Is There an International Duty to Protect Persons in the Event of an Epidemic?

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In 2006, the International Law Commission began a study into the role of states and international organizations in protecting persons in the event of a disaster. Special Rapporteur Mr. Eduardo Valencia-Ospina was appointed to head the study, and in 2011 the findings of the study will be presented to the United Nations General Assembly. Of interest to this paper has been the inclusion of "epidemics" under the natural disaster category in all of the reports detailing the Commission's program of work on the protection of persons. This paper seeks to examine the legal and political ramifications involved in including "epidemic" into the concept of protection by exploring where sovereign responsibility for epidemic control begins and ends, particularly in light of the revisions to the International Health Regulations by the World Health Assembly in 2005. The paper will first analyze the findings already presented by the Special Rapporteur, examining the existing "responsibilities" of both states and international organizations. Then, the paper will consider to what extent the concept of protection entails the duty to assist individuals when an affected state proves unwilling or unable to assist their own population in the event of a disease outbreak. In an attempt to answer this question, the third part of the paper will examine the recent cholera outbreak in Zimbabwe.

INTRODUCTION

Between 1900 and 2005, there was a significant increase in the number of natural disasters of a biological, geological and hydrometeorological nature.[1] If scientific predictions are correct, climate change will increase the number of natural disasters that the world will face in the coming century. The Intergovernmental Panel on Climate Change (IPCC) found we are already experiencing the effects of climate change with increased tropical cyclonic activity in the North Atlantic, unusually prolonged drought across the Southern hemisphere and changes in infectious disease vectors.[2] The question of whether governments are prepared to mitigate the effects of natural disasters upon their population has become a key concern to the international community. Recent events where these concerns have come into play include the aftermath of Cyclone Nargis in the Ayeyawady delta, Myanmar in May 2008, when the junta initially refused international humanitarian assistance in spite of its failure to meet the needs of the affected population.[3] In the same year, Zimbabwe experienced one of the worst-ever recorded cholera outbreaks, with fatality rates at five percent (usually cholera infections have a fatality rate of less than one percent) and the subsequent spread of cholera infections to Botswana, Mozambique, South Africa and Zambia.[4]

These, and other cases, give rise to two particular problems. First, there have been instances where states have refused international humanitarian assistance, despite being unable to meet the needs of those affected by disasters. Second, there have been occasions where even if consent has been granted, the affected state has been unable or unwilling to ensure that aid is distributed quickly, effectively and equitably.[5] These factors have prompted some governments and international institutions to call for the development of clearer guidelines to direct states in their response to natural disasters, based on the idea that people possess a fundamental right to humanitarian assistance. To date, the main outcome of this push was the 2005 World Conference on Disaster Reduction which led to the Hyogo Framework for Action 2005-2010. The Framework for Action includes a process for evaluating the role of the state in alleviating the economic, health and social vulnerabilities that confront populations in the aftermath of a disaster.

Echoing the work done in relation to internally displaced persons (IDPs), the focus has been on the question of what existing legal protection is available to states, regional and international organizations and, most importantly, affected persons, in the event of a disaster (and its aftermath). This led to the commission of a study by the International Law Commission (ILC) on the protection of persons in the event of a disaster (hereafter referred to as "protection of persons") in 2006. The purpose of the study (which runs until 2011) is to examine what existing instruments and texts are applicable to the "main aspects of disaster prevention and relief assistance (including disaster response), as well as to the protection of persons in the event of disasters."[6] The study also seeks to clarify whether there is, or should be, an equivalent legal "right" to humanitarian assistance in the event of a natural disaster, that is similar to the right that civilians have under international humanitarian law during "complex emergencies" brought about by armed conflict (i.e. rights to food, shelter, medical aid).

In his 2008 report, the ILC Special Rapporteur on the Protection of Persons in the Event of Disasters specifically mentioned the need to include epidemics into his remit of study because of the "high degree of arbitrariness in disaster categorization, militating in favor of a more holistic approach."[7] He went on to cite the example of epidemic outbreaks occurring in situations where there has been a failure by coordinating authorities (i.e. states) to ensure hygienic conditions for disaster survivors. This question of the degree and source of protection available to persons in the event of a disease epidemic goes to the heart of the debate concerning what duties the sovereign owes its populations, when to judge that the sovereign has failed in fulfilling this responsibility and what this failure entails. Public health is primarily understood to be a domestic issue that falls under the sovereign jurisdiction of the state. However, the inclusion of infectious disease outbreaks as an area of concern to the protection agenda by the Special Rapporteur was not entirely novel. In 2004, the United Nations Secretary-General's High-level Panel on Threats, Challenges and Change made a clear link between the duty of the state to respond to disease outbreaks that threaten their population *and* the wider duties of the international

community in cases where the state is unable or unwilling to control the outbreak:

> Given the potential international security threat posed by the intentional release of an infectious biological agent or an overwhelming natural outbreak of an infectious disease, there is a need for the WHO Director-General, through the Secretary-General, to keep the Security Council informed during any suspicious or overwhelming outbreak of infectious disease. In such an event, the Security Council should be prepared to support the work of WHO investigators or to deploy experts reporting directly to the Council, and if existing International Health Regulations do not provide adequate access for WHO investigations and response coordination, the Security Council should be prepared to mandate greater compliance. In the event that a State is unable to adequately quarantine large numbers of potential carriers, the Security Council should be prepared to support international action to assist in cordon operations. The Security Council should consult with the WHO Director-General to establish the necessary procedures for working together in the event of a suspicious or overwhelming outbreak of infectious disease.[8]

In essence, the Special Rapporteur's memorandum speaks to the High-Level Panel's call for international community to consider the containment of diseases as a duty owed by all states, which translates into an international responsibility when the state fails. The duty to protect persons in the event of a disease outbreak has the potential to radically widen the concept of what the state "owes" its population. The question of what duties are owed by states will be discussed in the first section of this article. The purpose of this brief exploration is to consider how the international community has arrived at the point where it could be seriously considered that international actors have a right to "step in the place" of a state should that state be "unable to adequately quarantine large numbers of potential carriers." In the second section, this paper will evaluate how the Special Rapporteur has identified the health protection responsibilities of both states and international organizations in light of the revisions to the International Health Regulation by the World Health Assembly in 2005. Finally, this paper will examine the case of the cholera outbreak in Zimbabwe between 2008-2009 to reveal how calls for the expansion of the protection duties owed by the state to the individual is already affecting state practice in the event of disease outbreaks.

STATE RESPONSIBILITY FOR THE PROTECTION OF CIVILIANS

The notion of the responsible sovereign is long established, if not always adhered to in practice. Hobbes' *Leviathan* established that the state's authority depended on its capacity to protect individuals from the brutishness of the state of nature. As Peter Berkovitz explains: "only an agreed-upon sovereign with absolute and

indivisible powers, argues Hobbes, can protect subjects from each other and from threats. But in the end, the subject's obligation to obey runs no further than the sovereign's capacity to protect."[9] The idea that sovereigns should assist other sovereigns in the event of a disaster also has deep historical roots. In the eighteenth century, Emmerich de Vattel argued that:

> [W]hen the occasion arises, every Nation should give its aid to further the advancement of other Nations and save them from disaster and ruin...To give assistance in such dire straits is so instinctive an act of humanity that hardly any civilized Nation is to be found which would absolutely refuse to do so...Whatever be the calamity affecting a Nation, the same help is due to it.[10]

Neither of these examples should give the impression that sovereignty as responsibility extended beyond these positions put forward by legal and political scholars. In international law, states owed no obligations to their citizens or to other sovereigns to relieve humanitarian distress until the 1949 Geneva Conventions, which applied only in situations of armed conflict.[11] In the event of disasters,[12] man-made or natural, international law traditionally prioritized the right of the sovereign to determine whether assistance was required over the right of the persons affected to receive assistance or the duty of other sovereigns to assist.[13]

The absence of the right to assistance does not imply that there has been no international concept relating to the protection for persons, but that it is declarative and thus not legally binding. The evolution of sovereignty has "almost always entailed responsibilities," but what has undergone change is the "scope of the relevant responsibilities, the identity of those to whom sovereigns are responsible and the effect of that relationship."[14] We can see this development of sovereignty as responsibility when the Universal Declaration of Human Rights in 1948 declared the "equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world."[15] The International Covenant on Economic, Social and Cultural Rights (ICESCR) clearly refers to multiple rights that individuals have the right to claim from their sovereign in times of peace, disaster and conflict – which include the right to life, food, shelter and health.[16] Since then, the General Assembly has passed numerous resolutions that declare the need for persons to be protected and rendered assistance in times of disaster. For example, in 1990 it agreed that: "[A]bandonment of the victims of natural disasters and similar emergency situations without humanitarian assistance constitutes a threat to human life and an offence to human dignity,"[17] and in 1991: "[E]ach state has the responsibility first and foremost to take care of the victims of natural disasters and other emergencies occurring on its territory."[18]

Attempts to articulate the specific responsibilities of sovereigns developed in earnest in the 1990s. The catalyst, Bellamy argues,[19] was the end of the Cold War and the United Nations Secretary General Boutros Boutros-Ghali's appointment of Francis Deng in 1992 to explore the urgent humanitarian need of displaced persons that had dramatically increased during and in the immediate

aftermath of the Cold War period. It was the growing humanitarian crisis of internal displacement (there were 30 million displaced people by 1996), which led Deng to argue that it was one thing for sovereigns to claim territorial integrity as justification for non-intervention, but it should be another thing altogether to use it to deny humanitarian assistance.[20] Francis Deng, with his colleague Roberta Cohen, both Senior Fellows at the Brookings Institution, conducted an in-depth study into the problem of IDPs. Prior to this, Deng and others had called for a "pragmatic attempt at reconciling state sovereignty with responsibility" in the case of mass internal displacement in Africa.[21] They argued that by "effectively discharging its responsibilities for good governance, a state can legitimately claim protection for its national sovereignty."[22]

In 1996 and 1998, Deng and Cohen presented to the UN Human Rights Commission a two part study titled, "Compilation and Analysis of the Legal Norms" of IDPs, which led to the Commission recommending that Deng draft the Guiding Principles on Internal Displacement. The Guiding Principles were presented to the Commission in 1998. What was significant about the Guiding Principles was that they did not try to create "new rights," but instead articulated the rights that states had already committed to, and rights that individuals could claim from in situations where:

> [I]nternally displaced persons...who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognized State border.

Though the Guiding Principles are not legally binding, they have been adopted by the Human Rights Commission, the Executive Committee of the Office of the United Nations High Commissioner for Refugees (UNHCR) and reaffirmed by the General Assembly in the 2005 World Summit Outcome Document.[23] The Guiding Principles were based on the premise that both international humanitarian law and international human rights law articulate the responsibilities of governments for which they must be held accountable. What was important about the Guiding Principles was Deng's argument that sovereignty as responsibility meant that if a government was unwilling to provide protection and assistance (in this case to displaced populations), it "*must* accept aid from the international community."[24]

It was after the presentation of the Guiding Principles in 1998 that similar language was evoked by the UN Secretary-General Kofi Annan in relation to the right of protection. In 2001, Annan argued that while sovereignty offered vital protection it should "not be a shield for crimes against humanity."[25] Furthermore, in the same year, he suggested to the General Assembly that a framework outlining the responsibilities of states for receiving and providing assistance in the *event of a natural disaster* should be considered.[26] Neither point was received well by the General Assembly. However, as Bellamy notes, Annan's efforts "helped to re-focus the debate. The question was now not whether

sovereigns had responsibilities but what those responsibilities were, how they were best realized and what role international community should play."[27]

The doctrine of sovereignty as responsibility was further developed when the Canadian government established an International Commission on Intervention and State Sovereignty (ICISS) in 2000 – chaired by Gareth Evans and Mohammed Sahnoun – with the endorsement of Secretary-General Annan. Though the ICISS Report, which issued its findings in 2001 after extensive consultations via regional roundtables and national consultations, focused rather narrowly on the question of intervention, it drew almost unanimous agreement that there was indeed a sovereign responsibility to protect vulnerable populations (including in the event of a natural disaster).[28] The sovereignty as responsibility concept was subsequently outlined in the 2004 Report of the Secretary-General's High Level Panel on Threats, Challenges and Change, which argued that sovereignty "clearly carries with it the obligation of a State to protect the welfare of its own peoples and meet its obligations to the wider international community."[29] Furthermore, picking up on Deng's argument from 1999, it held that if a state remained unwilling to meet its obligations then "the principles of collective security mean that some portion of those responsibilities should be taken up by the international community, acting in accordance with the Charter of the United Nations and the Universal Declaration of Human Rights, to help build the necessary capacity or supply the necessary protection."[30] Furthermore, the Secretary-General commended the High Panel for presenting a "*broader, more comprehensive concept* of collective security: one that tackles new and old threats and addresses the security concerns of all States."[31] Moreover, the High-Level Panel called for a broader concept of international peace and security to include a duty of the Security Council to contain infectious disease outbreaks in the case of a state's inability or unwillingness to control the outbreak. Finally, before the 2005 UN World Summit, Annan again argued that "if national authorities are unable or unwilling to protect their citizens, then the responsibility shifts to the international community to use diplomatic, humanitarian and other methods to help protect the human rights and well being of civilian populations."[32]

In 2005, states unanimously endorsed a narrow understanding of the responsibility to protect (R2P) at the World Summit.[33] It is important to note that the scope of the 2005 World Summit was limited to only four specific crimes, and it is therefore imperative to distinguish between R2P, which applies only to genocide, war crimes, crimes against humanity and ethnic cleansing, and the wider concept of sovereignty as responsibility. Some have argued that the 2005 World Summit Outcome Document is only the start of a sweeping change to the practice of sovereignty[34] - such that the sovereign's claim of exclusive jurisdiction will increasingly fail to be a plausible excuse for inaction when populations are at risk. The call for intervention to assist populations devastated by Cyclone Nargis in Burma on 2 May 2008, when the Junta failed to allow humanitarian agencies access to the affected Ayeyawady Delta, has been offered as a case in point.[35] However, not only was there no international legal justification for intervening to assist the Burmese population, but any attempt to provide humanitarian assistance through non-consensual intervention effort would have, in all

likelihood, worsened the situation. Furthermore, as grave as the situation was in the Ayeyawady Delta, it did not amount to one of the four crimes under the responsibility to protect.[36]

As will be discussed in the next section, the protection of persons in the event of a disaster calls for different obligations to the responsibility to protect principle. What is important to note from this section is that the ILC's program of work on the protection of persons in the event of a disaster shares normative roots with the responsibility to protect in that both have developed from the sovereignty as responsibility norm. In the case of the ILC protection of persons study, based on the reports presented on the topic thus far, despite there being no legal requirement for states to permit international humanitarian access, there is an emerging convention that states ought to grant such assistance if they are unable to meet their population's needs. In turn, this sense of duty is impacting on how external states respond in situations of disaster as is illustrated further below in the case of the Zimbabwe cholera outbreak in 2008-2009.

PROTECTION OF PERSONS IN THE EVENT OF A DISASTER

In 2004, the same year the UN Secretary-General's High Level Panel published its report and three years after Secretary-General Kofi Annan had suggested to the General Assembly that a framework outlining the responsibilities of states for receiving and providing assistance in the event of a natural disaster should be considered,[37] the ILC considered a submission from the Working Group on the Long-Term Program of Work to study the protection of persons in critical situations. This was not the first time that some within UN Headquarters had raised the need for the codification of existing rules pertaining to responses to disasters by states, international organizations, and non-governmental organizations. In 1984, the then UN Secretary-General Javier Perez de Cuellar had attempted to introduce a convention on the provision of humanitarian assistance in the case of natural disasters, which failed to gain the support of the General Assembly. In 1994, Monaco proposed a convention on the establishment of safety zones in armed conflict and humanitarian disasters, which was also unsuccessful.[38] By 2004, the UN Secretariat had adopted a different strategy. Rather than seek immediate General Assembly support for a new instrument, the Secretariat decided that it would first be useful to identify the degree of existing responsibility that states had already agreed to in the area of disaster response, then through the ILC program highlight the protection and rights gaps that both states and international community needed to "fill" to ensure the protection of vulnerable persons.[39]

In addition, calls for a study into existing legal rules surrounding protection of persons were generated by the Indian Ocean tsunami on 26 December 2004. The tsunami devastated coastal populations in Aceh Indonesia, Thailand, Sri Lanka, India and Maldives, killing an estimated 227,000 people.[40] The humanitarian response to this immense disaster was generally effective, but some within the United Nations described it as a "chaotic shoe-string operation in which small groups of overworked and exhausted people in the field and at headquarters constantly improvise[d] to meet the unexpected problems and

challenges of an extreme intercontinental catastrophe," not to mention the difficulties involved in convincing UN agencies to work under a new joint operation.[41] The scale of the disaster prompted a large number of non-governmental organizations to deploy to the region in a way that was generally "unregulated or regulated [but] in a disparate manner."[42] In 2006, after much discussion within the Sixth Committee of the General Assembly and the Working Group itself, the convergence of the tsunami event and the long standing push within the UN for codification of the protection of persons led to the ILC accepting into its program of work the "protection of persons in the event of a disaster." The intent was for the focus to be broad enough to include the existing legal norms surrounding the protection and humanitarian assistance needs of persons, but also narrow in that the focus would be on natural disasters and how to reconcile the sovereign right of the state to refuse assistance with the right of persons to receive assistance.

Some agencies, such as the UN Inter-Agency Task Force for the International Strategy for Disaster Reduction (ISDR) (tasked with assisting states to implement disaster reduction strategies and the 2005 Hyogo Framework for Action)[43] – argued that the Commission should address both man-made and natural disasters as the "distinction between natural and man-made is somewhat artificial."[44] As will be discussed below, Special Rapporteur Eduardo Valencia-Ospena also argued that the study should explore both man-made and natural disasters, but this has not been met with unanimous support amongst states in the Sixth Committee. One proposed solution was for the study to address "disasters that emerge from a natural cause (including those natural disasters that may occur in the theatre of an armed conflict)" in the first instance, to allow investigation into the rights surrounding persons affected by a natural disaster.[45]

In line with this rationale, the UN's Office of Legal Affairs suggested that the original focus of the study be on natural disasters, or natural disaster components of broader, complex emergencies. Two reports, one confidential and one more publicly available in the 2006 ILC report, explored how the protection of persons topic could be developed. The openly available report defined the protection of persons topic as including natural hazards such as "earthquakes, floods, volcanic eruptions, landslides, hurricanes (typhoons and cyclones), tornadoes, tsunamis (tidal waves), droughts and plagues."[46] The Secretariat acknowledged that there was scope to include man-made disasters (which in turn can cause natural disasters), but for the meantime, the immediate focus should remain on natural disasters. As noted above, the main finding of the Secretariat's 2006 exploration of the topic was that there should be a "set of provisions which would serve as a legal framework for the conduct of international disaster relief activities; clarifying the core legal principles and concepts and thereby creating a "legal" space in which such disaster relief work could take place on a secure footing."[47] Of interest to this paper, there is nothing in the ISDR literature to suggest the preclusion of pandemics from the natural hazard definition (i.e. as a natural phenomena), and indeed, communications with the UN Office for Legal Affairs confirms that the work of the Commission does apply to epidemics with a transnational effect.[48] This is particularly well illustrated by the recent revisions

to the International Health Regulations (IHR) in 2005, which are discussed below.

With acceptance of the "protection of persons" as part of the Commission's program of work in 2006, the ILC appointed Eduardo Valencia-Ospina as Special Rapporteur. In the same year, the Secretariat was invited by the ILC to prepare a Memorandum detailing the existing legal instruments and texts that apply to disaster prevention, relief assistance and the protection of persons. The Secretariat's key finding was that the law on the right to humanitarian assistance in natural disasters remained inconclusive.[49] Furthermore, it found no general convention that governs all aspects of disaster relief, which was notable when compared to international humanitarian law which protects civilians during armed conflicts.[50]

The Memorandum found that on the question of humanitarian access, international law tended to privilege the protection of sovereignty and territorial integrity over the protection of populations. The "principles of sovereignty and non-intervention contain two important corollaries: that disaster relief carried out by assisting actors is subject to the consent of the receiving State and that the receiving State has the primary responsibility for the protection of persons on its territory and subject to its jurisdiction or control during a disaster."[51] The Memorandum went on to argue that states have remained reluctant to cede sovereign control because they are suspicious that external actors will use the guise of "humanitarian assistance" to promote their own political agendas. Even the 2005 World Summit Outcome document – despite at least four references to disaster preparedness and response – did not affirm the right of individuals to assistance in the event of a natural or man-made disaster.[52]

However, the Memorandum also revealed that while legal convention yielded to sovereignty on the question of humanitarian access, there has been, over the last couple of decades, a growing expectation within the international community that sovereigns (though not legally proscribed) *not deny* assistance, especially when needed. One important development in this area was a finding in 1986 by the International Court of Justice (ICJ) in *Nicaragua vs. United States of America* (US). The US government had claimed that its military assistance to the rebel Contras was humanitarian.[53] In finding against the US, the ICJ judged that while states could refuse assistance, the "provision of strictly humanitarian aid to persons or forces in another country, whatever their political affiliation or objectives, cannot be regarded as *unlawful intervention*, or as in any other way contrary to international law."[54] In sum, the ICJ found that although the provision of military assistance by the US was unlawful, the provision of genuine humanitarian aid without the consent of the host state would not have been an unlawful act under international law (it would still, of course, have violated domestic law). As the Memorandum notes, this was a landmark decision for it revealed that the sovereign right to refuse humanitarian aid does not prevail in situations where the aid is necessary, nor does the provision of humanitarian aid without government consent breach sovereignty. Thus, the ICJ found that humanitarian aid in response to disasters was significantly different to other forms of intervention in legal terms.

The Memorandum found that the duty to accept assistance had been further supported by two General Assembly Resolutions - 45/100 (1990) and 46/182 (1991).[55] The first resolution (45/100) specified the responsibility of the state to take care of victims of natural disasters, and the primary role of the sovereign to coordinate humanitarian assistance within its territory. General Assembly Resolution 46/182, which was passed in 1991, goes on to detail the responsibility to accept assistance. The fourth paragraph set out in very clear terms the right of the sovereign to decide whether to request and accept humanitarian assistance, but paragraph six qualified this, stating, "states whose populations are in need of humanitarian assistance are called upon to facilitate the work of these (humanitarian) organizations in implementing humanitarian assistance, in particular the supply of food, medicines, shelter and health care, for which access to victims is essential."[56] We see this corresponding duty of sovereigns to accept assistance aimed at protecting persons in the event of a disaster emerge again in the 1998 Guiding Principles on IDPs. The Guiding Principles stated bluntly that "national authorities have the primary duty and responsibility to provide protection and humanitarian assistance to internally displaced persons within their jurisdiction." This obligation, as noted earlier, extends to persons displaced by natural disasters.[57]

In addition to the sources identified above, the protection of persons concept has recently been reinforced by a number of international initiatives such as the Hyogo Framework, and (most important for this article) the IHR. There have also been various regional agreements under the Association of South East Asian Nations (ASEAN), European Union (EU) and Organization of American States (OAS), in which states have recognized a sovereign duty to address disasters by, among other things, agreeing to monitor the vulnerability to disasters and setting in place response strategies to deal with a disaster's aftermath, including in some texts a responsibility to reduce the "spillover" effects of a disaster that might affect neighboring states (e.g. water contamination after floods).[58]

In early 2005, 168 states were present at Hyogo, Japan for the adoption of the 2005 Hyogo Declaration and the 2005-2015 Hyogo Framework for Disaster Reduction, which stated that:

> Taking into account the importance of international cooperation and partnerships, each State has the primary responsibility for its own sustainable development and for taking effective measures to reduce disaster risk, including for the protection of people on its territory, infrastructure and other national assets from the impact of disasters. At the same time, in the context of increasing global interdependence, concerted international cooperation and an enabling international environment are required to stimulate and contribute to developing the knowledge, capacities and motivation needed for disaster risk reduction at all levels.[59]

Within both the Framework above and the Declaration below, states acknowledged their responsibility to protect their populations in the event of a disaster, and to mitigate the effect of a disaster through risk reduction.

> We affirm that States have the primary responsibility to protect the people and property on their territory from hazards, and thus, it is vital to give high priority to disaster risk reduction in national policy, consistent with their capacities and the resources available to them. We concur that strengthening community level capacities to reduce disaster risk at the local level is especially needed, considering that appropriate disaster reduction measures at that level enable the communities and individuals to reduce significantly their vulnerability to hazards. Disasters remain a major threat to the survival, dignity, livelihood and security of peoples and communities, in particular the poor. Therefore there is an urgent need to enhance the capacity of disaster-prone developing countries in particular, the least developed countries and small island developing States, to reduce the impact of disasters, through strengthened national efforts and enhanced bilateral, regional and international cooperation, including through technical and financial assistance.[60]

Though not legally binding, 168 states recognized their responsibility to protect people from hazards that significantly increase their risk of harm. While there remains gaps in this Framework – in particular the resistance of industrialized countries to providing financial assistance to low-income, disaster-prone countries – this far-reaching declaration linking the "responsibility" of states to the protection of their population in the event of a disaster was a significant breakthrough for the sovereignty as responsibility concept.

The importance of the Hyogo Framework is evidenced by its inclusion in the most recent regional framework on disaster response - the 2005 ASEAN Agreement on Disaster Management and Emergency Response - which is particularly noteworthy for advancing the notion of a sovereign's duty to respond to disasters. The Agreement also recalled General Assembly Resolutions 46/182 (1991)[61] and 57/578 (2002)[62] to highlight pre-existing responsibilities to integrate disaster management "in all its aspects," adopt a culture of prevention and, strengthen cooperation amongst states in the field of disaster preparedness and response.[63] Furthermore, the Agreement's definition of "disaster" was quite broad – defining disasters as a "serious disruption of the functioning of a community or a society causing widespread human, material, economic or environmental losses."[64] The agreement thus made no effort to delineate between "man-made" and "natural" disasters and in Article 5(a) identified both "natural and human-induced hazards" as requiring state responses.[65]

There are two further important points regarding the ASEAN Agreement. First, it states that Member States have a general obligation to "immediately respond to a disaster occurring within their territory." Furthermore, "when the said disaster is likely to cause possible impacts on other Member States, [the

affected state shall] respond promptly to a request for relevant information sought by a Member State or States that are or may be affected by such disasters, with a view to minimizing the consequences."[66] Second, each state is to set up a National Focal Point who can communicate their response to the ASEAN Coordinating Center for Humanitarian Assistance (AHA Center) on disaster management to indicate what action they are taking to identify and monitor disaster risk. Moreover, the AHA Center can request data from National Focal Points on disaster risk management and response, and provide data identifying their response to disasters management and provide regional-risk level analysis.[67]

In the ASEAN Agreement, we see a regional organization, renowned for its emphasis on national sovereignty and non-interference, adopting measures that call upon states to respond to natural or man-made disasters (including pandemics), to prepare for disasters, and to accept regional efforts to respond and mitigate the effects of the disaster from reaching them. Sovereignty as responsibility is a corollary of the Agreement – that when sovereigns fail to adequately respond to a disaster, ASEAN can approach the state to request that it accepts assistance. To some extent, we saw this in practice with the role played by ASEAN Secretary-General Surin Pitsuwan in the aftermath of Cyclone Nargis in Myanmar in May 2008.[68]

For the purposes of this paper though, the most important recent example of the protection of persons concept being incorporated into international law was the reformulation of state obligations to respond to health emergencies that constitute "a public health risk to other States through the international spread of disease" into the International Health Regulation (IHR) revisions in 2005.[69] The World Health Assembly (WHA) agreed unanimously in 2005 to revise the infectious disease notification protocols under the IHR. The revised IHR calls upon a signatory state to notify WHO and neighboring states of a suspected disease outbreak that could constitute a "public health emergency of international concern" (PHEIC) and, if the affected state does not notify WHO, then neighboring states and non-state actors under the revised IHR have the right to notify WHO of the suspected disease outbreak.[70] In contrast to the Hyogo Declaration, the revised IHR are legally binding (as all 192 WHA members passed the revised IHR in 2005). The revised IHR represents an important shift in thinking about what sovereigns are responsible for in relation to containing and responding to domestic events.[71] Furthermore, the duty placed upon states is significantly greater than under the previous IHR. For instance, the criteria under which a state is to notify WHO of a potential PHEIC is quite broad. An extraordinary public health event is determined according to whether it constitutes a public health risk to other states through the international spread of disease and requires a coordinated international response. The PHEIC decision criterion requires, under IHR Annex 2, states to consider when deciding whether to notify WHO the following: Is the public health impact of the event serious? Is the event unusual or unexpected? Is there a significant risk of international disease spread? Is there a significant risk of international travel or trade restrictions? Then the WHO Director-General makes the final determination of whether or not a PHEIC exists. While it is important to note that in the case of

the IHR, the WHO still requires the state to verify the report of an outbreak before it can send fieldwork response teams to assist in containing the outbreak, and the obligation to report only exists if the domestic event could pose an international threat, the state has a duty to report if the event may be "serious" or of "risk" spreading beyond the state – this has led to a very broad syndromatic definition of when PHEIC may apply.

Developments such as the revised IHR represent a shift from the "reactive reassertion of sovereignty" that Francis Deng noted in the early 1990s, to a more nuanced, negotiated understanding of "reconciling state sovereignty with responsibility."[72] While none of the frameworks, agreements or rules indicates an international legal shift in relation to the primary role of the state when it comes to humanitarian assistance and the protection of persons, they do reflect growing recognition that sovereigns have responsibilities to protect persons and contain the risk of disaster hazards spreading beyond territorial borders. Therefore, there is an emerging sovereign duty to request assistance, if not yet an individual right to receive assistance. Importantly, the scope of the sovereign's duty increases if the disaster is deemed to have implications for neighboring states and the broader international community. As indicated in some of the multilateral agreements noted above, especially the 2005 IHR, these developments contributed to an already evolving positive duty on the part of affected states to request assistance - especially if domestic capacity is overwhelmed or if the disaster has the potential to become a "trans-boundary hazard."

But what recourse do populations have in the event of a disaster if their host state is incapable or unwilling to provide basic aid and is reluctant to request international assistance? Valencia-Ospina concluded that the right to humanitarian assistance is directly related to the protection of persons because "it is presently uncertain whether existing international law takes into account all of the legitimate needs of persons affected by disaster."[73] Likewise, the ILC Memorandum argued that "the unique situation that disasters present leads to yet another specialized conceptualization of protection, including, for example, access to the victims, securing safe zones, the provision of adequate and prompt relief and ensuring respect for human rights."[74] Existing human rights obligations already provide people with rights in these situations but fulfillment of these obligations is dependent upon states recognizing that they have a duty to respect, protect and fulfill such rights.[75] It was therefore clear that work remains in translating these general rights and principles into something more concrete in terms of protection to vulnerable populations.

The response of states in the Sixth Committee of the General Assembly to the Special Rapporteur's preliminary report can be categorized into three main concerns. First, the granting of humanitarian access is the exclusive privilege of sovereigns and the articulation of an individual right to protection in the event of a disaster should not abrogate or limit sovereign rights. Second, it was argued that sovereigns are responsible for establishing the capacity to respond to disasters, and that international law cannot compel states do this through the use of "rights" language. Third, and partly as a result of the first two points, it was argued that the focus for efforts to strengthen the protection of persons should be on bilateral and regional arrangements rather than an international framework.[76]

However, what was not disputed was that "the principles of sovereignty and non-intervention should not mean that a State affected by a disaster may deny victims access to assistance, and it was suggested that if the affected State was unable to provide the goods and services required for the survival of the population, it must cooperate with other States or organizations willing to do so."[77] Therefore, while the findings of the Special Rapporteur remain pending, one important product of the Commission's work has been the identification of a states' duty to accept aid in instances where they are unable or unwilling to provide victims access to assistance. In the specific area of public health, we have also seen the emergent trend towards identifying disease outbreaks that pose a serious risk to individuals as amounting to an international public health concern. But to what degree do these developments affect actual state behavior? In the next section, this paper will examine the case of the cholera outbreak in Zimbabwe in 2008-2009, and reveal how calls for the expansion of the protection duties owed by the state to the individual shaped the Zimbabwean government's response.

PROTECTION OF PERSONS IN THE TIME OF CHOLERA: THE CASE OF ZIMBABWE

As already mentioned above, in his 2008 report the Special Rapporteur specifically referred to epidemics as falling within his remit of study because of the "high degree of arbitrariness in disaster categorization, militating in favor of a more holistic approach," (citing the example that epidemics sometimes occurred not because of human agency, but aggravated by it due to neglect of hygiene within camps of refugees or internally displaced persons).[78] The question of whether people have a right to assistance in the event of a disease epidemic goes to the heart of the sovereignty as responsibility debate. Public health is primarily understood to be a domestic issue that falls under the sovereign jurisdiction of the state. Yet the UN Secretariat's Memorandum and the Special Rapporteur both identified scope in existing agreements and laws for the international protection of persons to extend to health.

Cholera, an infection of the intestines caused by contaminated food or water by the bacterium *Vibrio cholerae*, primarily affects Africa, South East Asia and Latin America. In 2008, the number of infections and countries reporting cholera outbreaks increased. WHO registered 190,130 cases and 5,143 deaths in 2008, which represents a case-fatality rate of 2.7 percent both the number of cases. Comparing 2008 to 2007, there was a 7.6 percent increase in the number of cholera outbreaks and a 27 percent increase in the number of deaths. The 2008 outbreak in Zimbabwe (60,055 cases), Democratic Republic of Congo (DRC) (30,150) and Guinea-Bissau (14,323 cases) accounted for much of the 2008 increase. Across the past five years there was a steady trend of increased cholera infections – up 24 percent over the 2004 to 2008 period.[79] According to WHO, one of the "biggest outbreaks ever recorded in recent history began in mid-August 2008 in Zimbabwe."[80] In February 2009 the disease had peaked at 8,000 cases per week.[81] By the end of May 2009, there was a cumulative case load of 98,424 suspected cases; 4,276 deaths with a case fatality rate (CFR) of 4.3 percent - in January the peak had been nearly 6 percent.[82] On the degree to which the disease spread in Zimbabwe, estimates have varied from 55 to 60

districts (out of 62 districts) in all 10 provinces.[83] The outbreak also spread into Botswana, South Africa, Zambia and Mozambique, causing thousands of infections amongst the populations bordering Zimbabwe. The cause of trans-border infections included polluted water causeways from Zimbabwe running into towns on the border, and Zimbabwean "health refugees" crossing the border to seek treatment and relief from the outbreak (just during December 2008 hundreds had fled into South Africa seeking treatment).[84] The fatality rate for Zimbabwe has been twenty times higher than the fatality rate that WHO usually estimates for cholera when proper treatment is available - a five percent infection rate has held steady for most of the crisis – resulting in the disease reaching epidemic proportions.[85] In January 2009, Eric Laroche, Assistant Director-General for WHO's Health Action in Crises Cluster, described the outbreak as an "extraordinary public health crisis that requires from us all an extraordinary public health emergency response." He went on to argue that the outbreak was far from being brought under control and other countries in the southern Africa region faced the threat of "spill over epidemics."[86]

It has been alleged that the Zimbabwe government first tried to cover up the infections in August 2008, but word quickly spread amongst the humanitarian agencies that had been allowed to stay after the 2008 March general parliamentary elections that cholera was sweeping the rural districts and would soon reach the urban areas. By the time cholera deaths had started to peak in Harare in November and December, the government had closed all public hospitals in the capital due to a lack of running water, medicine, food and equipment.[87]

In sum, the cholera outbreak in Zimbabwe depicted both a disaster as defined by UN ISDR, and a PHEIC as defined by the 2005 IHR. Recall, a disaster is defined by the UN ISDR as "a serious disruption of the functioning of a community or a society causing widespread human, material, economic or environmental losses which exceed the ability of the affected community or society to cope using its own resources."[88] The WHO's revised IHR (2005) lists cholera as one of the diseases that states are required to notify WHO about due to its ability to cause serious public health impact and to spread internationally. Furthermore, the IHR requires that states request international assistance if they have insufficient antidotes, drugs, vaccine, protection equipment and financial, human and material resources to contain the disease.[89] The breakdown of the public health system in Zimbabwe, the case fatality rate of cholera victims, and the speed at which the disease spread all pointed to the state being unable to effectively contain the disease outbreak.

Did the cholera epidemic in Zimbabwe constitute a disaster, and as such, did Zimbabwe have a duty to accept the assistance offered by WHO and various non-governmental organizations? In keeping with the definitions set out by the ISDR, the Hyogo Declaration, IHR 2005, and the Memorandum by the UN Secretariat on the protection of civilians in the event of a disaster, the answer would seem to be clearly in the affirmative. Between August and December 2008, the outbreak spread to all ten provinces in Zimbabwe, had a five percent CFR,[90] and spread to neighboring Botswana, Mozambique, South Africa and Zambia.[91] The cholera outbreak became a trans-boundary hazard as infected people and

water was carried over into neighboring countries, there was increased internal displacement as people sought treatment and clean water in districts less affected by the outbreak, and the local health care system proved unable to contain the disease due to lack of adequate treatment, staff, nourishment or resources.[92]

The cholera epidemic in Zimbabwe was caused largely by the financial and political mismanagement of public health for well over a decade.[93] After the general elections in March 2008, President Mugabe ruled that the opposition led by Morgan Tsvangirai did not have the right to form a government, even though it appeared that Tsvangirai's Movement for Democratic Change (MDC) party had won the majority of seats in the election. Those humanitarian groups who condemned the election result were expelled, which placed further strain on the agencies that remained, primarily WHO, UNICEF, MSF, World Vision, IFRC, Merlin and Plan International. The European Union and United States responded with sanctions against the Zanu-PF led government, which were used as justification for the government's failure to supply core medical equipment, drugs and food.

In the midst of political turmoil, however, international pressure was brought to bear on the government. First, the international community began to condemn the government for failing to protect its population, arguing that the state was deemed a "failure" because of the high case fatality rate. The considered opinion was that the cholera outbreak would not have been so deadly if the state had provided basic medical services and nutrition to the affected population. Second, the crisis escalated to the point where it started to spread beyond Zimbabwe and into Botswana, Mozambique, South Africa and Zambia. At this point, Zimbabwe was no longer able to plausibly deny what humanitarian officials had been reporting on the ground – that the outbreak had reached the point where it was a public health emergency of international concern. The high case fatality rate provided evidence that the state had *failed* to contain the outbreak, and was further demonstrated by cholera "refugees" fleeing to neighboring countries seeking treatment. In essence, what the growing chorus of criticism against Zimbabwe was demonstrating was that the perceived duty of care that the state owed its citizens had been breached in this case. Furthermore, because the state had failed to deliver on its duty of care, international actors insisted that it had a duty to accept the assistance being offered by the international community.[94]

When the disease was confirmed as having spread to Botswana, Mozambique, South Africa and Zambia, Kenyan Prime Minister Raila Odinga suggested that if Zimbabwe proved unwilling or unable to contain the outbreak then the African Union (AU) should "allow the UN to send its forces into Zimbabwe with immediate effect, to take over control of the country and ensure urgent humanitarian assistance to the people dying of cholera."[95] British Prime Minister Gordon Brown described the outbreak as "an international rather than a national emergency...International because disease crosses borders. International because the systems of government in Zimbabwe are now broken. There is no state capable or willing of protecting its people."[96] The United States Ambassador to the United Nations, Susan Rice, argued that the Mugabe led government's failure to contain the cholera epidemic represented a failure to govern, and that

nations of the Southern African region had a responsibility to force Mugabe to step down.[97] While it was not until the disease had spread beyond Zimbabwe's borders that the international community voiced concern about the effectiveness of the Zimbabwe government, what is significant about the Zimbabwe case in light of the ILC's preliminary report on the protection of persons is the invocation of "duty" language by parts of the international community. Seemingly, bowing to pressure, the Zimbabwe government declared the cholera outbreak as a national emergency on 4 December 2008, and invited WHO to coordinate a Health Cluster response effort with the cooperation of the Zimbabwe health ministry and other nongovernmental agencies.[98]

The collective international response–from WHO to members of the United Nations Security Council such as the United Kingdom (UK) and US–was that Zimbabwe not only had to contain the disease but the state could be deemed as failing unless it contained the disease. The duty of the state to provide assistance to persons affected constituted such a sovereign responsibility that failure to meet this responsibility would lead to the state itself being defined as a failure. The Zimbabwe cholera outbreak evoked a clear position by the international community that there is, indeed, a sovereign duty to contain disease outbreaks within the state's border, but also to effectively prevent and control the disease within the state.[99] While this event is far from delivering a "responsibility to practice" doctrine in the area of public health that could apply in instances where states prove unwillingly or incapable of responding to overwhelming outbreaks of infectious disease,[100] it does represent progress in the identification of the sovereign duty to assist civilians in time of disaster, and moreover, to accept international assistance. As WHO's Dr. Laroche argued, "political differences need to be put aside, economic barriers overcome, health services in the country's periphery strengthened and community awareness to respond enhanced to save many more people from dying due to a disease that can be readily prevented and treated."[101]

CONCLUSION

The initial reluctance of Zimbabwe to notify the WHO of the outbreak, to allow unfettered humanitarian access, and to permit aid distribution into areas supportive of the political opposition, all point to the difficulties associated with articulating and operationalizing a right that persons have to assistance and protection in the event of disaster. However, the Zimbabwe experience also reveals progress on identifying the responsibilities that states owe to their populations and marshalling international consensus on that point. In this case, the international community agreed that Zimbabwe was failing in its responsibility and applied diplomatic pressure, prompting the government to relent and accept international assistance. But it is important to note the inherent limits to this idea. First, the duty to assist relies upon the government acknowledging that it bears such a duty.[102] The distinction needs to be made between a state being unwilling to protect persons from an epidemic and a state that is unable to do so. Naturally, states that are simply unable to assist are less likely to resist offers of international assistance. The Zimbabwe government's

response initially ranged from denial, to assertions that the government had the situation under control, and once this was proven to be untrue, President Mugabe alleged that the outbreak was the result of a biological weapon attack by the US and UK. As such, the extent of the cholera outbreak could have been limited were it not for the government's inertia and refusal to acknowledge the gravity of the situation. This is vastly different to a situation where a state is willing to assist its population, but does not have the capacity to do so.[103] When states are unwilling to assist, it is possible that diplomatic pressure will fail to generate the sense of responsibility required from the host state with the result that more coercive measures might be needed. In the case of Zimbabwe, however, diplomatic pressure had the desired effect.

This leads to the next point, which is that it was not until the disease threatened neighboring state populations that Zimbabwe was condemned and financial, as well as diplomatic, efforts were launched to assist WHO and non-government agencies with the task of cholera treatment.[104] The importance of Special Rapporteur Ospina's ILC study is that it will assist in articulating and setting out the responsibilities that states, such as Zimbabwe, have already agreed to in their role to protect civilians in the event of a disaster. It also articulates what responsibilities the international community has to render assistance to populations affected by disasters. What the Zimbabwe case showed is that there is already a broad framework of international human rights and disaster response rules and guidelines which enjoy international legitimacy.

The real challenge therefore lies not in developing new obligations, but identifying and implementing the ones states have already agreed to. Here, again, the case of Zimbabwe provides some useful clues. First, as noted above, the 2005 Hyogo Framework and Secretariat Memorandum for the ILC both noted pre-existing economic, political, social and environmental conditions that make some countries more vulnerable to the devastation of particular disasters than other countries. Whether it is a poor health system, populations living in unsafe housing, or conditions of severe underdevelopment exacerbated by political, social or economic causes, it creates a situation where - when disaster strikes - the likelihood of the disaster reaching hazardous proportions will be inevitably high. This is essential to note because it also means that humanitarian agencies are already going to be present in the majority of countries that endure such vulnerabilities.[105] Zimbabwe is a perfect example of this. As such, the question of humanitarian access is therefore more complex and nuanced than often presented; it may "simply" require creating the conditions that permit already in-country agencies to do their work, as much as allowing access to new agencies. Second, the international community has a responsibility to remain financially and politically engaged by assisting regional organizations and individual states in meeting their risk reductions strategies under the Hyogo Framework.[106] International actors are more likely to be thought legitimate and to have leverage if they are already committed to assisting states with economic development and capacity building.

What remains crucial therefore, is not the further creation of legally binding obligations demanding the right to protection – such calls are merited, but are not likely to be any more successful in delivering practical adherence to

the principle. Rather, the key is persuading governments to fulfill their responsibilities and encouraging external actors to provide assistance when needed. Thus, when it comes to actualizing the protection of persons, sovereigns already have a duty to accept assistance when they are not able or willing to render it themselves. Thus, states need to be held accountable for the rights that they have already signed on to in various international rules and agreements: such as to the ICESCR pertaining to the provision of food, water, shelter and medicine - which they reaffirmed in General Assembly Resolutions 45/100 (1990) and 46/182 (1991); their membership to legally binding agreements such as the 2005 International Health Regulations; and of their collective responsibility to prevent a disaster from causing greater undue harm and suffering, as signed on to by 168 states under the 2005 Hyogo Declaration and Framework. In the case of Zimbabwe, the two key factors that persuaded the state to declare a national emergency and scale up its acceptance of international aid was the presence of humanitarian workers reporting the extent of the cholera outbreak and second, diplomatic pressure from neighboring states. It is unlikely that any convention declaring the right of protection could have achieved more access or success in Zimbabwe without these factors in play. Zimbabwe was ultimately persuaded to accept offers of assistance because it recognized a shared expectation among states and international organizations that states have a duty to protect their populations from national disasters and that the international community has a legitimate role to play should states fail.

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[102] I thank the reviewer for this point.
[103] Which raises the question of how far do we extend sovereignty as responsibility – does the duty extend to an adequate public health system that can adequately respond to epidemics? I thank the reviewer for this point.
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