emergency of international concern* even though case numbers were still in decline.[92] However, the fight entered phase 3, which is focused on understanding every chain of transmission in order to counter Ebola more effectively. Next to the repeated calls for common border management and continuation of travel and transport to and from the region, the committee raised several new issues. It demanded better interagency collaboration, deplored a lack of understanding due to language problems, and, most importantly, singled out Guinea-Bissau, a country that was not affected by the Ebola-outbreak. Due to violent protests in this nation, allegedly targeting Ebola-preparedness efforts,[93] the Emergency Committee feared that Ebola would spread to Guinea-Bissau. Again, the

90 WHO, 'Statement on the 4th meeting of the IHR Emergency Committee on the 2014 Ebola outbreak in West Africa', 21 January 2015, available at http://www.who.int/mediacentre/news/statements/2015/ebola-4th-ihr-meeting/en/ (last visited 1 August 2016).

91 WHO, 'Statement on the 5th meeting of the IHR Emergency Committee on the 2014 Ebola outbreak in West Africa', 10 April 2015, available at http://www.who.int/mediacentre/news/statements/2015/ihr-ec-ebola/en/ (last visited 1 August 2016).

92 WHO, 'Statement on the 6th meeting of the IHR Emergency Committee on the 2014 Ebola outbreak in West Africa', 7 July 2015, available at http://www.who.int/mediacentre/news/statements/2015/ihr-ebola-7-july-2015/en/ (last visited 1 August 2016).

93 M. Brice, 'Ebola threat to Guinea Bissau rises as border zone heats up', *Reuters* (1 June 2015), available at http://www.reuters.com/article/2015/06/01/us-health-ebola-guinea-idUSKBN0OH3LE20150601 (last visited 1 August 2016).

Director General restated the determination of the outbreak as *public health emergency of international concern* as well as the existing and newly proposed recommendations.

After the outbreak settled down, the Emergency Committee regarding Ebola met again in October 2015. Numbers in the three most affected countries had declined significantly, with no new case of Ebola in Liberia since 3 September 2015, but still within the 42-days time frame before the country could be declared Ebola-free.[94] Despite the progress, several States had travel restrictions to the region. The Emergency Committee regarding Ebola upheld its recommendation that the situation constituted a *public health emergency of international concern* and its prior measures. For the first time, the Emergency Committee explicitly stated the individuals infected with Ebola should not travel. The Director General affirmed the Committee's recommendations and stated that the 7th recommendations were to supersede any prior temporary recommendation.

At the end of 2015 more progress was made in interrupting the original Ebola-chains transmission. Under these circumstances, the 8th meeting of the Emergency Committee regarding Ebola took place.[95] However, newer chains of the virus were still occurring. Even though these outbreaks could have been controlled rather rapidly, the situation still constituted extraordinary events requiring cooperation by all States with the affected countries. The Committee remained deeply concerned about continuing travel and transport restrictions by several States. As it had recommended earlier, the Committee asked the heads of States to continue to address their nations. Additionally, States should take precautionary measures such as exit screenings. Trade and travel restrictions are counterproductive and should be abolished. Given the success in containing the virus the Committee seemed uncertain as to whether or not the situation remained a *public health emergency of international concern*. Between the lines it becomes obvious that it would have preferred to declare an "'intermediate' level of alert".[96] Within the WHO, a review process is taking place and is looking at

94 WHO, 'Statement on the 7th meeting of the IHR Emergency Committee on the 2014 Ebola outbreak in West Africa', 5 October 2015, available at http://www.who.int/mediacentre/news/statements/2015/ihr-ebola-7th-meeting/en/ (last visited 1 August 2016).

95 WHO, 'Statement on the 8th meeting of the IHR Emergency Committee on the 2014 Ebola outbreak in West Africa', 18 December 2015, available at http://www.who.int/mediacentre/news/statements/2015/ihr-ebola-8th-meeting/en/ (last visited 1 August 2016).

96 *Ibid*.

potential changes. Still, the Director General declared a *public health emergency of international concern* and affirmed the Committee's recommendations.

Finally, the 9th meeting of the Emergency Committee regarding Ebola in March 2016 advised the Director General to declare the *public health emergency of international concern* to be over and to terminate the temporary recommendations.[97] This was due to the fact that the original chains of the virus had been interrupted successfully. While newer chains still erupted, the countries affected were able to confine and counter these outbreaks quickly. The Committee called upon the international community to continue to support outbreak response activities in countries in need of such support. The Director General determined that the *public health emergency of international concern* was indeed over and she consequently terminated the temporary recommendations.[98]

To repeat, while the recommendations by the Emergency Committee regarding Ebola and the Director General cover a vast array of aspects, the measures adopted nevertheless remain recommendations to States, without any legal effect.

2. Evaluation of the WHO's Response

The WHO itself initiated a review process over its response. In a first step, it established the Ebola Interim Assessment Panel. It was tasked to assess the roles and responsibilities of the WHO during the Ebola crisis. After a preliminary report published in May 2015,[99] the final report was issued in July 2015.[100] In a second step, a Review Committee on the Role of the *IHR (2005)* in the Ebola Outbreak and Response was set up, that delivered its report in May 2016.[101]

97 WHO, 'Statement on the 9th meeting of the IHR Emergency Committee on the 2014 Ebola outbreak in West Africa', 29 March 2016, available at http://www.who.int/mediacentre/news/statements/2016/end-of-ebola-pheic/en/ (last visited 1 August 2016).

98 WHO, 'WHO Director-General briefs media on outcome of Ebola Emergency Committee', 29 March 2016, available at http://www.who.int/mediacentre/news/statements/2016/ihr-emergency-committee-ebola/en/ (last visited 1 August 2016).

99 WHO, Report by the Secretariat, *Ebola Interim Assessment Panel*, A68/25, 8 May 2015.

100 WHO, Report of the Ebola Interim Assessment Panel, 7 July 2015, available at http://www.who.int/csr/resources/publications/ebola/report-by-panel.pdf?ua=1 (last visited 1 August 2016) [July 2015 Report].

101 WHO, Report of the Review Committee on the Role of the IHR (2005) in the Ebola Outbreak and Response, *Implementation of the International Health Regulations (2005)*, A69/21, 13 May 2016 [Review Committee on the Role of the IHR. Ebola Outbreak and Response].

At the outset, the Ebola Interim Assessment Panel was of the opinion that significant changes throughout the WHO were needed to re-establish the WHO's authority:[102] The panel found that the WHO lacked both the capacity as well as the "organizational culture to deliver a full emergency public health response."[103] This went so far as to discuss a proposal to either establish a new health emergency organization or confer the lead in such cases to another UN agency.[104] As both would certainly have meant the end of the WHO as such, the panel urged the WHO to invest in its emergency operational capacity. In doing so, improvements were needed in governance, and leadership, financing, organizational culture, and procedures, as well as the work force, and regional, and international collaboration. In addition, research and development should be focused. The panel recalled that member States of the WHO were responsible for raising the funds of the WHO. Without increased funding, all attempts of reform and improvement would be futile.[105]

The Ebola Interim Assessment Panel also found shortcomings within the *IHR (2005)*, which were deemed not strong enough by the panel. First, the declaration of a *public health emergency of international concern* was in this case not satisfactory. The panel highlighted that to declare a situation a *public health emergency of international concern*, the Director-General and her staff need to be independent and courageous.[106] However, this was absent during the first months of the crisis.[107]

Second, neither the Director-General nor the member States took the *IHR (2005)* seriously enough.[108] For example, member States have failed to fulfil their obligations under the *IHR (2005)* to develop a preparedness strategy that could be independently evaluated.[109] As under the current *IHR (2005)*, States will be penalized by other countries if they report outbreaks quickly and transparently. Even though the *IHR (2005)* oblige States to act responsibly in case of an outbreak, the closing of borders and travel and trade restrictions

102 July 2015 Report, *supra* note 100, 5 in this vein also eq.
103 *Ibid*., para. 26.
104 *Ibid*., para. 27.
105 WHO Ebola Response Team, 'Ebola Virus Disease in West Africa – The First 9 Months of the Epidemic and Forward Projections', 371 *New England Journal of Medicine* (2014) 22, 1481, 1482.
106 July 2015 Report, *supra* note 100, para. 8.
107 Cf., *ibid*., para. 20 *et seq*.
108 *Ibid*., para. 10.
109 *Ibid*., para. 11 *et seq*.

hurt the countries affected by the crisis without benefiting anyone.[110] Here, the weakness of the *IHR (2005)* became very visible: Without any means to enforce its recommendations, States will most likely continue to defy temporary measures in situations of a *public health emergency of international concern*.[111] The panel proposed possible sanctions "for inappropriate and unjustified actions."[112] It also introduced the idea of calling on the Security Council in such cases.[113]

To summarize, the panel found shortcomings in leadership, organization, and the behaviour of member States. The *IHR (2005)* are, in the view of the panel, to soft and without an enforcement mechanism.

The Secretariat did not let this severe condemnation stand and responded with an official paper.[114] With regard to the *IHR (2005)* the secretariat announced a review process, albeit without going into detail on what changes could be imagined. It envisaged, however, an intermediate stage before declaring a *public health emergency of international concern*.[115] With regard to possible disincentives or even sanctions for ignoring either the *IHR (2005)* or the temporary recommendations, the secretariat kept rather quiet. It referred to the review process of the *IHR (2005)*, which may focus on these issues.[116] Still, it is unfortunate that the secretariat did not take a stand on such a crucial issue. For example, it could have envisaged a role of the Security Council, as recommended by the Ebola Interim Assessment Panel and the African Union (AU).[117] In essence, it promised to work more efficiently and signalized institutional reforms to be prepared by several advisory bodies.

The Ebola Interim Assessment Panel has raised several important factors. From a legal perspective, the effectiveness of both the *IHR (2005)* and the temporary recommendations issued in a concrete *public health emergency of international concern* needs to be increased. This could was made possible first trough making the recommendations legally binding and second by introducing sanction-mechanisms. Given that there is no such mechanism currently in

110 *Ibid*., para. 16.

111 Gostin & Friedman, 'Retrospective and Prospective Analysis', *supra* note 6, 1904.

112 July 2015 Report, *supra* note 100, para. 19.

113 *Ibid*.

114 WHO, *Secretariat response to the Report of the Ebola Interim Assessment Panel*, August 2015, available at http://www.who.int/csr/resources/publications/ebola/who-response-to-ebola-report.pdf (last visited 1 August 2016).

115 *Ibid*., para. 10.

116 *Ibid*., para. 8.

117 WHO, *July 2015 Report*, *supra* note 100, para. 19; Statement of the representative of the AU, *7502nd meeting*, *supra* note 11, 8.

place, even a soft one would be an improvement. Here, the Security Council could play a pivotal role. However, given that already the recommendations of 2011 to adapt the *IHR (2005)* in response to the swine flu pandemic of 2009 were ignored by the WHO and it's member States, it is not very likely that those regulations will be updated soon.

In a second step and in line with the Ebola Interim Assessment Panel's recommendation, the WHO started reviewing its *IHR (2005)*. It had established a Review Committee on the Role of the *IHR (2005)* in the Ebola Outbreak and Response, which met in August 2015 for the first time. In its report[118] the Review Committee set the agenda for their next meetings and identified areas of main concern. Basically, they are the same as already acknowledged by the Ebola Interim Assessment Panel and the WHO Secretariat.

In its final report issued in May 2016, the Review Committee on the Role of the *IHR (2005)* in the Ebola Outbreak and Response identified similar problems as the Ebola Interim Assessment Panel. Starting with a lack of knowledge or understanding of the *IHR (2005)*, the Review Committee acknowledged a need for further implementation and not amendment of the regulations.[119] It recommended to "incentivize compliance"[120] by supporting countries more, which adhere to the *IHR (2005)*. Namely, funding could be prioritized to support activities in compliant countries. In addition, secrecy hampers overall compliance, in the view of the committee. Thus, it advised to increase transparency and publicity about compliance with *IHR (2005)* and temporary recommendations issued during a *public health emergency of international concern*.[121]

III. The United Nations Mission for Ebola Emergency Response (UNMEER)

The reaction by the United Nations was rather innovative. The Secretary General as well as the Security Council took unprecedented steps to counter the threat posed by Ebola.

118 WHO, *Report of the First Meeting of the Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response*, 25 August 2015, available at http://www.who.int/ihr/review-committee-2016/IHRReviewCommittee_FirstMeetingReport.pdf (last visited 1 August 2016).

119 WHO, *Review Committee on the Role of the IHR. Ebola Outbreak and Response*, *supra* note 101, paras 4 *et seq*., 154 *et seq*.

120 *Ibid*., para. 78.

121 *Ibid*., 66.

The Secretary General reacted to a letter by the Presidents of the three most affected countries.[122] In this letter, the three heads of State painted an alarming picture of the situation in the region. While the countries enjoy a phase of "relative peace, security and stability",[123] the Ebola-outbreak "has dealt a devastating blow" to their respective efforts to stabilize their countries.[124] In line with the recommendations by the Emergency Committee regarding Ebola, the Presidents stressed that their countries face "virtual economic sanctions and trade embargoes" aggravating the effects of the outbreak and leaving their countries feeling "ostracized, sanctioned and abandoned."[125] They asked the international community for help and suggested a coordinated international response to end the outbreak with the WHO providing strategic guidance, a coordinated international response to support the affected societies and economies by maintaining trade and transportation links, and an international education campaign.

In response to this letter, the Secretary General wrote a letter to the Presidents of the Security Council and the General Assembly, outlining his measures to address the Ebola-outbreak.[126] Given the fact that the outbreak has not only health implications, but also "has become multidimensional, with significant political, social, economic, humanitarian, logistical and security dimensions"[127], the Secretary General announced a comprehensive approach, including WHO, World Bank, and International Monetary Fund as well as other UN agencies. Most importantly, he established the United Nations Mission for Ebola Emergency Response (UNMEER), which should

> "harness the capabilities and competencies of all the relevant United Nations actors under a unified operational structure to reinforce unity of purpose, effective ground-level leadership and operational direction, in order to ensure a rapid, effective, efficient and coherent response to the crisis"

122 'Joint Letter Dated 29 August 2014', Annex to *Letter dated 15 September 2014 from the Secretary-General addressed to the President of the Security Council*, UN Doc. S/2014/669, 15 September 2014 [Joint Letter].

123 *Ibid*.

124 *Ibid*.

125 *Ibid*.

126 Identical letters, *supra* note 80.

127 *Ibid*., 1.

while being "mindful of the potential peace and security implications, cognizant of the fact that all three affected countries are presently within the ambit of the Peacebuilding Commission." UNMEER should be guided by six principles, namely to reinforce government leadership; deliver rapid impact on the ground; closely coordinate and collaborate with actors outside the United Nations; tailor responses to particular needs in the different countries; reaffirm WHO lead on all health issues; identify benchmarks for transition post-emergency and ensure that actions strengthen systems. The missions strategic objective, catalysing a rapid and massive mobilization of international human, material, logistic and financial resources under a single overarching framework, would be achieved by focusing on twelve mission-critical actions, in particular identification and tracing of people with Ebola virus disease; care for the infected and infection control; safe and dignified burial; medical care for responders; food security and nutrition; access to basic health services; cash incentives for health workers; economic protection and recovery; supplies of material and equipment; transportation and fuel; social mobilization; and messaging.

The UN General Assembly had welcomed the intention of the Secretary General and requested him to take necessary steps to implement his plan.[128] The Security Council has referenced UNMEER on several occasions,[129] but has failed to include any reference to it in its most important Res. 2177 (2014), which was adopted after the Secretary General had announced his plans to the members of the Security Council.[130]

1. The Legal Base for UNMEER

Being the first-ever UN emergency health mission, the legal base for UNMEER needs to be established. The search for an explicit article in the *UN-Charter* remains unsuccessful. The search is then complicated by the fact that the Security Council explicitly *requested* the Secretary General

128 UN General Assembly, *Measures to contain and combat the recent Ebola outbreak in West Africa*, UN Doc. A/RES/69/1, 23 September 2014, paras 1, 2.

129 *Record of the 7279th meeting of the Security Council*, UN Doc. S/PV.7279, 14 October 2014; Statement by the President of the Security Council, UN Doc. S/PRST/2014/24, 21 November 2014, [SC President Statement].

130 *Record of the 7268th meeting of the Security Council*, UN Doc. S/PV.7268, 18 September 2014, 3, 7 [7268th meeting].

> "to help to ensure that all relevant United Nations System entities, including the WHO and UNHAS, in accordance with their respective mandates, accelerate their response to the Ebola outbreak"

(without mentioning UNMEER but basically embracing the mission) and *requested* him to "develop a strategic communication platform using existing United Nations System resources and facilities in the affected countries" to combat misinformation about Ebola and its transmission. Overall, these statements hint at the Security Council as the origin of UNMEER, entailing its legal powers under the *UN-Charter*. On the other hand, the General Assembly *welcomed* the Secretary General's establishment of UNMEER and at the same time *requested* him to take measures required to execute his intention and report on the progress. This could be read as if the Security Council *entrusted* the Secretary General with other functions as mentioned in Article 98 *UN-Charter*.

In the end, nonetheless, the initiative to establish UNMEER was taken by the Secretary General as the chief administrative officer of the UN. He took an administrative decision to gather resources and maintain a combined health mission. It was not a political proposal to the General Assembly or the Security Council, which they needed to agree to. For UNMEER, no new competencies were created nor was it in any other way required by law to involve another actor. Moreover, UNMEER is to be seen in relation to the appointment of a United Nations System Senior Coordinator for Ebola Virus Disease as well as, after activating the UN's emergency response mechanism for the first time, a Deputy Ebola Coordinator and Emergency Crisis Manager. These two men fulfil, as their job title suggests, coordinating functions. Thus, they are not aiding the Secretary General in his political functions under Article 99 *UN-Charter*, but under Article 98 *UN-Charter*. In this sense, UNMEER is an umbrella for several specialized UN-institutions to efficiently and effectively counter the Ebola-outbreak.

2. The Powers of UNMEER

Given this evaluation, it is evident that the Secretary General could not create any new powers for UNMEER. As described above, UNMEER's purpose is limited to an umbrella and operational structure. Still, UNMEER could have enjoyed more powers – if only the Security Council had used its chapter VII powers to equip UNMEER with such powers. As will be shown in the next section, the Security Council did not opt for this possibility and failed to effectively shape and enforce international health law.

3. UNMEER's Aftermath

UNMEER terminated at the end of July 2015 after – in the view of the UN – it achieved its core objectives.[131] The oversight over UN response to Ebola shifted to the WHO. Within the Security Council, an August 2015 debate addressed the UN's response to Ebola. Nigeria proposed this meeting and prepared issued to be considered at the meeting.[132] In this meeting, however, nothing new was stated. As usual within Security Council debates, the members congratulated themselves on their actions. Even though some members voiced concerns about the international communities' response,[133] neither harsh criticism nor specific demands were voiced. The measures taken by the WHO were not openly addressed by the Council, unlike the scathing criticism voiced by Médecins Sans Frontières.[134] Rather, the WHO's willingness to reform was applauded by members of the Security Council.

UNMEER was much more explicitly condemned by the WHO's Ebola Interim Assessment Panel. While UNMEER was more or less successful outside of Western Africa, it failed to help in the affected countries.[135] The panel went so far as to propose not to use such a mission in future scenarios.[136]

Remarkably, the members of the Security Council were in total disagreement about priorities with regard to the specific past response and possible future preparation. While the US identified getting to zero cases as top priority,[137] the Chinese representative called for alleviation of poverty and development,[138] and the Spanish representative called for better research.[139] Also, the lessons learned were vastly different: The AU, for example, learned the importance of speedy response and collaboration between (public and private)

131 UN, 'Secretary-General Announces Closure of Ebola Emergency Response Mission as Core Objective Achieved, Oversight to Be Led By World Health Organization' (31 July 2015), available at http://www.un.org/press/en/2015/sgsm16982.doc.html (last visited 27 July 2016); Statement of the UN Secretary General Special Envoy on Ebola D. Nabarro, *7502nd meeting*, *supra* note 11, 4.

132 Letter dated 5 August 2015 from the Permanent Representative of Nigeria to the United Nations addressed to the Secretary-General, UN Doc. S/2015/600, 5 August 2015.

133 Cf. the Statements by the Representatives of States, *7502nd meeting*, *supra* note 11, USA Powell, 12; Angola Gaspar Martins, 15 *et seq*.; United Kingdom Wilson, 19; New Zealand Van Bohemen, 25.

134 Cf. Meier & Mori, *supra* note 7, 105; *High-level Panel*, *supra* note 1, 25, paras 11, 40..

135 Cf. also A, Kamradt-Scott *et al*., *Saving Lives* (2015), 9 *et seq*.

136 July 2015 Report, *supra* note 100, para. 78.

137 Statement by the Representative of the USA Power, *7502nd meeting*, *supra* note 11, 11.

138 Statement by Representative of the People's Republic of China Liu Jieyi, *ibid*., 17.

139 Statement by the Representative of Spain Gasso Matoses, *ibid*., 20.

partners, flexibility in health care missions, need for sophisticated technology, State's preparedness for health emergencies, cost efficiency, bridging the gap between the UN and the WHO, and African solidarity as underlying factor.[140] The WHO Director-General restated that the lack of public health capacities and corresponding infrastructures were the major challenge in the fight against the disease.[141] The WHO attempts to reform itself, including the establishment of a global health emergency work force, which can engage quickly.[142] It seems as if the members of the Security Council have not learned any lessons by the Ebola-outbreak – they do not even have the same perception of this particular Ebola-outbreak in Western Africa.

As if he saw this coming, the UN Secretary General took further steps to address future world-wide health crises. Already in April 2015, he appointed a High-Level Panel on Global Response to Health Crises. It was explicitly asked to take account the lessons learned by the Ebola-outbreak 2014 and make recommendations "to strengthen national and international systems to prevent and manage further health crises".[143]

4. The UN High-Level Panel on Global Response to Health Crises

The panel delivered a final report in January 2016.[144] Boldly stating that the Ebola-outbreak 2014 has been a "preventable tragedy"[145], the panel started with the forecast that "future pandemic threats will emerge and have potentially devastating consequences."[146] Thus, it is pivotal for the international community to be prepared.

A major part of the panel's report is devoted to the WHO and its failures during the crisis. Given the focus on the WHO, the Panel issued recommendations similar to the WHO's review bodies. First and foremost, the panel reiterated how important it is for States to comply with the *IHR (2005)* and temporary recommendations issued in an emergency.[147] The best way to

140 Statement by the Representative of the AU António, *ibid*., 6 *et seq*.
141 Statement by the WHO Director-General Dr. M. Chan, *ibid*., 2.
142 *Ibid*., 3; another proposal is made by Aginam, *supra* note 6, 559.
143 UN, 'Secretary-General Appoints High-Level Panel on Global Response to Health Crises' (2 April 2015), available at http://www.un.org/press/en/2015/sga1558.doc.htm (last visited 4 October 2016).
144 *High-level Panel*, *supra* note 1.
145 *Ibid*., para. 34.
146 *Ibid*., 7.
147 *Ibid.,* Recommendations 1, 6, 23.

achieve this is to implement a periodic review of the member States efforts, which produces publically available reports. This is comparable to the WHO's Review Committee on the Role of the *IHR (2005)* call for more transparency and publicity.[148] Like this body, the High-level panel considers the existing *IHR (2005)* to be good enough and not in need of any amendment or modification.[149] A major contributor for better compliance would be an increase in funding, by member States and international organizations.[150] It also proposed to create a WHO Centre for Emergency Preparedness and Response[151] with the task to survey unusual health events as well to act as an open data-platform. It could establish *significant operational capabilities* to enhance the WHO's response to an epidemic or pandemic.

But the panel did not solely focus on the WHO, it identified a lack of coherence and coordination in the entire UN-system.[152] In short, there should be an automatism to react to health crises so that a waste of time and resources will be averted. Part of that effort could be the establishment of a High-level Council on Global Public Health Crises, which would monitor issues related to possible public health crises.[153] Within the WHO this recommendation met opposition: According to the WHO's Review Committee on the Role of the *IHR (2005)* such a council would diminish the WHO's mandate and leadership in health crises.[154] Given the mandate of the WHO, the view of the Review Committee is correct and the UN system should trust the WHO with the fight against epidemics. If the UN is not prepared to do so, the better approach is to improve the WHO's governance or its funding before creating a duplicate within the UN-system. However, the Review Committee is to be applauded for its recommendation to create a standing advisory committee, which may issue an intermediate level of alert.[155] Such an intermediate level of alert is currently missing.

148 Review Committee on the Role of the IHR. Ebola Outbreak and Response, *supra* note 101, 66.
149 *High-level Panel, supra* note 1, paras 70 *et seq*.
150 *Ibid*., Recommendations 17-22.
151 *Ibid*., paras 146 *et seq*.
152 *Ibid*., para. 155.
153 *Ibid*., Recommendation 26.
154 *Ibid*., para. 163.
155 *Ibid*., Recommendation 6, 64.

In the end, the panel recommends a summit on global public health in 2018.[156] Whether or not the political moment will be lost by then (as the panel fears[157]) and the summit will take place remains to be seen.

IV. The Security Council as Facilitator of International Public Health Law

1. Security Council Res. 2177 (2015)

Astonishingly, the Security Council addressed the Ebola-outbreak in one resolution[158] under chapter VII as well as in a presidential statement of November 2014[159]. To begin with, in Res. 2177 (2015), the Security Council highlighted the severance of the Ebola-outbreak. Taking note of the different actors, in example, the countries affected, neighbouring States, UN-organs and organizations, NGOs as well as first-line responders, the Security Council called upon them to collectively address the threat posed by the epidemic. In the operative part of said resolution, the Council commended the actors for their contributions but *encouraged*, *called* and *urged* these actors to do even more. Noteworthy is not the fact that the Council was not satisfied with the efforts to date, but that the Council did not *decide* on a common strategy, nor did it *demand* specific measures or *requested* concrete actions. It could have done so in regard to travel and trade restrictions, border management or access of health care workers to affected countries or regions – issues that are addressed by the WHO as well as by the Council, but only as recommendations.[160] Also, the recommendations by the WHO were not transformed into legal binding obligations by virtue of Security Council actions under chapter VII *UN-Charter*. The Council could have easily demanded from member States that they keep open their borders to affected countries, cooperate with them with regard to border management (exit and entry screenings that is) or address domestic actors to continue travel and transport to and from West Africa.[161] In essence, the Council refrained from addressing the epidemic by legal means and issued mere recommendations.

156 *Ibid*., Recommendation 27.
157 *Ibid*., para. 233.
158 SC Res. 2177, UN Doc. S/RES/2177 (2014), 18 September 2014.
159 SC President Statement, *supra* note 129.
160 Cf. SC Res. 2177, *supra* note 158 Preamble paras 9 and 17.
161 Similar Gostin & Friedman, *Retrospective and Prospective Analysis*, *supra* note 6, 1906.

2. Ebola as a *Threat to the Peace*

Nevertheless, the operative part of Res. 2177 (2015) is – from a legal perspective – rather unexciting after an audacious move by the Council. Namely, the Council determined "that the unprecedented extent of the Ebola outbreak in Africa constitutes a threat to international peace and security", thus opening its powers under chapter VII. This is an innovative approach. Given, there is a discussion about the scope of the notion *threat to international peace and security* under Article 39 *UN-Charter*. Yet in practice, "a threat to the peace is whatever the Security Council says is a threat to the peace."[162] Nevertheless, one should not accept any determination simply because it was made by the Security Council. As is well known, scholarship is divided on the interpretation of *peace* in Article 39 *UN-Charter*. Some[163] argue for a wide understanding of *peace*, which includes aspects of positive peace, for example, also "broader conditions of social development".[164] Others take a more cautious approach, understanding the term to cover only negative peace, in other words the absence of armed violence between States.[165]

Here, an interesting parallel to the term *health* can be drawn. As shown earlier, *health* can be understood as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity"[166] while the human right to health is limited to the human right to the "enjoyment of the highest attainable standard of physical and mental health" (Article 12 (1) *ICESCR*). In a philosophical sense, the appropriate ambition in the face of any evil is not only the abolition of said evil, but the achievement of the opposite.[167] Consequently, the powers of the WHO are extended to the achievement of *positive health* while the powers of the Security Council to achieve *positive peace* are still debated.

With the Security Council understanding the Ebola-outbreak as a *threat to international peace and security*, one could assume that the Council now opts

162 Akehurst & Malanczuk, *A modern introduction to international law* (1987), 219.

163 Cf. Gostin & Friedman, 'Retrospective and Prospective Analysis', *supra* note 6, 1903 *et seq*.

164 P. Malanczuk, *Akehurst's Modern Introduction to International Law* (1987), 219.

165 Cf. only C. Tomuschat, 'Obligations arising for States without or against their will', 241 *Recueil des Cours de l'Academie de droit international de la Haye* (1993) 4, 195, 334 *et seq*.

166 *Constitution of the World Health Organisation*, 14 UNTS 185 22 July 1946 [WHO-Constitution]; Cf. also *Declaration of Alma-Ata*, *supra* note 13, Article 1.

167 The author specifically thanks one of the two anonymous reviewers for this thought.

for a wider interpretation of that notion as before. Is there any merit to this claim?

First of all, the Security Council never before understood Article 39 *UN-Charter* as to include health aspects. While the Council prudently hinted that HIV/AIDS "may pose a risk to stability and security",[168] the Council did not dare to make that recommendation in the decades that followed this suggestion.[169] In addition, the human right to health is not closely related to negative peace, it is a part of positive peace. Also, the Council highlights the vast challenges, which are posed by the Ebola-outbreak, beginning with care for infected persons, safe burials of victims, misinformation about the virus and its transmission, food insecurity, a functioning domestic health care system, and other. Contrary to its usual practice, the Council did not address the question of refugees explicitly as constituting a threat. This could be understood as a move away from the fear of refugees as a destabilizing factor. In addition, 130 States co-sponsored the draft-resolution, making it the most supported chapter VII resolution ever. This seems to demonstrate a unanimous understanding between member States of the UNO as authorized interpreters of Article 39 *UN-Charter* to include positive peace aspects in this notion.

Interpreting Res. 2177 (2015) in this way, however, ignores the wording of the resolution. First of all, the Council clearly states that the *unprecedented extent* of the outbreak constitutes the threat and not the mere existence of an epidemic or a pandemic. Granted, the claim that something is unique may be made quite easily and is not decisive. Second, and most importantly, the Council relates the Ebola-outbreak to international peace and security in a rather traditional way. Res. 2177 (2015) emphasizes such aspects throughout the preamble paragraphs. The Council not only reiterates the international dimension of the disease, affecting several countries in the region, but links the disease directly to international security issues: The Security Council recognizes

> "that the peacebuilding and development gains of the most affected countries concerned could be reversed in light of the Ebola outbreak and underlining that the outbreak is undermining the stability of the most affected countries concerned and, unless contained,

168 SC Res. 1308, UN Doc. S/RES/1308 (2000), 17 July 2000.

169 SC Res. 1983, UN Doc. S/RES/1983 (2011), 7 June 2011, which repeats the phrasing of SC Res. 1308, *supra* note 168.

> may lead to further instances of civil unrest, social tensions and a deterioration of the political and security climate."[170]

The meeting record is affluent with references to the instable situation in the most affected countries and the region.[171] Voices that based Res. 2177 (2015) on the health crisis alone are minor.[172] For example, the representative of Brazil emphasized "the need to treat the outbreak first and foremost as a health emergency and a social and development challenge rather than a threat to peace and security."[173]

In this sense, Res. 2177 (2015) does not interpret Article 39 UN-Charter in an innovative way, it keeps in line with the conservative understanding of the notion *threat to international peace and security*. Ultimately, it is not Ebola that led the Security Council to act, but the anticipated instability of the region due to Ebola. In this sense, the Security Council remains an actor in the field of security, but not in health governance.[174]

3. Subsequent Practice of the Security Council

The Security Council kept the situation in West Africa on its agenda. In November 2014, the President of the Security Council issued a statement

170 SC Res. 2177, *supra* note 158, Preamble para. 4.

171 Cf. for example Statements by the Representatives of the member States, *7268th Meeting*, *supra* note 130: Argentina Perceval, 20; Australia Quinlan, 16; Chad Mangaral, 19; Chile Barros Melet, 22; China Wang Min, 16; France Delattre, 10; Jordan Kawar, 21; Lithuania Murmokaitè, 14; Luxembourg Loucas, 18; Republic of Korea Oh Joon, 13; Rwanda Nduhungirehe, 12 and United Kingdom Lyall Grant, 17; as well as Statement by the Representatives of participating States under Rule 37 of the *Security Council's provisional Rules of Procedure*, UN Doc. S/96/Rev.7, *ibid*.: Brazil Patriota, 29; Canada Rishchynski, 32; Colombia Ruiz, 45; Estonia Kolga 41; Germany Thoms, 44; Guinea Fall, 24; Guyana Talbot, 47; Italy Lambertini, 39; Japan Yoshikawa, 33; Morocco Hilale, 29; Netherlands Van Oosterom, 35; Norway Stener, 42; Sierra Leone Kamara, 26; Spain Gonzáles de Lineares Palou, 38; Switzerland Zehnder, 30; Turkey Çevik, 32 and Statement by Representatives of international organizations as the AU António, 37, *ibid*. As a side note, the traditional aspects were already highlighted in Joint Letter, *supra* note 122.

172 Statement by the Representative of the United States, *7268th meeting*, *supra* note 130, 7.

173 Statement by the Representative of the Brazil Partiota, *ibid*., 28.

174 Cf. R. Frau, 'Combining the WHO's International Health Regulations (2005) with the UN Security Council's Powers: Does it make sense for Health Governance?', to be published in 2016.

concerning the Ebola-outbreak.[175] The President reiterated the Council's concerns for the wider circumstances and thanked several actors for the efforts. For the first time, the Council addressed UNMEER explicitly, but overlooked the WHO while still recalling the *IHR (2005)*, which, in the words of the Council, "aim to improve the capacity of all countries to detect, assess, notify and respond to all public health threats." Overall, the statement does not add much to Res. 2177 (2015). The President echoes the concerns of the Council as a whole and restates the recommendations made in aforementioned resolution.

Obviously, in its agenda on peace consolidation in West Africa the Security Council kept the Ebola-outbreak in mind.[176] The Council's member applauded UNMEER and other UN efforts to counter Ebola.[177] More specifically, with regard to the United Nations Mission in Liberia (UNMIL), the Council was mindful of the outbreak and its implications on the mission.[178] In December 2014 the Council extended UNMIL's mandate "to coordinate with UNMEER, as appropriate".[179] This is a rather vague mandate. Given the fact that Res. 2190 (2014) was adopted under chapter VII the Council made that decision with legally binding effect. The powers of UNMIL as of now include the authority to cooperate with UNMEER.

V. Further Actors

1. World Bank Group

Within the World Bank Group two institutions joined the international effort. The International Bank for Reconstruction and Development (IBRD) and the International Development Association (IDA) acted within their respective mandates.

First, the IBDD is explicitly tasked to

175 SC President Statement, *supra* note 129.

176 Cf. only *Report of the 7357th meeting of the Security Council*, UN Doc. S/PV.7357, 8 January 2015, 3.

177 *Report of the 7279th meeting of the Security Council*, UN Doc. S/PV.7279, 14. October 2014; *Report of the 7480th meeting of the Security Council*, UN Doc. S/PV.7480, 7 July 2015.

178 SC Res. 2176, UN Doc. S/RES/2176 (2014), 15 September 2014, Preamble para. 2; SC Res. 2188, UN Doc. S/RES/2188 (2014), 9 December 2014, Preamble paras 5, 6; SC Res. 2190, UN Doc. S/RES/2190 (2014), 15 December 2014, Preamble para. 5; SC Res. 2215, UN Doc. S/RES/2215 (2015), 2 April 2015, Preamble paras 2, 3.

179 *Ibid.*

> "assist in the reconstruction and development of territories of members by facilitating the investment of capital for productive purposes, including the restoration of economies destroyed or disrupted by war, the reconversion of productive facilities to peacetime needs and the encouragement of the development of productive facilities and resources in less developed countries" (Article 1 *Articles of the Agreement of the International Bank for Reconstruction and Development*[180]).

In order to accomplish that goal, the IBRD may make or facilitate loans. This has been done in the case of the three most affected countries.[181]

Second, the IDA's purpose is to

> "promote economic development, increase productivity and thus raise standards of living in the less-developed areas of the world included within the Association's membership (…), thereby furthering the developmental objectives of the IBRD and supplementing its activities" (Article 1 *Articles of Agreement of the International Development Association*, 1960[182]).

The IDA provides financing for development projects (Article 5 (1) *IDA-articles*) and like the IBRD, the IDA has provided funds for the three most affected countries.[183]

Both IBRD and IDA are independent international organizations. However, they are both specialized agencies of the UN under Article 57 *UN-Charter*. As such, the legal base for their cooperation lies in Article 57 *UN-Charter*, Article 5 (8) *IBRD-articles*, Article 6 (7) *IDA-articles* and the respective relationship agreement between the UN and IBRD and IDA.[184]

180 *Articles of Agreement of the International Bank for Reconstruction and Development*, 27 December 1945, 2 UNTS 134 [IBRD-articles].

181 The World Bank, 'World Bank Group Ebola Response Fact Sheet', available at http://www.worldbank.org/en/topic/health/brief/world-bank-group-ebola-fact-sheet (last visited 1 August 2016) [WBG Ebola Fact Sheet].

182 *Articles of Agreement of the International Development Association*, 24 September 1960, 439 UNTS 249 [IDA-articles].

183 'WBG Ebola Fact Sheet', *supra* note 181.

184 GA Res. 124 (II), UN Doc. A/RES/124(II), 15 November 1947; GA Res. 1594 (XV), 27 March 1961.

In foresight, the World Bank Group plans to establish a Pandemic Emergency Facility (PEF)[185] to cooperate with other actors in comparable future scenarios. The respective articles of agreement provide for such a program. While joined programs against disasters are nothing new in the World Bank Group (for example, the IDA Crisis Response Window and the catastrophe deferred drawdown option), the establishment of PEF is due to the Ebola-outbreak. PEF is supposed to "channel funds swiftly to governments, multilateral agencies, NGOs and others to finance efforts to contain dangerous epidemic outbreaks before they turn into pandemics." PEF is, however, not created to cover pandemic preparedness or reconstruction efforts. The establishment of PEF has been endorsed by the 2015 G7 summit in Germany.[186]

In the end, the Ebola-outbreak 2014 has not created new powers under international law for any organization within the World Bank Group. Nevertheless, existing mechanisms and capacities have been used to finance the fight against Ebola. In addition, the creation of PEF, while not being an innovative tool, adds a mechanism to counter similar threats in the future. In this sense, the Ebola-outbreak 2014 helped to reshape international law, in particular with regard to international organizations.

2. AU, ECOWAS and the African Development Bank

Of course, regional actors were part of the international response. Before all others, the AU addressed the Ebola-outbreak. The AU Peace and Security Council emphasized the wider circumstances of the Ebola-outbreak a month before the UN Security Council took action.[187] It called on member States and other States to renew their efforts to fight the outbreak. In order to do so, the Peace and Security Council authorized the immediate deployment of a military and civilian humanitarian mission, the AU Support Mission for the fight against the Ebola Outbreak in West Africa or in short ASEOWA. This mission, comprising medical doctors, nurses and other medical and paramedical personnel, is the regional umbrella for States that provide healthcare personnel, financial and material resources to the countries most affected by the Ebola epidemic. The military component to the mission is safeguarding the effectiveness

185 The World Bank, 'Pandemic Emergency Facility: Frequently Asked Questions', available at http://www.worldbank.org/en/topic/pandemics/brief/pandemic-emergency-facility-frequently-asked-questions (last visited 1 August 2016).

186 G7 Germany, Leaders Declaration (7-8 June 2015), 12 *et seq*.

187 AU Peace and Security Council, *Communiqué*, PSC/PR/COMM.(CDL), 19 August 2014.

and protection of the mission. The Council embraced the concerns of the UN Security Council and called for a lift of travel and trade bans and the like during the months that followed.[188] However, the Council did not take innovative decisions.

The AU Executive Council, which coordinates and takes decisions on policies in areas of common interest to member States, foreshadowed parts of Res. 2177 (2015) when it called on AU member States to "urgently lift all travel bans and restrictions to the principle of free movement".[189] The AU Council referred to the recommendations by the WHO and even noted the "responsibility of member States to protect their citizens and public health consistent with IHR (2005)".[190] Given the fact that the AU Executive Council may not legislate, its decision did not alter the nature of the non-binding recommendations by the WHO.

ECOWAS, the Economic Community of West African States, is tasked to promote cooperation and integration leading up to an economic union in West Africa in order to facilitate development.[191] To counter the Ebola-epidemic, its member States have pledged to deploy military medical personnel.[192]

Moreover, the African Development Bank has supported the WHO and other actors in the fight. It too provided funds to the three most affected countries, like the agencies of the World Bank Group.[193]

188 AU Peace and Security Council, *Communiqué*, PSC/PR/COMM.(CDLXIV), 29 October 2014; AU Peace and Security Council, *Communiqué*, PSC/PR/COMM.(DXX), 29 June 2015.

189 AU Executive Council, *Decision on the Ebola Virus Disease (EVD) Outbreak*, Ext/EX.CL/Dec.1(XVI), 8 September 2014, para. 10 ii).

190 *Ibid*., para. 2.

191 *Revised Treaty of the Economic Community of West African States*, 24 July 1993, Article 3, 2373 UNTS 233, 238-239 [ECOWAS].

192 ECOWAS, 'ECOWAS member States pledge military medical personnel to bolster ebola fight', available at http://www.ecowas.int/ecowas-member-States-pledge-military-medical-personnel-to-booster-ebola-fight/ (last visited 1 August 2016).

193 African Development Bank, Ebola, available at http://www.afdb.org/en/topics-and-sectors/topics/ebola/ (last visited 1 August 1016); African Development Bank, Ebola Project Brief, 15 April 2015, available at http://www.afdb.org/fileadmin/uploads/afdb/Documents/Generic-Documents/Ebola_project_brief.pdf (last visited 1 August 2016).

D. Re-shaping the Framework During the Ebola-Outbreak 2014: A Summary of the Response

I. *Help as one* – A Unified Effort by the International Community?

Taking a look at UNMEER and the combined efforts of numerous actors, one is tempted to describe the international community's measures with regard to the Ebola-outbreak as unified answer to a common threat. Several institutions, among them universal organizations like the agencies of the World Bank Group as well as regional organizations such as the AU joined their powers and capacities to counter a common challenge under the leadership of the UN. As such, it was an interdisciplinary response, taking into account a vast array of factors and addressing them by the proper agencies.

It would be naive, however, to draw that conclusion. Even from the most important perspective – helping infected persons – the international response was rather slow, disorganized and at times even incompetent.[194] From within the WHO, voices criticized the organizations internal communication in the particular case as well as the appointments in the African office in general.[195] If the example of UNMEER will add some value to the UN, or if it will be just another brick in the UN's bureaucracy remains to be seen.

From a legal perspective this claim also does not sustain. True, the organizations and agencies acted within their respective mandates. As such, they provided personnel, medical expertise and equipment, funding and other support. They called on the private sector to contribute to the effort in general and on airlines and shipping companies in particular. The Security Council addressed the epidemic in a rather innovative way, in example by means of chapter VII *UN-Charter*.

Nonetheless, the *legal* response could have been more intense. More specifically, the Security Council missed an opportunity to act swiftly and effectively and re-shape international health law or at least facilitate its development. Once the Council had determined that the unprecedented extent of the Ebola outbreak in Africa constituted a *threat to international peace and security*,[196] it could have issued binding decisions under Article 41 and 42 *UN-Charter* and not mere recommendations under Article 40 *UN-Charter*. The need

194 Cf. the critical references cited in Meier & Mori, *supra* note 7, 105 and *High-level Panel*, *supra* note 1, 25, para. 40.

195 Cf. 'Bungling Ebola Documents', *supra* note 11.

196 SC Res. 2177, *supra* note 158, Preamble *para*. 5.

for effective action was evident, at least by the repeated calls of the Emergency Committee regarding Ebola to address border management, exit and entry screening as well as a lift to trade and travel bans. Given the fact that the majority among the UN member States was willing to deal with the crisis under chapter VII *UN-Charter*, including all permanent and elected members of the Security Council, binding measures seemed to be a viable option.

The Council could have used its far-reaching powers under Article 41, 42 *UN-Charter* in the following ways: For example, it could have authorized the deployment of troops in order to provide much needed staff for safe burials of victims or border management, in example, to conduct exit or entry screenings. Furthermore, it could have elevated the WHO's temporary recommendations as proposed by the Emergency Committee regarding Ebola to legally binding obligations, where applicable. Surprisingly, the *IHR (2005)* do not reference the Security Council in any way and neither did the Security Council establish any relations to the WHO.[197] Also, it could have decided that borders to the three most affected countries had to stay open in order to halt the isolation of these countries and communities and subsequent protests and violence, which challenged the three States. After all, all the factors that the members of the Security Council feared contributed to the likelihood of new civil wars in the region.[198]

Given the consent of the three most affected countries,[199] a binding resolution under chapter VII *UN-Charter* was probably not required to provide help in the aforementioned sense. But if the consent was so evident, there was also no need to make a determination under Article 39 *UN-Charter*. It seems as if the Council dared to open the door to chapter VII without actually entering it – a half-hearted resolution.

To be clear, the Security Council remained also on safe grounds when it based its determination under Article 39 *UN-Charter* not on the epidemic alone but on exacerbating factors in the region, such as political instability and mistrust against the respective governments, specifically on the security apparatus. In this sense, the general interpretation of Article 39 *UN-Charter* was not fundamentally altered.

Still, the experience with Ebola has already sparked a debate about future changes to the *IHR (2005)*, most prominently by an interdisciplinary research

197 Statement of the Representative of the AU António, *7502nd meeting*, *supra* note 11, 8.
198 Cf. *High-level Panel*, *supra* note 1, Recommendations 1, 6, 23.
199 Joint Letter, *supra* note 122.

group.[200] Just as after previous incidents,[201] the lack of compliance with the *IHR (2005)* and the lack of an effective enforcement mechanism is still an unresolved issue. Unfortunately, all efforts of reform are too late for the recent outbreak of the Zika-virus in Latin America and the Caribbean.[202]

II. Ignoring the Human Right to Health

Most appalling is the ignorance of the human right to health. As has been shown above, different actors have taken measures to combat the epidemic. They referred to diverse reasons for their actions, among them political and economic reasons as well as more altruistic aspects such as food shortages and stigmatization of nationals from the three most affected countries.[203] However, none of the above-mentioned actors referred to the human rights dimension as stated in Article 12 *ICESCR*. Neither the Security Council as such, which chose a rather traditional approach, nor the vast majority out of nearly 50 State representatives, who spoke during the discussion after the adoption of the resolution referred to a human right. Only one representative hinted at a human rights dimension[204] while all other participants were silent on that matter. Compared to classic examples of *threats to the peace*, as referenced by States,[205] human rights aspects seem to be of only marginal relevance. Likewise, also the General Assembly does not cite the human right to health in its key resolution 69/1.

If even UN-organs ignore the human rights dimension, it does not surprise that other institutions did not address this right as well. Consequently, neither the WHO's Director General nor the Emergency Committee regarding Ebola mentioned the human right to health. Keeping in mind the preamble of the *WHO-Constitution*, the Director General could have referred to this dimension as well. At least for the Emergency Committee, this lies outside of

200 S. Moon *et al*., 'Will Ebola change the game? Ten essential reforms before the next pandemic. The report of the Harvard-LSHTM Independent Panel on the Global Response to Ebola', 386 *The Lancet* (2015) 10009, 2204.

201 Condon & Sinha, *supra* note 35, 6; Silver, *supra* note 11, 234; C. Murray, 'Implementing the New International Health Regulations: The Role of the WTO's Sanitary and Phytosanitary Agreement', 40 *Georgetown Journal of International Law* (2009) 625, 627 *et seq*; Gostin, *supra* note 24, 359 *et seq*.

202 Cf. *High-level Panel*, *supra* note 1.

203 Cf. Statements in *7318th meeting of the Security Council*, UN Doc. S/PV.7318, 21 November 2014.

204 Statement by the Representative of Morocco Hilale, *7268th meeting*, *supra* note 130, 30.

205 Cf. *High-level Panel*, *supra* note 1, Recommendations 1, 6, 23.

their powers under *IHR (2005)*. Neither the World Bank Group nor the African Development Bank is mandated to address human rights issues. Yet the AU could have done so.

Overall, neither the individual human right to health nor a possible human right to public health has been advanced. States and international organizations have failed to address global health challenges by means of international law.[206] Even more disturbing, when WHO and UN evaluated their respective responses in the aftermath of the crisis,[207] no word was lost on the human rights dimension. With no time pressure and the possibility to take a step back and look at past actions, it would have been easy to take into account human rights.

Overall, the Ebola-outbreak did not help in reshaping the human right to health. For future cases, the human right to health in emergency situations, its applicability *ratione loci* and the central point of international cooperation[208] has not been shaped. With regard to Ebola, a chance was lost to further advance the right to health by itself and international health law by utilizing the human rights dimension.[209]

E. Conclusion: Raised Awareness and a New Approach to Threat to the Peace, but no News for the Human Right to Health

As Rieux forecasted in fiction, worldwide epidemics and pandemics of fatal diseases will occur in future real life scenarios.[210] Scenarios like the Ebola-outbreak 2014, affecting many communities, may in the future destabilize single countries or entire regions. International law will not stop a disease from spreading. However, a legal framework surrounds all efforts to counter a pandemic; the international community has many tools at hand. Some of them have been utilized in the Ebola-outbreak. Nevertheless, while there has been a more or less common international response from various actors, some tools

206 Already critical to the overall approach to the human right to health Meier & Mori, *supra* note 7, 121 *et seq*.

207 Cf., *High-level Panel*, *supra* note 1; WHO Director General, *WHO response in severe, large-scale emergencies*, A69/26, 6 May 2016.

208 Tobin, *supra* note 56, 368.

209 The human right as a catalyst is brought forward by Gostin, *supra* note 24, 243, 256 *et seq*.; The present author continues this approach, cf. Frau, *supra* note 174.

210 Statement of the UN Secretary General Special Envoy on Ebola Dr. D. Nabarro, *7502nd meeting*, *supra* note 11, 5; *High-level Panel*, *supra* note 1, 7.

were left aside. Most importantly, the Security Council remained behind its abilities. Institution wise, the fight opened collaborations and identified the need for a global and interdisciplinary strategy, taking into account diverse factors. Whether or not lessons were learned will be seen during the next pandemic. While the institutions more or less worked effectively together, another aspect of international law was ignored by all actors: Unfortunately, the human right to health was not a decisive factor during the crisis. Here, the international community failed to address a major issue of pandemics. In the end, the Ebola-outbreak helped to re-shape some parts of international health law. The human rights dimension, however, remains vague in the case of pandemics. For future scenarios, this is regrettable.