universität wien

MASTER THESIS

Titel der Master Thesis / Title of the Master's Thesis

„An Evaluation of the United States' COVID-19 Pandemic Response Under International Legal Standards"

verfasst von / submitted by

Ryan Lee

angestrebter akademischer Grad / in partial fulfilment of the requirements for the degree of

Master of Arts (MA)

Wien, 2020 / Vienna 2020

Studienkennzahl lt. Studienblatt / Postgraduate programme code as it appears on the student record sheet:	UA 992 884
Universitätslehrgang lt. Studienblatt / Postgraduate programme as it appears on the student record sheet:	Master of Arts in Human Rights
Betreut von / Supervisor:	Assoz. Prof. Mag. Mag. Dr. Christina Binder

Acknowledgments

First and foremost, I would like to thank my beloved family. My wife, Brittany, and our newborn baby girl, Charlotte, have stood by my side through all the positives and negatives of writing this thesis on a short time frame. They endured my stress of combining work and thesis writing, child-rearing and moving to a new home. Even when I was alone, I was never lonely.

Thank you to my parents for helping and supporting me in getting to where I am today. Parenting has taught me even more how grateful I am for your love and dedication.

I would like to thank my supervisor, Professor Christina Binder for her guidance and support throughout this process. She encouraged me when I thought I was lost and worked through dense components of international law with me despite a large gap in time zones. Without her, this would never have been possible by the deadline.

I would like to thank my mentor in international human rights law and ski companion, Dr. Manfred Nowak. His guidance when my initial topic became impossible due to COVID-19 and his help with pulling together my second topic has been invaluable, as has been all he has taught me and worked with me on over the last two years.

I would also like to thank my colleague and friend, Tyler Sanderson, for his insight into this paper and for introducing me to new and improved methods of academic research.

Finally, I would like to thank my friends who have kept me sane during this whole process. My partners in the Master Program and life in general: Anthony McBride and Kaitlyn Rice. DSGC and Fogside have provided a forum for all of our fears, anxieties and unrest to dissipate into the glassy abyss. And of course, Hayes Whitney, my lifelong best friend, for helping me through the last two weeks of lonely stress and constant work.

Above all else, I want to thank the brave healthcare workers fighting COVID-19 on the front lines around the clock. Special gratitude and respect to my friend Dan King, who chased the virus up to New York City in April 2020 to face the worst and deadliest of this evil being. Kudos to you all and thank you for your work and dedication to keeping us all safe and alive. Our human rights to health and life are so much safer in your hands.

TABLE OF CONTENTS

List of Abbreviations

AAP	American Academy of Pediatrics
ACHR	American Convention on Human Rights
CDC	US Centers for Disease Control and Prevention
CESCR	Committee on Economic, Social and Cultural Rights
COVID-19	Coronavirus Disease 2019
FDA	US Food and Drug Administration
HHS	US Department of Health and Human Services
HRC	Human Rights Commission
ICCPR	International Covenant on Civil and Political Rights
ICERD	International Covenant on the Elimination of All Forms of Racial Discrimination
ICESCR	International Covenant on Economic, Social and Cultural Rights
IHR	International Health Regulations (2005)
JAMA	Journal of the American Medical Association
MERS	Middle East Respiratory Syndrome
OAS	Organization of American States
PHEIC	Public Health Emergency of International Concern
PPE	Personal Protective Equipment
SARS	Severe Acute Respiratory Syndrome
SARS-CoV-2	Severe Acute Respiratory Syndrome Coronavirus 2
UDHR	Universal Declaration of Human Rights
UN	United Nations
US	United States
UNDP	United Nations Development Program
WHO	World Health Organization

Section 1. Introduction

1.1. Background

"I want to be straight with you: there will be no return to the 'old normal' for the foreseeable future."[1] World Health Organization (WHO) Director-General Tedros Adhanam Ghebreyesus ominously announced this disheartening forecast on 13 July 2020, following a weekend where 450,000 new cases of Coronavirus Disease (COVID-19) were confirmed in just two days.[2] As of 7 August 2020, there were 18,902,735 confirmed cases and 709,511 deaths at the hands of COVID-19 worldwide.[3] The United States (US) accounts for 4,888,070 of these cases and 160,157 deaths as of the same date.[4] The Director-General continued, "the virus remains public enemy number one, but the actions of many governments and people do not reflect this."[5]

The world is challenged with a common threat to every nation's security, to international peace and security, to global public health and also to human rights. An opportunity has presented itself to governments worldwide for effective measures on the ground, global cooperation and respect for human rights. When governments have failed to consider both health security and human rights, the suffering has fallen on millions of individual people worldwide. The focus of this paper is on the United States and its response to the pandemic, which has been a textbook example of a failure from both a governance and a human rights standpoint since the initial onset of COVID-19 in early 2020.

---

[1] World Health Organization (WHO), 'WHO Director-General's opening remarks at the media briefing on COVID-19 – 13 July 2020,' 13 July 2020, https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---13-july-2020 (accessed 16 July 2020).
[2] WHO, 'WHO Coronavirus Disease (COVID-19) Dashboard,' https://www.who.int/redirect-pages/page/novel-coronavirus-(covid-19)-situation-dashboard (last accessed 8 August 2020).
[3] *Ibid*.
[4] Center for Systems Science and Engineering at Johns Hopkins University, 'COVID-19 Dashboard,' https://gisanddata.maps.arcgis.com/apps/opsdashboard/index.html#/bda7594740fd40299423467b48e9ecf6 (last accessed 8 August 2020).
[5] WHO, 13 July 2020.

1.1.1. Succinct History of COVID-19

The world at the end of 2019 was a very different place than the world is in July 2020. For many people, the mere mention of '2019' brings nostalgic feelings of a past lifetime now extinct. The situation began in November 2019 in the city of Wuhan in China's Hubei province. Here, the first case of COVID-19 in humans was confirmed by local health authorities. It is currently believed that 'patient zero' of COVID-19 contracted the illness on 17 November 2019.[6] Within months, the global economy tanked as businesses and factories closed worldwide. Thousands of people were dying every week. Freedom of movement was limited in almost every country on earth. By early 2020, the media around the globe was talking about only one thing: the ubiquitous topic of 'COVID-19' or as most news outlets refer to it, 'The Coronavirus.'

A virus similar to that which caused the Severe Acute Respiratory Syndrome (SARS) outbreak that began in 2002 transferred zoonotically to humans in a more virulent form at the very end of 2019. That successor virus was appropriately named the 'Severe Acute Respiratory Syndrome Coronavirus 2' (SARS-CoV-2). This virus causes the deadly illness known as COVID-19. As it spread rapidly from China to eventually every region of the world, the WHO declared COVID-19 a "global pandemic" on 11 March 2020.[7] By the end of that month, the entire world knew about and was directly impacted in some way by COVID-19.

Almost every nation in the world responded independently, despite the WHO calling for a unified and uniform response. The world's leading economy, the United States, mistakenly considered itself to have one of the best healthcare systems in the world.[8] Notably, however, studies had already been emerging which showed that the US healthcare

---

[6] J. Ma, 'Coronavirus: China's first confirmed COVID-19 case traced back to November 17,' *South China Morning Post*, 13 March 2020, https://www.scmp.com/news/china/society/article/3074991/coronavirus-chinas-first-confirmed-covid-19-case-traced-back (accessed 16 July 2020).
[7] WHO, 'WHO Director-General's opening remarks at the media briefing on COVID-19 – 11 March 2020,' 11 March 2020, https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020 (accessed 8 April 2020).
[8] J. Potyraj, 'The Quality of US Healthcare Compared with the World,' *American Journal of Managed Care*, 11 February 2016, https://www.ajmc.com/contributor/julie-potyraj/2016/02/the-quality-of-us-healthcare-compared-with-the-world (accessed 16 July 2020).

system was facing substandard mortality rates for treatable and preventable diseases prior to COVID-19.[9] The United States also inaccurately touted itself as a champion of human rights.[10] In responding to the COVID-19 pandemic, however, the US quickly took the spotlight on 12 April 2020 by surpassing the then-leader Italy with the highest COVID-19 death toll.[11] Such tragic suffering at the hands of a deadly virus directly implicates the fundamental human rights to life and to health above all else. The primary focus of this paper is to assess the US federal government's failures to protect the lives and health of its citizens under international legal standards for human rights. Other dimensions of legal obligations, such as international health law, will be briefly mentioned. As a subcomponent of this paper, I will succinctly mention some additional human rights and civil liberties impacted by restrictive measures applied by US states in response to the COVID-19 pandemic. This issue is important to mention because restrictive measures aimed at protecting life and health must inherently interfere with other human rights. The question of whether the US properly limited such rights in the name of life and health should be a topic for another paper.

1.1.2. Relevant Aspects of International Human Rights Law

International human rights law prescribes legally binding obligations on States to respect, protect and fulfill the human rights of its citizens. The binding nature of these obligations is determined by 'primary rules of law,' provided by either conventional or customary international law.[12] Conventional law is derived from treaties and is clear, similar to provisions governing a contractual agreement. Customary international law, however, is derived primarily from "general State practice" and *opinio juris*, or judicial

---

[9] *Ibid*.
[10] J. Dakwar, 'The United States Considers Itself a Human Rights Champion. The World Begs to Differ,' *ACLU Human Rights Program*, 8 May 2015, https://www.aclu.org/blog/human-rights/united-states-considers-itself-human-rights-champion-world-begs-differ (accessed 15 July 2020).
[11] BBC, 'Coronavirus: US death toll overtakes Italy as world's highest,' *BBC*, 12 April 2020, https://www.bbc.com/news/world-us-canada-52258284 (accessed 28 April 2020).
[12] R. Barnridge, 'The Due Diligence Principle Under International Law,' *International Community Law Review*, vol. 8, 2006, p. 87.

interpretations of the law.[13] The specific binding nature of norms provided by customary international law is concededly less clear and direct than treaties. A State's failure to ratify a treaty, however, does not automatically render that State unencumbered by international law or universal duties to behave a certain way as a member of the international community. This is especially true during a global crisis like COVID-19.

The two most authoritative international human rights treaties are the International Covenant on Civil and Political Rights (ICCPR)[14] and the International Covenant on Economic, Social and Cultural Rights (ICESCR).[15] The majority of the rights protected under these treaties were first codified in 1948 by the Universal Declaration of Human Rights (UDHR).[16] The ICCPR, ICESCR and UDHR are referred to collectively as the International Bill of Human Rights.[17] While the UDHR is not conventional binding law like the ICCPR and ICESCR, there is little argument over 70 years after its establishment that many provisions of the UDHR constitute customary international law.[18] Due to the universal acceptance and longevity of the UDHR mean that it "may be even more easily invoked as a source or evidence of customary international law than a corresponding treaty provision."[19] Its provisions develop binding legal codification and jurisprudence internationally, regionally and nationally over the years, strengthening its status as customary international law.[20] As World War II became the impetus to the UDHR, the next global threat of COVID-19 could very well lead to additional significance for the Declaration. This common crisis has the potential to further expand the role and extent of

[13] United Nations, *Statute of the International Court of Justice*, 18 April 1946; T. Stephens and D. French, 'ILA Study Group on Due Diligence in International Law: Second Report,' International Law Association, July 2016, https://www.ila-hq.org/index.php/study-groups (accessed 27 July 2020).
[14] International Covenant on Civil and Political Rights (adopted 16 December 1966, entered into force 23 March 1976) 999 UNTS 171.
[15] International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, entered into force 3 January 1976) 999 UNTS 3.
[16] UN General Assembly, *Universal Declaration of Human Rights*, 10 December 1948, 217 A (III).
[17] UN General Assembly, *International Bill of Human Rights*, 10 December 1948, A/RES/217(III)A-E.
[18] H. Hannum, 'The UDHR in National and International Law,' *Health and Human Rights*, vol. 3, no. 2, 1998, pp. 147-148.
[19] *Ibid*., p. 146.
[20] *Ibid.*, pp. 147-148.

international legal obligations protecting human rights. Moreover, COVID-19 further illustrates that the rights to life and health are inextricably intertwined.

The primary focus of this paper will be on the rights to life and health. The right to life is provided by the ICCPR, which the US has ratified. The right to health is found in the ICESCR, which the US has not ratified. As the most authoritative and comprehensive authority over the right to health, however, the ICESCR is the proper determinant of specific obligations.[21] The international standards of focus thus come from the ICCPR and the ICESCR, as well as the authoritative interpretations of the relevant treaty bodies for each. Respectively, the Human Rights Committee (HRC) and the Committee on Economic, Social and Cultural Rights (CESCR) establish the specific standards under which US compliance will be assessed. The specific nature of these obligations in the context of COVID-19 is the focus of this paper. A few complementary sources will also contribute to the evaluation in this context.

The extent to which international legal obligations have been met can be further measured under the principle of 'due diligence.' Due diligence is a customary norm under international law that assesses the degree of adherence to human rights standards based on a standard of conduct and the degree of reasonable care in exercising a State's duties.[22] Due diligence requires States to take prudent steps to avoid a range of bad outcomes, with the failure to do so possibly constituting a violation of international law.[23] From a non-legal perspective, due diligence is "a byword for responsible decision-making in the policy sphere."[24] The customary principle of due diligence is complementary to international legal standards, but not independently a source of binding international law. Accordingly, it provides additional insight into the standards imposed by conventional and customary international law.

---

[21] E. Riedel, 'The Human Right to Health: Conceptual Foundations,' in A. Clapham and M. Robinson (eds.), *Realizing the Right to Health*, Rüffer & Rub, Zurich, 2009, pp 36-37.
[22] A. Coco and T. de Souza Dias, 'Prevent, Respond, Cooperate: States' Due Diligence Duties vis-à-vis the COVID-19 Pandemic,' *Journal of International Humanitarian Legal Studies*, 2020, p. 2.
[23] N. McDonald, 'The Role of Due Diligence in International Law,' *International and Comparative Law Quarterly*, vol. 68, no. 4, October 2019, p. 1049.
[24] *Ibid*.

International human rights law is also complemented by international health law in the context of a global health crisis. For example, the US has ratified the WHO Constitution and the International Health Regulations 2005 (IHR), the binding treaty governing infectious diseases and pandemics.[25] This framework provides for an international legal authority charged with protecting international public health. This authority confers additional obligations on states that can extend beyond protecting their own citizens within their own borders. The COVID-19 pandemic is a global public health crisis unprecedented since the establishment of international institutions in the mid-20th century. The international community is currently in a "situation in which we are being forced to negotiate new norms in the new normal of an emergency state."[26] Additional authorities, at minimum, provide helpful insight into uncharted territories.

The United States also has obligations under non-binding concepts such as morality and good governance to protect its people from a global pandemic while minimizing interference with human rights throughout the process.[27] Both requirements and justifications for emergency measures taken in the face of a national and international public health threat are supported by the concept of the "securitization of health."[28] As will be briefly discussed, States must calculate a balance between the overall health of society and the consequential impacts of a pandemic such as economic collapse and mental health impacts against the human rights and civil liberties of its citizens.[29] These obligations are not legal in nature but rather are supported by general concepts of political science such as

[25] On 6 July 2020, President Donald Trump announced that he had formally submitted a notice to withdraw from the WHO, effective one year later on 6 July 2021. For purposes of this paper and the timeline of its publication, this is addressed but does not impede the arguments for the WHO's authority during the pandemic response in 2020.
[26] C. Ferstman and A. Fagan (eds.), 'Covid-19, Law and Human Rights: Essex Dialogues,' Project of the School of Law and Human Rights Centre, University of Essex, 1 July 2020, https://www.essex.ac.uk/research-projects/covid-19-law-and-human-rights-essex-dialogues (accessed 28 July 2020), p. 19.
[27] E. Kinney, 'Recognition of the International Human Right to Health and Health Care in the United States,' *Rutgers Law Review*, vol. 60, no. 2, 2008, p. 341.
[28] S. Elbe, 'Securitizing Epidemics: Three Lessons from History,' in C. Enemark and M. Selgelid (Eds.), *Ethics and Security Aspects of Disease Control: Interdisciplinary Perspectives*, Ashgate, 2012, p. 79.
[29] M. Selgelid, 'The Value of Security: A Moderate Pluralist Perspective,' in C. Enemark and M. Selgelid (Eds.), *Ethics and Security Aspects of Disease Control: Interdisciplinary Perspectives*, Ashgate, 2012, p. 27.

good governance in providing guidance and justifications when faced with a threat to health security.

While the human rights to life and health will be the primary focus of this paper, it is also important to briefly consider some other human rights impacts in assessing the US response overall. The human rights to life and health are foundational in that the protection of other human rights serves little purpose if millions of people are sick and dying. It thus follows that limitations of other rights might be necessary to protect life and health from a deadly pandemic. States worldwide have imposed measures, based on past pandemics, that restrict other human rights in the defense of human lives and health.

Under international human rights law and as guided by the Siracusa Principles, a state may justifiably interfere with certain human rights in order to protect national security or emergencies threatening public health and safety.[30] In responding to the threat presented by the pandemic, however, States must consider how to "operationalize human rights" in implementing measures by conducting and based on necessity, proportionality, legality, and restrictiveness in comparison to alternatives.[31] Lockdowns and other restrictive measures have interfered with numerous civil and political human rights including freedom of movement and the right to assembly, as well as with several economic, social and cultural rights such as the rights to work and gather for cultural or religious purposes. Such measures, however, are intended for the critical purpose of protecting the two most vital human rights: the rights to life and health. Whether the US government effectively protected these two paramount rights is the focus of this paper.

1.2. Research Question

The research question to be considered in this paper is based on whether the US has taken reasonably sufficient measures to comply with its obligations under international human rights law concerning the rights to health and life in responding to the COVID-19

[30] UN Commission on Human Rights, *The Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights*, 28 September 1984, E/CN.4/1985/4.
[31] N. Hostmaelingen and H. Bentzen, 'How to operationalize human rights for COVID-19 measures,' BMJ Global Health, 2020, https://gh.bmj.com/content/5/7/e003048, p. 1.

pandemic. The US is bound under international law to respect, protect and fulfill the human rights to life and health. The COVID-19 pandemic is a threat unprecedented since the creation of the UN and international law. Did the United States meet its obligations to ensure these two vital human rights? International human rights law provides the standards under which an assessment can be made. Due diligence standards complement this evaluation with additional insights into reasonableness. Certainly, the relevant standards cannot require any State to have prevented the outbreak or any deaths entirely. The conclusion thus turns on a determination of the threshold these standards require given the information the US government had, how it handled that information and its resultant acts or omissions in the face of this deadly pandemic.

Research Question: Through its acts and omissions while responding to the COVID-19 pandemic, did the United States comply with its obligations under international human rights law concerning the rights to health and life?

1.3. Relevance

At the time of writing, there exists no topic more ubiquitous than COVID-19. One cannot turn on a television, open a newspaper or magazine or even log on to any social media platform without constant discussion of COVID-19, the global pandemic, the 'lockdown' and other measures enacted to fight the virus. While the pandemic itself is omnipresent in all forms of media and constantly discussed in conversations worldwide, the human rights component of pandemic response measures constitutes a small percentage of the overall discussion, especially in the United States where human rights rarely reach the forefront of news coverage.

This is somewhat understandable, as health and safety are primary concerns and eye-catching headlines, particularly those that promote fear, tend to attract more readers and viewers. Nonetheless, many civil liberties, schools, businesses and other common components of pre-COVID life are being shut down or stagnated. An analysis hereunder

with a forward view towards improvement provides an opportunity for human rights scholars and practitioners to expand upon the current human rights regime.

International human rights law is still very much in its developmental stage with issues such as enforcement difficulties, international disagreement on the universality of certain rights and the rise of authoritarianism in regions worldwide. An evaluation and discussion of an international response to a common enemy like COVID-19 from a human rights perspective allows opportunities for the human rights regime to grow stronger and further demonstrate its necessity, even in the face of global emergencies and public health crises. An opportunity exists to capitalize on a global disaster in order to advance protections and accountability for global public health and human rights simultaneously.

It would be easiest to throw human rights to the wind and focus exclusively on security and public health, which some States are certainly doing. Several states have acted with due consideration for human rights. Others such as Hungary, Chile and Israel have taken advantage of being able to justify the use of emergency powers and exploited them to further cement an authoritarian approach to governance.[32] Human rights groups even agree that such extraordinary times do, in fact, call for extraordinary measures.[33] However, the failure to properly consider human rights at such a critical time only exacerbates the overall impact of this massive public health threat. The COVID-19 pandemic, specifically as will be demonstrated in the context of the United States, has demonstrated to the world in a new way the extent of interplay between security and liberty. A proper balance between human rights versus national and international security, must be devised based on COVID-19 before the beginning of the next public health crisis. This refers to the belief held by some public health experts that this is not 'the big one,' as far as devastating pandemics in the 21st century.[34]

---

[32] S. Gebrekidan, 'For Autocrats, and Others, Coronavirus Is a Chance to Grab Even More Power,' *The New York Times*, 30 March 2020, https://www.nytimes.com/2020/03/30/world/europe/coronavirus-governments-power.html (last accessed 2 April 2020).
[33] *Ibid*.
[34] M. Osterholm and M. Olshaker, 'Chronicle of a Pandemic Foretold: Learning From the COVID-19 Failure – Before the Next Outbreak Arrives,' *Foreign Affairs*, vol. 99, no. 4, July/August 2020, pp. 10-24.

The opportunity to evaluate a balance of human rights and learn from this situation in a way that can benefit human rights worldwide going forward, however, is crucial. The COVID-19 pandemic is a clear situation where certain human rights must be curtailed to some extent in favor of the rights to health and life. Studying, analyzing and evaluating approaches to the first global pandemic since the establishment of international organizations and human rights protections as they are today from a human rights lens is an unprecedented opportunity to learn how to develop an effective and more universal human rights regime and provide guidance for when and how to appropriately and proportionally interfere with certain human rights in order to protect others. Without life and health, other human rights certainly become less attainable if not entirely unattainable.

As of 31 July 2020, more than 17 million cases were confirmed and more than 668,000 people had died at the hands of COVID-19 worldwide.[35] The US had the worst numbers worldwide, reporting more than 4.3 million cases and 150,000 deaths as of this same day.[36] These numbers have since increased steadily and only include cases that had been reported. Research suggests the actual number of infections could be up to 10 times this many.[37] Presumably, these affected people and their families would prefer that their government restrict their movements or prohibit them from gathering in public in order to keep them healthy or even save their lives. An evaluation of when and how states can and should act to protect lives and health is critical. The international community would suffer to allow such an opportunity to assess and further develop the international human rights regime pass by unaddressed. There is literature emerging faster than it can all be read with regard to COVID-19. Some of this pertains to human rights. Nobody, however, has yet conducted an extensive discussion of the United States and its battle with COVID-19 strictly from a perspective under the human rights to life and/or health.

---

[35] WHO, 'COVID-19 Dashboard.'
[36] *Ibid*.
[37] A. Bendix, 'US coronavirus cases are probably 10 times higher than the official numbers, more and more research suggests,' *Business Insider*, 25 July 2020, http://businessinsider.com/real-us-coronavirus-cases-compared-to-official-count-2020-7 (accessed 31 July 2020).

In addition to the relevance of the research question and analysis of the United States' COVID-19 response, the argument in this paper providing new bases to support the existence of international legal obligations for the US to respect, protect and fulfill the rights to life and health also benefits the academic community. COVID-19 provides novel circumstances and thus new topics for discussion and debate. This is especially important given some experts' predictions that subsequent pandemics will follow and could potentially be much worse with regard to life and health. As COVID-19 has shown in a dramatic fashion, it is critical that the rights to life and health are universally recognized and that accountability measures are instated and enforced.

An effective international human rights regime needs cooperation and equal commitments from the country with the largest economy and third largest population in the world to reach its true potential. The COVID-19 pandemic and the scholarly and legal analyses resulting therefrom regarding the US and human rights, particularly the right to health, will be beneficial in advancing human rights generally and, ideally, facilitating the US return to the forefront of sincere human rights advocacy and protection. Exposing serious violations occurring during a pandemic is beneficial to the international community, academia and human rights practitioners.

1.4. Methodology

At the time of publication, the COVID-19 pandemic is still very much in full swing, even gaining momentum throughout July 2020.[38] On 27 June 2020, for example, the US alone reported 42,597 new confirmed cases of the virus and 2,516 deaths.[39] On 12 July 2020, the US set a new record with 66,281 new cases, although the deaths have averaged between 500 and 1,000 per day after the dreadful day of 27 June, when the US reported 2,516 deaths, the most since mid-May.[40] As of 11 August, travel restrictions are mostly in

[38] L. Du and M. Fay Cortez, 'Global Covid-19 Cases Hit 10 Million as Pandemic Gains Momentum,' *Bloomberg,* 28 June 2020, https://www.bloomberg.com/news/articles/2020-06-28/global-covid-19-cases-hit-10-million-as-pandemic-gains-momentum?utm_campaign=news&utm_medium=bd&utm_source=applenews (last accessed 28 June 2020).
[39] *Ibid*; WHO, 'COVID-19 Dashboard.'
[40] WHO, 'COVID-19 Dashboard.'

full effect, and businesses across the United States that had reopened are being closed again as states such as Texas and Arizona see new spikes in cases and deaths.[41] This changing nature inherently makes most forms of primary research and data collection difficult.

For example, by the week of 7 June, the US COVID-19 infection and death rates were declining, and a victory appeared possible in the not-so-distant future. Beginning on 19 June 2020, however, the US saw unprecedented daily spikes in infections, and deaths continued by the hundreds or even thousands.[42] It is therefore nearly impossible to properly and effectively write this paper by only providing the numbers as of the publication date. As a result, there will be times when dates are used to describe certain events and metrics that occurred weeks if not months before the publication date. I believe this effectively illustrates the rapidly changing nature of the situation without contradicting or negating any points made throughout the paper.

Fortunately, an assessment of the US response can be conducted remotely, as every source of media provides a watershed of COVID-19-related reporting. An important necessity has been balancing the sources of media, as many news outlets in the US have worked to advance political agendas by finding 'experts' and allowing ample leeway to anchors to spin information as desired with clear underlying political motives. Both sides of the political spectrum have accordingly reported the pandemic differently, and often contradictorily.[43] International news outlets such as BBC, the Economist, the Guardian and Al-Jazeera are additionally necessary to balance information and stories against the heavily politicized realm of American journalism. This political divide has been further elucidated during both the pandemic and with massive protests against racial inequality occurring throughout summer 2020.

---

[41] J. Interlandi, 'Why We're Losing the Battle with COVID-19,' *New York Times*, 14 July 2020, https://www.nytimes.com/2020/07/14/magazine/covid-19-public-health-texas.html (accessed 15 July 2020).
[42] WHO, 'COVID-19 Dashboard.'
[43] L. Bursztyn, et. al, 'Misinformation During a Pandemic,' *University of Chicago, Becker Friedman Institute for Economics Working Paper No. 2020-44*, 15 June 2020, https://dx.doi.org/10.2139/ssrn.3580487 (accessed 15 July 2020), p. 1.

Scholarly literature specifically about COVID-19 was nonexistent in March 2020. By late April 2020, peer-reviewed articles were beginning to surface. Nonetheless, the fact that COVID-19 was only discovered eight months prior to the publication of this paper limits the amount of scholarly work available directly addressing it, especially in the context of human rights law. Consequently, the research for this paper required an uncharacteristically high proportion of news sources. On the other hand, one benefit of writing this paper in the midst of the COVID-19 pandemic was that once academic sources worldwide did eventually begin to emerge, they were often free of charge. This was due in part to the necessity of information-sharing during a global public health crisis. As a result, some of the scholarly research did not yet have time to be published in journals or other mediums and was therefore simply available for free download on databases such as SSRN. This also means, however, that not all academic literature relevant to COVID-19 has necessarily been peer reviewed.

For purposes of COVID-19 numbers and details, data fixation points will be used throughout to help illustrate the growth and continuation of the pandemic. The dynamic 'dashboards' provided by the WHO, US government and other public health institutions are updated on a daily basis. The dynamic nature of response mechanisms also proved difficult to keep up with at times. In the US, measures were initially avoided in February and most of March 2020. Then they were implemented rapidly in late March and early April 2020. Next, measures were relaxed in many states by June 2020. Shortly thereafter, however, measures were reinstated in several states in late June and July 2020. This paper's topic is the epitome of 'writing against a moving target.' Circumstances change almost daily, and unforeseeable events occur at any time.

In May and June 2020, for example, racial inequality surged to the forefront of US politics and media after several additional killings of black Americans by police officers throughout the US, a problem dishearteningly familiar to the United States for decades. This led to mass protests in the streets despite 'stay-at-home' orders and a failure of the response measures to sufficiently 'flatten the curve' yet within the nation's borders. New developments such as this naturally impact certain sections or even the overall structure of

the paper and can alter certain conclusions previously reached. The situation is getting worse in America as of July 2020. The original conclusion of this paper, which was scrapped at the beginning of June 2020, was actually that the US had justifiably restricted other civil and political rights in its efforts to flatten the curve and sufficiently reduce transmission, thereby meeting its obligations under the rights to health and life.

Overall, the predominant form of data in this paper is from academic research and extensive perusing of media outlets and other forms of communication such as social media. The WHO and Johns Hopkins Dashboards have been instrumental in tracking data over time. Additionally, UN press releases and other forms of reliable data have been beneficial when working to keep up with the changing situation. Other crucial data will not be available until well after the publication of this paper, and certain dynamics or unforeseen events such as the aforementioned protests could very well occur and necessitate further research and literature on the very same research question, except under further nuanced circumstances. The nature of writing this paper parallels the nature of the pandemic itself: it is dynamic, it requires adaptation to events and situations unprecedented and unforeseen and it reflects a rapidly changing and unpredictable human rights component. As previously stated, the methodology of this paper is best characterized as 'writing against a moving target.'

Section 2. Pandemic Response Measures and COVID-19

2.1. Brief History of Pandemics and Responses

COVID-19 presents a unique opportunity with regard to its impact on the human rights to life and health in the 21st century. International human rights law is one of many important sources from which to analyze the actions taken in response to the pandemic. While this analytical framework makes the COVID-19 situation relatively unique, pandemics and the need for leaders to take critical action in order to protect the lives and health of citizens are nothing new to humankind.

The prominence of deadly pandemics is tragically embedded in history. The threat of deadly diseases has plagued human history for millennia, and it does not appear to be going anywhere. Some believe that the genuine threat of disease as an "overwhelming existential threat" has waned in the last century with the advancements of modern medicine and international attention to global public health at the institutional level.[44] Recent history supports this contention to an extent, as the last truly global pandemic that rapidly spread and decimated the planet was the Spanish Flu in 1918, where the H1N1 virus killed at least 50 million people.[45] The recent emergence of the COVID-19 pandemic, however, has been on a much larger scale than anything else in the last century. As mentioned, there is concern amongst public health experts that the subsequent threat of another pandemic significantly deadlier than COVID-19, more similar to the Spanish Flu, is not a question of 'if' but of 'when.'[46]

Epidemics and outbreaks have occurred almost annually throughout the 21st Century, but at varying degrees of severity, mortality and geographic scope. A non-exhaustive list of notable disease outbreaks of the 21st Century includes numerous influenza, cholera and measles outbreaks in various regions, the 2014 Ebola outbreak in West Africa, and the worldwide Zika epidemic in 2015. Of particular relevance to the current pandemic, however, are the outbreaks in 2002-03 of Severe Acute Respiratory Syndrome (SARS), which struck Taiwan, China and Canada, and of Middle East Respiratory Syndrome (MERS) that struck Saudi Arabia in 2015. These two are pertinent because they were also caused by coronaviruses similar to SARS-CoV-2, the coronavirus that causes COVID-19.[47] The 2002-03 SARS outbreak is the best point of comparison because it also spread to numerous countries worldwide and resulted in similar response measures to the current pandemic.

---

[44] Elbe, pp. 79-82.
[45] B. Jester, T. Uyeki and D. Jernigan, 'Readiness for Responding to a Severe Pandemic 100 Years After 1918,' *American Journal of Epidemiology*, vol. 187, no. 12, 2018, p. 2596.
[46] Osterholm and Olshaker, pp. 12-13.
[47] C. Del Rio and P. Malani, 'COVID-19: New Insights on a Rapidly Changing Epidemic,' *Journal of the American Medical Association (JAMA)*, 28 February 2020, https://jamanetwork.com/journals/jama/fullarticle/2762510 (accessed 29 March 2020).

2.1.1. 2002-03: The Original SARS Outbreak

Like COVID-19, the 2002-03 SARS outbreak emerged from a province in China in November. SARS also reached the global forefront the following March just like COVID-19. In March 2003, the WHO issued its first global health alert in the organization's history in response to SARS, which reached 26 countries in regions worldwide.[48] Also analogously to COVID-19, SARS was unknown at the time, there was no cure and there is still currently no vaccine.[49] Additionally, similar questions arose as to jurisdiction and appropriate legal authorities, the justification and measurable impact of limiting human movement and other rights in the name of public health and the potential negative outcomes associated with the restrictions on human rights and civil liberties that would and did result from response measures.[50] For example, the two vastly different governments of China and Canada both immediately amended domestic health legislation to include SARS and provide far-reaching powers to public health officials to conduct investigations and implement restrictive measures such as quarantine to contain the spread at the expense of individual rights and liberties.[51]

SARS spread to numerous countries and led to overcrowded hospitals, overworked and endangered healthcare workers, a limited supply of medical equipment and other issues that should sound virtually identical to the current horror stories resulting from the COVID-19 pandemic. More than 8,000 people were infected with SARS and 774 died.[52] On its face, it was epidemiologically very similar to COVID-19. SARS-CoV and today's SARS-CoV-2 share 86% genome similarity, a nearly identical transmission method, and even trigger a similar progression for patients that contract the resultant diseases.[53] While it did not spread to the global extent as COVID-19, SARS still reached 26 countries despite being

---

[48] L. Jacobs, 'Rights and Quarantine During the SARS Global Health Crisis: Differentiated Legal Consciousness in Hong Kong, Shanghai, and Toronto,' *Law & Society Review*, vol. 41, no. 3, 2007, p. 512.
[49] *Ibid*., p. 513.
[50] D. Barbisch, K. Koenig and F. Shih, 'Is There a Case for Quarantine? Perspectives from SARS to Ebola,' *Disaster Medicine and Public Health Preparedness*, Vol. 9, no. 5, 2015, pp. 548-49.
[51] Jacobs, pp. 520-21.
[52] Barbisch, Koenig and Shih, p. 549.
[53] A. Wilder-Smith, C. Chiew and V. Lee, 'Can we contain the COVID-19 outbreak with the same measures as for SARS?,' *The Lancet*, vol. 20, no. 5, May 2020, p. e102.

significantly less virulent than the current coronavirus.[54] Moreover, SARS was brought fully under control after only 8 months in August 2003.[55] Using what were then considered as "top-down draconic" measures, the global community and individual nations were ultimately able to defeat the 2002 SARS coronavirus in the absence of a vaccine or any cure within a year from the discovery of patient zero.[56] One of the ongoing questions as of July 2020 is whether the same measures will also effectively slow down SARS-CoV-2 and the resultant COVID-19 pandemic. The only certainty is that this will not occur within nearly the same time frame in which SARS was contained.

A brief human rights synopsis of measures used in the SARS outbreak demonstrates the critical balance between human rights and emergency measures from recent history. Of particular interest with regard to a human rights analysis of COVID-19 in the United States was that, during SARS, concerns with human rights were also marginalized in countries that had a "surface" reputation for taking human rights seriously, such as Canada.[57] One case study on China, Hong Kong and Toronto found that the measures implemented in Toronto were far more restrictive of rights than those in China and Hong Kong.[58] While the United States has a recent track record that draws its human rights commitments into question, the US was nonetheless a foundational leader of international human rights law as well as the UN, and it has historically been considered a beacon of fundamental freedoms.

In Taiwan, quarantine measures involved locking a mix of symptomatic and asymptomatic patients, along with healthcare workers, inside medical facilities in an attempt to contain transmission.[59] A case study on Taiwan's response found that quarantine measures, as implemented, "resulted in increased mortality while concurrently impeding the personal freedom of asymptomatic individuals."[60] That is the ultimate failure in the face

[54] *Ibid*.
[55] *Ibid*.
[56] *Ibid*.
[57] Jacobs, p. 513.
[58] *Ibid*., p. 511.
[59] Barbisch, Koenig and Shih, pp. 548-550.
[60] *Ibid*., p. 550.

of a pandemic: excessively curtailing human rights while simultaneously failing to contain the virus.

The measures implemented during the SARS outbreak are familiar for those living through the COVID-19 pandemic in most countries around the world. China, in addition to the aforementioned quarantine and isolation procedures, imposed additional restrictions on rights such as travel bans, mandatory temperature screening at airports, health declarations and the requirement to wear masks in public.[61] Today, China is commended, at least strictly scientifically speaking, for its large-scale quarantine measures that were "national, unambiguous, rational, and widely followed, under central guidance."[62] While measures can be as drastic as China's full-fledged lockdown, less restrictive methods can include the phrase now ubiquitous in 2020, 'social distancing,' or other forms of prohibiting activities that would bring people together.

2.1.2. Quarantine Measures and HR Implications

All of these aforementioned measures can essentially be considered under the umbrella of quarantine and its methods and goals of keeping the sick separate from the healthy in order to curb the transmission of a contagious disease. This ultimately calls for a brief discussion about quarantine specifically as the overarching measure under which the majority of civil liberties and human rights infringements would be derived from during both the SARS outbreak and the COVID-19 pandemic.

Restrictive measures, primarily quarantine, have been used for centuries with a relative decrease in severity and ill-treatment of humans. The word "quarantine" comes from the Italian word *quaranta*, meaning '40.'[63] In 1397, the Venetian Republic imposed a 40-day isolation period for any people arriving at the port of Ragusa from plague-infected areas.[64] Quarantine measures are designed to reduce the movements and interactions between sick and healthy people, either through force, legal restrictions or more thorough

[61] *Ibid.*, p. 527.
[62] Wilder-Smith, Chiew and Lee, p. e103.
[63] Barbisch, Koenig and Shih, p. 547.
[64] Elbe, p. 85.

methods of surveillance for the population.[65] It differs from isolation measures, which work to separate symptomatic individuals only.[66] Quarantine is more broad in that asymptomatic people potentially exposed can also be separated from the population. It would theoretically reduce the risk of transmission to zero. This is only realistically attainable if such a procedure was not logistically impossible.[67] Because of such an impossibility, however, the analysis of how and when to implement quarantine and its inherent restrictions on fundamental human rights and civil liberties should be decided with a risk-benefit analysis.[68] This balance is difficult to measure in the face of an imminent outbreak and thus often overlooks the human rights component in favor of the security of the people or the economy. Desperate measures that restricted other rights, however, proved necessary and properly prioritized the rights to life and health above others.

Quarantine is a human rights issue because it naturally cannot be implemented without restricting rights. More specifically, however, it is deeper than this. One of the biggest issues with quarantine is its history of being "discriminatory in character," with consistently disparate impacts throughout time against vulnerable groups such as minorities and the poor.[69] From a broader perspective, any sort of detention is a deprivation of physical liberty and thus can potentially constitute an interference with human rights.[70] It is paramount to recall, however, that it is imperative States act somehow to protect the human rights to life and health above all else, and to do so without discrimination.

By February 2020, American medical professionals were discussing quarantine measures, with some stating in the Journal of the American Medical Association (JAMA) that such measures could be effective at reducing transmission but with the caveat that "human rights must be respected."[71] On 6 March 2020, the UN High Commissioner for Human Rights, Michele Bachelet, who is also a physician, urged the global community to

---

[65] *Ibid.*
[66] Barbisch, Koenig and Shih, p. 547.
[67] *Ibid.*, p. 548.
[68] *Ibid*.
[69] Jacobs, p. 522.
[70] *Ibid.*, pp. 523-23.
[71] Del Rio and Malani.

consider human rights at the center of all response measures to COVID-19.[72] Drawing on her medical background, the OHCHR director stated that she understood the "need for a range of steps to combat COVID-19" and "the often difficult balancing act when hard decisions need to be made."[73] She urged states to consider the dangers of the measures on the population as a whole, but with a particular emphasis on the severity of the discriminatory impact the restrictive measures would have on vulnerable and neglected groups such as those of lower socioeconomic background, the elderly and medically vulnerable and women and children.[74] The international community and the American medical community alike recognize the need to respect human rights, but also the need for effective containment measures in order to protect the rights to life and health.

As world leaders scrambled to organize their country's response to COVID-19, it was clear that a balancing act would be necessary. Human rights must be protected, but there is a compelling argument that the securitization of a country justifies human rights interferences. This is particularly important when the security sought is that of human life and health, two fundamental human rights that remain at the core of all other rights.

2.1.3. Securitization Argument in Favor of Restrictive Measures

As mentioned, one of the preeminent sources of justifying restrictive measures and other acts in response to the COVID-19 pandemic is health security. When an infectious disease "threatens the existence or stability of society and/or when emergency measures are required to address it," then it can be deemed a security threat.[75] The UN Security Council can even go so far as to deem a health issue a threat to international peace and security, invoking a higher level of power and authority.[76] Indeed, the UN Security Council

---

[72] UN Office for the High Commissioner of Human Rights (OHCHR), 'Coronavirus: Human rights need to be front and centre in response, says Bachelet,' 6 March 2020, https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25668&LangID=E (accessed 26 March 2020).
[73] *Ibid*.
[74] *Ibid*.
[75] M. Selgelid and C. Enemark, 'HIV/AIDS, Security and Ethics,' in C. Enemark and M. Selgelid (Eds.), *Ethics and Security Aspects of Disease Control: Interdisciplinary Perspectives*, Ashgate, 2012, p. 45.
[76] *Ibid*.

unanimously passed its first COVID-19 focused resolution pursuant to this authority with regard to countries suffering from conflict and humanitarian crisis.[77] Essentially, where a health issue threatens a population, it will likely require some degree of emergency measures to protect that population.

It naturally follows that deadly infectious diseases such as COVID-19 meet the definition of a 'security threat' when they endanger the health and lives of people anywhere that the disease might spread. Moreover, large-scale infectious diseases impact the national health system simultaneously by drastically increasing the demand for drugs or treatments, beds, ventilators, personal protective equipment (PPE), the space and capacity of health care facilities and, critically, the capacity and health of the healthcare workers responsible for combating the disease.[78] This establishes a more ominous threat against to life and health across society overall, in addition to those actually infected with SARS-CoV-2.

Securitization provides a strong basis for measures enacted to combat a global pandemic. The consequences of the threat or confirmation of a dangerous, contagious illness and the death of large numbers of people can include severe economic downturns, widespread panic and civil disruption, which in turn further threaten public safety, health and overall security.[79] When complementing a massive illness, such outcomes can have devastating consequences on people within a nation and around the world. It thus follows that "the implementation of liberty-infringing measures might be justified when there is reason to expect that they would contain and/or reduce the impact of what otherwise would be a devastating infectious disease outbreak."[80] Basically, the securitization perspective emphasizes the primary importance of life and health above all else. In theory, this essentially requires prioritizing life and health through restrictive emergency measures like those implemented during SARS.

---

[77] UN Security Council, *Security Council Resolution 2532 (2020)*, 1 July 2020, S/RES/2532.
[78] Selgelid, p. 27.
[79] *Ibid*.
[80] *Ibid.*

From a political science perspective, there are arguments balancing the good of the individual versus the good of society, as well as ascertaining a calculated value for 'the good of society' as the sum of wellbeing, equality and liberty.[81] From a human rights perspective, the balance is between the protection of rights threatened by the disease itself, such as the human rights to life and health, versus other civil, political, economic, social and cultural rights that restrictive government measures must infringe upon in order to protect the threat to the health and lives of its citizens. When a spreading infectious disease amounts to a global pandemic, those necessary obligations can extend to global health as well. Overall, the merging of health and security issues posed by the threat of infectious diseases is referred to as the "securitization of health," and efforts made towards that securitization process inherently pose dangers to individuals' civil liberties.[82] This serves as a primary basis for a State to act extraordinarily in order to protect life and health.

There is another concept that can be interpreted as a merging of several concepts including health, human rights and securitization. The United Nations Development Programme (UNDP) began referring to the concept of "human security" in the 1990s as a "people-centric" approach towards dealing with non-military threats to national security or international security.[83] The 1994 UNDP report referenced that human security would be at the forefront when a non-military threat emerges that transcends national borders and threatens the entire world together.[84] This could hardly be better exemplified than by a deadly pandemic with a truly global reach.

2.1.4. COVID vs. SARS

The big question in 2020 has been whether similar quarantine measures to those applied to the SARS outbreak would be equally as effective against COVID-19. With momentum still gaining for infections in parts of the world and thousands of daily deaths

[81] *Ibid.*, pp. 32-43.
[82] Elbe, p. 79.
[83] *Ibid.*, p. 91.
[84] UN Development Programme (UNDP), *Human Development Report 1994: New Dimensions of Human Security*, New York, 1994, http://www.hdr.undp.org/en/content/human-development-report-1994 (accessed 14 July 2020).

still occurring globally in August 2020, it is now impossible that the 8-month eradication period for SARS will be matched in the fight against COVID-19. Scientific reasons offered for this drastic difference in infections and deaths, geographic scope and longevity of COVID-19 in contrast to its predecessor coronavirus disease include: (1) a different beginning in Wuhan that allowed millions of potentially infected people to leave the region or even the country in the early days, (2) a different viral incubation period leading to more asymptomatic carriers, (3) a higher transmissibility in which each person is more likely to infect more people with COVID-19 than SARS, (4) a different clinical spectrum that can allow more mild cases than the rapid and deadly SARS, and (5) a higher level of community spread in day to day life in contrast to SARS being confined mostly to hospitals.[85] One issue with how large COVID-19 has become is that the short-term costs of containment are likely far lower than the long-term costs of failing to contain it.[86]

The short-term costs referred to inherently include restrictions on human rights, but the long-term costs mean jeopardizing the human rights to life and health on a larger scale over a longer period. As a result, the lessons from SARS provide measures and an indication of their efficacy to encourage similar measures with COVID-19. The scale of COVID-19, however, is concerning because it is already clear it will not be stopped as quickly and as efficiently as SARS, meaning those measures will be longer and more taxing on the human rights of people worldwide. If the measures can protect the human rights to life and health, however, there is a strong justification in their favor. With this background in mind, I will now turn to the international standards that provide specific obligations, governing what States must actually do under international human rights law concerning the rights to life and health.

[85] Wilder-Smith, Chiew and Lee, pp. e104-e105.
[86] *Ibid*., p. e106.

Section 3. International Human Rights Law and COVID-19

Past pandemics can provide useful guidance on what has been done in similar situations and the costs to certain human rights that restrictive measures might impose. The key component of SARS, however, was that it was eradicated with a focus on life and health above all else. The impact on health and life that SARS caused pales in comparison to what COVID-19 has done so far. The guidance for response measures must therefore take into account the human rights to life and health first and foremost. These international standards guide the necessary evaluation of a State's response under its legal obligations to respect, protect and fulfill the human rights to life and health.

It is useful to recall that human rights obligations require negative action and positive action. The negative obligation to respect requires States to abstain from acting in a way that would interfere with the human rights of its people. The obligation to protect requires positive action from States, such as through legislative or other measures, to ensure others do not violate its citizens' human rights. The obligation to fulfill includes obligations of result, which do not concern what the action was so much as what actually happened, and obligations of conduct, such as requiring states to implement a system and policies that directly operate to help citizens achieve equal realization of their human rights.[87] Through this overall lens, I will now discuss the specific obligations required by international standards with respect to the rights to life and health.

3.1. Overview of the Relevant Sources of International Law

The first true codification of international human rights came with the UDHR in 1948.[88] The preamble of the UDHR recognizes "the inherent dignity and…the equal and inalienable rights of all members of the human family" as the "foundation for freedom, justice and peace in the world."[89] Article 1 declares that "[a]ll human beings are born free and equal in dignity and rights," while Article 2 affirms that all people are "entitled to all

[87] M. Nowak, 'The Right to Education – Its Meaning, Significance, and Limitations,' *Netherlands Quarterly of Human Rights*, vol. 9, no. 4, 1991, pp. 421-423.
[88] UN General Assembly, *Universal Declaration of Human Rights*, 10 December 1948, 217 A (III).
[89] *Ibid.*, 'Preamble.'

the rights and freedoms set forth in this Declaration, without distinction of any kind…"[90] These two declarations demonstrate the drafters' understanding that humans are naturally entitled to fundamental rights as the basis for a free, just and peaceful society, and that these rights must unequivocally be provided without discrimination to every single person by the sole virtue of their being human. As stated, the two paramount human rights in the COVID-19 context are the rights to life and health.

Article 3 of the UDHR immediately provides for the "right to life, liberty and security of person."[91] 'Life's' placement at the forefront of an extensive list of human rights demonstrates its significance and the foundational nature as a human right without which no other rights are essentially plausible. Article 25(1) states that "[e]veryone has the right to a standard of living adequate for the health and well-being of himself and of his family, including…medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control."[92] While the UDHR itself was not drafted as a binding document, many of its provisions constitute customary international law, equally as binding on States as conventional treaties.[93] Over time, it has acquired "significant legal status."[94] COVID-19, as the first international public health crisis indiscriminately threatening the international community since 1948, marks the next big step for the legal status of the UDHR, specifically with regard to the right to health. COVID-19 itself directly threatens the rights to health and life, so legal obligations under these rights entail States taking action to protect its people from the virus, its resultant disease, and death.

Although the UDHR is a declaration rather than a treaty and therefore contains no expressly binding legal authority, it often establishes customary international law.[95] The two most important international treaties are the aforementioned ICCPR, which contains

[90] *Ibid.*, Arts. 1-2.
[91] *Ibid.*, Art. 3.
[92] *Ibid*., Art. 25.
[93] Hannum, pp. 146-148.
[94] *Ibid.*, p. 147.
[95] *Ibid.*

the right to life, and the ICESCR, which provides for the right to health. As the two most important instruments in international human rights law, these two covenants along with the UDHR are collectively referred to as the International Bill of Human Rights.[96] The US' obligations under the right to life are clearly delineated by ICCPR Article 6.[97] Despite the US not yet ratifying the ICESCR, Article 12 and its authoritative interpretations still provide that clearest derivation of specific standards and obligations under the right to health, which binds the US under customary international law.[98] While a strong argument already existed that the right to health is universally binding, an international public health crisis provides additional sources of laws, rules, norms and principles that collectively establish legal obligations to the entire international community to protect life and health domestically and internationally by taking reasonable measures against COVID-19.

States have legally binding human rights obligations that extend to any form of state action or actors operating under authority of the state. State governments and others acting on behalf of the state have obligations to respect, protect and fulfill human rights both internationally and domestically.[99] In the COVID-19 context, these obligations extend to examples such as governments passing legislation, public hospitals deciding who should receive healthcare or doctors caring for the elderly in public institutions.[100] States that do not implement measures of disease control during a global pandemic will be in violation of their human rights obligations under the rights to health and life.[101] Moreover, the spread of an infectious disease that overwhelms healthcare systems throughout a country threatens

---

[96] UN General Assembly, *International Bill of Human Rights*, 10 December 1948, A/RES/217(III)A-E.
[97] ICCPR, Art. 6.
[98] E. Kinney, 'The International Human Right to Health: What Does This Mean for Our Nation and World?,' *Indiana Law Review*, Vol. 34, no. 1457, 2001, pp. 1457-1475; Kinney, 2008; Riedel, pp. 22, 32; Hannum, pp. 145-148.
The argument that the UDHR has achieved status as customary international law for most provisions, including the right to health, is common in legal and academic scholarship and thus assumed for purposes of this paper. For extensive arguments for a human right to health in the US under both international and domestic law, see the publications of Professor Eleanor Kinney cited herein, as well as the other sources cited in this footnote.
[99] Hostmaelingen and Bentzen, p. 1.
[100] *Ibid*.
[101] *Ibid*.

not only the lives and health of those directly affected by the disease, but also the right to life and access to healthcare for individuals needing treatment for other conditions.[102] Some measures must therefore be taken, and the restrictiveness of those measures will ultimately be analyzed under the Siracusa Principles. This, however, is a topic for another paper. The primary focus here is a case-by-case analysis under the duties to respect, protect and fulfill the human rights to life and health. This requires a determination here as to the threshold for which a State's acts or omissions taken meet or violate these obligations.

Restrictive measures will inherently interfere with other human rights in some capacity. Nondiscrimination, however is an underlying principle of all international human rights legal protections The requirement that all States must apply all measures equally and without discrimination based on race, gender, ethnicity, national origin, religion, age or other personal characteristics is especially pertinent during COVID-19 as the evidence continues to emerge showing disproportionate suffering and a higher mortality risk from the virus on certain racial and ethnic minorities and on the elderly.[103] Omissions that lead to discrimination will equally violate this core human rights principle.

Government acts or omissions that result in disparate treatment or disproportionate outcomes for any persons based on personal characteristics such as race, age, gender, sexual orientation, national origin, ethnicity or any other factor will constitute discrimination in violation of international law.[104] Non-discrimination is imperative for the actual realization of all human rights for all people. It is thus a critical underlying principle for the international standards governing obligations under the human rights to life and health. These standards will be extensively discussed in the subsequent section.

[102] A. Spadaro, 'COVID-19: Testing the Limits of Human Rights,' *European Journal of Risk Regulation*, vol. 11, no. 2, 2020, p. 319.
[103] *Ibid*., pp. 1-2.
[104] ICCPR, Art. 2.

3.2. International Standards Governing the Rights to Life and Health

The international standards governing the rights to life and health as provided by the ICCPR and ICESCR, and governed by each Covenant's respective treaty body, are the critical determinants of state obligations under international human rights law. An assessment of each right's respective standards will provide the necessary guidance to determine: (1) what state obligations are relevant during a global pandemic, (2) what acts and omissions are required to meet those obligations and (3) what constitutes violations of the rights to life and health in the context of a State's COVID-19 response.

3.2.1. The Right to Life (ICCPR Art. 6)

As the HRC affirms, "the right to life is the supreme right from which no derogation is permitted, even in times of armed conflict and other public emergencies that threaten the life of the nation."[105] Furthermore, "the effective protection of which is the prerequisite for the enjoyment of all other human rights and the content of which can be informed by other human rights."[106] When confronted with the threat of a deadly pandemic, States must focus first and foremost on protecting the lives of their citizens.

Similar to UDHR Article 3, the ICCPR recognizes the paramount importance of the right to life as a foundational human right upon which the others depend and accordingly places the right to life at the forefront. Following several articles outlining core principles such as equality and non-discrimination, the first specific human right listed is in Article 6(1), which states that "[e]very human being has the right to life."[107] Article 6(1) further provides that the right to life "shall be protected by law" and that "no one shall be arbitrarily deprived of life."[108] Article 6(1) is short in language, but there is an authoritative

[105] UN Human Rights Committee (HRC), *General Comment No. 36, Article 6 (Right to Life)*, 3 September 2019, CCPR/C/GC/35., para. 2.
[106] *Ibid*.
[107] ICCPR, Art. 6(1).
[108] *Ibid*.

interpretation that is critical for ascertaining the standards for legal obligations under the right to life.

In 2018, the HRC, the treaty body responsible for interpreting and enforcing the ICCPR, published its most recent commentary on Article 6 and the right to life: General Comment No. 36.[109] General Comment 36 supersedes all previous General Comments on Article 6, so it is the most recent and overarching guiding authority on the right to life.[110] From this authoritative interpretation, several key components are particularly applicable to the COVID-19 pandemic.

DUTIES

First of all, the HRC explains that the right to life contains "the entitlement of individuals to be free from acts and omissions that are intended or *may be expected* to cause their unnatural or premature death, as well as to enjoy a life with dignity."[111] The key components of the right to life in the COVID-19 context are those emphasizing the foreseeability of threats to human life. It specifically requires state action through laws and through other measures "to protect life from all reasonably foreseeable threats."[112] "Deprivation of life" in violation of Article 6 includes both "intentional *or otherwise foreseeable and preventable* life-terminating harm or injury, caused by an act or omission."[113] Thus, not only must a State Party refrain from acting to deprive citizens of life, but it also must not fail to act in the event of reasonably foreseeable and preventable life-threatening harm.

Most importantly with respect to COVID-19 is General Comment No. 36, paragraph 26. Here, the HRC expresses state obligations to "take appropriate measures to address the general conditions that may give rise to direct threats to life," including the express imposition of a duty to protect people from the "prevalence of life-threatening

[109] UN Human Rights Committee (HRC), *General Comment No. 36, Article 6 (Right to Life)*, 3 September 2019, CCPR/C/GC/35.
[110] *Ibid*., para. 1.
[111] *Ibid*., para. 3.
[112] *Ibid*., para. 18.
[113] *Ibid*., para. 6 (emphasis added).

diseases."[114] Paragraph 26 further requires measures to "ensure access without delay by individuals to essential goods and services such as…health care."[115] International standards governing the right to life thus clearly and directly obligate States to address both the disease itself, as well as conditions on the ground such as health care. Certainly, this cannot extend to preventing all death from an illness that has killed hundreds of thousands of people worldwide. Nonetheless, States have legal obligations to act in order to prevent unnecessary loss of life at the hands of COVID-19.

Examples of such obligations under the duty to protect include "the bolstering of emergency health services," the development of contingency plans for disaster management and emergency response operations.[116] Moreover, the duty to protect obligates States to act to "ensure access without delay…to essential goods and services such as…health care."[117] It therefore follows that international standards for the right to life directly address public health crises and necessitate reasonable measures, legal and practical, aimed at combating threats like a global pandemic. The failure to adequately respond to COVID-19 can accordingly constitute human rights violations when a State falls short of the duty to protect the right to life from foreseeable threats.

The HRC further states that States can still violate ICCPR Article 6 even if "foreseeable threats and life-threatening situations…do not result in loss of life."[118] The right to life is clearly implicated in regard to those that die from the virus, but it additionally protects those who merely *might be* exposed to or infected by the deadly illness. State obligations therefore extend to appropriately managing and directly addressing foreseeable threats and life-threatening situations so as to not even compromise the right to life in a theoretical sense. Overall, States must act diligently and quickly in the face of a disease that poses a threat to life on a massive scale like COVID-19.

---

[114] *Ibid*., para. 26.
[115] *Ibid*.
[116] *Ibid.*
[117] *Ibid.*
[118] *Ibid*., para. 7.

While numerous government actors could be found to violate state obligations, there is an overarching requirement that the federal government take charge. States must "organize all State organs and governance structures through which public authority is exercised in a manner consistent with the need to respect and ensure the right to life."[119] This also requires states to organize its healthcare system, as an organ of the state, to effectively protect from excessive loss of life. This includes "establishing by law adequate institutions and procedures for preventing deprivation of life."[120] Failing to contain or mitigate the threat would thus constitute violations under this obligation. This is particularly relevant to the United States, where the federal structure contains state and local governments that each must act overtly to contain the pandemic.

This particular provision is important to evaluating state obligations during a pandemic, as it is not effectively possible to individually assess whether each person that died from COVID-19 constitutes a separate human rights violation. This is especially complicated when it is presumed that not every one of the hundreds of thousands of persons that died from COVID-19 worldwide did so because of a human rights violation. Failing to adequately respond to foreseeable threats in general and systematically can constitute the human rights violation, which is much more attainable to establish.

Lastly in regard to the duty to protect the right to life, the HRC provides certain specific applications of this duty to vulnerable groups. This of course encompasses the universal principle of nondiscrimination, applicable to all human rights. It also includes taking "special measures" to protect "persons in vulnerable situations whose lives have been placed at particular risk because of specific threats."[121] COVID-19 has different effects on different people, such as the elderly and immuno-compromised. A failure to take extra actions tailored to protect vulnerable groups could thus also violate state obligations even in the absence of a failure to protect the general population. This obligation covers any groups of people whose lives may be particularly at risk from COVID-19. For example, the

[119] *Ibid.*, para. 18.
[120] *Ibid.*
[121] *Ibid.*, para. 23.

duty to protect additionally extends to those deprived of liberty, whether incarcerated in public or private facilities.[122] People who die in custody under unnatural circumstances are entitled to a "presumption of arbitrary deprivation of life by State authorities."[123] Whether detention was valid or not is an issue for another paper. Regardless, people in detention constitute vulnerable groups.

The obligations imposed under the ICCPR Article 6 right to life in the COVID-19 context are primarily focused around the duty to protect life and to fulfill its duties through reasonably effective government action. The duty to respect focuses mostly on the death penalty, police use of force and other violent acts where the State itself would be responsible for arbitrary deaths. This is not relevant in the COVID-19 context, so the principle takeaway in this context is the extent of specific obligations under the duty to protect. Allegations of violating Article 6 require independent investigations and adequate remedies such as reparations.[124] The enforcement mechanisms under international law, however, are beyond the scope of this paper.

STANDARDS

Turning to how a State Party's acts or omissions would be assessed under international law, the overall requirement to ensure the right to life and to do so without discrimination of any kind comes from ICCPR Article 2.[125] The analysis of a State meeting its obligations under the duties to protect and fulfill, and without discrimination, would thus require the standard case-by-case analysis of human rights obligations under the duties to respect, protect and fulfill. It is quite clear from the HRC throughout General Comment No. 36 that failing to take any actions at all against a threat to life such as COVID-19 would unequivocally violate the right to life. The analysis would thus turn on what acts or omissions the United States took, with a particular focus on the relevant provisions guiding

[122] *Ibid.*, para. 25.
[123] *Ibid.*, para. 29.
[124] *Ibid.*, para. 28.
[125] ICCPR, Art. 2(1).

the duty to protect life as provided by HRC. The US' acts and omissions will be compared to what the standards say should have been done, at minimum, under its legal duties.

The HRC expressly imposes a "due diligence" standard under the right to life, requiring state action in the form of "reasonable, positive measures that do not impose disproportionate burden on [the State] to protect individuals against reasonably foreseeable threats originating from private persons and entities whose conduct is not directly attributable to the State."[126] The references throughout the HRC guidelines to preventable, foreseeable harm, including an express reference to life-threatening disease, demonstrate this due diligence standard applies not only to 'private persons' or 'entities.' One scholar argues that the language of 'private persons' still expressly covers COVID-19 because private persons carrying COVID-19 and infecting others would be the direct cause of the specific threat to the lives of other individuals.[127] This also applies to entities, such as hospitals that poorly contained the risk and thus unnecessarily infected others. Regardless, a reasonableness evaluation under due diligence principles is an appropriate means for assessing a State Party's acts or omissions in response to a clear threat to human life. The threshold for analysis is consequently that of reasonableness in the circumstances.

Overall, the US is bound under the ICCPR to respect, protect and fulfill the rights to life at all times and without exception. During this pandemic, most state obligations are primarily under the duties to protect and fulfill. Acts or omissions that unnecessarily jeopardize human life in the presence of a clear threat violate the human right to life under international law. The duty to protect extends to foreseeable threats, including deadly disease. Standards clearly require actions to at least mitigate the threat. These duties extend to state organs, obligating the federal government to properly organize them. A failure to take extra actions to protect vulnerable groups could thus also violate a State Party's obligations under the duty to protect life. Finally, the overarching principle of nondiscrimination must be satisfied as well.

---

[126] HRC General Comment No. 36, paras. 7, 21.
[127] Spodaro, p. 318.

The analysis will thus focus on whether the acts and omissions of the US government in response to the COVID-19 pandemic were reasonably sufficient to comply with its obligations to protect the right to life. Specific considerations include: (1) the foreseeability of the threat to life, (2) the existence or absence of government measures in response to that threat, (3) the expediency of actions taken, (4) the impact of measures or lack thereof towards mitigating the threat, (5) the availability of alternative options and (6) the scale of deaths. Many of these considerations will also be pertinent with respect to the right to health.

3.2.2. The Right to Health (ICESCR Art. 12)

The human right to health is another fundamental human right upon which numerous other rights depend. The first instrument to recognize a right to health at the international level was the UDHR in 1948. Article 25(1) of the UDHR states: "Everyone has the right to a standard of living adequate for the health of himself and of his family, including…medical care."[128] The ICESCR requires States to recognize "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health," and it provides steps States must take "to achieve the full realization of this right."[129] The most authoritative and comprehensive codification of the right to health comes from the ICESCR's treaty body: the CESCR.[130]

Despite the US' failure to ratify the ICESCR, the right to health has acquired status as customary international law.[131] Evidence of general practice under UN and other regional treaties recognizing international human lights can therefore impose international legal obligations under the right to health on states that have not ratified the ICESCR.[132] Evidence of general practice regarding the Article 12 right to health includes the fact that the majority of the countries in the world have ratified the treaty while even more have

[128] UDHR, Art. 25.1
[129] ICESCR, Art. 12 (1), (2).
[130] UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)*, 11 August 2000, E/C. 12/2000/4, para. 2.
[131] Kinney 2001, pp. 1457-1475; Kinney, 2008; Riedel, pp. 22, 32; Hannum, pp. 145-148.
[132] Kinney 2001, p. 1464.

expressly committed to the human right to health in regional treaties or their national constitutions.[133] This is complemented in the case of the United States by the fact that Western democracies and even many developing nations establish an explicit right to health in their constitutions.[134] The US Constitution itself allows Congress to provide a right to health, and several state constitutions expressly incorporate this right.[135] This provides evidence of such a practice from within the United States itself.[136] Lastly, the WHO includes a similarly worded right to health in its Constitution.[137] Considering all of these factors plus the ICESCR's place in the International Bill of Human Rights alongside the UDHR and ICCPR, this Convention and its authoritative interpretation constitute the international legal standards for state obligations under the right to health.

The authoritative interpretation of ICESCR Article 12 and the right to health comes from the CESCR in their guiding publication entitled, 'General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12).'[138] It is affirmed by the WHO in full.[139] The most relevant provisions from this comprehensive interpretation for the purpose of defining legal standards are as follows.

Article 12(1), as stated above, provides for the "highest attainable standard of health." Article 12(2) provides a non-exhaustive list of specific examples and guidance from which governments must develop measures to respect, protect and fulfill the right to health. The latter will be explored following an assessment of the meaning of Article 12(1).

The right to health contains both freedoms and entitlements, the latter of which are most relevant here. One crucial entitlement in regard to COVID-19 is "the right to a system of health protection which provides equality of opportunity for people to enjoy the highest

---

[133] Kinney 2008, p. 364.
[134] Kinney 2001, p. 1464.
[135] *Ibid.*, p. 1465; US Constitution, Art. I, section 8; Wyoming Constitution, Art. 7, sect. 20; South Carolina Constitution, Art. XII, section 1; Montana Constitution, Art. II, sect. 3; Alaska Constitution, Art. 7, sect. 5.
[136] *Ibid.*, p. 1466.
[137] International Health Conference, *Constitution of the World Health Organization*, 1946.
[138] CESCR General Comment No. 14.
[139] World Health Organization (WHO), 'Fact Sheet no. 31: The Right to Health,' Office of the High Commissioner for Human Rights (OHCHR), Geneva, June 2008.

standard of health."[140] It is impracticable to expect any State to completely protect its population from every risk or threat to health. The "highest attainable standard of health" from Article 12(1) consequently "must be understood as a variety of the facilities, goods, services and conditions necessary for the realization" of that standard.[141] As will be discussed later in this section, economic conditions and a State's available resource are relevant in determining the extent of specific obligations.[142] Without regard to any specific State's capabilities, there are four general guiding standards for assessing the adequacy of measures and conditions in general.

The four overarching standards for the right to health everywhere are: (1) availability, (2) accessibility, (3) acceptability and (4) quality. These standards are "interrelated and essential," although the degree of specific obligations varies by country.[143] 'Availability' requires sufficient quantities of goods and services, as well as functioning public health and healthcare facilities.[144] Examples include hospitals, competitively paid and well-trained healthcare personnel, and health programs.[145] In the context of COVID-19, failures to have sufficient space, equipment and personnel to provide reasonable, equitable and nondiscriminatory care to a State's populations could be violations of the right to health. 'Accessibility' affirms the requirements of nondiscrimination and for special attention to vulnerable or marginalized groups and also includes access to information.[146] Goods, services and the "underlying determinants of health" must be provided based on the concept of equity, made available to both urban and rural populations and afforded without discrimination.[147] Several groups are more vulnerable than others to COVID-19. Moreover, equal access to information is critical during a pandemic where certain behaviors can make people safer or less likely to get sick. 'Acceptability' means that health-related goods,

[140] *Ibid.*, para. 8.
[141] *Ibid.*, para. 9.
[142] *Ibid*.
[143] *Ibid.*, para. 12.
[144] *Ibid*., para. 12(a).
[145] *Ibid*.
[146] *Ibid.*, para. 12(b).
[147] *Ibid.*

services and facilities must be respectful of ethics and respectful of other cultures.[148] 'Quality' further mandates that goods, services and facilities be "scientifically and medically appropriate."[149] Examples include skilled medical personnel, scientifically approved drugs, hospital equipment, water and sanitation.[150] Overall, health goods, services facilities and information must be of reasonable quality, equally available to all citizens and accessible throughout the nation.

Article 12(2) provides a non-exhaustive list of examples guiding actions that must be taken by states in order to meet obligations under the right to health. Article 12(2)(c) provides the most relevant and critical component in the context of a pandemic: "the prevention, treatment and control of epidemic, endemic, occupational and other diseases."[151] The CESCR elaborates that this provision requires the establishment of prevention and education programs for health concerns, particularly behavior-related concerns.[152] Moreover, it provides a right to "a system of urgent medical care in cases of…epidemics and similar health hazards."[153] While control of COVID-19 has proven problematic worldwide, this right requires both individual and joint actions by States regarding relevant technologies, epidemiological surveillance and data collection "on a disaggregated basis," the implementation of immunization programs and "other strategies of infectious disease control."[154] As will be discussed in Section 3.4, this complements duties under international health law as provided by the WHO.

Finally, ICESCR Article 12(2)(d) provides the right to health facilities, goods and services, which includes "the creation of conditions which would assure to all medical service and medical attention in the event of sickness."[155] This includes "equal and timely access" for the physically and mentally ill, as well as preventive health services and health

[148] *Ibid*., para. 12(c).
[149] *Ibid.*, para. 12(d).
[150] *Ibid.*
[151] ICESCR, Art. 12(2)(c).
[152] CESCR General Comment No. 14, para. 16.
[153] *Ibid.*
[154] *Ibid.*
[155] ICESCR, Art. 12(2)(d).

education.[156] The CESCR expressly lists "appropriate treatment of prevalent diseases…preferably at the community level," as well as the provision of essential drugs.[157] In the context of COVID-19, preventive health services as well as appropriate treatment would include 'equal and timely' access to testing. It also provides the obligation that, in the event of a health emergency, States have or make medical facilities available to treat the sick in a timely manner and without discrimination of any kind.

Overall, States must actively address pandemics by prevention programs, proper education for all people, accurate information and with an adequate system for urgent medical care. It is important to recall that all state obligations under the right to health must be unequivocally provided under the core human rights principles of equal treatment and nondiscrimination.[158] This principle is clearly established under international law. It is also worth noting that the International Covenant on the Elimination of Racial Discrimination (ICERD) provides an additional obligation that States guarantee to everyone equitable enjoyment of the human right to "public health and medical care."[159] The US is a State Party to the ICERD, and thus also bound under conventional law in this regard.

Lastly, the CESCR elaborates that the ICESCR right to health reaffirms the importance of preventive care and treatment for the elderly, with special attention to care for the terminally ill, "sparing them from avoidable pain and enabling them to die with dignity."[160] Disparate impacts or the lack of special attention to the elderly and marginalized groups would consequently violate state obligations under the right to health.

As with the right to life and other fundamental human rights, state obligations under the right to health include the obligations to respect, protect and fulfill. The CESCR elaborates extensively on these obligations generally, but I will focus exclusively on those relevant to the US response to COVID-19. Under the negative obligation to respect, states

---

[156] CESCR General Comment No. 14, para. 17.
[157] *Ibid.*
[158] *Ibid*., para. 18-19.
[159] International Covenant on the Elimination of All Forms of Racial Discrimination (adopted 21 December 1965, entered into force 4 January 1969) 660 UNTS 195, Art. 5(d)(iv).
[160] CESCR General Comment No. 14, para. 25.

must refrain from denying or limiting access to medical care for all persons, including prisoners, detainees, minorities and illegal immigrants.[161] The crux of the obligation to respect in this context is that states must not enforce or directly allow discriminatory practice. Also relevant to the US response, states must refrain from "marketing unsafe drugs."[162] The majority of state obligations in the COVID-19 context, however, arise from the positive obligations to protect and fulfill.

The obligation to protect requires states to implement legislation and other measures that serve to realize the right to health. In particular, these measures must ensure equal access to health services, whether those services are provided by the government itself or by third parties.[163] Moreover, measures must ensure that the privatization of healthcare does not constitute a threat to the elements of availability, accessibility, acceptability and quality.[164] The obligation to protect and its mention of 'other measures' in general extends to the government requirements to take positive action and introduce measures to protect its population from health threats, similar to the obligations and standards provided by the ICCPR right to life.

The obligation to fulfill complements the obligation to protect. It requires the government to take actions that give national recognition to the human right to health, such as via a detailed health policy.[165] Regarding a pandemic, states must "adopt measures…against any other threat as demonstrated by epidemiological data."[166] This clearly applies to COVID-19. States also have an obligation to "promote" the right to health through measures that create, maintain and restore the health of the population.[167] This includes recognizing research and information necessary to protect health and proper dissemination of health information.[168] The obligations under the right to health also extend

[161] *Ibid.*, para. 34.
[162] *Ibid.*
[163] *Ibid.*, para. 35.
[164] *Ibid*.
[165] *Ibid.*, para. 36.
[166] *Ibid*.
[167] *Ibid*., para. 37.
[168] *Ibid*.

to individuals, thereby requiring states to provide an environment where all relevant actors, from individuals and families to medical professionals, may discharge their responsibilities.[169] In conjunction with the needs for accurate and quality information dissemination and for education on healthy behaviors, this requires sufficient government leadership, assistance to the healthcare field and accurate communications in the time of a global health crisis.

In determining the extent of obligations that the ICESCR imposes on states under the right to health, however, it is also necessary to consider the nuances of implementation. Acknowledging that resources and other constraints might impair certain States' ability to immediately achieve the full realization of the right to health, the CESCR allows for "progressive realization."[170] Two clear and immediate legal obligations, regardless of any financial or other constraints impeding a States' full realization of the right to health, are that of (1) nondiscrimination at all times and (2) the obligation to take steps towards full realization.[171] There are certain dimensions which may therefore be realized progressively, but core obligations extend to all States at all times.

Core obligations are non-derogable. The relevant core obligations include the access to health facilities, goods and services to all; special attention to vulnerable and marginalized groups; equitable distribution of healthcare facilities, goods and services and nondiscrimination.[172] Especially relevant to the COVID-19 response, a state must adopt a transparent and closely monitored national plan, "based on epidemiological evidence," to address the health concerns of a whole population.[173] In addition to these core obligations, additional requirements of "comparable priority" include taking measures to "prevent, treat and control epidemic and endemic diseases" and providing access to information concerning the "main health problems in the community, including methods of preventing

[169] *Ibid.*, para. 41.
[170] *Ibid.*, para. 30.
[171] *Ibid.*
[172] *Ibid.*, paras. 43(a), (e).
[173] *Ibid*., para. 43(f).

and controlling them."[174] There is accordingly an express state obligation that requires governments to combat COVID-19 and to provide the public with consistent and accurate information about what roles individuals and third parties must play to help prevent and control the spread of the disease.

The final key component of the standards governing state obligations under the right to health concerns violations. The CESCR provides an extensive but non-exhaustive list of examples of violations of the obligations to respect, protect and fulfill.[175] This paper will only focus on the relevant general principles. First, it is important to recognize the difference between a State's inability to comply with its obligations from its *unwillingness* to comply.[176] Violations can either occur by act or omission.[177] Here, the analytical focus will remain mostly on omissions, or failures to take sufficient measures necessary to protect and promote public health.

Violations of the right to health are particularly serious, thereby making state obligations under this right especially important. Violations of the right to health lead to "unnecessary morbidity and preventable mortality."[178] The latter consequently enmeshes with state obligations under the right to life as well. Even though the implementation component differs from the direct and universal nature of the right to life, the right to health operates on a continuum where, at the very minimum level, it provides the right to "conditions that help protect health in the population."[179] Its core obligations therefore must be adhered to, regardless of a State's domestic situation and resources. These core obligations include express requirements to satisfactorily combat infectious diseases like COVID-19.

The analysis will thus focus on whether the acts and omissions of the US government in response to the COVID-19 pandemic were reasonably sufficient to comply

[174] *Ibid.*, paras. 44(c), (d).
[175] *Ibid.*, paras. 46-52.
[176] *Ibid.*, para. 47.
[177] *Ibid.*, paras. 48-49.
[178] *Ibid.*, para. 50.
[179] Kinney 2001, p. 1457.

with its obligations to protect the right to health, using similar due diligence standards to those expressed above regarding the right to life. Specific considerations include: (1) the foreseeability of the pandemic; (2) the existence or absence of government measures in response to that threat; (3) the expediency of actions taken; (4) the equality and timeliness of access to health facilities, goods, services and information; (5) the availability of alternative options and (6) the effectiveness of emergency health measures. Like with the right to life, attention to vulnerable groups and the principle of nondiscrimination will be equally imperative.

3.2.3. Relationship of Rights to Life and Health

It is important to address the relationship between the right to life and the right to health. During a deadly global pandemic, all states have an obligation under human rights law to protect its citizens' health and lives by directly combating the pandemic.[180] As proclaimed in the Vienna Declaration and Programme of Action in 1993, "all human rights are universal, indivisible and interdependent and interrelated."[181] In the context of a global health emergency like the COVID-19 pandemic, the most obvious link is that between the protection of the rights to health and life.[182] A threat against the health and lives of a State's citizens imposes obligations on the state that will ultimately result in the same measures being designed to address both rights.

In interpreting the rights to life and health, the HRC and CESCR both incorporate the other right by explicit reference. HRC General Comment No. 36 on the right to life directly expressed the obligation for timely and equal access to health care and emergency health services, especially during threats caused by life-threatening disease.[183] Conversely, the CESCR states in General Comment No. 14 that state actions that "contravene the standards" of the right to health are likely to result in "unnecessary morbidity and

[180] Spadaro, p. 324.
[181] UN General Assembly, *Vienna Declaration and Programme of Action*, 12 July 1993, A/CONF.157.23, Art. 5.
[182] Spadaro, p. 319.
[183] HRC General Comment No. 36, para. 26.

preventable mortality."[184] This direct connection between the rights to life and health is magnified during the COVID-19 pandemic, such as measures to prevent deadly disease spread, the bolstering of an emergency response system to a health threat, access to reliable information, protection of vulnerable groups and nondiscrimination. These connections can naturally lead to some analytical overlap.

3.3. Other Sources of International Standards

The International Bill of Rights is the primary source of state obligations in the context of this paper. With its two Covenants and the UDHR collectively establishing legal standards under conventional and customary international law, it is the most authoritative and thus most important source. Moreover, the respective interpretations by the HRC and CESCR provide comprehensive guidance to determine the specific obligations the United States has in regard to COVID-19. It is nonetheless worth briefly discussing other relevant standards and sources for evaluating human rights obligations in this context.

3.3.1. Regional Standards for the Rights to Life and Health

The rights to life and health and the international standards imposing state obligations are clear from the two core treaties of the International Bill of Human Rights. While the international level will be the primary focus, it is also important to briefly review the standards derived from regional human rights treaties. In addition to its membership status with the UN at the international level, the United States is also a Member State of the Organization of American States (OAS).

In 1969, the OAS published a declaration of human rights similar to the UDHR, entitled the 'American Declaration of the Rights and Duties of Man.'[185] Article 1 of this declaration provides that "every human being has the right to life…"[186] Article 9 provides for the "preservation of health…through sanitary and social measures relating to…medical

[184] CESCR General Comment no. 14, para. 50.
[185] American Declaration on the Rights and Duties of Man, March 30-May 2, 1948, O.A.S. res. XXX, adopted by the Ninth International Conference of American States, Bogota, OEA/Ser. L/V/II, 23 doc., 21 rev. 6, 1948.
[186] *Ibid.*, Art. I.

care."[187] Like the UDHR, the American Declaration is not a binding treaty. It does, however, effectively affirm the standards of customary international law regarding the right to health by further demonstrating its general practice at the regional level as well.

Also similar to the international level, the OAS provides regional treaties providing the rights to life and health. The right to life is found in the American Convention on Human Rights (ACHR), established in 1969.[188] Just like the ICCPR, the ACHR protects civil and political rights and provides that no one shall be "arbitrarily deprived" of life.[189] The US has signed but not ratified the ACHR. The right to health is expressly provided by the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights of 1988, otherwise referred to as the "Protocol of San Salvador."[190] The US has neither signed nor ratified this Protocol.[191]

While the US' failure to ratify both treaties means the US would not be subject to the jurisdiction of the enforcement bodies at the regional level, it is still important to demonstrate that the standards in the regional organization mirror those at the international level. This consistency with the relevant international standards and state obligations supplements the authority of international conventional and customary law in regulating and guiding a State's compliance with the rights to life and health.

3.3.2. Due Diligence Principle

One commonality of all the applicable legal obligations governing and assessing the US response to the COVID-19 pandemic is the supplementary component of due diligence. Due diligence serves as a component to international standards to help assess a State's compliance with its obligations. As stated, compliance is evaluated overall on a case-by-case basis, assessing the threat and response taken. Due diligence thus assists in

---

[187] *Ibid.*, Art. IX.
[188] Organization of American States (OAS), *American Convention on Human Rights, "Pact of San Jose,"* Costa Rica**,** 22 November 1969 (entered into force 18 July 1978).
[189] *Ibid.*, Art. 4.
[190] Organization of American States (OAS), *Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights ("Protocol of San Salvador"),* 17 November 1988 (entered into force 16 November 1999), O.A.S T.S. 69, Art. 10.
[191] Kinney 2001, pp. 1462-64.

determining the threshold for compliance with standards governing the rights to life and health.

It is important to recognize that due diligence is not in and of itself a legal obligation. The role of due diligence in international law is often determined on a case-by-case basis with reference to the actual law or principle under which due diligence requirements are being asserted.[192] Due diligence operates, therefore, not as a general principle or independent international law. The legal obligations due diligence imposes on States must be derived from other established rules or principles of international law.[193] While this principle can thus have different applications under different primary rules, it can apply similarly to the rights to life and health when facing a deadly pandemic like COVID-19. In this case, it provides a reasonableness standard, likely giving some deference to States due to the global impact of the pandemic.[194]

One crucial characteristic to understand about due diligence, however, is that it does not exist in a general sense or provide an overarching obligation under international law for States to simply 'exercise due diligence.'[195] In particular, due diligence exists as a component part of a primary rule established in international law.[196] It therefore requires a "primary rule to trigger an obligation" under international law, which the ICJ has held can be either by treaty or customary international law.[197] Thus, due diligence serves as a customary component to primary laws, whether conventional or customary. It is thus useful in analyzing a state's compliance with international human rights standards and obligations.

Due diligence is analogous to the basic legal standard of 'duties of care,' or obligations to take reasonable measures and maintain standards of conduct to address risks,

---

[192] McDonald, p. 1044.
[193] *Ib*id., 1045.
[194] HRC General Comment No. 36, para. 21.
[195] McDonald, p. 1042.
[196] *Ib*id.
[197] *Ibid.*, pp. 1045-1046, *Pulp Mills on the River Uruguay (Argentina v. Uruguay)*, 2010, ICJ Rep 14; *Corfu Channel (UK v. Albania)*, 1949, ICJ Rep 4.

threats or harms.[198] Due diligence complements obligations under international human rights law by incorporating standards of good governance to the legal obligations under treaties or customary international law.[199] From a legal perspective, the standard is assessed on a case-by-case basis by reference to the rule for which it provides the standards of reasonable care.[200] It can also obligate other positive conduct such as reasonable attempts to prevent harm and danger from a perceived threat, or at least to minimize risk to the best of a State's capacity.[201] Violations of the primary rights occur due to psychological fault, whether willful or negligent, that leads to acts or omissions in the face of reasonably foreseeable threats or outcomes in breach of due diligence obligations.[202]

The standard of reasonable care can thus be applied to state obligations under international standards concerning the human rights to life and health. When assessing a State's compliance, one must look first to the rules provided by the ICCPR and ICESCR and their interpretations, then to the actions of the State in response to the COVID-19 pandemic. Due diligence in this context provides a lens of "reasonableness" that considers specific state obligations based on a risk or perceived threat to life and health. Under the rights to life and health, as governed by their respective international standards in this case, an overall due diligence approach helps assess the reasonableness of the US response in the specific case of COVID-19.

3.4. WHO, IHR and International Health Law

Another authoritative source for state obligations during a global pandemic is international health law as provided by the WHO. The WHO Constitution expressly requires that all health regulations and obligations under its treaties be implemented with respect for human rights.[203] The WHO has also directly incorporated the international

[198] Coco and de Souza Dias, p. 2; A. Sennett, '*Lenahan (Gonzales) v. United States of America*: Defining Due Diligence?,' *Harvard International Law Journal*, vol. 53, no. 2, 2012, pp. 537-547; *Velásquez Rodríguez v. Honduras*, Judgment, Inter-Am. Ct. H. R. (ser. C), no 4, 1989, para. 172.
[199] *Ibid.*, pp. 2-3.
[200] McDonald, pp. 1044-1045.
[201] Coco and de Souza Dias, pp. 2-5.
[202] Barnridge, p. 82
[203] WHO Constitution, Art. 3.

human right to health as provided under the ICESCR, UDHR and its own Constitution.[204] Supplementing the work of the CESCR with regard to the right to health, the WHO also interprets and elaborates upon the ICESCR right to health in an extensive guiding document entitled "Fact Sheet No. 31."[205] This document directly parallels and affirms each provision of ICESCR Article 12, as well as the CESCR guidelines from General Comment No. 14.[206] Accordingly, WHO law regarding international health and infectious diseases directly complements and supports the international standards governing the right to health and, by virtue of the deadly nature of the COVID-19 pandemic, the right to life.

The most important source of authority for an argument that there is such a thing as "international pandemics law" comes from the WHO Constitution and the IHR.[207] Article 2 of the WHO Constitution, to which the United States is one of 194 ratifying Member States, describes the overall function of the WHO as "the directing and co-ordinating authority on international health work."[208] The WHO is a unique international organization in that it has the competence to issue regulations that bind Member States even without national ratification procedures.[209] Through its main body, the World Health Assembly, the WHO has norm-creating powers that complement a direct mandate in the field of pandemics.[210] COVID-19 is the largest pandemic that has swept the international community since the creation of the WHO in 1946 and the entry into force of its Constitution in 1947. It therefore follows that the WHO has extensive influence and binding authority to impose requirements on Member States that directly impact the rights to health and life.

Following the 2002 emergence of SARS, the WHO acknowledged that the momentum created by the "first global health emergency of the 21st century" warranted an

[204] WHO, Fact Sheet no. 31, pp. 1-2.
[205] *Ibid.*
[206] *Ibid.*, pp. 3-30.
[207] A. Von Bogdandy and P. Villarreal, 'International Law on Pandemic Response: A First Stocktaking in Light of the Coronavirus Crisis, *MPIL Research Paper Series*, No. 2020-07, 2020.
[208] WHO Constitution, Art. 2
[209] *Ibid.*, Art. 21 and 22.
[210] Von Bogdandy and Villarreal, p. 4.

update to global public health protocol and decided to revise the outdated International Health Regulations of 1969.[211] On 23 May 2005, the Fifty-eighth World Health Assembly approved an updated, superseding IHR, which went into force in 2007.[212] It covers all 194 WHO Member States plus Liechtenstein and the Holy See, thereby including all major powers and all countries affected by the COVID-19 pandemic.[213] In addition to being a Member State of the WHO, the United States has ratified the IHR.[214] The IHR thus provides binding state obligations on all States, including the US.

Article 2 of the IHR states as the treaty's purpose and scope: "to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade."[215] Article 3 requires that implementation be "with full respect for the dignity, human rights and fundamental freedoms of persons."[216] Article 3 further requires that implementation of the IHR be guided by the UN Charter and the WHO Constitution, which both authoritatively protect human rights.[217] The IHR is legally binding and supplements international standards for human rights obligations in this context. To adhere to the scope of this paper, only the provisions relevant to international human rights legal standards will be discussed.

At the core focus of the IHR lies information and public health responses, both of which are key components and obligations under the standards for the human rights to life and health. IHR Article 5 requires States Parties to implement surveillance programs with the capacities to detect, assess, notify and report events related to potential international public health threats.[218] Article 7 requires "information-sharing during unexpected or unusual public health events," mandating that all relevant information be immediately

---

[211] World Health Organization, *International Health Regulations (IHR) (2nd Ed.)*, 2005, p. 1 (Foreword).
[212] *Ibid.*, p. 6.
[213] *Ibid.*
[214] US ratification included reservations that do not directly impact the scope of this paper or the arguments herein.
[215] IHR, Art. 2
[216] *Ibid.*, Art. 3(1), (4).
[217] *Ibid.,* Art. 3(2), (4).
[218] *Ibid.*, Art. 5.

provided to the WHO.[219] The information-sharing obligations pursuant to Part II of the IHR means that inaccurate, incomplete, untimely or unreliable information constitutes a legal issue, such as when China failed to promptly notify the WHO at the beginning of the SARS outbreak in 2002.[220] While the latter provision primarily focuses on reporting to the WHO, adherence to this binding standard would naturally facilitate accurate information-sharing obligations under human rights law.

Another important concept from the IHR here is the impact of declaring a "public health emergency of international concern (PHEIC)." Article 1 of the IHR defines a PHEIC as "an extraordinary event which is determined…(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."[221] Needless to say, the scale and virulence of the COVID-19 outbreak meets the criteria of a PHEIC. WHO Director-General Ghebreyesus accordingly declared a PHEIC on 30 January 2020.[222] When the WHO Director-General declares a PHEIC, it requires states to take action.[223] PHEIC declarations are essentially "an instrument of international public authority."[224] IHR Article 13 requires States Party to develop the capacity to respond to public health risks and PHEICs and to "support WHO-coordinated response activities."[225] PHEIC declarations therefore formalize the WHO's stance on the severity and international threat of health emergencies. This is particularly relevant with regard to the foreseeability of the threats to life and health that govern assessment of state obligations under human rights law. A primary effect is thus that a

[219] *Ibid.,* Art. 7.
[220] Von Bogdandy and Villarreal, p. 7.
[221] IHR, Art. 1.
[222] World Health Organization, 'Statement on the second meeting of the International Health Regulations (2005) Emergency Committee regarding the outbreak of novel coronavirus (2019-nCov), 30 January 2020, available at https://www.who.int/news-room/detail/30-01-2020-statement-on-the-second-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-outbreak-of-novel-coronavirus-(2019-ncov) (accessed 7 July 2020).
[223] Von Bogdandy and Villarreal, p. 7.
[224] *Ibid.*, p. 12.
[225] IHR, Art. 13.

PHEIC declaration negates states' claims that the extent or severity of threats to the rights to life and health were not foreseeable or known.

Article 43 imposes restrictions on measures, expressly discouraging travel restrictions and other unduly burdening measures.[226] These are similar to the provisions on limitations as provided under international human rights law. Two main reasons the WHO counsels against travel bans are that they can inhibit necessary access to aid and technical support to dependent parts of the world and that it creates a false sense of security within countries.[227] Proponents of the WHO's anti-travel ban policy further note that the impacts on trade and the economy overall further harms the global population and individual countries at a critical time.[228] Those in favor of border closures and travel bans, however, argue that such policies slowed the exportation of the virus to the rest of the world, thereby allowing more time to prepare an effective response for the inevitable importation of the virus.[229] While this debate is outside the scope of this paper, it is interesting to consider that the vast majority of countries in the world still imposed travel restrictions.

Lastly, IHR Article 42 states that "health measures taken pursuant to these Regulations shall be initiated and completed without delay and applied in a transparent and non-discriminatory manner."[230] Consequently, the IHR complements the timeliness, transparency and nondiscrimination requirements under the international human rights standards for the rights to life and health.

The IHR is a pertinent legal instrument guiding both procedure and human rights considerations during a pandemic like COVID-19. Its content and authority complement the international standards for the human rights to life and health. The IHR provides a legal framework to allow the WHO to lead collective global action against infectious diseases.[231]

---

[226] *Ibid.*, Art. 43.
[227] S. Devi, 'Travel Restrictions hampering COVID-19 response,' *The Lancet*, vol. 395, 25 April 2020, p. 1331.
[228] *Ibid.,* p. 1332.
[229] C. Wells, et al., 'Impact of international travel and border control measures on the global spread of the novel 2019 coronavirus outbreak,' *PNAS*, vol. 117, no. 13, 31 March 2020, pp. 7507-7508.
[230] IHR, Art. 42.
[231] Devi, p. 1331.

Its status as binding 'hard law' is also clear.[232] Due to its support to international human rights legal obligations and direct incorporation of human rights, a brief analysis under WHO law and the IHR will be pertinent to this paper's central argument. Overall, however, the focus of the US response will primarily be evaluated under the international standards governing the paramount human rights of life and health described earlier in this section.

Section 4. The US Response to COVID-19

The international standards provide interpretations of the relevant provisions governing the human rights to life and health. Additionally, those standards provide clarity regarding a base line of necessary acts that can be applied to the US' response to the COVID-19 pandemic. It is clear that no action would violate international human rights law. The Trump administration had overall authority to decide, act and lead the US response from the moment the threat posed by COVID-19 was determined in January 2020. Trump, however, refused to act pursuant to any of the relevant standards prescribed under the rights to life and health. Under the standards outlined above, the US response fell short, and continues to fall short of its obligations to respect, protect and fulfill the human rights to life and health. While numbers alone might suggest such a failure, it has been the failures to act as required that solidify the violations of these two core human rights.

The measures taken first by China, subsequently by European nations and eventually by the United States can be collectively described as "lockdown." When China first issued its 'lockdown' on 23 January 2020 by imposing quarantine requirements, ordering residents to stay at home, shutting down businesses and implementing other restrictive measures, the world first viewed these measures as "draconian."[233] In the following months, however, countries around the world and eventually the United States

[232] M. Halpern, 'State Obligations Under Public International Law During Pandemics,' *Emory International Law Review*, vol. 35, 2020, https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3636848 (accessed 29 July 2020), p. 6.
[233] Ren, X., 'Pandemic and lockdown: a territorial approach to COVID-19 in China, Italy and the United States,' *Eurasian Geography and Economics*, 8 May 2020, http://doi.org/10.1080/15387216.2020.1762103 (accessed 15 July 2020), p. 1.

would follow suit. In the absence of federal leadership, guidance or oversight, individual governors of all 50 US states began implementing lockdowns on a state-by-state basis, calling them instead 'stay-at-home orders.'[234] This compartmentalized, federalist approach caused more harmful effects than benefits. While the lockdown measures themselves were restrictive in nature, they were similar to those imposed by most other nations with varying degrees of success.

Lockdowns inherently incur costs, including costs for human rights. Restrictive measures naturally require the suspension of civil liberties and human rights by restricting movement, closing businesses and schools, and infringing on other fundamental rights. They are also criticized because they are very expensive due to the closures and are considered by some as less effective than other measures.[235] Most importantly in this context, they exacerbate inequality in numerous ways, such as how 'work from home' options or outright termination of jobs directly affects those from lower socioeconomic classes and minority groups.[236] There are examples of alternative measures that are less restrictive on certain individual human rights and civil liberties than quarantine measures, but more invasive to privacy rights.

For example, Hong Kong, South Korea and Taiwan were able to curtail the virus by taking a more 'relational' approach by mass testing and contract tracing, while only thereafter resorting to quarantining and treating the sick where necessary.[237] South Korea was successful in flattening the curve even though it did not even implement quarantine measures. It is worth noting, however, that these three nations are all either physically or effectively island nations drastically smaller than the United States. Moreover, the cultural differences of an "independent" mindset characteristic of many Americans can have an impact on citizens' willingness to adhere to the rules and guidelines of restrictive measures.

---

[234] *Ibid*.
[235] *Ibid.*
[236] *Ibid.*, pp. 1-2.
[237] *Ibid*., p. 2.

Overall, it is difficult to imagine similar measures working as effectively in the United States given its geographic size and federal composition where each state had to enact its own emergency circumstances in the absence of federal mandates. This seems that it should also be true for comparable regions such as Europe that have porous land borders similar to those of US states, large populations and a large geographic territory. As of 30 June 2020, however, EU countries were reporting on average around 15 cases per 100,000 people in contrast to the US reporting more than 130 cases per 100,000.[238] Thus, while lockdown measures aimed at reducing transmission became the norm throughout most of the world, similar measures had much more positive impacts in regions such as Asia and Europe than they did in the United States.

This illustrates the relative failure on behalf of the US government at protecting the health and lives of its citizens from COVID-19. While the exact reasons will be debated for time to come as the pandemic continues to ravage the US, two predominant and related explanations for the disparate impact of the US response are: (1) the federal government's failure to act or lead, (2) the impact of the resultant state-by-state response pursuant to the federalist structure of the United States, (3) the failure to adequately care for vulnerable groups and (4) the disproportionate, discriminatory impact on marginalized groups.

4.1. The Initial Reaction of the United States Government

The US government first began officially reacting publicly to the spread of the novel coronavirus and COVID-19 in late January and early February 2020. At this time, US President Donald Trump openly downplayed the threat of the disease and the likelihood that it would affect the United States in any significant way.[239] On 22 January 2020, the day after the first US COVID-19 case was confirmed in Washington State, President Trump stated in an interview with CNBC at the World Economic Forum in Davos: "We have it totally under control. It's one person coming in from China, and we have it under control.

[238] L. Laurent, 'For the EU, Banning American Tourists is the Easy Part,' *Bloomberg*, 30 June 2020, https://www.bloomberg.com/opinion/articles/2020-06-30/coronavirus-the-eu-s-american-travel-ban-is-the-easy-part (accessed 30 July 2020).
[239] Ren, p. 8.

It's – going to be just fine."[240] In his State of the Union address on 4 February 2020, Trump stated that his administration was working closely with China and "will take all necessary steps to safeguard our citizens from this threat."[241] Over the following months, Trump repeatedly downplayed the virus, making claims that it would disappear "like a miracle" and even going so far as to call it the Democrats' "new hoax" at a rally in South Carolina.[242] This is particularly important because Trump is the leader of the United States and viewed by millions of people as its authoritative guiding voice, despite the constant absence of scientific bases for claims and conflicting opinions of public health experts.

These positions taken and a failure to take early action occurred despite the fact that Trump, the House Intelligence Committee and the Senate Intelligence Committee received "ominous, classified warnings in January" from intelligence agencies tracking the virus in China, as well as from the Department of Health and Human Services (HHS).[243] Moreover, on 29 January 2020, Trump's trade adviser, Peter Navarro, wrote a letter to the National Security Council warning of the imminence and severity of the foreseeable impacts of COVID-19 on health, human life and the economy.[244] There is ample evidence that US public health officials were briefing the relevant parties in the federal government on the nature and gravity of the situation. The initial response, particularly from the White House, can be characterized by a failure to act and a failure to lead.

By the end of the initial reaction period, March 2020 was beginning, and certain facts were known that established the breadth and severity of the COVID-19 threat. China

---

[240] CNBC News Release, 'CNBC Transcript: President Donald Trump Sits Down with CNBC's Joe Kernen at the World Economic Forum in Davos, Switzerland,' *22 January 2020,* https://www.cnbc.com/2020/01/22/cnbc-transcript-president-donald-trump-sits-down-with-cnbcs-joe-kernen-at-the-world-economic-forum-in-davos-switzerland.html (accessed 15 July 2020).
[241] White House, 'Remarks by President Trump in State of the Union Address,' 4 February 2020, https://www.whitehouse.gov/briefings-statements/remarks-president-trump-state-union-address-3/ (accessed 15 July 2020).
[242] C. Peters, 'A detailed timeline of all the ways Trump failed to respond to the coronavirus,' *Vox*, 8 June 2020, https://www.vox.com/2020/6/8/21242003/trump-failed-coronavirus-response (accessed 6 July 2020).
[243] S. Harris, et al., 'U.S. intelligence reports from January and February warned about a likely pandemic,' *Washington Post*, 20 March 2020, https://www.washingtonpost.com/national-security/us-intelligence-reports-from-january-and-february-warned-about-a-likely-pandemic/2020/03/20/299d8cda-6ad5-11ea-b5f1-a5a804158597_story.html (accessed 15 July 2020).
[244] Osterholm and Olshaker, p. 16.

had locked down early and its numbers were decreasing, while Italy had hesitated to act despite the WHO recommendations to implement measures to prevent transmission.[245] When the virus ravaged Italy and began to spread through Europe, the US government continued to downplay it, with the President continuing his remarks that it would "go away" for months to come. Italy reacted to correct its initial mistakes, implementing strict measures prohibiting citizens from leaving the home without documentation explaining their essential purpose.[246] Many European nations implemented and actually enforced similar measures, and the decreased spread of the virus and flattening of death counts in Europe soon reflected the diligent measures. While European nations were taken actions to protect the human rights to life and health, the US government continued to delay, resulting in numbers of infections and deaths that continue to rise as of August 2020.

4.2. The US Response (March 2020– August 2020)

The initial response of President Trump and the US government carried over seamlessly throughout every month since the initial discovery of COVID-19 and the WHO's declaration of a PHEIC. The lack of federal oversight or guidance consequently led each state to take its own actions and often with its own resources. President Trump expressly and intentionally avoided carving out a clear role for the federal government. Trump defined this role as "merely a back-up to state governments" in a letter to U.S. Senator Chuck Schumer.[247] The federal response has thus been described as: "to avoid a national strategy on what was clearly a national problem."[248] The lack of a clear federal strategy led to the initial delay that proved so devastating for infection and death rates beginning as early as March 2020.

Also important with regard to President Trump's public responses is the open conflict between the White House and expert public health officials within the US

[245] Coco and de Souza Dias, p. 16.
[246] Spodaro, p. 319.
[247] D. Kettl, 'States Divided: The Implications of American Federalism for COVID-19,' *Public Administration Review*, vol. 80, no. 4, 2020, p. 595.
[248] *Ibid*.

government, including the Centers for Disease Control and Prevention (CDC). Within a five-day span at the end of March, for example: (1) the US reached 1,000 deaths; (2) Dr. Anthony Fauci, America's top infectious disease specialist, predicted more than 100,000 cases; and (3) President Trump nonetheless announced his intentions to compel states to re-open the lockdowns that had been implemented pursuant to CDC guidelines by as early as 12 April.[249] The "long-simmering tensions" between Trump and leading experts such as Dr. Fauci continued months later into July 2020 as COVID-19 deaths surpassed 130,000.[250] Moreover, as of 15 July 2020, Trump has not attended meetings of his coronavirus task force in months.[251] This is in stark contrast to the WHO, who releases daily "Situation Reports" providing science-based information on COVID-19 for the global public.[252] Additionally, Mark Meadows, Trump's Chief of Staff, has repeatedly "impressed upon" Dr. Fauci and other public health officials not to publicly discuss restrictions or other policies with the media, effectively eliminating the highest levels of infectious disease science from the public message.[253]

Four former directors of the CDC authored a piece describing Trump's approach compared to their experience in the past. Their overall point was that in the last fifteen years, they have never encountered a case where "political pressure led to a change in the interpretation of scientific evidence."[254] They further criticize Trump for undermining scientific evidence-based guidelines the CDC releases, such as safe measures for attempting

---

[249] Peters, 8 June 2020.
[250] K. Liptak and N. Valencia, 'Trump now in open dispute with with health officials as virus rages,' *CNN*, 8 July 2020, https://www.cnn.com/2020/07/08/politics/trump-fauci-cdc-redfield-experts-coronavirus/index.html (accessed 15 July 2020).
[251] *Ibid.*
[252] World Health Organization (WHO), 'Coronavirus disease (COVID-2019) situation reports,' https://www.who.int/emergencies/diseases/novel-coronavirus-2019/situation-reports/?gclid=Cj0KCQjwgo_5BRDuARIsADDEntQk5hu3kLjbRrfNqTFFJsqrLGB0jF6FkrdDQLkktJvNcDifUqen__8aAgG0EALw_wcB (accessed 31 July 2020).
[253] P. Rucker, et al., 'The lost days of summer: How Trump fell short in containing the virus,' *Washington Post*, 8 August 2020, https://www.washingtonpost.com/politics/trump-struggled-summer-coronavirus/2020/08/08/e12ceace-d80a-11ea-aff6-220dd3a14741_story.html (accessed 8 August 2020).
[254] T. Frieden, et al., 'We ran the CDC. No president ever politicized its science the way Trump has,' *Washington Post*, 14 July 2020, https://www.washingtonpost.com/outlook/2020/07/14/cdc-directors-trump-politics/ (accessed 11 August 2020).

to re-open schools during the height of the pandemic, as well as for the US' position as the "global outlier in the coronavirus pandemic."[255] Stating that the US should be nowhere close to re-opening safely due to the politicization and misrepresentation of science, the former CDC directors blame Trump's statements and actions for the increasing public unwillingness to abide by the social distancing measures proven to slow the spread of the virus.[256]

The federal response overall has been characterized by Trump's constant, inaccurate downplaying combined with the federal government's refusal to regularly inform its citizens based on science-based information and also a steady stream of conflicting information from government leaders and public health officials. All of this collectively exemplifies one scholar's characterization of the federal government response: "haphazard," without clear leadership and poorly coordinated.[257] As will be discussed, legislative measures have been passed, but they primarily focus on economic recovery rather than public health. Despite its lack of coordination from the federal level, governors of all 50 individual states ultimately acted independently and enacted measures that mirrored those taken by the majority of countries worldwide.

Since the US government remained silent on guidance or requirements, the 50 US states eventually acted independently. State governors ultimately implemented similar COVID-19 response measures to those instated throughout the world. The overarching term is colloquially referred to as "quarantine" amongst the population, although it entails more than that. Measures have varied in every state, especially in the absence of federal leadership and guidance. State measures have included mandated 'stay-at-home' orders, school closures, closures of 'non-essential' businesses, restaurant limitations on number of customers, closures of bars, prohibitions of mass gatherings and mandated uses of face

[255] *Ibid*.
[256] *Ibid.*
[257] Ren., pp. 9-10.

masks in public.[258] Overall, the methods are aimed at reducing transmission in the absence of a vaccine or any scientifically supported treatment.

By the end of May 2020, however, most states had lifted at least one restriction, calling into question the long-term support for such liberty-restricting measures.[259] A study comparing data from cell phone movements in 2019 to the same months in 2020 during the COVID-19 pandemic found that social distancing measures were effective in slowing the spread of the virus between February and June 2020.[260] Data from a group of studies has also shown a correlation between compliance with recommended measures and both political party affiliation and media preference. Counties throughout the US that supported Donald Trump in the 2016 election as well as counties that preferred Fox News over CNN were correlated with less social distancing efforts, regardless of whether a state mandate was in place.[261] Fox News is a conservative news outlet, while CNN is a liberal news outlet. The former tends to support President Trump and advance his messages, while the latter tends to critique and disagree with him. The authors contemplate that the disparity in compliance is related to President Trump and Fox News' constant assertions during this period that people were not likely to contract COVID-19 or that its effects would not be severe, "leading to less voluntary distancing."[262]

This also calls attention to the fact that state measures were generally not enforced by police, courts or other forms of law enforcement the way they were in parts of Europe and China. There were mandates, but it was up to the people to follow them while they were still effectively allowed to travel in private cars, walk around in public, and cross state

---

[258] KFF, 'State Data and Policy Actions to Address Coronavirus,' 13 July 2020, https://www.kff.org/health-costs/issue-brief/state-data-and-policy-actions-to-address-coronavirus/#socialdistancing (last accessed 11 August 2020).
[259] M. Andersen, 'Early Evidence on Social Distancing in Response to COVID-19 in the United States,' 5 April 2020 (revised 25 June 2020), http://dx.doi.org/10.2139/ssrn.3569368 (accessed 13 July 2020), p. 2.
[260] *Ibid.*, pp. 11-16.
[261] *Ibid*., pp. 15-16; L. Bursztyn, et. al, 'Misinformation During a Pandemic,' *University of Chicago, Becker Friedman Institute for Economics Working Paper No. 2020-44*, 15 June 2020, https://dx.doi.org/10.2139/ssrn.3580487 (accessed 15 July 2020), pp. 5-28.
[262] Andersen, p. 15.

lines.[263] The important takeaway is that the American people also played an independent role through their participation or lack thereof in social distancing mandates proven to reduce the spread of transmission in COVID-19, just like these measures did with SARS. Like response measures, public trust and willingness to behave as recommended by public health experts varied across the 50 US states.

The Kaiser Family Foundation (KFF) is a California-based non-profit that collects, verifies and provides accurate and current data on US national health policies and its role in global health. One beneficial example of this non-partisan organization's work is an extensively detailed state-by-state collection of data and policy status that is updated on a regular basis in response to the evolving situation.[264] For purposes of this paper and in light of the constantly evolving circumstances, the last data collection point here was on 11 August 2020. Despite climbing COVID-19 numbers, 27 states have reopened bars, 42 have permitted non-essential businesses to re-open, 37 have lifted bans on public gatherings, and 44 have either lifted or eased 'stay-at-home' orders.[265]

As of 11 August 2020, about half of the states in the US and a couple territories officially required masks to be worn in public.[266] No states actually enforce this requirement directly. It is left up to businesses to enforce their own policies and refuse entry without masks if they so desire. Only seven states have "reopened," as states like Texas, Florida, South Carolina and Arizona reversed orders to fully reopen after massive surges of the virus in June and July.[267] All 51 states have declared emergencies in order to facilitate access to government emergency powers and funds.[268] The federal government, on the other hand, is only now considering declaring a public health emergency in order to block US citizens and residents from returning to the country via Mexico if they are

---

[263] Ren, p. 8.
[264] KFF, 'State Data.'
[265] *Ibid.*
[266] A. Kim, 'These are the states requiring people to wear masks when out in public,' *CNN*, 13 July 2020, https://www.cnn.com/2020/06/19/us/states-face-mask-coronavirus-trnd/index.html (last accessed 14 July 2020).
[267] KFF, 'State Data.'
[268] *Ibid.*

suspected of having the virus.[269] Another rare example of the use of federal emergency powers was related: Trump exercised his authority and cited the pandemic in order to immediately expel thousands migrants to Mexico, a policy goal he had pursued long before the pandemic.[270] This is further archetypal of the federal government's unwillingness to utilize its public health authority unless it has ulterior motives.

Further exemplifying indifference to public health concerns, Trump has continually reiterated his position that schools should reopen in the fall despite the nation's continued increase of infections and deaths.[271] This is despite a report from the American Academy of Pediatrics (AAP) revealing that more than 380,000 children had tested positive for the pandemic as of 6 August 2020, with a 90% increase in cases occurring over the prior four weeks and 90,000 children testing positive in the prior two weeks.[272] In a press conference on 10 August 2020, days after the release of the report, Trump stated that the report did not give him pause because children experience a "tiny fraction of death…and they get better very quickly."[273] The consistent dismissal of the severity of the virus has continued since the initial claims six months earlier that it would go away "like a miracle."

Throughout that same press briefing, President Trump continued to commend his administration on the "tremendous" work they are doing, citing economic relief packages and the economy, while only referencing public health measures with regard to what individual states are doing.[274] Although he did mention that the federal government was "monitoring" areas of higher risk, not one direct federal government action regarding the

---

[269] C. Janes, et al., 'White House looks at plan to keep out citizens and legal residents over the virus,' *Washington Post*, 10 August 2020, https://www.washingtonpost.com/politics/white-house-looks-at-plan-to-keep-out-citizens-and-legal-residents-over-virus/2020/08/10/d8233910-db0c-11ea-b205-ff838e15a9a6_story.html?utm_campaign=wp_post_most&utm_medium=email&utm_source=newsletter&wpisrc=nl_most (accessed 11 August 2020).
[270] *Ibid.*
[271] White House, 'Remarks by President Trump in Press Briefing – August 10, 2020,' 10 August 2020, https://www.whitehouse.gov/briefings-statements/remarks-president-trump-press-briefing-august-10-2020/ (accessed 11 August 2020).
[272] American Academy of Pediatrics (AAP), 'Children and COVID-19: State Level Data Report,' 6 August 2020, https://services.aap.org/en/pages/2019-novel-coronavirus-covid-19-infections/children-and-covid-19-state-level-data-report/ (accessed 11 August 2020).
[273] White House, 10 August 2020.
[274] *Ibid.*

virus itself was cited.[275] This is characteristic of the public statements President Trump has made in which he claims the US is doing a tremendous job and that the only reason the US numbers are so high is because of extensive testing.[276] This argument does make sense, as more tests will naturally lead to more recorded infections. When asked about deaths, however, President Trump has yet to provide an answer as to why the US holds such a substantial lead on COVID-19 deaths worldwide and a continued rate of more than 1,000 deaths per day as of August 2020.[277] In an interview with Axios on HBO, Trump responded to this question by at one point stating, "[People] are dying, that's true…It is what it is. But that doesn't mean we aren't doing everything we can."[278] What "everything" the federal government "can" means remains unclear in the absence of any direct measures or guidance. When Axios' Johnathan Swan gave Trump several opportunities to explain what the US government has actually done, the president failed to provide any specific measures related to public health or the goal of decreasing the daily loss of American lives.[279]

Moreover, in July 2020, Trump transferred responsibility for COVID-19 data collection, management and sharing from the CDC to the Department of Health and Human Services.[280] This is particularly concerning for the future of the US response following publication of this paper. While the CDC is an independent organization comprised of thousands of infectious disease experts, doctors and scientists, HHS is an arm of the executive branch with a broad array of tasks, many of which are unrelated to infectious disease. More ominously, HHS answers directly to President Trump.[281] There are concerns that the president will capitalize on the data no longer being managed in an "open and

[275] *Ibid*.
[276] Axios on HBO, 'President Trump Exclusive Interview: Full Episode,' filmed 28 July 2020, aired 3 August 2020, https://www.axios.com/full-axios-hbo-interview-donald-trump-cd5a67e1-6ba1-46c8-bb3d-8717ab9f3cc5.html (accessed 8 August 2020); White House, 10 August 2020.
[277] Axios on HBO.
[278] *Ibid*.
[279] *Ibid.*
[280] Nature Editorials, 'Stop sidelining the CDC,' *Nature*, vol. 583, 30 July 2020, https://www.nature.com/articles/d41586-020-02231-6 (accessed 7 August 2020).
[281] *Ibid.*

science-friendly way" in order to further his narrative in anticipation of the election.[282] More importantly, the change in reporting has caused confusion amongst hospitals and public health departments at a time when impediments to the response must be avoided at all costs.[283] The refusal to collaborate with public health officials, most importantly the CDC, continues as of August 2020.

Overall, the US response can be characterized as late, sporadic, dysfunctional and unenforced under the federal government's 'response,' which was effectively yielding and avoiding responsibility. Moreover, the White House spent months distributing misinformation, contradicting public health experts and the WHO and circumventing scientific bases for the information it 'provided' about COVID-19. In a rarity in contemporary America, many of Trump's political allies and enemies alike agree on something: President Trump has "failed" at "confronting the pandemic with a clear strategy and consistent leadership."[284] In the absence of central leadership and guidance, the response has instead relied on state governors and local leaders.

4.3. Federalism and its Impact on Response Measures

The United States is unique due to its federalist system, with 50 states and several territories having some governmental autonomy. The lack of federal oversight or guidance consequently led each state to take its own actions and often with its own resources. This has led to different situations in different US states over the course of 2020.

On the other hand, there are some rational bases for state governments taking the lead in responding to COVID-19. For one thing, the initial outbreaks were isolated to certain states such as Washington State, California and eventually New York.[285] Evidence shows that the practice of state-by-state decisions to mandate restrictions, such as shelter in

---

[282] *Ibid*.
[283] *Ibid*.
[284] A. Parker and P. Rucker, 'One question still dogs Trump: Why not try harder to solve the coronavirus crisis?,' *Washington Post*, 27 July 2020, https://www.washingtonpost.com/politics/trump-not-solve-coronavirus-crisis/2020/07/26/7fca9a92-cdb0-11ea-91f1-28aca4d833a0_story.html?utm_campaign=wp_post_most&utm_medium=email&utm_source=newsletter&wpisrc=nl_most (accessed 27 July 2020).
[285] *Ibid*.

place, in fact significantly reduced the potential spread that the virus could have had.[286] This is particularly true for the states that acted earlier. Nonetheless, the states still acted late and only in a slowly staggered manner because the federal government never took the initiative to respond.

In fact, it was actually the National Collegiate Athletic Association (NCAA) that made the first decision to implement any lockdown measures by canceling the annual college basketball tournaments on 11 March 2020, citing a "global health crisis."[287] Subsequently, California locked down on 19 March.[288] Within two weeks, 41 states had issued "stay-at-home" orders and some municipalities in the states without such orders followed suit.[289] The United States is certainly unique in that its initial lockdown procedures were inspired not by the President of the United States, but by the president of a collegiate athletic association.

In addition to a lack of federal guidance, there was also a lack of federal assistance beginning in the earliest months of the pandemic. When states with the highest number of infections such as New York and New Jersey pleaded with the federal government to redistribute critical supplies such as N95 masks and ventilators for use by healthcare works on the frontline of the fight, no such provision occurred.[290] In the absence of federally-led redistribution efforts, states were forced to compete with each other over a limited supply of PPE for healthcare workers and other critical, life-saving equipment for the sick.[291] Individual state governments were therefore obliged to prioritize their own inhabitants over the well-being of other states' citizens and the US as a whole.[292] Such competition not only further impeded a cohesive response, it also led to an imbalance in states' capabilities

---

[286] *Ibid*.
[287] Kettl, p. 596.
[288] *Ibid*.
[289] Ren, p. 8.
[290] *Ibid.*, p. 8.
[291] *Ibid*.
[292] M. Ranney, et al., 'Critical Supply Shortages – The Need for Ventilators and Personal Protective Equipment during the COVID-19 Pandemic,' *New England Journal of Medicine*, vol. 382, 30 April 2020, https://www.nejm.org/doi/full/10.1056/NEJMp2006141 (accessed 11 August 2020), p. e41.

compared to others. The WHO called for international cooperation, but the US failed to even demonstrate state cooperation within its own borders.

A closer look at the results of the disparate actions of states in the absence of federal guidance and action shows even more concerning data. Statistical data comparing death rates and timing of lockdowns demonstrates a lack of correlation in many US states between the number of death rates and the likelihood of lockdown measures in the months of March and April 2020.[293] There was, however, strong positive correlation between states' investment in their public health programs and their affirmative decisions to lock down in March, as well as a correlation between states that voted to expand Medicaid programs years before COVID-19 and their willingness to lockdown early.[294] This further illustrates that certain states were willing toa act to protect health and lives better than others in the absence of federal guidance and assistance.

There is little dispute amongst academics, scholars and the international community that the United States failed its people from a governance standpoint in responding to COVID-19 from the early stages on. One question though is whether this failure occurred because the US "relied so heavily on states as laboratories," a phrase that Supreme Court Justice Louis Brandeis coined in 1932 to describe a foundational concept of American democracy and federalism.[295] It appears that Americans consequently suffered nationwide due to the variation in results at the state level, coupled with the ability to freely move across state borders during times when outbreaks were occurring in one state while a neighbor could be seeing relative success.[296] In a nation that relies so heavily on interstate business, travel and collaboration, it logically follows that an unguided and unaided response with variations from within the borders of all 50 states failed abundantly in the face of an enemy that transcends every border on the planet.

---

[293] Kettl, p. 596-97.
[294] *Ibid*., p. 597
[295] *Ibid*., p. 600; *New State Ice Co. v. Lieberman*, 285 U.S. 262 (1962).
[296] Ren, p. 8.

This is not to suggest that federalism and decentralization of responses inexorably fails to face a global pandemic. It can work quite favorably with proper federal oversight and use of scientific evidence. Germany, for example, applied a science-focused, centrally guided federalist approach and became a role model to the international community in how to properly curtail the spread of COVID-19 domestically.[297] But the German response has several fundamental similarities to the US response. Like the US, the German government elected not to invoke emergency powers.[298] Restrictive measures were largely the same in both countries, including primarily physical or social distancing measures, quarantines for the infected, the closure of schools and "non-essential" businesses and restrictions on or occasionally the full prohibition of mass gatherings.[299] Germans also took to the streets in protest of the restrictive measures like Americans did, even filing hundreds of legal proceedings with regard to the violation of civil liberties.[300]

One critical difference, however, is that the German federal government took early action and made guiding recommendations based on scientific data and public health experts. These recommendations still needed to be implemented by the states, who in turn copied each other's restrictive measure within days of the first to do so.[301] This federalist but still collective response demonstrates the potential of a similarly structured State to lead its sub-states towards an effective combination of cohesion and independence.[302] The principal difference in federal government response approaches between Germany and the United States at the macro level was Germany's trustworthy, science-based use of federal guidance and recommendations.

It is helpful to compare and contrast these two federalist systems' approaches in a vacuum without regard to factors such as the underlying attitude of the people and their

---

[297] M. Siewert, et al., 'A German Miracle? Crisis Management during the COVID-19 Pandemic in a Multi-Level System,' in M. Inacio and A. Burni (eds.), *PEX Special Report: Coronavirus Outbreaks, Presidents' Responses and Institutional Consequences*, 2020, https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3637013 (accessed 14 July 2020).
[298] *Ibid*, pp. 1-2.
[299] *Ibid*, pp. 2-3.
[300] *Ibid*., p. 4.
[301] *Ibid.*, pp. 6-8.
[302] *Ibid*.

trust of government, any conflicting statements between politicians and public health experts, and the preceding political situation prior to COVID-19. The overall responses are nearly identical at the general level. Both nations, for example, have a "unitary political culture" with "constitutionally delineated competences for federal and 'state' levels."[303] In a study conducted over March and April of 2020 in Germany, the results demonstrated that Germans would (1) like to give more power to the executive branch and (2) be willing to pay for maximum state protection against COVID-19.[304] Based on the political unrest and divisive state of American politics combined with the expressed distrust in the Trump Administration, it is unlikely that this same survey would yield the same results in the US. One survey found that as of 13 July 2020, 49% of 72,180 registered American voters were "not satisfied at all" with the federal government's response.[305] As can be expected in the divisive environment of US politics in the 21st century, political party affiliation overall has had a dramatic impact on one's view of the government response.[306]

4.4. Summary of Responses

In conclusion of this section, I will provide a few other responses for comparison purposes and summarize the US' response. China was the first nation to encounter SARS-CoV-2 and the first nation to react to the spread of COVID-19. The most populous country in the world, China is home to almost 1.4 billion people.[307] By January 2020, early models predicted that everyone carrying the virus would infect 2 more people, leading to an estimate that 500 million people in China alone might contract COVID-19 in the absence of intervention.[308] China immediately implemented drastic measures to restrict movement,

---

[303] M. Tepe, et al., 'Pandemic Balancing Acts: Early COVID-19 lockdown changes how Germans trade off lives and weigh constitutional powers,' *OSF Preprints*, 13 May 2020, https://osf.io/geu52 (accessed 14 July 2020), p. 5. See this study when
[304] *Ibid*., pp. 9-10.
[305] Civiqs, 'Coronavirus: Government Response,' https://civiqs.com/results/coronavirus_response?uncertainty=true&annotations=true&zoomIn=true (last accessed 14 July 2020).
[306] Andersen, p. 2.
[307] World Bank, 'Population – total, China,' https://data.worldbank.org/indicator/SP.POP.TOTL?locations=CN (accessed 22 July 2020).
[308] D. Cyranoski, 'What China's COVID-19 response can teach the rest of the world,' *Nature*, vol. 579, March 2020 https://www.nature.com/articles/d41586-020-00741-x (accessed 28 June 2020), pp. 479-480.

particularly in and out of Hubei Province, and put 760 million people on residential lockdown.[309] The initial shutdown of Wuhan, in terms of population, constituted the largest attempted quarantine event in human history.[310] As of 22 July 2020, China has reported only 86,361 cases and 4,655 deaths.[311] It is, however, possible that China's numbers are not necessarily accurate as reported.

In contrast to the United States' measures, China's response was significantly more restrictive. Moreover, a widespread information dissemination campaign conveyed the measures nationwide and effectively.[312] While some blame China's delay in immediately responding at the first identification of the virus for the global spread of COVID-19, studies show that the restrictive measures implemented nonetheless delayed the growth and size of the pandemic and averted hundreds of thousands of cases by mid-February 2020.[313]

Several countries, such as Germany and South Korea, experienced much better success by acting promptly with a plan of action. As of 11 August 2020, Germany reports 217,293 cases and 9,201 deaths despite less time to react than the US and its proximity to Italy.[314] South Korea reports only 14,660 cases and 305 deaths despite its high population density and proximity to China.[315] These and numerous other countries' examples demonstrate that the virus can be contained if proper measures are taken to protect human lives and health.

Overall, the US did not take drastic measures nor act as quickly as most other countries in the world. The US has also seen how ineffective social distancing requirements can be when left unenforced. This is especially true when the government officials and health experts are constantly delivering conflicting information. There are compelling arguments in favor of strict measures as the only truly effective means of fighting a virus

---

[309] *Ibid.*, pp. 479-480.
[310] H. Tian, et al., 'The impact of transmission control measures during the first 50 days of the COVID-19 epidemic in China,' *medRXiv*, 10 March 2020, https://doi.org/10.1101/2020.01.30.20019844 (accessed 22 July 2020), p. 3.
[311] WHO, 'COVID-19 Dashboard.'
[312] Tian, p. 3.
[313] *Ibid.*, pp. 1-4.
[314] WHO, 'COVID-19 Dashboard.'
[315] *Ibid.*

with such "severity and anonymity."[316] One key issue, however, is the rapidity with which strict measures are implemented. Another is the willingness of citizens to trust in their leaders and abide by such restrictions.[317]

In summary, the US' response was characterized by an unwillingness to act, constant misinformation from the President, an absence of leadership and guidance, conflict amongst politicians and public health experts and a chaotic response that was ultimately left in the hands of each state governor. Moreover, the failure to provide sufficient resources led states to compete with each other over life-saving resources. As will be discussed in the subsequent section, the US government's response, which mostly consisted of omissions rather than acts, did not satisfy its obligations prescribed under the international standards concerning the human rights to life and health.

Section 5. Human Rights Analysis

The crux of this analysis will focus on whether the United States satisfied its human rights obligations under international legal standards governing the human rights to life and health. Each right will be independently discussed, although some overlap is inevitable because the rights to life and health are so intertwined in the context of the deadly COVID-19 pandemic. Each right will be analyzed under the international legal standards as provided by its respective Covenant with a brief reference to the complementary principle of due diligence. Lastly, I will briefly explore WHO law and the human rights significance of international health law during a pandemic.

The overall argument here is that the United States failed to take satisfactory measures to meet its legal obligations under the rights to life and health. The US is bound to the international standards governing the right to life by treaty and the right to health under customary international law.[318] COVID-19 was foreseeable as a threat to both health

[316] P. Tabari, et al., 'International Public Health Responses to COVID-19 Outbreak: A Rapid Review,' *Iranian Journal of Medical Sciences*, vol. 45, no. 3, May 2020, pp. 164-165.
[317] *Ibid.*, p. 164.
[318] Kinney 2001, pp. 1457-1475; Kinney, 2008; Riedel, pp. 22, 32; Hannum, pp. 145-148.

and life, as evidenced by American and international public health experts, intelligence reports and the WHO's declaration of a PHEIC on 30 January 2020. The US could have responded with more coordinated and direct action to the known severity of the threat as evidenced by its effects in other countries before it arrived in the US. Moreover, a timelier response implemented months before the US acted in any manner to protect its citizens would have better protected the human rights to health and life in the US.[319] Recognition of this initial failure and sufficient attempts to remedy it could have mitigated the overall assessment here. Unfortunately, few additional acts have occurred as of 11 August 2020.

An example from the last week prior to publication further illustrates this overall point. At the end of July 2020, President Trump finally admitted for the first time that the virus might not simply go away as he had consistently stated up to this point, and he took small actions such as resuming meetings of the coronavirus task force and revisiting the government's need to play an active role and actually combat the pandemic.[320] Throughout the following week, Trump was back to his original public message in a highly criticized interview with Axios and a subsequent press conference, falsely claiming that the government is doing a great job in comparison to the rest of the world and that it will simply "go away…sooner than later."[321] As usual, this was despite conflicting information coming from the infectious disease experts at the CDC.[322] It would be markedly difficult, albeit perhaps not surprising, if the government tried to argue at this point against the foreseeability and severity of the threat to human life and health.

Concededly, the US is not directly liable for every one of the hundreds of thousands of Americans to die from COVID-19. Nations worldwide encountered varying amounts of

---

[319] S. Joseph, 'COVID-19 and Human Rights: Past, Present and Future,' *Journal of International Humanitarian Legal Studies* (forthcoming), Griffith Law School Reaserch Paper No. 20-3, 26 May 2020, https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3574491 (accessed 28 July 2020).
[320] R. Klein and A. Wiersema, 'The Note: Trump changes course as COVID-19 response faces critical tests,' *ABC News*, 21 July 2020, https://abcnews.go.com/Politics/note-trump-covid-19-response-faces-critical-tests/story?id=71880637 (accessed 30 July 2020).
[321] J. Walters and J. Wong, 'Trump again claims COVID-19 will 'go away' as Fauci warns of long road ahead,' *The Guardian*, 5 August 2020, https://www.theguardian.com/us-news/2020/aug/05/donald-trump-covid-19-go-away (accessed 7 August 2020).
[322] *Ibid.*

infections, and several saw thousands of deaths. A failure on the part of the US could potentially be implied solely from its sheer numbers of cases and deaths in comparison to the rest of the world. A better case can be made, however, under international legal standards governing state obligations under the rights to life and health.

This paper argues specifically that the US failed to comply with its obligations under international human rights law to take reasonable steps to protect its citizens from the COVID-19 pandemic. No country was reasonably expected to completely avoid or defeat the virus in the first seven months. Nonetheless, the United States government was exceptional in its failure to meet its obligations to the rights to life and health when the whole world faced the common threat of COVID-19. This has resulted in unnecessary death and sickness for thousands of Americans.

5.1. Right to Life Analysis

5.1.1. International Standards

The non-derogable, fundamental human right to life is provided in Article 6 of the ICCPR. The United States government itself wasted no time emphasizing the paramount importance of the right to life, including the "unalienable Rights" of "Life, Liberty and the pursuit of Happiness" in its Declaration of Independence in 1776.[323] The US Constitution further embodies the right to life in its Bill of Rights.[324] In the context of COVID-19, the overarching legal standard from which specific obligations are derived as provided by the ICCPR obligates the US to protect its people from "reasonably foreseeable threats and life-threatening situations that can result in the loss of life."[325] This extends also to threats and situations that do not actually result in the loss of life.[326] It consequently follows that a deadly public health threat like COVID-19 meets the threshold of a threat to life and thus mandates the US government to meet its obligations to respect, protect and fulfill the right to life in response to the pandemic.

[323] United States (US), *Declaration of Independence*, 4 July 1776.
[324] U.S. Constitution, amend. V, XIV.
[325] HRC General Comment no. 36, para. 6.
[326] *Ibid.*, para. 7.

The specific obligations fall under the Article 6 requirement that the US protect its citizens from "life-threatening diseases" by implementing "measures designed to ensure access without delay by individuals to essential goods and services such as…health care."[327] This obligation expressly includes a requirement to "bolster emergency services [and] emergency response operations."[328] Warnings from the WHO, the declaration of a PHEIC in January 2020, evidence of the severity of the disease from Asia and Europe, intelligence reports about the virus and warnings from the CDC and experts on public health and infectious diseases collectively establish the foreseeability of the threat to American lives.

Every nation in the world saw disease and death at the hand of COVID-19, but there is a discernible threshold of such where it becomes hard to deny that a State failed its human rights obligations under the right to life. This is markedly true when that threat to life has already killed more than 150,000 Americans in six months. Putting a specific number on that would be dubious. Instead, one must look to a government's acts or omissions, the timeline of said acts or omissions and the extent of the threat to life known.

The US' obligations under international law during the COVID-19 pandemic are primarily under the obligations to protect and fulfill. These obligations require positive action from the US government in the form of measures aimed at protecting its citizens from "unnatural or premature death."[329] The obligations to protect and fulfill require legislation, but also other measures and specific state actions. In the COVID-19 context, state actors run the gamut from federal leadership down to the acts of public health institutions and even individuals.

Overall, the relevant obligations that will be discussed under Article 6 are the requirements for legislative action, other measures against foreseeable threats, timely and diligent action to avoid unnecessary loss of life, organization of the relevant government actors, protection of vulnerable groups and nondiscrimination.

---

[327] *Ibid.*, para. 26.
[328] *Ibid*.
[329] *Ibid*., para. 3.

Legislative Action

First, the obligation to protect the right to life includes requirements for legislative action. The US Congress did act, passing four resolutions beginning in early March. The first resolution from 4 March 2020 allocated merely $8.3 billion to boost the public health system in response to what it perceived the threat of COVID-19 to be at the time, with this coming from a nation boasting a GDP of over $21 *trillion* in 2019.[330] This is undeniably legislative action on its face. Allotting such a miniscule percentage of the government's wealth to public health, however, falls tragically short of the obligation for the US to act in order to protect its people from life-threatening diseases, especially when the magnitude, virulence and mortality of that disease is known to the government. A government's false belief that a deadly virus the WHO had declared a PHEIC six weeks before the first legislative act does not justify such disproportionately insignificant action to protect human lives. Domestic intelligence, the CDC and public health experts had also been warning of the deadly threat since January.

Congress did proceed over the coming weeks to pass more legislation allocating over ten times that initial attempted aid package on both 18 and 27 March, but both resolutions primarily targeted economic recovery rather than the public health defense. Most notably, on 27 March Congress passed a staggering $2.2 trillion stimulus bill, known as the Coronavirus Aid, Relief and Economic Security Act (CARES Act).[331] This bill, however, allocated over 90% to economic recovery rather than frontline workers and the actual fight to stop the deadly virus.[332] It was also late to the game. On that same day of 27 March, over a month after President Trump had assured the American people that the "China virus" would disappear "like a miracle," the US now had 80,735 positive cases and over 1,000 deaths.[333] Legislative action must be timely and contribute to the overall goal

[330] H.R. 6074, 116th U.S. Congress, 2020; World Bank, 'GDP (current US$) – United States,' https://data.worldbank.org/indicator/NY.GDP.MKTP.CD?locations=US (accessed 4 August 2020).
[331] H.R. 748, 116th U.S. Congress, 2020
[332] *Ibid.*
[333] L. Lutton, 'Coronavirus case numbers in the United States: MARCH 27,' *Medical Economics*, https://www.medicaleconomics.com/view/preparing-for-three-federal-mandates-to-improve-healthcare-in-2021 (accessed 1 August 2020).

that measures be taken 'without delay' to avoid 'unnecessary' loss of life. These measures did not satisfy those obligations.

Other Measures

Of particular relevance to the COVID-19 pandemic is paragraph 3 of HRC General comment No. 36, which states: the right to life "concerns the entitlement of individuals to be free from acts and *omissions* that are intended or *may be expected to cause* their unnatural or premature death, as well as to enjoy a life with dignity."[334] A State can violate the right to life whether an individual's life is knowingly put into danger by a lack of access to emergency treatment or, on a larger scale, lives are lost due to "systemic and structural dysfunction in hospital services."[335] The absence of effective measures, whether they are administrative, regulatory or practical measures such as responding to the emergency shortages of healthcare equipment, PPE and other life-saving goods, as well as overcrowded hospitals nationwide.[336]

Moreover, the safety and lives of healthcare workers is unnecessarily threatened in the absence of government assistance to provide life-saving equipment. Without adequate facilities and supplies, healthcare workers' lives are at risk due to the lack of a "safe and healthy working environment" as required by the right to health.[337] According to an investigative project by *The Guardian* and Kaiser Health News, 898 frontline healthcare workers have died fighting COVID-19 as of 23 July 2020.[338] Not only has the US' failure to adequately contain COVID-19 allowed led to over 22% of the global total of COVID-19 deaths being Americans, despite Americans accounting for only 5% of the world population, but the only people actually able to fight the disease on the frontlines are dying in excess due to the general conditions on the ground. The lack of the federal government's

[334] *Ibid*., para. 3 (emphasis added).
[335] Coco and de Souza Dias, p. 8.
[336] Spodaro, p. 329.
[337] *Ibid.*, pp. 318-319.
[338] The Guardian, 'Lost on the frontline,' *The Guardian*, 17 June 2020 (updated 23 July 2020), https://www.theguardian.com/us-news/2020/jun/17/covid-19-coronavirus-healthcare-workers-deaths (last accessed 31 July 2020).

willingness to take decisive action to protect healthcare workers and support facilities is another clear failure under its obligations to ensure the right to life.

This interpretation is supported by the fact that April 2020 saw death rates in the US soar to more than 2,000 people per day. States have a positive duty to take necessary and adequate steps to safeguard the lives of their citizens and to "do all they can to prevent avoidable risks thereto."[339] While COVID-19 itself was not avoidable, other countries such as Germany and South Korea have demonstrated that the death rate per capita does not have to be anywhere near as high as it has been in the United States. The key difference in the United States is the absence of federal leadership, especially given that Germany responded in a state-led but federally guided manner. The United States government's insistence in denying science and ignoring experts led to an absence of federal action and an inadequate degree once the strategy of purely omissions finally began to give way to occasional actions.

Government Coordination & Leadership

Additionally, the duty to protect life requires the federal government to "organize all state organs and governance structure…in a manner consistent with the need to respect and ensure the right to life."[340] The federal government expressly and intentionally declared its intention *not* to lead the US response. Individual state governments were thus charged with deciding when and how to respond to COVID-19.[341] Accordingly, the US had already violated this obligation when President Trump refused to take the lead and also failed to coordinate any component of the government. States were required to organize their own plans, coordinate their own healthcare systems, compete for life-saving resources, decide their own guidelines based on conflicting information from the federal level and decide how or if to implement and enforce measures to protect citizens' lives. Bear in mind, this is after the federal government's official position via President Trump was that the virus was

[339] Coco and de Souza Dias, pp. 7-8.
[340] HRC General Comment No. 36, para. 18.
[341] Kettl, p. 595.

not a real threat, that the economy was more important than public health and lives and that basic guidelines of domestic and international health organizations were unnecessary.[342]

Notwithstanding, states were expected to handle the pandemic themselves with no guidance. Moreover, the federal stance of downplaying of the severity has led to large percentages of the populations being unwilling to abide by scientifically supported behavioral guidelines and restrictions.[343] To complement this lack of coordination and structure in the response, President Trump regularly and openly disputed warnings, findings and recommendations of public health officials. Most notably, he openly disagreed constantly with Dr. Anthony Fauci, who for decades has been the leading infectious disease expert in the United States, as well as the CDC, the leading public health and infectious disease institution in the United States.

Protection of Vulnerable People & Non-Discrimination

Next, state obligations under the right to life also require "special measures of protection towards persons in vulnerable situations" or otherwise at risk due to a specific threat...[344] Moreover, the ICCPR prohibits discrimination in the realization of rights based on any characteristic, including age, race, ethnicity and national origin.[345] Accordingly, all measures must be enacted without discrimination and with an emphasis on protecting persons in particularly vulnerable situations. Thus, acts or omissions by the government can be found in violation of state obligations independently. Additional violations occur even if reasonable efforts are made but discriminatory impacts or unequal treatment occurs.[346] Furthermore, violations will occur if vulnerable populations are not allocated additional protections to their lives from the threat to which they are more vulnerable.[347]

Measures must both (1) provide extra protection to vulnerable groups and (2) apply equally to all people without discrimination of any kind. It is scientifically established that

---

[342] *Ibid.*
[343] Sodaro, p. 329.
[344] HRC General Comment No. 36, para. 23.
[345] ICCPR, Art. 2(1).
[346] *Ibid.*
[347] HRC General Comment No. 36, para. 23.

the COVID-19 disease is more likely to be severe for elderly people compared to younger people when either contracts SARS-CoV-2. Accordingly, older people constitute a vulnerable population. While the US cannot be held responsible for the virus' discriminatory treatment of this group, state obligations under the right to life require special attention to groups more vulnerable to the threat to life. Moreover, COVID-19 has had a dramatically different impact on minorities, particularly African Americans and Hispanics. Finally, an influx of people from different national origins has led to the US practice of immigration detention facilities, which will be discussed later.

Older people are more susceptible to severe cases of COVID-19. In the United States, over 80% of deaths have been among adults 65 and older.[348] The right to life does not impose obligations on States Parties to achieve equal death rates across age groups. This is unrealistic given the basis for this discriminatory impact is the virus itself. As stated by the HRC, the right to life does, however, impose obligations to address groups that are vulnerable to the specific threat compromising the human right to life. This includes increasing access to critical and life-saving care, improving facilities caring for the elderly and avoiding triaging or other medical decisions that discriminate against the lives of older persons.[349] For example, one in every five American deaths as of May 2020 occurred in nursing homes, despite such a tiny percentage of the population living in such homes.[350] Many of these homes are public institutions, thereby representing state action themselves. Failing to adequately protect the right to life through additional attention to patients in nursing homes constitutes violations of state obligations.

Furthermore, the practice of 'triaging' patients refers to choosing between allocating medical equipment and care for one patient rather than another. This has been rendered mandatory in certain hospitals due to the shortage of ICU beds, ventilators, other life-saving equipment and healthcare workers. The US Department of Health and Human

[348] UN, 'Policy Brief: The Impact of COVID-19 on older persons,' May 2020, https://unsdg.un.org/sites/default/files/2020-05/Policy-Brief-The-Impact-of-COVID-19-on-Older-Persons.pdf (accessed 31 July 2020), p. 5.
[349] *Ibid*., pp. 2-6.
[350] *Ibid.*, p. 7.

Services even provides an extensive list of resources on proper practices for this emergency procedure.[351] Procedural guidance is supposed to encourage treatment of the most severe symptoms first. The US, however, was one of many nations faced in April with the issue of having to triage care to those with the highest chance of survival.[352] This, in addition to the factors still considered in July 2020 such as mobility, cognition, mental health and attitude, attribute to unfavorable triage decisions for elderly people.[353]

The positions on government leaders with regard to risking older people in order to re-open the economy have been quite concerning. Even 70-year-old Texas Lieutenant-Governor Dan Patrick publicly stated in late March that senior citizens would gladly take the risk to their lives to reopen the country, specifically saying, "We'll take care of ourselves. But don't sacrifice the economy."[354] This was in response President Trump's concurrent push to reopen the economy by early April, despite the clear risk to people at that time, especially senior citizens due to the absence of time to implement any effective measures to protect them.[355] Overall, rather than meet its state obligations to protect older people, a vulnerable group, the US healthcare system has systematically discriminated against the elderly, thereby violating two obligations concurrently.

The negative impact that COVID-19 has had on marginalized minority groups such as African American and Hispanic people has dramatically illustrated the US' failure under the obligations to protect and fulfill to have a national health policy and system in place that operates without discrimination and gives special attention to marginalized groups. The death rate for Hispanics at one point was more than twice as high as whites during the peak

---

[351] US Department of Health and Human Services (HHS), 'Topic Collection: COVID-19 Hospital Triage/Screening Resources,' https://asprtracie.hhs.gov/technical-resources/119/covid-19-hospital-triage-screening-resources/99 (accessed 4 August 2020).
[352] L. Forman, 'The Evolution of the Right to Health in the Shadow of COVID-19,' *Health and Human Rights Journal*, vol. 22, no. 1, June 2020, p. 375.
[353] P. Barnes, 'Sentencing Older COVID-19 Patients to Death by Triage,' *Forbes*, 2 July 2020, https://www.forbes.com/sites/patriciagbarnes/2020/07/03/sentencing-older-covid-19-patients-to-death-by-triage/#66f6f28f276b (accessed 1 August 2020).
[354] C. Viggo Wexler, 'Coronavirus has Donald Trump and Dan Patrick ready to sacrifice elderly people,' *NBC News: Think*, 26 March 2020, https://www.nbcnews.com/think/opinion/coronavirus-has-donald-trump-dan-patrick-ready-sacrifice-older-people-ncna1169126 (accessed 20 July 2020).
[355] *Ibid*.

of infections in New York City.[356] These numbers are consistent in other parts of the country as well. In Illinois, 43% of COVID-19 deaths and 28% of cases were African Americans, which comprise only 15% of the state's population.[357] In Michigan, African Americans accounted for 33% of infections and 40% of deaths, despite only accounting for 14% of the state's population.[358]

This tragic imbalance is exacerbated when coupled with age as well, further exposing the vulnerability of marginalized groups. For example, in a study conducted from CDC data from February through June 2020, death rates among black people aged 55-64 were higher than the death rates for white people aged 65-74.[359] Black and Hispanic death rates for people aged 45-54 were 6 times higher on average with deaths of white people, with black people in this age group specifically reaching 10 times higher death rates than whites.[360] Stark inequalities exist for American Indians in this regard too, but data is less available.[361] Conditions for those detained based on immigration status and national origin have also led to a disproportionately large number of deaths to marginalized groups.

Not only do immigration facilities implicate discriminatory impact against people detained due to their national origin, it also relates to death in detention facilities generally. There is "a presumption of arbitrary deprivation of life *by State authorities*" when anyone dies in custody.[362] Horror stories in detention facilities and prisons alike have continually arisen throughout the entirety of the COVID-19 pandemic. These are significantly more

---

[356] Mays, J. and A. Newman, 'Virus is Twice as Deadly for Black and Latino People Than Whites in N.Y.C.,' *New York Times*, 8 April 2020, https://www.nytimes.com/2020/04/08/nyregion/coronavirus-race-deaths.html (accessed 18 April 2020).
[357] *Ibid.*
[358] J. Eligon, et al., 'Black Americans Face Alarming Rates of Coronavirus Infection in Some States,' *New York Times*, 7 April 2020, https://www.nytimes.com/2020/04/07/us/coronavirus-race.html (accessed 22 July 2020).
[359] T. Ford, et al., 'Race gaps in COVID-19 deaths are even bigger than they appear,' *Brookings*, 16 June 2020, https://www.brookings.edu/blog/up-front/2020/06/16/race-gaps-in-covid-19-deaths-are-even-bigger-than-they-appear/ (accessed 30 July 2020).
[360] *Ibid.*
[361] *Ibid.*
[362] HRC General Comment No. 36, para. 29.

concerning with regard to immigration facilities, where the incarceration of many detainees, including children, is questionable in the first place.

Detention facilities in general are of particular concern during this pandemic because of crowding and the near impossibility of physical distancing, the proportion of people from vulnerable groups detained and limited access to medical care.[363] Sanitation facilities such as showers, toilets and sinks are shared, as well as food preparation and the service of food in communal settings.[364] Further increasing the risk, staff members depart from and return to the facilities often, which is especially dangerous given the asymptomatic infection capabilities of this coronavirus.[365] All of this dramatically increases the risk of exposure to those incarcerated in jails, prisons and detention facilities. This is even more concerning when there is a compelling argument that those exposed in these dangerous conditions should not be detained therein in the first place.[366]

Between late April to late May 2020, COVID-19 cases in ICE detention facilities increased by 500% with at least 2,500 infected immigrant detainees and two deaths.[367] In addition, ICE employees that work in facilities across the country are testing positive for COVID-19 and further exposing their colleagues and the detainees to the deadly virus.[368] The fact that the laws under which immigrants are placed in these detention centers are contested and, in some cases, under legal review brings the potential arbitrariness of immigration detention further to the forefront during this pandemic.[369] A Human Rights Watch report from 2018 concluded that ICE "has proven unable or unwilling to provide adequately for the health and safety of those it detains" after finding dozens of deaths of

---

[363] J. Amon, 'COVID-19 and Detention: Respecting Human Rights,' *Health and Human Rights Journal*, Vol. 22, No. 1, June 2020, pp. 367-370, p. 367.
[364] *Ibid*., p. 368.
[365] *Ibid*.
[366] E. Katz, 'ICE Struggles to Protect Detained Immigrants as Coronavirus Spreads in its Facilities,' *Government Executive*, 24 June 2020, https://www.govexec.com/management/2020/06/ice-struggles-protect-detained-immigrants-coronavirus-spreads-its-facilities/166410/ (accessed 9 July 2020).
[367] *Ibid.*
[368] T. La Gorce, ''Everybody Was Sick:' Inside an ICE Detention Center,' *New York Times*, 15 May 2020, https://www.nytimes.com/2020/05/15/nyregion/coronavirus-ice-detainees-immigrants.html?auth=login-facebook
[369] *Fraihat v. DHS-ICE,* U.S. District Court, CD California, 2018.

detainees resulted directly from substandard healthcare in ICE detention facilities.[370] As a direct arm of the federal government, ICE's actions that violate human rights obligations constitute violations on behalf of the US.

Overall, the international standards provide clear duties and obligations to respect, protect and fulfill the human right to life. Of the specific obligations derived from the context of a global pandemic, it is abundantly clear that the overwhelming balance of omissions compared to acts that characterized the US response fail to adhere to these standards on its face. A brief discussion of the principle of due diligence will further illustrate the reasonableness standard and the threshold that differentiates anticipated suffering and death from violations of the human right to life.

5.1.2. Due Diligence Considerations

The due diligence standard is expressly provided for with regard to the right to life. It is the standard under which to assess a State's adherence to obligations under the right to life, requiring that the US take "reasonable, positive measures that do not impose disproportionate burdens on [the State]."[371] This gives a bit of deference to US, but does not negate the requirements of reasonable and positive measures.

Due diligence under the ICCPR right to life helps provide specific thresholds regarding the duties required under international standards. At a minimum, the duty to protect life in a pandemic requires advance planning or an immediate response to mitigate the spread of life-threatening diseases.[372] This refers to the emergency response measures provided by General Comment 36, paragraph 26. Recognizing that "prevention is better than the cure" lies at the core of due diligence in responding to a global pandemic.[373] Generally speaking, due diligence in this context suggests that reasonableness is a heightened standard because of the severity and imminence of a threat to life. Therefore,

---

[370] Human Rights Watch, 'Code Red: The Fatal Consequences of Dangerously Substandard Medical Care in Immigration Detention,' 20 June 2018, https://www.hrw.org/report/2018/06/20/code-red/fatal-consequences-dangerously-substandard-medical-care-immigration (accessed 11 July 2020).
[371] HRC General Comment No. 14, para. 21.
[372] Coco and de Souza Dias, p. 10.
[373] *Ibid.*, p. 15.

adherence to the international standards requires extra duties of care, in contrast to the US taking virtually no reasonable care in its response to COVID-19.

Since due diligence practices, especially by world leaders such as the United States, can potentially serve a "law-generating function, over time,"[374] an analysis under due diligence is helpful in providing forward-looking approaches for use in the next global health crisis. Overall, with regard to international standards, due diligence operates complementarily to the rights to life and health to help determine the threshold of those obligations in a specific context. Due diligence, for example, refers to "fact-finding to inform conduct" and "responsible decision-making in the policy sphere."[375] The fact-finding component, as will be discussed, is particularly relevant given the US government's failure to heed warnings from public health experts both domestically and internationally as well as intelligence agencies and advisers within the Trump administration and other governmental agencies.

While this paper does not argue that the US must stand trial before the ICJ for its actions or omissions, there are (1) the authoritative international court's interpretation of due diligence and its resultant obligations and (2) the emphasis on prevention in certain contexts that have broader implications.[376] Certainly, a complete absence of any measures aimed at curtailing the spread of the virus that allowed it to spread freely amongst the population and kill hundreds of thousands of people would be a violation of the right to life. The important analytical approach, therefore, is to draw the line as to where a State's acts or omissions constitute a violation of the State's obligations under international law to respect, protect and fulfill the human right to life.[377] The issue arises when a shortage of physical and human resources needed to combat the virus puts extensions of the State such

[374] McDonald, p. 1053.
[375] *Ibid*.
[376] *Pulp Mills on the River Uruguay (Argentina v. Uruguay)*, 2010, ICJ Rep 14; *Corfu Channel (UK v. Albania)*, 1949, ICJ Rep 4.
[377] Joseph, pp. 6-7.

as doctors in public hospitals and public health institutions themselves in a position to make choices between who lives and dies.[378]

The global public health crisis caused by the COVID-19 pandemic has effectively, albeit tragically, demonstrated the increased level of demands on every single state to protect its own national public health in order to contribute to a collective effort to protect international global health.[379] To be fair, many countries around the world have seen 1,000 deaths to COVID-19. That alone likely does not meet the threshold for human rights violations at that time. Inadequate measures that reflect a failure to properly grasp the threat to public health and, consequently, lives do violate state obligations. Constant dismissals of the severity of the risk to human life further affirm this determination.

5.2. Right to Health Analysis

5.2.1. International Standards

The human right to health, under customary international law, imposes state obligations on the United States under international human rights law. These obligations are guided by the ICESCR, the core component of the International Bill of Human Rights with regard to the right to health. The CESCR's authoritative interpretation of ICESCR Article 12 provides specific standards and examples from which to determine the US' obligations under the right to health. Moreover, the interdependence and interrelatedness of the human rights to health and life are magnified immensely when a deadly pandemic leads to a global public health crisis. This analysis accordingly assumes legal obligations as provided by customary international law and the guiding authority of the ICESCR.[380]

Three of the four elements provided by the ICESCR are relevant here: accessibility, availability and quality. The US must accordingly provide equal and timely access to goods, services and facilities. This includes hospitals, life-saving equipment, doctors and other healthcare workers, PPE for those workers and testing. The provision of these

[378] *Ibid.*
[379] Forman, p. 367.
[380] Kinney, 2001, pp. 1457-1475; Kinney, 2008; Riedel, pp. 22, 32; Hannum, pp. 145-148.

elements must be implemented by direct government action, whether by legislation or other measures. Some scholars assert that it was the reluctance to spook economic markets that prevented governments from taking measures strong enough to curtail the explosive spread of SARS-CoV-2 in its earliest stages prior to its rampant global spread.[381] While restrictions went into place rapidly, measures such as testing, contract tracing and preparing health care facilities dragged far behind in many nations.[382]

One key aspect of the right to health that is very relevant to the COVID-19 pandemic relates to the entitlements the right provides.[383] These entitlements include the right to a system of health protection providing equality of opportunity for everyone to enjoy the highest attainable level of health.[384] Specifically, the US is obligated to take positive measures towards the prevention, treatment and control of epidemic diseases, access to essential medicines, equal and timely access to basic health services and health-related education and information.[385] Failure to fulfill these obligations would consequently result in violations of the right to health. Systematic failures to provide these entitlements are present at all stages of the US response.

The core obligations under the right to health are non-derogable and are not subject to the justifiable defenses of progressive realization.[386] These include the requirements of equitable access and distribution of health facilities, goods and services, especially with regard to vulnerable and marginalized groups.[387] The non-discrimination requirement includes de facto discrimination. Additional obligations given "comparable priority" include the obligation to "take measures to prevent, treat and control epidemic and endemic diseases" and the obligation to provide education and information on the "main health problems in the community."[388] Similar to under the right to life, these core obligations

[381] Forman, p. 375.
[382] *Ibid*.
[383] WHO, Fact Sheet no. 31, p. 3.
[384] ICESCR, Art. 12.
[385] *Ibid.*, Art. 12(2)(c); CESCR General Comment No. 14, para. 43(c).
[386] CESCR General Comment No. 14, paras. 43-44.
[387] *Ibid.*, para. 43.
[388] *Ibid.*, paras. 43, 44.

mandate the government to respect, protect and fulfill the human right to health. While these obligations refer to health and healthcare in general, they are especially pertinent during a global pandemic.

US Government Failures

President Trump expressly stated that the federal government would take a "back-up" role, thus requiring individual state governments to take their own measures to combat the COVID-19 pandemic. On 31 January 2020, the day after the WHO declared COVID-19 a PHEIC, President Trump invoked his authority to impose a restriction banning the entry of any non-US citizens from China, Hong Kong and Macau.[389] This was after COVID-19 had already made its way into the US.[390] On 11 March, Trump extended the ban to Iran, Europe and others.[391] With the exception of these two measures and those described in the previous section, the US federal government took no substantial action aimed at preventing or controlling COVID-19. Contrarily, President Trump constantly took to social media and news outlets to provide assurances that the virus would simply disappear and that the US had it under control. This misinformation provided a false sense of security that led millions of Americans to gather in mass and protest restrictions, refuse simple guidelines from international and domestic health authorities to wear masks and to rush to bars and restaurants before the pandemic was measurable under control at all.[392]

As of 7 August 2020, infections and deaths are still climbing in the US despite a short-lived decline before June. Rather than taking measures to prevent, treat and control the outbreak, the US president's actions can be characterized as effectively doing the

---

[389] White House, 'Proclamation on Suspension of Entry as Immigrants and Nonimmigrants of Persons Who Pose a Risk of Transmitting 2019 Novel Coronavirus,' 31 January 2020, https://www.whitehouse.gov/presidential-actions/proclamation-suspension-entry-immigrants-nonimmigrants-persons-pose-risk-transmitting-2019-novel-coronavirus/ (accessed 31 July 2020).
[390] *Ibid.*
[391] White House, 'Proclamation – Suspension of Entry as Immigrants and Nonimmigrants of Certain Additional Persons Who Pose a Risk of Transmitting 2019 Novel Coronavirus,' 11 March 2020, https://www.whitehouse.gov/presidential-actions/proclamation-suspension-entry-immigrants-nonimmigrants-certain-additional-persons-pose-risk-transmitting-2019-novel-coronavirus/ (accessed 31 July 2020). As will be discussed in Section 5.3, these measures likely violate IHR anyway.
[392] Frieden, et al.

opposite since as early as January and continued on through the time of publication. The government has a duty under the obligation to protect to actively regulate the activities of individuals so as to prevent them from violating the right to health of others.[393] By encouraging the millions who listen to and believe what President Trump says *not* to take seriously the virus and precautionary measures as outlined by the WHO and CDC, Trump actively encouraged part of the population to violate the right to health of other parts of the population, which had a significant health impact nationwide, particularly for vulnerable groups. It was not until July 2020 that President Trump finally changed his narrative to more accurately reflect how out of control COVID-19 is in the US and first encouraged the population to wear masks in compliance with international and domestic health guidelines.[394]

Government Requirements and Actions

A clear requirement under the duties to protect and fulfill the right to health is that a government must take action, through legislative and other measures, to meet its obligations. This is especially true when needing to comply with its additional obligation to combat the epidemic.[395] Congress passed four resolutions during the COVID-19 pandemic aimed at combating the virus, but only in part. The President signed all four into effect. The first was passed on 4 March 2020, allocating $8.3 billion to primarily to fund public health and vaccine development.[396] This relatively miniscule funding to provide medical equipment, while simultaneously attempting to rapidly develop a groundbreaking vaccine had little impact, as the numbers began to rise the following week and have since escalated into millions of cases and over 170,000 American deaths.

Moreover, state governments were forced to compete for limited resources and PPE due to the lack of available materials nationwide and the failure of the US government to remedy the shortage. On 18 March, Congress passed the Families First Coronavirus

[393] CESCR General Comment No. 14, para. 51.
[394] BBC, 'Coronavirus: 'I'm all for masks,' says Trump in change of tone, *BBC*, 2 July 2020, https://www.bbc.com/news/world-us-canada-53258792 (accessed 11 July 2020).
[395] ICESCR, Art. 12(2)(c); CESCR General Comment No. 14, para. 44(c).
[396] H.R. 6074, 116th U.S. Congress, 2020.

Response Act, this time recognizing the severity of COVID-19 a bit more and sending $104 billion in assistance, although the vast majority was to help Americans economically rather than bolster the capacity of the healthcare system.[397] The dramatic increase in size of the two subsequent bills demonstrates the government's slow recognition of the severity of the crisis and need to enact effective legislation, which is obligated under the duties to protect and fulfill the right to health.

Government Actions and Impact

As stated, Congress passed the CARES Act on 27 March 2020, which provided $2.2 trillion dollars in response to the COVID-19 situation.[398] The CARES Act, however, was again tailored primarily towards the economy, allocating $175 billion, just under 8%, to healthcare facilities and workers fighting COVID-19.[399] Since the massive stimulus package, smaller allocations such as a recent provision of $10 billion to "high impact COVID-19 areas"[400] constitute some of the only direct acts of the federal government that could even fall under its obligations to protect and fulfill. While the stimulus entailed a lot of money on its face, the impact clearly fell short. Hospitals remained underfunded, PPE and medical equipment were in short supply and unnecessary death occurred by the thousands over the following months.[401]

Allocation of Resources

The CESCR expressly lists as an example of a violation of the obligation to fulfill: "insufficient expenditure or misallocation of public resources which results in the non-enjoyment of the right to health by individuals and groups, particularly the vulnerable or marginalized."[402] $2.2 trillion dollars is an unprecedented sum for a relief fund, but when only 8% of it goes to the healthcare industry, that is a misallocation of resources resulting

[397] H.R. 6201, 116th U.S. Congress, 2020.
[398] H.R. 748, 116th U.S. Congress, 2020
[399] US Department of Health and Human Services (HHS), 'HHS To Begin Distributing $10 Billion in Additional Funding to Hospitals in High Impact COVID-19 Areas, 17 July 2020, https://www.hhs.gov/about/news/2020/07/17/hhs-begin-distributing-10-billion-additional-funding-hospitals-high-impact-covid-19-areas.html (accessed 22 July 2020).
[400] *Ibid*.
[401] Interlandi.
[402] CESCR General Comment No. 14, para. 52.

in insufficient expenditure to protect Americans' health. Further supporting this assessment, the US was already underfunding its healthcare systems for years before COVID-19 and somehow doing so despite spending more on medical care overall than any other country in the world.[403] This led to hundreds of hospital closures and the loss of tens of thousands of beds prior to the pandemic, which immediately skyrocketed the demand for facilities and equipment.[404]

This was especially true for rural hospitals, which face a higher risk of losing funding for healthcare in general as a result of the COVID-19 pandemic and states' focus on urban areas.[405] State obligations under the right to health are not only for emergency purposes. They also must be met in regular circumstances. The impacts this has on those suffering from health issues unrelated to COVID-19 further violates state obligations under the right to health as "inequitable distribution of health facilities, goods and services."[406] This illustrates a key component in contrast to the right to life in this context. The right to health focuses on proper conditions overall. There is no need for a foreseeable threat to create a threshold for certain obligations under the right to health.

Vulnerable and Marginalized Groups

Additionally, the obligations to protect and fulfill are significantly impacted when omissions or inadequate actions fail to give special attention to vulnerable and marginalized groups. Not only has the US response to COVID-19 failed to give special attention to vulnerable and marginalized groups, but it has had a dramatically disproportionate impact on them. For one thing, elderly people are significantly more vulnerable to serious illness and death from COVID-19.[407] Inadequate attention to the elderly therefore violates state obligations under the right to health. The shortage of PPE and underfunded systems where

[403] S. Haeder, 'Opinion: Even before coronavirus, U.S. was underfunding public health,' *MarketWatch*, 17 March 2020, https://www.marketwatch.com/story/even-before-coronavirus-us-was-underfunding-public-health-2020-03-17 (accessed 31 July 2020).
[404] A. Diaz, et al., 'The COVID-19 Pandemic and Rural Hospitals – Adding Insult to Injury,' *Health Affairs Blog*, 3 May 2020, https://www.healthaffairs.org/do/10.1377/hblog20200429.583513/full/ (accessed 30 July 2020).
[405] *Ibid*.
[406] CESCR General Comment No. 14, para. 52.
[407] S. LaFave, 'The impact of COVID-19 on older adults,' *The Hub at Johns Hopkins University*,

caregivers could no longer safely care for the elderly further contributed to a discriminatory impact. While the virus itself is responsible for the direct vulnerability of the elderly, the government is responsible for giving special treatment to vulnerable groups under the obligations to protect and fulfill the right to health, just like with the right to life.

With respect to the obligation to maintain a system already tailored to respect nondiscrimination, an underlying basis is that the marginalization of certain groups and fundamental structural inequalities within a society can make these groups more susceptible to poverty and, consequently, poor health.[408] The WHO states that it is not surprising that this leads to marginalized groups often bearing a disproportionate share of health problems in general.[409] This has proven remarkably true in the United States during the COVID-19 pandemic. As described in the previous section, COVID-19 has had significantly disproportionate impacts on African Americans and Hispanics in states across the country, especially in comparison to their proportion of those states' populations. Also described above, the impact is exacerbated in this context when these racial and socioeconomic factors are coupled with the especially vulnerable status of age. The same analysis from the right to life section applies here as to these disparate impacts signifying violations of the principle of nondiscrimination and the right to health obligation to give special attention to vulnerable groups.

A health crisis having such disproportionate impacts on racial minorities not only clearly violates state obligations under the ICESCR right to health, but it also violates the US' human rights obligations to provide for the equal realization of the right to health under the ICERD, to which the US is bound as a State Party.[410] There is no question that nondiscrimination in meeting the core obligations under the right to health is non-derogable and of paramount importance. Furthermore, it exposes a government's true failure to provide for the right to health. COVID-19 has illuminated such failures in a dramatic manner. This catastrophe has illustrated the prevalence of human rights violations based on

[408] WHO Fact Sheet no. 31, p.7.
[409] *Ibid.*
[410] ICERD, Art. 5(d)(iv).

systemic failures in a way that was easier to conceal, or at least less commonly discussed, prior to the pandemic. This global health crisis provides additional burdens such as implementing measures to prevent, treat and control epidemic diseases. Other violations of the right to health, however, have been ongoing for decades. This is most clear with the impact of COVID-19 and the ongoing violations of the principle of nondiscrimination that the virus has exposed.

Preventive Measures

With regard to effectively responding under the right to health, testing and contract tracing proved successful in countries such as South Korea, who contained the virus phenomenally by acting early and testing. "Equal and timely access" to preventive measures under ICESCR Article 12(2)(d) can be interpreted in this context to include testing and other relevant screening procedures.[411] While the US is finally testing at a higher rate in July 2020, it only began testing in March 2020, when it was still only testing dozens of people per week out of a population of over 300 million.[412] Despite experts determining that the US needed to be conducting 500,000 tests a day at the time, the number only increased to 100,000 per day by the end of March and eventually plateaued around 220,000 a day by the end of April.[413] This shortage occurred even though these months saw the highest infection and death rates so far, quickly bringing the US to the number one spot worldwide in both regards, where it has remained ever since. At the time of publication, it is still difficult to get a rapid test in the absence of clear COVID-19 symptoms, with tests depending on labs in only a few locations and taking days if not weeks to return.[414] This is true despite the fact that the virus spreads when people are asymptomatic, which can last days and lead to unnecessary spread of the virus.

---

[411] CESCR General Comment No. 14, para. 17.
[412] G. Lopez, 'April was another lost month for Trump's coronavirus response,' *Vox*, 5 May 2020, https://www.vox.com/2020/5/5/21246327/coronavirus-trump-april-lost-month-jeremy-konyndyk (accessed 30 June 2020).
[413] *Ibid*.
[414] A. Goodnough, 'Testing Falls Woefully Short as Trump Seeks an End to Stay-at-Home Orders,' *New York Times*, 28 April 2020, https://www.nytimes.com/2020/04/15/us/coronavirus-testing-trump.html (accessed 11 August 2020).

Most of the aforementioned obligations involve the positive obligations to protect and fulfill. The obligation to respect also imposes negative obligations, such as its contributions to nondiscrimination, but also to refrain from marketing unsafe drugs.[415] The obligation to respect also obligates governments not to withhold, censor or misrepresent public health information.[416] These both turn to President Trump's constant misrepresentations regarding the dangers of the virus and the necessary precautions, his direct contradictions of public health experts and his false assertions that hydroxychloroquine, an anti-malarial drug, was both safe and effective in treating COVID-19. He even went so far as to secure millions of pills despite the absence of any proof that they effectively treat the virus, misallocating crucial funds.[417] The US Food and Drug Administration (FDA) released a statement on 1 July 2020 cautioning Americans about the safety concerns of using hydroxychloroquine to treat COVID-19.[418] The CDC still maintains months later in July 2020 that the drug is unsafe and unapproved by the FDA.[419] Marketing unsafe drugs violates state obligations by misrepresenting information needed about health and treatment during COVID-19.[420] Accurate and transparent information is a critical obligation under the right to health as supported by the CESCR and the WHO.

WHO Director-General Ghebreyesus famously stated, "we're not just fighting an epidemic; we're fighting an infodemic" in reference to 'fake news' that "spreads faster and more easily than the virus."[421] The WHO explains that an 'infodemic' is when people

---

[415] CESCR General Comment No. 14, para. 34.
[416] *Ibid.*, paras. 25-26.
[417] S. Gay Stolberg, 'A Mad Scramble to Stock Millions of Malaria Pills, Likely for Nothing,' *New York Times*, 16 June 2020, https://www.nytimes.com/2020/06/16/us/politics/trump-hydroxychloroquine-coronavirus.html (accessed 9 July 2020).
[418] US Food and Drug Administration (FDA), 'FDA Cautions against use of hydroxychloroquine or chloroquine outside of the hospital setting or a clinical trial due to risk of heart rhythm problems,' 1 July 2020, https://www.fda.gov/drugs/drug-safety-and-availability/fda-cautions-against-use-hydroxychloroquine-or-chloroquine-covid-19-outside-hospital-setting-or (accessed 9 July 2020).
[419] Centers for Disease Control and Prevention (CDC), 'Information for Clinicians on Investigational Therapeutics for Patients with COVID-19,' 25 April 2020, https://www.cdc.gov/coronavirus/2019-ncov/hcp/therapeutic-options.html (accessed 9 July 2020).
[420] Coco and de Souza Dias, pp. 5-8.
[421] UN Department of Global Communications (UNDGC), 'UN tackles 'infodemic' of misinformation and crime in COVID-19 crisis,' 31 March 2020, https://www.un.org/en/un-coronavirus-communications-team/un-

spread "an excessive amount of information about a problem, which makes it difficult to identify a solution."[422] Misinformation on the news and social media or even between individuals in person can impede efforts to adequately inform the population on how to behave during a global pandemic. Early on, rumors spread constantly. Examples include that the virus can be killed by hot water, that consuming large quantities of garlic or ginger can cure those infected with COVID-19 and Trump's unfounded information regarding hydroxychloroquine and its effective treatment of the virus.[423] The WHO thus expressly rebuked his claims, but tens of millions of Americans nonetheless believe them and have continued to act accordingly.

5.2.2. Due Diligence Standards

For the sake of brevity and avoiding repetition, the same principles apply as those under the right to life. As stated, due diligence itself is a customary standard under international law.[424] It applies equally to conventional law and customary international law. Because many of the obligations are the same under the inextricably intertwined rights of life and health in this situation, the due diligence standard thus applies the same. Accordingly, this means that due diligence influences the standards upon which to assess the US' adherence to international legal obligations under the right to life apply to the right to health. For example, the duty to protect health requires minimum standards of immediate response to a pandemic, just like with life, only derived from paragraphs 43 and 44 of General Comment 14.[425]

As determined above the US failed to meet its obligations under any standard of duties as guided by reasonableness. Like with the right to life, this is exemplified by the severity of COVID-19's impact generally, coupled with the absence of state action to respect, protect and fulfill its human rights obligations. Moreover, the failure to protect

---

tackling-%E2%80%98infodemic%E2%80%99-misinformation-and-cybercrime-covid-19 (accessed 8 June 2020).
[422] *Ibid*.
[423] *Ibid.*
[424] McDonald, pp. 1044-45.
[425] Coco and de Souza Dias, p. 10.

vulnerable groups and the discriminatory impact on marginalized groups support the determination that the US failed its obligations under the right to health. Tragically, the US did so at a time when the cost to human health and life was extraordinarily high.

Overall, the US failed to take reasonable steps to comply with its obligations under international standards governing the right to health. In addition to already having poor conditions on the ground, the US failed to take sufficient measures to combat COVID-19 by supporting and reinforcing its healthcare system and taking proper emergency actions at times of fatal shortages of life-saving equipment. Moreover, this failure further endangered healthcare workers. The response was neither timely nor transparent, as is required under the right to health. Information was neither readily available nor accurate, with Trump instead refuting the scientific evidence of public health officials and experts and misleading the public accordingly. Additionally, health protections did not take into account vulnerable groups nor serve to avoid nondiscrimination for marginalized groups. For many of the similar omissions and failures that violated the right to life, the US government also violated the human right to health. Lastly, I will briefly discuss the WHO and international health laws role in relation to the rights to life and health and the measures necessary during a global pandemic.

5.3. WHO + IHR Analysis

An analysis of the US response strictly under public health law such as the IHR would be beneficial as another paper topic. The important components here are its binding nature on the US and its affirmation of human rights standards and its emphasis on the need for actions to protect the right to health. By virtue of the deadly pandemic under which these assessments are being made, this consequently impacts the right to life as well. The specific IHR requirements to be discussed are the importance of science, the requirements after a PHEIC declaration, and the focus on information.

As stated in Section 3.4, IHR Article 43 provides limitations on health measures that can be put in place. In particular, they must be based on science.[426] This was clearly not

[426] IHR, Art. 43.

the case in the US, where Trump has repeatedly dismissed science and undermined it throughout his entire discourse.[427] The same provision also restricts travel bans unless absolutely necessary and, again, based on science.[428] Almost every nation in the world implemented some sort of travel ban in direct defiance of the IHR. It is interesting, however, that one of Trump's only actions was to ban travel into the United States while contradicting evidence of science, thus violating the IHR.

Most importantly, IHR Article 1 defines a PHEIC and requires that States take additional action upon the declaration in order to combat the emergency.[429] The PHEIC declaration in January 2020 had no impact on Trump, as no measures even began to go in place until March, when they did so only at the state level. Article 13 further requires States to develop the capacity and respond to PHEICs, implementing effective measures both for domestic and international health protections.[430] These functions basically grant the WHO an authority to call on every State to do what is necessary or at least make reasonable efforts to contain the pandemic in order to protect the rights to health and life of people all over the world. This is not a requirement that each State end the crisis, but it does require "promptly and effectively" taking state action.[431] This complements the international standards and specific obligations under international human rights law.

The CDC has a response plan specifically for a US response to influenza pandemics in which the declaration of a PHEIC is relevant to determining "Initiation Intervals" for response procedures at the federal and state levels.[432] With regard to WHO law, however, the US does not have legislation that alters obligations pursuant to the declaration of a PHEIC.

---

[427] Frieden, et al.
[428] IHR, Art. 43.
[429] *Ibid.*, Arts. 1, 18.
[430] *Ibid.*, Art. 13.
[431] Coco and de Souza Dias, pp. 8-10.
[432] Centers for Disease Control and Prevention, 'Updated Preparedness and Response Framework for Influenza Pandemics,' 26 September 2014, available at https://www.cdc.gov/flu/pandemic-resources/pdf/mmwr-rr6306.pdf (accessed 8 July 2020).

Article 5 through 7 of the IHR focus on information-sharing. This comes back to surveillance and other requirements, but mainly focuses on sharing information with the international community and WHO.[433] The information component and recommendations of proper surveillance are relevant given the US' failure in both of these regards. Since these sections focus heavily on cooperating with the WHO, they are beyond the scope of this paper and thus worth only an honorable mention.

The WHO and IHR provide supplementary guidance in evaluating responses to pandemics that threaten human lives and health. As the WHO itself has stated, however, the IHR relies on "peer pressure and public knowledge" rather than hard law enforcement mechanisms to hold States accountable to their obligations.[434] Some scholars have argued for the expansion of the IHR beyond soft law to allow sanctions under Article 41 of the UN Charter, noting that sanctions are one of the most effective diplomatic threats possible.[435] The use of force, of course, would not be a legal option at this time. Binding authority with more teeth, however, would be beneficial in protecting the human rights to health and life in the event of a future global pandemic.

Few nations, including the United States, have adhered to the IHR requirements. Importantly, however, is that the WHO is already considering using this catastrophe as an opportunity to again update the IHR and overhaul it to be able to deal with future public health crises.[436] If such an overhaul is successful as envisioned, an improved international authority to govern global public health crises with stronger accountability and enforcement mechanisms could potentially emerge from the ashes of COVID-19.

Section 6. Conclusion and Recommendations

The international standards governing compliance with state obligations under the rights to health and life provide numerous related requirements in the context of a global

[433] IHR, Arts. 5-7.
[434] Halpern p. 7; World Health Organization (WHO), 'IHR FAQs,' https://www.who.int/ihr/about/faq/en/ (accessed 29 July 2020).
[435] Haplern, p. 7 (citations omitted).
[436] Devi, p. 1332.

pandemic. COVID-19 has taken a massive toll on health and life worldwide, with the deadliest impact occurring in the United States. The rights to life and health require positive state action to protect and fulfill each right. They also require negative action to respect those rights, which in this context is most relevant regarding non-discrimination. The foreseeability of the threat posed by COVID-19 requires reasonable steps to prevent unnecessary sickness and loss of life. While the virus would inevitably cause some harm to both, the US was required by international law to do much more than it did to protect its citizens' rights to life and health. Due diligence elaborates that these standards require at least some level of reasonableness and positive measures. The context of a deadly pandemic and the scale of its potential impact on the rights to life and health heightens these standards. Notwithstanding, hardly doing anything at all and instead misleading the American people does not meet the standards provided under international human rights law in any case of a health issue that threatens human life.

Despite the US government's initial failures, efforts towards adapting and improving its response at any point could have alleviated the impact of early failures and served to reasonably protect the lives and health of its citizens. The absence of adequate actions from the onset of COVID-19 to the time of publication affirms that the US failed its people in a time of crisis, and the worst consequences have been the impacts on the health and lives of thousands of Americans. The failure to lead, the failure to allow science to guide decision-making, the failure to spread accurate health information and the failures to take the virus seriously and act accordingly all contributed to the determination that the US did not comply with its obligations under international human rights law. This is combined with the disproportionate impact on vulnerable and marginalized groups that was exposed within America but never addressed.

Regardless of the lack of effective options under international law to hold the US accountable and remedy the tragic tolls COVID-19 is still taking on American health and lives, the fact remains that nothing in effect at the time of writing can adequately and efficiently change the behavior of the current administration or hold it truly accountable for its failures to protect the human rights of its citizens. Putting politics and personal pride

above the health and safety of a country with over 300 million inhabitants clearly constitutes a failure on the part of the US government to meet its human rights obligations. The half-hearted, state-by-state approach taken in the absence of federal guidance has proven unable to effectively limit unnecessary sickness and loss of life. Where the states have proven unable, the federal government has remained steadfastly unwilling. The federal government observed the ineffectiveness of the US response compared to most other countries for over six months and is still yet to take any central leadership role, yield political opinions to science or act to eliminate the persistent threat of COVID-19. Promises of an eventual vaccine provide little in the absence of any scientific evidence that those under development will be effective.

Although the US failed its human rights obligations with devastating effects during the COVID-19 crisis, the situation can still provide an impetus for improvement and radical change going forward. This, however, would require a change of leadership in the United States. President Trump shows no signs of changing his position on COVID-19, merely applauding his efforts and dodging questions about why so many Americans have died.

The proper solution would begin with efforts to collaborate on an effective plan with public health experts, following the requirements of responding based on science-based evidence as provided by the WHO. Instead of working with the WHO and CDC, Trump has attempted to withdraw from the WHO and continues to take power and credibility away from the CDC and its epidemiological experts in favor of his own ideas, such as unsafe drugs that have no proven impact on COVID-19. It is foreboding that Trump's actions in 2020, such as taking data collection away from the CDC in favor of his own executive branch, are aimed at consolidating more authority over the COVID-19 response when he has proven both unwilling and unable to effectively combat the virus. When a leader's immediate response to a national public health crisis is to delegate a response to over 50 governors and territorial leaders and subsequently ignore the need to take decisive and significant action for months during a worsening situation, the solution should not be to grant that leader more authority over the response. President Trump's statements make it clear that the rights to life and health are not a true concern his.

Therefore, it does not seem likely that a response compliant with the human rights to life and health is a realistic possibility under the current administration.

In light of recommendations that will likely never occur, the option remains that a change of leadership brings the only opportunity for a change in approach. Many believe the 2020 election will ultimately be decided upon the perception of Trump's handling of the COVID-19 pandemic.[437] It is impossible to know what exactly a new administration would do, but if they continued operating with negligence and disregard to the human rights to life and health, the situation would simply remain at the status quo.

While legal accountability and enforcement may be difficult to implement, this pandemic must be seen as the opportunity it undeniably is to make the necessary transformations towards a global public health system that accounts for human rights. Prioritizing the rights to health and life are mandatory in a global public health emergency, especially when the WHO officially declares a PHEIC. The international system can benefit overall from the hard lessons learned during this pandemic and act to prepare for future deadly disease outbreaks in ways that comply with the standards prescribed by the human rights to life and health. Moreover, the IHR will be useful in guiding future improvements in international cooperation and disease preparedness.

The global environment has evolved in almost every way since the adoption of the UDHR and subsequent international human rights law instruments. The COVID-19 pandemic shows that the changes going forward will likely be "dramatic and precipitous" rather than "slow and incremental.[438]" Scholars and sociologists hope that this compelled experiment on the global social order "allows us to see its rules more clearly."[439] A shock that has indiscriminately affected every single nation on earth has an opportunity unprecedented since the establishment and codification of international human rights law.

---

[437] Economist Intelligence Unit, 'Coronavirus and the US Election,' 9 April 2020, https://www.eiu.com/n/coronavirus-and-the-us-election/ (accessed 11 August 2020).
[438] Forman, p. 376.
[439] *Ibid*.

After all, it was the "shock-response impact of crisis" that led to the creation of the UN and international human rights law after World War II in the first place.[440]

Global public health is something few can disagree is important, especially after COVID-19. It can thus be the vehicle through which human rights returns to the forefront of focus both within the US and internationally. As stated by the WHO, "in the 21st century, health is a shared responsibility, involving equitable access to essential care and collective defense against transnational threats."[441] COVID-19 may require various new insights into existing and sometimes outdated structures and legal bases. Enforcement mechanisms for the ICCPR and ICESCR rights to life and health must be improved, if possible. Even if the US government maintains that it is not bound to any international legal obligation to uphold the right to health domestically, it is certainly bound by the ICCPR right to life and the IHR to take reasonable measures to prevent and contain pandemics within its borders. The latter also requires it to cooperate with the international community to provide information and cooperate to contain the spread of COVID-19 worldwide.[442]

In a perfect world, this paper would conclude with a demand that the United States government face repercussions for its refusal to comply with international human rights obligations to protect its citizens' rights to life and health. Unfortunately, at this time, this paper can only conclude with a positive determination that the United States failed to meet its human rights obligations and that it is disappointing that nothing can actually be done to hold it appropriately accountable under international law. The American public, however, have an opportunity to pursue justice and accountability for the Trump administration in the 2020 Presidential Election. The only possible solution at this time is dramatic change within the US itself that leads to proper human rights considerations in preparation of a plan *before* the next pandemic strikes and a more cohesive and calculated approach next time.

---

[440] *Ibid.*, p. 377.
[441] UN Secretary-General's Envoy on Youth, 'WHO: World Health Organisation,' https://www.un.org/youthenvoy/2013/09/who-world-health-organisation/ (accessed 29 July 2020).
[442] Halpern, pp. 13-14.

Judith Skhlar famously said that "civilization advances when what was perceived as misfortune is perceived as injustice."[443] This applies to the excessive number of people who suffered or died at the hands of COVID-19. It also pertains to injustices such as the racial inequality that was luminously exposed both directly and indirectly by COVID-19 in the United States. The extreme echelons of sickness and death that occurred and are still occurring in the US during this global pandemic have been touted by the Trump administration more as misfortunes – inevitabilities and collateral damage prior to the impending "miracle" where COVID-19 suddenly disappears on its own.[444] With guidelines and legal obligations in place regarding health – from the rights to life and health generally to specific IHR regulations regarding PHEICs – it would be shameful to perceive the results of the US government's failures as mere misfortunes. International treaties, customary international law, international human rights law and international public health law provide the bases from which to formally label the suffering of the American people at the hands of COVID-19 as 'injustice.' The 'misfortune' in this scenario is the lack of means to adequately hold those responsible accountable.

[443] J. Shklar, *The Faces of Injustice*, Yale University Press, 1990.
[444] D. Goldberg, ''It's going to disappear': Trump's changing tone on coronavirus,' *Politico*, 17 March 2020, https://www.politico.com/news/2020/03/17/how-trump-shifted-his-tone-on-coronavirus-134246 (accessed 30 April 2020).

Bibliography

Literature Sources:

Amon, J., 'COVID-19 and Detention: Respecting Human Rights,' *Health and Human Rights Journal*, Vol. 22, No. 1, June 2020, pp. 367-370.

Andersen, M., 'Early Evidence on Social Distancing in Response to COVID-19 in the United States,' 5 April 2020 (revised 25 June 2020), http://dx.doi.org/10.2139/ssrn.3569368 (accessed 13 July 2020).

Ash, K., 'U.S. Reservations to the International Covenant on Civil and Political Rights: Credibility Maximization and Global Influence,' *Northwestern Journal of International Human Rights*, vol. 3, no. 1, 2005, https://scholarlycommons.law.northwestern.edu/cgi/viewcontent.cgi?article=1018&context=njihr (accessed 28 June 2020).

Avafa, T., B. Konstantinov, et al., 'A Rights-Based Response to COVID-19: Lessons Learned from HIV and TB Epidemics,' *Health and Human Rights Journal*, 24 March 2020, https://www.hhrjournal.org/2020/03/a-rights-based-response-to-covid-19-lessons-learned-from-hiv-and-tb-epidemics/ (last accessed 30 March 2020)

Barbisch, D., K. Koenig and F. Shih, 'Is There a Case for Quarantine? Perspectives from SARS to Ebola,' *Disaster Medicine and Public Health Preparedness*, Vol. 9, no. 5, 2015, pp. 547-553.

Barnridge, R., 'The Due Diligence Principle Under International Law,' *International Community Law Review*, vol. 8, 2006, pp. 81-121.

Belser, J. and T. Tumpey, 'The 1918 flu, 100 years later,' *Science*, vol. 359, no. 6373, 2018, p. 255.

A. Von Bogdandy and P. Villarreal, 'International Law on Pandemic Response: A First Stocktaking in Light of the Coronavirus Crisis, *MPIL Research Paper Series*, No. 2020-07, 2020.

Buchanan, B., 'Covid-19 and the First Amendment: A running report (July 8),' *Free Speech Center at MTSU*, https://www.mtsu.edu/first-amendment/post/613/covid-19-and-the-first-amendment-a-running-report-june-26 (last accessed 9 July 2020).

Bursztyn, L., et. al, 'Misinformation During a Pandemic,' *University of Chicago, Becker Friedman Institute for Economics Working Paper No. 2020-44*, 15 June 2020, https://dx.doi.org/10.2139/ssrn.3580487 (accessed 15 July 2020).

Coco A. and T. de Souza Dias, 'Prevent, Respond, Cooperate: States' Due Diligence Duties vis-à-vis the COVID-19 Pandemic,' *Journal of International Humanitarian Legal Studies*, 2020, pp. 1-19.

Cyranoski, D., 'What China's COVID-19 response can teach the rest of the world,' *Nature*, vol. 579, March 2020, https://www.nature.com/articles/d41586-020-00741-x (accessed 28 June 2020), pp. 479-480.

Dakwar, J., 'The United States Considers Itself a Human Rights Champion. The World Begs to Differ,' *ACLU Human Rights Program*, 8 May 2015, https://www.aclu.org/blog/human-rights/united-states-considers-itself-human-rights-champion-world-begs-differ (accessed 15 July 2020).

Devi, S., 'Travel Restrictions hampering COVID-19 response,' *The Lancet*, vol. 395, 25 April 2020, pp. 1331-1332.

Del Rio, C. and P. Malani, 'COVID-19: New Insights on a Rapidly Changing Epidemic,' *Journal of the American Medical Association*, 28 February 2020, https://jamanetwork.com/journals/jama/fullarticle/2762510 (accessed 29 March 2020).

Elbe, S., 'Securitizing Epidemics: Three Lessons from History,' in C. Enemark and M. Selgelid (Eds.), *Ethics and Security Aspects of Disease Control: Interdisciplinary Perspectives*, Ashgate, 2012, pp. 79-95.

Enemark, C. and M. Selgelid (Eds.), *Ethics and Security Aspects of Disease Control: Interdisciplinary Perspectives*, Ashgate, 2012.

Ferstman, C. and A. Fagan (eds.), 'Covid-19, Law and Human Rights: Essex Dialogues,' Project of the School of Law and Human Rights Centre, University of Essex, 1 July 2020, https://www.essex.ac.uk/research-projects/covid-19-law-and-human-rights-essex-dialogues (accessed 28 July 2020).

Ford, T., et al., 'Race gaps in COVID-19 deaths are even bigger than they appear,' *Brookings*, 16 June 2020, https://www.brookings.edu/blog/up-front/2020/06/16/race-gaps-in-covid-19-deaths-are-even-bigger-than-they-appear/ (accessed 30 July 2020).

Forman, L., 'The Evolution of the Right to Health in the Shadow of COVID-19,' *Health and Human Rights Journal*, vol. 22, no. 1, June 2020, pp. 375-378.

Gamhewage, G., 'Evolutions in global epidemic and pandemic preparedness,' *International Journal of Infectious Diseases*, vol. 73, supp., 2018, p. 39.

Halpern, M., 'State Obligations Under Public International Law During Pandemics,' *Emory International Law Review*, vol. 35, 2020, https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3636848 (accessed 29 July 2020).

Hannum, H., 'The UDHR in National and International Law,' *Health and Human Rights*, vol. 3, no. 2, 1998, pp. 144-158.

Hostmaelingen, N., H. Bentzen, 'How to operationalize human rights for COVID-19 measures,' BMJ Global Health, 2020, https://gh.bmj.com/content/5/7/e003048, p. 1.

Hsiang, S., D. Allen, S. Annan-Phan, et al., "The effect of large-scale anti-contagion policies on the COVID-19 pandemic,' *Nature*, 8 June 2020, available at https://doi.org/10.1038/s41586-020-2404-8 (last accessed 9 June 2020).

Jacobs, L., 'Rights and Quarantine During the SARS Global Health Crisis: Differentiated Legal Consciousness in Hong Kong, Shanghai, and Toronto,' *Law & Society Review*, vol. 41, no. 3, 2007, pp. 511-552.

Jester, B., T. Uyeki and D. Jernigan, 'Readiness for Responding to a Severe Pandemic 100 Years After 1918,' *American Journal of Epidemiology*, vol. 187, no. 12, 2018, pp. 2596-2602.

Joseph, S., 'COVID-19 and Human Rights: Past, Present and Future,' *Journal of International Humanitarian Legal Studies* (forthcoming), Griffith Law School Reaserch Paper No. 20-3, 26 May 2020, https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3574491 (accessed 28 July 2020).

Kettl, D., 'States Divided: The Implications of American Federalism for COVID-19,' *Public Administration Review*, vol. 80, no. 4, 2020, pp. 595-602.

KFF, 'State Data and Policy Actions to Address Coronavirus,' 13 July 2020, https://www.kff.org/health-costs/issue-brief/state-data-and-policy-actions-to-address-coronavirus/#socialdistancing (last accessed 15 July 2020).

Kinney, E., 'Recognition of the International Human Right to Health and Health Care in the United States,' *Rutgers Law Review*, vol. 60, no. 2, 2008, pp. 335-379.

Kinney, E., 'The International Human Right to Health: What Does This Mean for Our Nation and World?,' *Indiana Law Review*, Vol. 34, no. 1457, 2001, pp. 1457-1475.

McDonald, N., 'The Role of Due Diligence in International Law,' *International and Comparative Law Quarterly*, vol. 68, no. 4, October 2019, pp. 1041-1054.

Nowak M., 'The Right to Education – Its Meaning, Significance, and Limitations,' *Netherlands Quarterly of Human Rights*, vol. 9, no. 4, 1991, pp. 418-425.

Osterholm, M. and M. Olshaker, 'Chronicle of a Pandemic Foretold: Learning From the COVID-19 Failure – Before the Next Outbreak Arrives,' *Foreign Affairs*, vol. 99, no. 4, July/August 2020, pp. 10-24.

Potyraj, J., 'The Quality of US Healthcare Compared with the World,' *American Journal of Managed Care*, 11 February 2016, https://www.ajmc.com/contributor/julie-potyraj/2016/02/the-quality-of-us-healthcare-compared-with-the-world (accessed 16 July 2020).

Ranney, M., et al., 'Critical Supply Shortages – The Need for Ventilators and Personal Protective Equipment during the COVID-19 Pandemic,' *New England Journal of Medicine*, vol. 382, 30 April 2020, https://www.nejm.org/doi/full/10.1056/NEJMp2006141 (accessed 11 August 2020), p. e41.

Ren, X., 'Pandemic and lockdown: a territorial approach to COVID-19 in China, Italy and the United States,' *Eurasian Geography and Economics*, 8 May 2020, http://doi.org/10.1080/15387216.2020.1762103 (accessed 15 July 2020).

Selgelid, M., 'The Value of Security: A Moderate Pluralist Perspective,' in C. Enemark and M. Selgelid (Eds.), *Ethics and Security Aspects of Disease Control: Interdisciplinary Perspectives*, Ashgate, 2012, pp. 27-44.

Selgelid M. and C. Enemark, 'HIV/AIDS, Security and Ethics,' in C. Enemark and M. Selgelid (Eds.), *Ethics and Security Aspects of Disease Control: Interdisciplinary Perspectives*, Ashgate, 2012, pp. 45-58.

Sennett, A., '*Lenahan (Gonzales) v. United States of America*: Defining Due Diligence?,' *Harvard International Law Journal*, vol. 53, no. 2, 2012, pp. 537-547.

Shklar, J., *The Faces of Injustice*, Yale University Press, 1990.

Siewert, M., et al., 'A German Miracle? Crisis Management during the COVID-19 Pandemic in a Multi-Level System,' in M. Inacio and A. Burni (eds.), *PEX Special*

Report: Coronavirus Outbreaks, Presidents' Responses and Institutional Consequences, 2020, https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3637013 (accessed 14 July 2020).

Spadaro, A., 'COVID-19: Testing the Limits of Human Rights,' *European Journal of Risk Regulation*, vol. 11, no. 2, 2020, pp. 317-325.

Stephens, T. and D. French, 'ILA Study Group on Due Diligence in International Law: Second Report,' International Law Association, July 2016, https://www.ila-hq.org/index.php/study-groups (accessed 27 July 2020).

Tabari, P., et al., 'International Public Health Responses to COVID-19 Outbreak: A Rapid Review,' *Iranian Journal of Medical Sciences*, vol. 45, no. 3, May 2020, pp. 157-169.

UN, 'Policy Brief: The Impact of COVID-19 on older persons,' May 2020, https://unsdg.un.org/sites/default/files/2020-05/Policy-Brief-The-Impact-of-COVID-19-on-Older-Persons.pdf (accessed 31 July 2020).

Wells, C., et al., 'Impact of international travel and border control measures on the global spread of the novel 2019 coronavirus outbreak,' *PNAS*, vol. 117, no. 13, 31 March 2020, pp. 7504-7509.

Wilder-Smith, A., C. Chiew and V. Lee, 'Can we contain the COVID-19 outbreak with the same measures as for SARS?,' *The Lancet*, vol. 20, no. 5, May 2020, pp. e102-e107.

World Health Organization (WHO), 'Fact Sheet no. 31: The Right to Health,' Office of the High Commissioner for Human Rights (OHCHR), Geneva, June 2008.

Yamin, A., 'The Right to Health Under International Law and Its Relevance to the United States,' *American Journal of Public Health*, vol. 95, no. 7, 2005, pp. 1156-1161.

Legal Sources:

American Declaration on the Rights and Duties of Man, March 30-May 2, 1948, O.A.S. res. XXX, adopted by the Ninth International Conference of American States, Bogota, OEA/Ser. L/V/II, 23 doc., 21 rev. 6, 1948.

International Covenant on Civil and Political Rights (adopted 16 December 1966, entered into force 23 March 1976) 999 UNTS 171.

International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, entered into force 3 January 1976) 999 UNTS 3.

International Covenant on the Elimination of All Forms of Racial Discrimination (adopted 21 December 1965, entered into force 4 January 1969) 660 UNTS 195.

International Health Conference, *Constitution of the World Health Organization*, 1946.

International Law Commission (ILC), *Draft Articles on Responsibility of States for Internationally Wrongful Acts*, November 2001, Supplement No. 10 (A/56/10), chp.IV.E.1.

Organization of American States (OAS), *Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights ("Protocol of San Salvador"),* 17 November 1988 (entered into force 16 November 1999), O.A.S T.S. 69.

Organization of American States (OAS), *American Convention on Human Rights, "Pact of San Jose,"* Costa Rica**,** 22 November 1969 (entered into force 18 July 1978).

United Nations (UN), *Statute of the International Court of Justice*, 18 April 1946.

UN Commission on Human Rights, *The Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights*, 28 September 1984, E/CN.4/1985/4.

UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)*, 11 August 2000, E/C. 12/2000/4.

UN General Assembly, *International Bill of Human Rights*, 10 December 1948, A/RES/217(III)A-E.

UN General Assembly, *Universal Declaration of Human Rights*, 10 December 1948, 217 A (III).

UN General Assembly, *Vienna Declaration and Programme of Action*, 12 July 1993, A/CONF.157.23.

UN Human Rights Committee (HRC), *General Comment No. 36, Article 6 (Right to Life)*, 3 September 2019, CCPR/C/GC/35.

UN Security Council, *Security Council Resolution 2532 (2020)*, 1 July 2020, S/RES/2532.

United States (US), *Declaration of Independence*, 4 July 1776.

U.S. Constitution.

World Health Organization, *International Health Regulations (IHR)(2nd Ed.)*, 2005.

H.R. 6074, 116th U.S. Congress, 2020.

H.R. 6201, 116th U.S. Congress, 2020.

Cases:

Corfu Channel (UK v. Albania), 1949, ICJ Rep 4.

Fraihat v. DHS-ICE, U.S. District Court, CD California, 2018.

Pulp Mills on the River Uruguay (Argentina v. Uruguay), 2010, ICJ Rep 14.

Velásquez Rodríguez v. Honduras, Judgment, Inter-Am. Ct. H. R. (ser. C), no 4, 1989.

Other Sources:

American Academy of Pediatrics (AAP), 'Children and COVID-19: State Level Data Report,' 6 August 2020, https://services.aap.org/en/pages/2019-novel-coronavirus-covid-19-infections/children-and-covid-19-state-level-data-report/ (accessed 11 August 2020).

Axios on HBO, 'President Trump Exclusive Interview: Full Episode,' filmed 28 July 2020, aired 3 August 2020, https://www.axios.com/full-axios-hbo-interview-donald-trump-cd5a67e1-6ba1-46c8-bb3d-8717ab9f3cc5.html (accessed 8 August 2020).

Barnes, P., 'Sentencing Older COVID-19 Patients to Death by Triage,' *Forbes*, 2 July 2020, https://www.forbes.com/sites/patriciagbarnes/2020/07/03/sentencing-older-covid-19-patients-to-death-by-triage/#66f6f28f276b (accessed 1 August 2020).

Bauer, S., 'Teenager allegedly threatened with jail over COVID-19 posts,' *AP News*, 3 April 2020, https://apnews.com/41c3a3d1fe3c00175bea2c0de771da7a (accessed 9 July 2020).

BBC, 'Coronavirus: 'I'm all for masks,' says Trump in change of tone, *BBC*, 2 July 2020, https://www.bbc.com/news/world-us-canada-53258792 (accessed 11 July 2020).

BBC, 'Coronavirus: US death toll overtakes Italy as world's highest,' *BBC*, 12 April 2020, https://www.bbc.com/news/world-us-canada-52258284 (accessed 28 April 2020).

Bendix, A., 'US coronavirus cases are probably 10 times higher than the official numbers, more and more research suggests,' *Business Insider*, 25 July 2020, http://businessinsider.com/real-us-coronavirus-cases-compared-to-official-count-2020-7 (accessed 31 July 2020).

Berg, T. and S. Kosel, 'Religious Freedom Lessons from COVID-19 Dispute,' *Christianity Today*, 15 June 2020, https://www.christianitytoday.com/ct/2020/june-web-only/religious-freedom-covid-church-restrict-reopening-lawsuits.html (accessed 7 July 2020).

Biscobing, D., 'Experts: Arizona officials unlawfully holding COVID-19 information,' *ABC 15 Arizona*, 27 April 2020, https://www.abc15.com/news/local-news/investigations/experts-arizona-officials-unlawfully-holding-covid-19-information (accessed 9 July 2020).

Center for Systems Science and Engineering at Johns Hopkins University, 'COVID-19 Dashboard,' https://gisanddata.maps.arcgis.com/apps/opsdashboard/index.html#/bda7594740fd40299423467b48e9ecf6 (last accessed 8 August 2020).

Centers for Disease Control and Prevention (CDC), 'Updated Preparedness and Response Framework for Influenza Pandemics,' 26 September 2014, available at https://www.cdc.gov/flu/pandemic-resources/pdf/mmwr-rr6306.pdf (accessed 8 July 2020).

Centers for Disease Control and Prevention (CDC), 'Information for Clinicians on Investigational Therapeutics for Patients with COVID-19,' 25 April 2020, https://www.cdc.gov/coronavirus/2019-ncov/hcp/therapeutic-options.html (accessed 9 July 2020).

Civiqs, 'Coronavirus: Government Response,' https://civiqs.com/results/coronavirus_response?uncertainty=true&annotations=true&zoomIn=true (last accessed 14 July 2020).

CNBC News Release, 'CNBC Transcript: President Donald Trump Sits Down with CNBC's Joe Kernen at the World Economic Forum in Davos, Switzerland,' *22 January 2020,* https://www.cnbc.com/2020/01/22/cnbc-transcript-president-donald-

trump-sits-down-with-cnbcs-joe-kernen-at-the-world-economic-forum-in-davos-switzerland.html (accessed 15 July 2020).

Code Switch, 'A Decade of Watching Black People Die,' 31 May 2020, *NPR*, https://www.npr.org/2020/05/29/865261916/a-decade-of-watching-black-people-die (accessed 9 July 2020).

Connolly, D. and M. Clark, 'Amid COVID-19, Trump administration keeps immigration courts open, putting judges, lawyers and immigrants at risk,' *USA Today*, 2 July 2020, https://www.usatoday.com/story/news/nation/2020/07/02/trump-immigration-courts-open-despite-covid-19-risks/5362169002/ (accessed 8 July 2020).

Da Silva, C., 'Nearly 20 ICE Workers Have Tested Positive for COVID-19 as Agency Sees First Case Among Detainees,' *Newsweek*, 25 March 2020, https://www.newsweek.com/nearly-20-ice-workers-have-tested-positive-covid-19-agency-sees-first-case-among-detainees-1494128 (accessed 2 April 2020).

Du, L. and M. Fay Cortez, 'Global Covid-19 Cases Hit 10 Million as Pandemic Gains Momentum,' *Bloomberg,* 28 June 2020, https://www.bloomberg.com/news/articles/2020-06-28/global-covid-19-cases-hit-10-million-as-pandemic-gains-momentum?utm_campaign=news&utm_medium=bd&utm_source=applenews (last accessed 28 June 2020).

Diaz, A., et al., 'The COVID-19 Pandemic and Rural Hospitals – Adding Insult to Injury,' *Health Affairs Blog*, 3 May 2020, https://www.healthaffairs.org/do/10.1377/hblog20200429.583513/full/ (accessed 30 July 2020).

Economist Intelligence Unit, 'Coronavirus and the US Election,' 9 April 2020, https://www.eiu.com/n/coronavirus-and-the-us-election/ (accessed 11 August 2020).

Eligon, J., ''It's a Slap in the Face:' Victims Are Angered as Jails Free Inmates,' *New York Times*, 24 April 2020 (updated 26 June 2020), https://www.nytimes.com/2020/04/24/us/coronavirus-jail-inmates-released.html (accessed 9 July 2020).

Eligon, J., et al., 'Black Americans Face Alarming Rates of Coronavirus Infection in Some States,' *New York Times*, 7 April 2020, https://www.nytimes.com/2020/04/07/us/coronavirus-race.html (accessed 22 July 2020).

Foulkes, I., 'Why did the US leave the UN Human Rights Council?,' *BBC*, 20 June 2018, https://www.bbc.com/news/world-us-canada-44552304 (last accessed 30 June 2020).

Frieden, T., et al., 'We ran the CDC. No president ever politicized its science the way Trump has,' *Washington Post*, 14 July 2020, https://www.washingtonpost.com/outlook/2020/07/14/cdc-directors-trump-politics/ (accessed 11 August 2020).

Gay Stolberg, S., 'A Mad Scramble to Stock Millions of Malaria Pills, Likely for Nothing,' *New York Times*, 16 June 2020, https://www.nytimes.com/2020/06/16/us/politics/trump-hydroxychloroquine-coronavirus.html (accessed 9 July 2020).

Goldberg, D., ''It's going to disappear': Trump's changing tone on coronavirus,' *Politico*, 17 March 2020, https://www.politico.com/news/2020/03/17/how-trump-shifted-his-tone-on-coronavirus-134246 (accessed 30 April 2020).

Gebrekidan, S., 'For Autocrats, and Others, Coronavirus Is a Chance to Grab Even More Power,' *The New York Times*, 30 March 2020, https://www.nytimes.com/2020/03/30/world/europe/coronavirus-governments-power.html (last accessed 2 April 2020).

Goodnough, A., 'Testing Falls Woefully Short as Trump Seeks an End to Stay-at-Home Orders,' *New York Times*, 28 April 2020, https://www.nytimes.com/2020/04/15/us/coronavirus-testing-trump.html (accessed 11 August 2020).

Haeder, S., 'Opinion: Even before coronavirus, U.S. was underfunding public health,' *MarketWatch*, 17 March 2020, https://www.marketwatch.com/story/even-before-coronavirus-us-was-underfunding-public-health-2020-03-17 (accessed 31 July 2020).

Hallerman, T., D. Wickert and S. Kallis, 'Atlanta officials balance safety, virus, First Amendment amid protests,' *Atlanta Journal-Constitution*, 5 June 2020, https://www.ajc.com/news/local/atlanta-officials-balance-safety-virus-first-amendment-amid-protests/mo3SFIL3qRnxzxDmMDPGHO/ (accessed 7 July 2020).

Hallum, M., 'FDNY sued by EMS workers for alleged violations of First Amendment rights,' *AMNY*, 11 June 2020, https://www.amny.com/coronavirus/fdny-sued-by-ems-workers-for-alleged-violations-of-first-amendment-rights/ (accessed 9 July 2020).

Harris, S., et al., 'U.S. intelligence reports from January and February warned about a likely pandemic,' *Washington Post*, 20 March 2020, https://www.washingtonpost.com/national-security/us-intelligence-reports-from-january-and-february-warned-about-a-likely-pandemic/2020/03/20/299d8cda-6ad5-11ea-b5f1-a5a804158597_story.html (accessed 15 July 2020).

Human Rights Watch, 'Code Red: The Fatal Consequences of Dangerously Substandard Medical Care in Immigration Detention,' 20 June 2018, https://www.hrw.org/report/2018/06/20/code-red/fatal-consequences-dangerously-substandard-medical-care-immigration (accessed 11 July 2020).

Human Rights Watch, 'Human Rights Dimensions of COVID-19 Response,' 19 March 2020, https://www.hrw.org/news/2020/03/19/human-rights-dimensions-covid-19-response (accessed 29 March 2020).

Interlandi, J., 'Why We're Losing the Battle with COVID-19,' *New York Times*, 14 July 2020, https://www.nytimes.com/2020/07/14/magazine/covid-19-public-health-texas.html (accessed 15 July 2020).

Janes, C., et al., 'White House looks at plan to keep out citizens and legal residents over the virus,' *Washington Post*, 10 August 2020, https://www.washingtonpost.com/politics/white-house-looks-at-plan-to-keep-out-citizens-and-legal-residents-over-virus/2020/08/10/d8233910-db0c-11ea-b205-ff838e15a9a6_story.html?utm_campaign=wp_post_most&utm_medium=email&utm_source=newsletter&wpisrc=nl_most (accessed 11 August 2020).

Katz, E., 'ICE Struggles to Protect Detained Immigrants as Coronavirus Spreads in its Facilities,' *Government Executive*, 24 June 2020, https://www.govexec.com/management/2020/06/ice-struggles-protect-detained-immigrants-coronavirus-spreads-its-facilities/166410/ (accessed 9 July 2020).

Klein, R. and A. Wiersema, 'The Note: Trump changes course as COVID-19 response faces critical tests,' *ABC News*, 21 July 2020, https://abcnews.go.com/Politics/note-trump-covid-19-response-faces-critical-tests/story?id=71880637 (accessed 30 July 2020).

Kim, A., 'These are the states requiring people to wear masks when out in public,' *CNN*, 13 July 2020, https://www.cnn.com/2020/06/19/us/states-face-mask-coronavirus-trnd/index.html (last accessed 14 July 2020).

La Gorce, T., ‘’Everybody Was Sick:’ Inside an ICE Detention Center,’ *New York Times*, 15 May 2020, https://www.nytimes.com/2020/05/15/nyregion/coronavirus-ice-detainees-immigrants.html?auth=login-facebook (accessed 28 June 2020).

Laurent, L., ust‘For the EU, Banning American Tourists is the Easy Part,’ *Bloomberg*, 30 June 2020, https://www.bloomberg.com/opinion/articles/2020-06-30/coronavirus-the-eu-s-american-travel-ban-is-the-easy-part (accessed 30 July 2020).

Liptak, K. and N. Valencia, ‘Trump now in open dispute with with health officials as virus rages,’ *CNN*, 8 July 2020, https://www.cnn.com/2020/07/08/politics/trump-fauci-cdc-redfield-experts-coronavirus/index.html (accessed 15 July 2020).

Lopez, G., ‘April was another lost month for Trump’s coronavirus response,’ *Vox*, 5 May 2020, https://www.vox.com/2020/5/5/21246327/coronavirus-trump-april-lost-month-jeremy-konyndyk (accessed 30 June 2020).

Lutton, L., ‘Coronavirus case numbers in the United States: MARCH 27,’ *Medical Economics*, https://www.medicaleconomics.com/view/preparing-for-three-federal-mandates-to-improve-healthcare-in-2021 (accessed 1 August 2020).

Ma, J., ‘Coronavirus: China’s first confirmed COVID-19 case traced back to November 17,’ *South China Morning Post*, 13 March 2020, https://www.scmp.com/news/china/society/article/3074991/coronavirus-chinas-first-confirmed-covid-19-case-traced-back (accessed 16 July 2020).

Mays, J. and A. Newman, ‘Virus is Twice as Deadly for Black and Latino People Than Whites in N.Y.C.,’ *New York Times*, 8 April 2020, https://www.nytimes.com/2020/04/08/nyregion/coronavirus-race-deaths.html (accessed 18 April 2020).

Nature Editorials, ‘Stop sidelining the CDC,’ *Nature*, vol. 583, 30 July 2020, https://www.nature.com/articles/d41586-020-02231-6 (accessed 7 August 2020).

Oppman, P., ‘In Panama, coronavirus lockdown means separating men and women,’ *CNN*, 2 April 2020, https://www.cnn.com/2020/04/01/world/panama-coronavirus-sex-intl/index.html (last accessed 2 April 2020).

Parker, A. and P. Rucker, ‘One question still dogs Trump: Why not try harder to solve the coronavirus crisis?,’ *Washington Post*, 27 July 2020, https://www.washingtonpost.com/politics/trump-not-solve-coronavirus-crisis/2020/07/26/7fca9a92-cdb0-11ea-91f1-28aca4d833a0_story.html?utm_campaign=wp_post_most&utm_medium=email&utm_source=newsletter&wpisrc=nl_most (accessed 27 July 2020).

Rich, M., 'Why Asia's New Wave of Virus Cases Should Worry the World,' *The New York Times*, 31 March 2020, https://www.nytimes.com/2020/03/31/world/asia/coronavirus-china-hong-kong-singapore-south-korea.html (last accessed 2 April 2020).

Rucker, P., et al., 'The lost days of summer: How Trump fell short in containing the virus,' *Washington Post*, 8 August 2020, https://www.washingtonpost.com/politics/trump-struggled-summer-coronavirus/2020/08/08/e12ceace-d80a-11ea-aff6-220dd3a14741_story.html (accessed 8 August 2020).

Science News Staff, 'The United States leads in coronavirus cases, but not pandemic response,' *Science Magazine*, 1 April 2020, https://www.sciencemag.org/news/2020/04/united-states-leads-coronavirus-cases-not-pandemic-response (last accessed 3 April 2020).

Sweet, L., 'Surprise: Justice Kavanaugh sides with Gov. Pritzker over Illinois Republican organizations in COVID-19 crowd restriction case,' *Chicago Sun Times*, https://chicago.suntimes.com/columnists/2020/7/5/21314083/surprise-justice-kavanaugh-sides-with-gov-pritzker-over-illinois-gop-in-covid-crowd-restriction-case (accessed 7 July 2020).

Tian, H., et al., 'The impact of transmission control measures during the first 50 days of the COVID-19 epidemic in China,' *medRXiv*, 10 March 2020, https://doi.org/10.1101/2020.01.30.20019844 (accessed 22 July 2020).

Tepe, M., et al., 'Pandemic Balancing Acts: Early COVID-19 lockdown changes how Germans trade off lives and weigh constitutional powers,' *OSF Preprints*, 13 May 2020, https://osf.io/geu52 (accessed 14 July 2020).

The Guardian, 'Lost on the frontline,' *The Guardian*, 17 June 2020 (updated 23 July 2020), https://www.theguardian.com/us-news/2020/jun/17/covid-19-coronavirus-healthcare-workers-deaths (last accessed 31 July 2020).

US Department of Health and Human Services (HHS), 'Topic Collection: COVID-19 Hospital Triage/Screening Resources,' https://asprtracie.hhs.gov/technical-resources/119/covid-19-hospital-triage-screening-resources/99 (accessed 4 August 2020).

UN Department of Global Communications (UNDGC), 'UN tackles 'infodemic' of misinformation and crime in COVID-19 crisis,' 31 March 2020, https://www.un.org/en/un-coronavirus-communications-team/un-tackling-%E2%80%98infodemic%E2%80%99-misinformation-and-cybercrime-covid-19 (accessed 8 June 2020)

UN Development Programme (UNDP), *Human Development Report 1994: New Dimensions of Human Security*, New York, 1994, http://www.hdr.undp.org/en/content/human-development-report-1994 (accessed 14 July 2020).

UN Office for the High Commissioner of Human Rights (OHCHR), 'Coronavirus: Human rights need to be front and centre in response, says Bachelet,' 6 March 2020, https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25668&LangID=E (accessed 26 March 2020).

US Food and Drug Administration (FDA), 'FDA Cautions against use of hydroxychloroquine or chloroquine outside of the hospital setting or a clinical trial due to risk of heart rhythm problems,' 1 July 2020, https://www.fda.gov/drugs/drug-safety-and-availability/fda-cautions-against-use-hydroxychloroquine-or-chloroquine-covid-19-outside-hospital-setting-or (accessed 9 July 2020).

Viggo Wexler, C., 'Coronavirus has Donald Trump and Dan Patrick ready to sacrifice elderly people,' *NBC News: Think*, 26 March 2020, https://www.nbcnews.com/think/opinion/coronavirus-has-donald-trump-dan-patrick-ready-sacrifice-older-people-ncna1169126 (accessed 20 July 2020).

Walters, J. and J. Wong, 'Trump again claims COVID-19 will 'go away' as Fauci warns of long road ahead,' *The Guardian*, 5 August 2020, https://www.theguardian.com/us-news/2020/aug/05/donald-trump-covid-19-go-away (accessed 7 August 2020).

White House, 'Proclamation on Suspension of Entry as Immigrants and Nonimmigrants of Persons Who Pose a Risk of Transmitting 2019 Novel Coronavirus,' 31 January 2020, https://www.whitehouse.gov/presidential-actions/proclamation-suspension-entry-immigrants-nonimmigrants-persons-pose-risk-transmitting-2019-novel-coronavirus/ (accessed 31 July 2020).

White House, 'Proclamation – Suspension of Entry as Immigrants and Nonimmigrants of Certain Additional Persons Who Pose a Risk of Transmitting 2019 Novel Coronavirus,' 11 March 2020, https://www.whitehouse.gov/presidential-actions/proclamation-suspension-entry-immigrants-nonimmigrants-certain-additional-persons-pose-risk-transmitting-2019-novel-coronavirus/ (accessed 31 July 2020).

White House, 'Remarks by President Trump in Press Briefing – August 10, 2020,' 10 August 2020, https://www.whitehouse.gov/briefings-statements/remarks-president-trump-press-briefing-august-10-2020/ (accessed 11 August 2020).

White House, 'Remarks by President Trump in State of the Union Address,' 4 February 2020, https://www.whitehouse.gov/briefings-statements/remarks-president-trump-state-union-address-3/ (accessed 15 July 2020).

World Bank, 'GDP (current US$) – United States,' https://data.worldbank.org/indicator/NY.GDP.MKTP.CD?locations=US (accessed 4 August 2020).

World Bank, 'Population – total, China,' https://data.worldbank.org/indicator/SP.POP.TOTL?locations=CN (accessed 22 July 2020).

World Health Organization (WHO), 'Coronavirus disease (COVID-2019) situation reports,' https://www.who.int/emergencies/diseases/novel-coronavirus-2019/situation-reports/?gclid=Cj0KCQjwgo_5BRDuARIsADDEntQk5hu3kLjbRrfNqTFFJsqrLGB0jF6FkrdDQLkktJvNcDifUqen__8aAgG0EALw_wcB (accessed 31 July 2020).

World Health Organization (WHO), 'IHR FAQs,' https://www.who.int/ihr/about/faq/en/ (accessed 29 July 2020).

World Health Organization (WHO), 'WHO Coronavirus Disease (COVID-19) Dashboard,' https://www.who.int/redirect-pages/page/novel-coronavirus-(covid-19)-situation-dashboard (last accessed 8 August 2020).

World Health Organization (WHO), 'WHO Director-General's opening remarks at the media briefing on COVID-19 – 11 March 2020,' 11 March 2020, https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020 (accessed 8 April 2020).

World Health Organization (WHO), 'WHO Director-General's opening remarks at the media briefing on COVID-19 – 13 July 2020,' 13 July 2020, https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---13-july-2020 (accessed 16 July 2020).

World Health Organization (WHO), 'WHO Director General's remarks at the G20 Extraordinary Leaders' Summit on COVID-19 – 26 March 2020,' 26 March 2020, https://www.who.int/dg/speeches/detail/who-director-general-s-remarks-at-the-g20-extraordinary-leaders-summit-on-covid-19---26-march-2020 (last accessed 27 March 2020).

Section 7. Abstrakt

Die COVID-19 Pandemie trat schlagartig und heftig auf und zeigte sich gleichgültig gegenüber Landesgrenzen. Sie betraf und durchdrang jede Nation innerhalb weniger Monaten ab dem Zeitpunkt des Virusausbruches. Bis zum 31. Juli 2020 hatte das neuartige Corona-Virus (SARS-CoV-2) über 16 Millionen Menschen infiziert, und die daraus resultierende Krankheit (COVID-19) hat zwischenzeitlich über 670.000 Menschen getötet. Die WHO riet der Staatengemeinschaft zum akkordierten Vorgehen, doch die meisten Staaten handelten eigenmächtig. Vom menschrechtlichen Gesichtspunkt gefährdet COVID-19 fundamentale Menschenrechte, wie das Recht auf Leben und auf Gesundheit. Restriktive Maßnahmen zur Pandemieeinschränkung wiederum beeinträchtigen andere Menschenrechte. Solche Beschränkungen können gerechtfertigt sein, jedoch nur um das Recht auf Leben und Gesundheit zu schützen. Die USA implementierten letztendlich solch restriktiven Maßnahmen und verärgerten damit Millionen Bürger. Nichtsdestotrotz, halten die USA einen traurigen Rekord betreffend die höchsten Zahlen an Infizierten und Toten weltweit. Reaktionen darauf waren hauptsächlich durch ein Regierungsversagen gekennzeichnet, es wurde unzureichend und zu spät gehandelt.
Internationale Menschenrechte sehen die bindende staatliche Verpflichtung zur Nichteinmischung, der Schutzpflicht sowie der Erfüllungsverpflichtung vor. Sie sehen gesetzliche Standards zur Einhaltung der Menschenrechte sowie deren Evaluierung vor. Diese Arbeit untersucht, ob die USA relevante, internationale Standards während der COVID-19 Pandemie eingehalten haben. Obwohl auch jene Regierungsmaßnahmen adressiert werden, die als ’Gesetze‘ andere Menschenrechte beeinträchtigen, so liegt der Hauptfokus doch auf den Versäumnissen der verantwortlichen Regierung. Basierend auf internationalen Standards und die Sorgfaltspflicht berücksichtigend untersuche ich, ob die US-Regierung in ihrem Handeln versagt und seine internationalen Verpflichtungen, insbesondere das Recht auf Leben und auf Gesundheit, verletzt hat.
Schlüsselwörter: COVID-19, Menschenrechte, Recht auf Leben, Recht auf Gesundheit, Internationales Recht, Vereinte Nationen, Vereinigte Staaten, Staatliche Verpflichtungen