

Responsibility for Epidemics

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Epidemics are the result of the actions of multiple actors, which necessitates a comprehensive allocation of responsibility. However, the traditional framework for responsibility, as well as the emerging norm of the responsibility to protect, are inadequate for addressing epidemics. Both perpetuate the fallacy that states can, on their own, cope with the increased incidence of epidemics and fail to adequately allocate responsibility.

Given these limitations, this Article argues for a new vision of responsibility. It develops the theory underlying the norm of common but differentiated responsibility and makes the case for expansion of this framework to the challenges posed by highly-infectious diseases. This Article articulates the distinctive normative bases for differentiating responsibilities based on need, culpability, and capacity. The framework developed herein better distributes responsibility and is less state-centric than rival norms. It accounts for structural inequality in ways that other frameworks do not. Further, it does not reify the false hierarchy between civil and political rights and economic and social rights that exists in other frameworks. It recognizes and accounts for the significant role of nonstate actors and provides a basis for holding such actors responsible, as opposed to the nonattribution of responsibility that exists.

There is reason for cautious optimism about the prospects of success of this framework. First, it is consistent with theoretical and existing foundations of law where responsibility is tethered to an actor's conduct and relationship to the harm through culpability. However, the framework does not treat the culpability model as a legal straitjacket and envisions a broad understanding of causation—direct, indirect, and historical. Additionally, the framework differentiates based on capacity, which is derived from human rights and global public health law. It also draws on extralegal incentives, building on moral and political conceptualizations of responsibility towards those in need. The common but differentiated responsibility framework is likely to gain approval and assist rapidly with the battle against epidemics. In fact, elements of it are already reflected in state practice. In sum, the theoretical framework developed in this

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I. Introduction

Worldwide highly-infectious diseases reflect global inequities: they make up five of the top ten leading causes of death in low-income countries, while constituting only one of the top ten causes of death in high-income countries.¹ Cholera is an infectious disease that impacts the poorest of the poor,² and like other highly-infectious diseases marked by poverty, such as Ebola, it has received inadequate attention. Cholera is now endemic in many countries.³ Yet endemic outbreaks of Cholera are distinguished from epidemics, wherein a significant increase of cases occurs in an area.⁴ While Cholera seems to have a relatively long and stable relationship with humankind,⁵ major epidemics generally do not occur in the Global North⁶ but continue to happen in the Global South. For example, in 1961 a Cholera pandemic began in Indonesia and spread to six continents,⁷ touching South Asia (1963), Africa (1970), Latin America (1991), and the Caribbean (2010).⁸ Peru's outbreak took place 100 years after the disease had been eliminated from South America; its spread across the continent led to the death of 10,000 people.⁹ Yemen is currently facing the largest documented

1. *The Top 10 Causes of Death*, WORLD HEALTH ORG. (May 24, 2018), <http://www.who.int/news-room/fact-sheets/detail/the-top-10-causes-of-death> [<https://perma.cc/UC7P-2G5X>] (noting that in low-income countries the list is as follows: lower respiratory infections (1), diarrhoeal diseases (2), HIV/AIDS (4), malaria (6), and tuberculosis (7), while in high-income countries the list includes only lower respiratory infections (6)).

2. *Cholera Fact Sheet*, WORLD HEALTH ORG. (Feb. 1, 2018), <http://www.who.int/mediacentre/factsheets/fs107/en/> [<https://perma.cc/8TDB-Z7ST>] [hereinafter *Cholera Fact Sheet*] (noting that Cholera is an “indicator of inequity and lack of social development”).

3. *Id.* (defining endemic as when Cholera cases are detected for the past three years through evidence of local transmission).

4. See CTRS. FOR DISEASE CONTROL AND PREVENTION, *PRINCIPLES OF EPIDEMIOLOGY IN PUBLIC HEALTH PRACTICE* 1–72 (3d ed. 2012), <https://www.cdc.gov/ophss/csels/dsepd/ss1978/lesson1/section11.html> [<https://perma.cc/T6VP-7GG4>] (“Epidemic refers to an increase, often sudden, in the number of cases of a disease above what is normally expected in that population in that area.”).

5. See Rita R. Colwell, *Global Climate and Infectious Disease: The Cholera Paradigm*, 274 *SCI. 2025, 2025* (1996) (describing the origin and early occurrences of Cholera).

6. This author uses the terms Global North and Global South to describe divisions that exist between the developed North and the less developed South, but these characterizations oversimplify and paper over wide diversity that exists in each category.

7. Dalong Hu et al., *Origins of the Current Seventh Cholera Pandemic*, 113 *PNAS* E7730, E7730 (2016); *Cholera Fact Sheet*, *supra* note 2.

8. Francois-Xavier Weill et al., *Genomic History of the Seventh Pandemic of Cholera in Africa*, 358 *SCI.* 785, 785 (2017).

9. *Cholera's Seven Pandemics*, *CBC NEWS* (Oct. 22, 2010), <http://www.cbc.ca/news/technology/cholera-s-seven-pandemics-1.758504> [<https://perma.cc/YE7V-F3NA>].

Cholera epidemic in modern times, with over a million cases suspected and over 2,300 deaths reported.¹⁰

Highly-infectious diseases typically do not respect borders, posing transnational challenges that require cooperation and action through law. This was witnessed with HIV/AIDS, where one case in 1959¹¹ led to 36.9 million people worldwide living with the disease by the end of 2017.¹² Indeed, due to the increasing interconnectedness of the world and the influence of a warming climate on the spread of highly-infectious diseases, previously obscure viruses are unlikely to be contained to the periphery. As old infectious diseases increase in incidence and geographic distribution, or reemerge where they were previously under control, new epidemics continue to surface. Further, there is increasing resistance to current drugs. Accordingly, epidemics force us to consider: Who is responsible for combating highly-infectious diseases? How should that responsibility be allocated? What should such responsibility look like? These questions are especially important for vulnerable countries that are not able to cope with epidemic disease.

In January 2010, a massive earthquake hit Haiti, killing thousands, leaving hundreds of thousands homeless, and devastating already weak infrastructure in the country. The earthquake created ripe conditions for Cholera. Nepalese peacekeepers that were part of the United Nations Stabilization Mission in Haiti introduced the virus in October 2010 near the Arbonite River, a main source of drinking water in Haiti.¹³ The source of the initial outbreak is no longer disputed; the viral strain in Haiti's river was a "perfect match" to the Nepali strain.¹⁴ Due to poor sanitation conditions, a twenty-eight-year-old Haitian man became exposed to Cholera while using

10. *Weekly Epidemiological Bulletin: Cholera Response in Yemen*, WORLD HEALTH ORG. (July 7, 2018), http://www.emro.who.int/images/stories/yemen/week_26.pdf?ua=1 [https://perma.cc/KGK2-Q54Z].

11. AIDS Inst., *Where Did HIV Come From?*, <https://www.theaidsinstitute.org/education/aids-101/where-did-hiv-come-0> [https://perma.cc/DGM5-SJ6G] (explaining that the earliest known case was detected in 1959 from a man in the Democratic Republic of the Congo and that how he became infected is unknown).

12. UNAIDS, *FACT SHEET—JULY 2018: 2017 GLOBAL HIV STATISTICS 1* (2018), http://www.unaids.org/sites/default/files/media_asset/UNAIDS_FactSheet_en.pdf [https://perma.cc/QBE9-DVE2].

13. *See, e.g.*, Sarah Cassidy-Seyoum, *United Nations Being Sued for Haitian Cholera Outbreak*, COUNCIL ON HEMISPHERIC AFFAIRS (July 15, 2014), <http://www.coha.org/united-nations-being-sued-for-haitian-cholera-outbreak/> [https://perma.cc/37ES-3SLG].

14. Philip Alston, *Extracting Accountability: Special Rapporteurs and the United Nations' Responsibility for Cholera in Haiti* 8 (N.Y. Univ. Sch. of Law Pub. Law & Legal Theory Research Paper Series, Working Paper No. 18-10, Feb. 2018), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3125084 [https://perma.cc/GVD7-6QYW]; *see also* William Booth, *U.N. Troops Assaulted, Blamed for Outbreak*, WASH. POST (Nov. 16, 2010), <http://www.washingtonpost.com/wp-dyn/content/article/2010/11/15/AR2010111507227.html> [https://perma.cc/F5PP-MNA7] (identifying the Cholera strain as originating from South Asia).

the river near the peacekeepers' camp;¹⁵ he died shortly thereafter. Scientists labeled him "Patient Zero" because members of his family who assisted with his burial became ill themselves.¹⁶ Within a year, approximately 4,000 people had died from Cholera.¹⁷ The contamination resulted in an epidemic in Haiti that has caused the death of 9,603 people and the infection of over 812,000 people at the time of writing.¹⁸ The epidemic in Haiti raises crucial questions about responsibility.

Comparable questions also arose during the largest Ebola epidemic in history, which occurred in 2014–2015 in West Africa. Epidemiologists identified Emile Ouamouno as "Patient Zero." Emile was a two-year-old child in Guinea when he got infected with a mysterious fever that spread to his family members, a rural health facility, a health worker's funeral, and—through related familial, social, and trading networks—to the Liberian, Guinean, and Sierra Leonean borders.¹⁹ This pattern—where an infected person goes to an under-resourced health facility without clean needles, a supply of gloves, or other necessities for successful treatment and containment of the disease, rendering both the patient and healthcare providers vulnerable and susceptible to transmission—resulted in the Ebola virus inevitably being transmitted.²⁰ Gaps in core capacities were especially

15. See, e.g., Daniele Lantagne et al., *The Cholera Outbreak in Haiti: Where and How Did It Begin?* (identifying the first victim of the outbreak), in CHOLERA OUTBREAKS 145, 160 (G. Balakrish Nair & Yoshifumi Takeda eds., 2014); R.R. Frerichs et al., *Nepalese Origin of Cholera Epidemic in Haiti*, 18 CLINICAL MICROBIOLOGY & INFECTION E158, E159 (2012) (explaining the Nepalese peacekeeper connection to the Cholera outbreak); see also ALEJANDRO CRAVIOTO ET AL., FINAL REPORT OF THE INDEPENDENT PANEL OF EXPERTS ON THE CHOLERA OUTBREAK IN HAITI 4, 27 (2011), <http://www.un.org/News/dh/infocus/haiti/UN-cholera-report-final.pdf> [<https://perma.cc/5DWT-MNAP>] (same). The panel members updated their findings two years after the release of the initial report. It states, "[T]he preponderance of the evidence and the weight of the circumstantial evidence does lead to the conclusion that personnel associated with the . . . facility were the most likely source of introduction . . ." Lantagne et al., *supra*, at 162.

16. Radio Interview by Marco Werman with Dr. Louise Ivers, Brigham & Women's Hosp. (Jan. 10, 2012), http://www.ph.ucla.edu/epi/snow/cholera_haiti_newdev37a.html [<https://perma.cc/FHV9-2GY5>].

17. E.g., Lewis A. Kornhauser, *Incentives, Compensation, and Irreparable Harm*, in DISTRIBUTION OF RESPONSIBILITIES IN INTERNATIONAL LAW 120, 148 (André Nollkaemper & Dov Jacobs eds., 2015).

18. *Epidemiological Update: Cholera*, PAN-AM. HEALTH ORG. & WORLD HEALTH ORG. (Aug. 6, 2018), https://www.paho.org/hq/index.php?option=com_docman&view=download&category_slug=cholera-2219&alias=45805-6-august-2017-cholera-epidemiological-update805&Itemid=270&lang=en [<https://perma.cc/47N5-L2E6>].

19. Bahar Gholipour, *Ebola 'Patient Zero': How Outbreak Started from Single Child*, LIVE SCI. (Oct. 30, 2014), <https://www.livescience.com/48527-ebola-toddler-patient-zero.html> [<https://perma.cc/4CAY-5A3W>].

20. Daniel G. Bausch & Lara Schwarz, *Outbreak of Ebola Virus Disease in Guinea: Where Ecology Meets Economy*, PLOS NEGLECTED TROPICAL DISEASES, July 2014, at 1, 4.

pronounced in Guinea, Liberia, and Sierra Leone²¹ because, concomitant with structural factors, the subregion had a recent history of conflicts and narrow post-conflict reconstruction, which cumulatively hollowed out the health sector.²² Due in part to the role of international laws and institutions, these states lacked the capacity to prevent the domestic and transnational spread of the disease.²³ The World Health Organization (WHO) estimates that this outbreak resulted in 28,616 cases of Ebola and 11,310 deaths in Liberia, Sierra Leone, and Guinea alone.²⁴

This Article uses the Cholera and Ebola epidemics to demonstrate the limitations of the law of responsibility for addressing epidemics. Both epidemics are ideal for this study because they resulted in a lack of responsibility. While the Cholera epidemic implicates clear lines of causation, the Ebola epidemic involves more diffuse and indirect lines of causation. Both involve structural factors, multiple actors, as well as historical and more contemporary action. The case studies of the Ebola and Cholera epidemics demonstrate quite vividly why conventional and emerging responsibility frameworks fail to find purchase in the context of global public health.

This Article argues that a common conceptualization of responsibility is necessary to effectively deal with highly-infectious diseases given their potential to become worldwide pandemics. It maintains that the traditional framework for responsibility, as well as the emerging norm of the Responsibility to Protect (R2P)²⁵ are inadequate for addressing challenges posed by epidemics. This Article proposes a common but differentiated responsibility (CBDR)²⁶ framework to fight highly-infectious diseases. It recommends this as a new vision of shared responsibility for epidemics.

21. See, e.g., Steven J. Hoffman, *Making the International Health Regulations Matter: Promoting Compliance Through Effective Dispute Resolution* (noting that many countries did not meet the WHO's International Health Regulations' 2012 implementation deadline and thus requested extensions to scale-up their pandemic preparedness), in *ROUTLEDGE HANDBOOK OF GLOBAL HEALTH SECURITY* 239, 239 (Simon Rushton & Jeremy Youde eds., 2015).

22. Matiangai Sirleaf, *Ebola Does Not Fall from the Sky: Structural Violence and International Responsibility*, 51 *VAND. J. TRANSNAT'L L.* 477, 501–02 (2018).

23. See *id.* at 492–95 (positing that reform policies of international institutions led directly to instability in the region, which more easily allowed for the spread of disease).

24. *Ebola Outbreak: 2014–2015*, WORLD HEALTH ORG. (June 10, 2016), <http://who.int/csr/disease/ebola/en/> [<https://perma.cc/685K-3FJX>].

25. R2P is a set of principles based on the idea that sovereignty is not a right, but a responsibility, and that where a state fails to protect its people from mass atrocities, the international community has the responsibility to intervene. For further discussion, see generally INT'L COMM'N ON INTERVENTION & STATE SOVEREIGNTY, *THE RESPONSIBILITY TO PROTECT* (2001), <http://responsibilitytoprotect.org/ICISS%20Report.pdf> [<https://perma.cc/N2UW-2AQT>] [hereinafter R2P REPORT].

26. See generally CTR. FOR INT'L SUSTAINABLE DEV. LAW, *THE PRINCIPLE OF COMMON BUT DIFFERENTIATED RESPONSIBILITIES: ORIGINS AND SCOPE* (2002), http://cisdl.org/public/docs/news/brief_common.pdf [<https://perma.cc/6CDP-2V4J>] [hereinafter CBDR: ORIGINS AND SCOPE].

This Article recommends a common but differentiated framework of responsibility to:

- (1) recognize special situations of need in one or more countries with epidemic diseases;
- (2) assign greater responsibility to those who have contributed more to an epidemic; and
- (3) assign greater responsibility to those who have more resources or capacity to deal with an epidemic.

It develops the framework of CBDR and extends and applies it to highly-infectious diseases in a way that directly addresses the shortcomings of existing responsibility paradigms. First, both the traditional principles of responsibility and R2P perpetuate the fallacy that states can cope with structural problems on their own, including the increased incidence of epidemics. The framework developed herein better distributes responsibility and is less state-centric than rival norms. Additionally, it does not reify the false hierarchy between civil and political rights and economic and social rights that exists in other frameworks. It also recognizes and accounts for the significant role of nonstate actors and provides a basis for holding such actors responsible, as opposed to the lack of responsibility that otherwise exists.

While some scholarship exists on responsibility for highly-infectious diseases,²⁷ few have sought to relate this to why extant approaches to responsibility should be reconceptualized.²⁸ This author does so, drawing widely on criminal law, tort, and remedies principles to formulate the core argument that existing frameworks are insufficient to address global public health threats like highly-infectious diseases. This Article develops the theory underpinning CBDR as a framework based on insights gleaned from its application to the Cholera and Ebola epidemics. It develops a theoretical framework of responsibility for epidemics (an area where international consensus exists on its salience), cognizant that this framework could be expanded and applied to cover more diseases and adapted to apply to other fields outside of global public health in the future.

27. See, e.g., David P. Fidler, *Return of the Fourth Horsemen: Emerging Infectious Diseases and International Law*, 81 MINN. L. REV. 771, 776 (1997) (arguing that current WHO proposals for revising extant international law in order to combat infectious diseases are inadequate and offering an alternative); Laurence Gostin & Katharina E. Ó Cathaoir, *Lurching from Complacency to Panic in the Fight Against Dangerous Microbes: A Blueprint for a Common Secure Future*, 67 EMORY L.J. 337, 341–42 (2018) (proposing a new plan for global health preparedness, which emphasizes shared, transnational responsibility and focuses on WHO reform); Rhett Larson, *Law in the Time of Cholera*, 92 NOTRE DAME L. REV. 1271, 1277 (2017) (addressing the issues of “silo thinking” and “attenuated decision-making” in transforming global water health).

28. See generally DISTRIBUTION OF RESPONSIBILITIES IN INTERNATIONAL LAW, *supra* note 17 (examining the faults of the international system in its apportionment of responsibilities among states and calling for reform and further development in the area).

This Article is organized as follows: Part II covers the legal framework—examining global public health law, human rights law, and the law of responsibility. Additionally, it demonstrates that the emerging norm of R2P represents an incomplete vision of responsibility and is inadequate to combat epidemics. Part III proposes the expansion of common but differentiated responsibility and develops a framework for battling epidemics. Part IV discusses the theoretical and policy implications of this Article—resolving inter- and intra-axis conflicts within the framework and exploring the limits of diffusion, as well as the issues raised with operationalizing CBDR in hard and soft law. The CBDR framework is broad enough to resonate with diverse actors and assist quickly in fighting highly-infectious diseases. For example, the Global Health Security Agenda (GHSa) is currently working to address threats posed by highly-infectious diseases through voluntary commitments made by members.²⁹ This initiative incorporates elements of the CBDR framework by differentiating based on capacity and need.³⁰ As such, elements of the framework are already reflected in state practice. This Article serves not only to provide useful guidance to actors in the face of epidemics but also to shift existing paradigms of responsibility in novel ways.

II. Legal Framework

States use international law and institutions to achieve common aims, solve shared problems, promote compliance with norms, reduce transaction costs, provide information, and coordinate orderly and peaceful dispute resolution. States also utilize international law to confront problems that overwhelm and transcend traditional boundaries. International law increasingly addresses every type of human activity, including those typically considered within the exclusive domestic jurisdiction of states—like public health and the treatment and prevention of epidemics. Prevention of epidemics is a shared concern of states. However, states have differential capacity to prevent and manage epidemics.

The legal framework for addressing pandemics is spread across multiple regimes. Global public health law is the most specific field regulating epidemics. The framework for determining responsibility for violations that arise during epidemics is governed by human rights law, while the regime for allocating responsibility for epidemics is located under principles of responsibility. Reconceptualizing responsibility is a project reflected in burgeoning shared responsibility norms like R2P. The below subparts indicate the limitations of each of these fields for combating epidemics and demonstrate why a new vision of shared responsibility is necessary.

29. *About*, GLOB. HEALTH SEC. AGENDA, <https://www.ghsagenda.org/about> [<https://perma.cc/5ESF-WEDN>] [hereinafter *GHSa About*].

30. *Id.*

A. *Responsibility for Combating Epidemics in Global Public Health and Human Rights Law*

1. *Responsibility for Combating Epidemics in Global Public Health.*—

The primary regime for regulating disease is global public health law. The International Health Regulations of 2005 (Regulations)³¹ is the core instrument. Its main purpose is to “prevent, protect against, control and provide a public health response to the international spread of disease”³² The Regulations create a system of state surveillance and notification for certain infectious diseases, which would then trigger an international response.³³ The Regulations articulate the procedures and framework for emergency decision-making in the event of a public health emergency of international concern.³⁴

Global public health law assigns principal responsibility for implementing health measures to combat highly-infectious diseases to national authorities and component parts.³⁵ The Regulations provide that states are to develop better functioning health systems to detect disease, surveil, report, verify, and respond, among others.³⁶ The state-centric nature of the Regulations fails to adequately recognize the structural conditions in the international system that give rise to states needing to develop core capacities. It is of limited utility because it does not assist with determining responsibility beyond the affected states. It also does not assist with how responsibility for capacity-building should be allocated. Overall, global public health law is an incomplete regime for conceptualizing and allocating global responsibility for combating epidemics.

2. *Responsibility for Combating Epidemics in Human Rights Law.*—

Another important framework for addressing epidemics is human rights law. Under it, states have three kinds of duties—to respect (not to intrude on rights), to protect (to restrain third parties from violating rights), and to fulfill

31. See generally WORLD HEALTH ORG., INTERNATIONAL HEALTH REGULATIONS (2d ed. 2005) [hereinafter INTERNATIONAL HEALTH REGULATIONS], http://apps.who.int/iris/bitstream/handle/10665/43883/9789241580410_eng.pdf;jsessionid=67DAC5BDF849A34F3E1DEB9A962A1CEB?sequence=1 [https://perma.cc/J959-MYGS] (“[T]he Constitution of WHO confers upon the World Health Assembly the authority to adopt regulations ‘designed to prevent the international spread of disease’”).

32. *Id.* art. 2.

33. *Id.* arts. 5–6.

34. *Id.* arts. 12–17, 48–49.

35. *Id.* art. 4.

36. *Id.* Annex I.A (detailing the core capacity requirements for surveillance and response).

(requiring states to help realize positive rights).³⁷ The Ebola and Cholera epidemics implicate several fundamental human rights, including protections against the arbitrary deprivation of life³⁸ and the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.³⁹ Under the International Covenant on Economic, Social and Cultural Rights, affected states are to take primary responsibility to prevent, treat, and control epidemic diseases.⁴⁰

Additionally, a fundamental principle of economic, social, and cultural rights is that a state should “undertake[] to take steps . . . to the maximum of its available resources, with a view to achieving progressively” the right to health as well as other economic, social, and cultural rights.⁴¹ “When the State has taken all reasonable steps to the maximum of its available resources, but for reasons beyond its control . . . is still unable to implement its obligations, then it bears no responsibility”⁴² It is more likely that human rights bodies will find states to be unwilling and in violation of their obligations as opposed to unable in the vast majority of cases.⁴³ This is because even where resources are strained, a state cannot justify noncompliance with any of its core obligations, which include the provision of essential levels of healthcare.⁴⁴ The Committee on Economic, Social and Cultural Rights, the enforcement body responsible for interpreting the Covenant on these rights, has found that a state claiming that it is unable to carry out its obligations for reasons beyond its control has the burden of proof.⁴⁵ Further, that state must also demonstrate that it has unsuccessfully sought to obtain international support.⁴⁶ Thus, human rights law does not absolve states that are incapable from responsibility; instead, it requires that they progressively develop capabilities to secure socioeconomic rights.

37. *E.g.*, Comm. on Econ., Soc. and Cultural Rights, General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the International Covenant on Economic, Social and Cultural Rights) ¶ 33, U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000) [hereinafter General Comment No. 14].

38. *See* International Covenant on Civil and Political Rights art. 6(1), Dec. 16, 1996, 999 U.N.T.S. 171 [hereinafter ICCPR] (“Every human being has the inherent right to life.”).

39. *See* International Covenant on Economic, Social and Cultural Rights art. 12(1), Dec. 16, 1966, 993 U.N.T.S. 3 [hereinafter ICESCR] (“The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”).

40. *Id.* art. 12(2)(c).

41. *Id.* art. 2.

42. ARNE VANDENBOGAERDE, TOWARDS SHARED ACCOUNTABILITY IN INTERNATIONAL HUMAN RIGHTS LAW: LAW, PROCEDURES AND PRINCIPLES 216 (2016).

43. *Id.* at 218.

44. General Comment No. 14, *supra* note 37, ¶¶ 43, 47.

45. *Id.* ¶ 47.

46. *See id.* (“[The State] has the burden of justifying that every effort has nevertheless been made to use all available resources at its disposal”).

Given the above, it should be the rare case that a state affected by an epidemic would be able to shield itself from responsibility.⁴⁷

Nonetheless, states and other international actors tend to perceive civil and political rights violations as more severe and deserving of responsibility and action. Thus, no matter how prolonged or systematic socioeconomic violations are, these violations tend to “recede drably into the background” without external obligation or action.⁴⁸ In part, this is due to the erroneous position that determining accountability for breaches of civil and political rights is more straightforward than for economic and social rights.⁴⁹ Some countries have not recognized socioeconomic rights as legally binding primary obligations.⁵⁰ Accordingly, violations of socioeconomic rights are perceived as less amenable to attribution of responsibility and subsequent accountability efforts. This neglect of the importance of the economic and social sector in international law has rendered already vulnerable countries in the Global South ill-equipped to deal with public health crises posed by epidemics.

While the Committee has held that “all members of society—individuals, including health professionals, families, local communities, intergovernmental and nongovernmental organizations, civil society organizations, as well as the private business sector—have responsibilities regarding the realization of the right to health,”⁵¹ this is not reflected in people’s lived experiences. Only state parties to the Covenant on Economic, Social and Cultural Rights are accountable for compliance with it.⁵² While states’ international obligations include ensuring that their actions as members of international institutions take due account of the right to health,⁵³ this does not always occur. Unfortunately, the law on the books is not always reflected in reality. For example, state actors tend to regard economic and social rights as territorial,⁵⁴ even though the Committee has found that

47. VANDENBOGAERDE, *supra* note 42, at 218.

48. Benjamin Authers & Hilary Charlesworth, *The Crisis and the Quotidian in International Human Rights Law*, 2013 NETHERLANDS Y.B. OF INT’L L. 19, at 30.

49. *Id.* at 31–32 (noting that economic and social rights were not perceived as justiciable nor capable of precise definition, which led to the creation of two separate covenants: one focusing on civil and political rights, and the other on economic, social, and cultural rights).

50. See *International Covenant on Economic, Social and Cultural Rights*, UNITED NATIONS TREATY COLLECTION, https://treaties.un.org/pages/ViewDetails.aspx?src=IND&mtdsg_no=IV-3&chapter=4&clang=_en [<https://perma.cc/P6N6-KH6P>] (reporting that the Covenant has 169 state parties but that, notably, the United States, Palau, the Comoros, and Cuba have not ratified the treaty).

51. General Comment No. 14, *supra* note 37, ¶ 42.

52. See, e.g., ICESCR, *supra* note 39, art. 2 (requiring the state parties to take steps to realize the rights recognized in the Covenant).

53. General Comment No. 14, *supra* note 37, ¶ 39.

54. Legal Consequences of the Construction of a Wall in the Occupied Palestinian Territory, Advisory Opinion, 2004 I.C.J. Rep. 136, ¶ 112 (July 9).

member states are also to respect the enjoyment of the right to health in other countries.⁵⁵ The Committee has stipulated that states are also to prevent third parties from violating the right to health in other countries if states are able to influence third parties by way of legal or political means that do not conflict with other international obligations.⁵⁶ The Committee has also opined that state parties should provide an environment that facilitates the discharge of responsibilities on the right to health.⁵⁷ Yet, this similarly does not pertain. One of the salient issues that arises when the obligation to realize the right to health shifts to the international community is that “an undistributed duty . . . to which everybody is subject is likely to be discharged by nobody unless it can be allocated in some way.”⁵⁸

Human rights law is an inadequate regime for conceptualizing and allocating responsibility for epidemics. First, the hyper-prioritization of the protection of civil and political rights over social and economic rights frustrates efforts aimed at combating highly-infectious diseases. Human rights law assigns responsibility for combating epidemics to the affected state primarily and to everyone else secondarily. This presents substantial challenges for providing full redress for violations witnessed with epidemics. The law of responsibility hypothetically fills the gaps where the above regimes leave off, but the next section demonstrates its limitations.

B. *Allocating Responsibility for Epidemics*

When dealing with indivisible harms like epidemics, there are inevitable challenges in attributing responsibility under traditional principles because it is difficult to determine what specific actor caused the exact action that subsequently produced a definite aspect of the damage witnessed.⁵⁹ Indivisible harms can be caused by governments—acting individually or collectively—international and regional organizations, civil society, corporations, community-based actors, and individuals, amongst others.

Yet, conventional understandings locate responsibility solely at the level of the state.⁶⁰ The traditional view of state responsibility under Article 2 of the International Law Commission’s Draft Articles on Responsibility of States for Internationally Wrongful Acts holds that states are responsible only

55. General Comment No. 14, *supra* note 37, ¶ 39.

56. *Id.*

57. *Id.*

58. DAVID MILLER, NATIONAL RESPONSIBILITY AND GLOBAL JUSTICE 98 (2007).

59. Iris Marion Young, *Responsibility and Global Justice: A Social Connection Model*, SOC. PHIL. & POL’Y, Jan. 2006, at 102, 115.

60. Int’l Law Comm’n, Rep. on the Work of Its Fifty-Third Session, Draft Articles on Responsibility of States for Internationally Wrongful Acts, U.N. Doc. A/56/10, at 42–43 (2001) [hereinafter Draft Articles on Responsibility of States].

for conduct attributable to them through action or omission.⁶¹ The general rule is that conduct is attributable to the state when it is committed by an organ of the government or when a person or entity is acting as an agent of the state and exercising elements of governmental authority.⁶² However, a state can also be responsible to the extent it fails to take necessary measures to prevent harm, imposing a standard of due diligence.⁶³

States generally resist principles of responsibility that would hold them responsible for conduct other than their own—whether those other actors are private, international organizations, or other state actors.⁶⁴ The way the International Law Commission attempts to deal with situations where there are multiple state actors responsible for wrongdoing is unsatisfactory. It does not clarify how responsibility is to be allocated.⁶⁵ Moreover, states are no longer the only relevant actors in the international order. The law of responsibility obscures the activities of international organizations, as well as other nonstate actors and the harm that results from their actions.

Accordingly, “responsibility gaps”⁶⁶ can occur in many ways. First, a responsibility gap may persist during pandemics because it is not obvious who should respond. This may lead to a bystander effect where no actor responds.⁶⁷ A responsibility gap may also occur because the individual actions of multiple actors may be distributed in a way that does not meet the legal requirements, which provide that responsibility is only assigned to actors whose individual contributions are significant enough to pass the minimum threshold.⁶⁸ Notably, in other areas of law, problems of overdetermination⁶⁹ are dealt with by a number of doctrines—joint and

61. *Id.* at 34.

62. *Id.* at 45.

63. See generally Monica Hakimi, *State Bystander Responsibility*, 21 EUR. J. INT’L L. 341 (2010) (providing a framework for determining when a state must protect someone from a third party).

64. André Nollkaemper & Dov Jacobs, *Shared Responsibility in International Law: A Conceptual Framework*, 34 MICH. J. INT’L L. 359, 386 (2013).

65. See Draft Articles on Responsibility of States, *supra* note 60, at 124–25 (explaining that the extent of responsibility is sometimes addressed in treaties, but otherwise not clarifying how responsibility is allocated).

66. See, e.g., André Nollkaemper, *Political Economy and the Responsibility of States: The Problem of Many Hands in International Law* (describing how diffusion of responsibility can lead to situations where responsibility is unclear, leading to so-called “responsibility gaps”), in *THE POLITICAL ECONOMY OF INTERNATIONAL LAW: A EUROPEAN PERSPECTIVE* 278, 289 (Alberta Fabbriotti ed., 2016).

67. See Hakimi, *supra* note 63, at 344–45 (explaining how the lack of a framework leads to confusion regarding responsibility and how the proposed framework helps decision makers identify when an actor should be responsible).

68. See Nollkaemper, *supra* note 66, at 290 (explaining that one likely reason for diffusion of responsibility is that the legal conditions for responsibility are not met).

69. For further discussion, see Jonathan Schaffer, *Overdetermining Causes*, 114 PHIL. STUD. 23, 23 (2003) (explaining and giving an example of what an overdetermining cause is).

several liability in tort law and joint criminal enterprise in international criminal law, by way of example.⁷⁰ These principles have not been incorporated into the law of responsibility.⁷¹ This likely reflects the practical consideration that the higher the risks of responsibility, the more cautious actors will be in accepting obligations.

Even if actors are willing to accept higher obligations, all international dispute settlement mechanisms are premised on state consent, and most do not have jurisdiction over other international institutions or corporations.⁷² Thus, a responsibility gap will likely be maintained where a harm occurs during an epidemic because adjudication of a claim may not be able to proceed against the state if it withholds its consent to jurisdiction and, in any event, would not include other international actors involved.

The law of responsibility is the extant framework for determining secondary obligations. It is also an imperfect regime for conceptualizing and allocating responsibility for combating epidemics because to address many of the most pressing problems, states acting alone will be powerless to make any significant difference.⁷³ The state-centric nature of the law of responsibility leaves important nonstate actors outside the circle. The law of responsibility, like other areas of law, is not neutral, as even the non-attribution of responsibility is a method of distributing responsibility. It reflects choices and practices of states. The sections below examine the conventional law of responsibility and illustrate its limitations as applied to addressing highly-infectious diseases.

70. For further discussion, see Nollkaemper & Jacobs, *supra* note 64, at 423 (discussing the substantive and procedural challenges with applying the private-law principle of joint and several responsibility into a public international law context); *id.* at 425 (discussing the challenges with applying the principle of joint criminal enterprise to determining the responsibility of states and international organizations, given the need to demonstrate *mens rea* and other concepts); see also Roger P. Alford, *Apportioning Responsibility Among Joint Tortfeasors for International Law Violations*, 38 PEPP. L. REV. 233, 239–40 (2011) (relating domestic tort law concepts to challenges of apportioning responsibility for international law violations); Kai Ambos, *Joint Criminal Enterprise and Command Responsibility*, 5 J. INT'L CRIM. JUST. 159, 159–61 (2007) (comparing joint criminal enterprise and command-responsibility liability in international criminal law prosecutions); Antonio Cassese, *The Proper Limits of Individual Responsibility Under the Doctrine of Joint Criminal Enterprise*, 5 J. INT'L CRIM. JUST. 109, 110 (2007) (noting the difficulties in identifying specific contributions of each party to a crime); Jens David Ohlin, *Three Conceptual Problems with the Doctrine of Joint Criminal Enterprise*, 5 J. INT'L CRIM. JUST. 69, 70 (2007) (analyzing the doctrine); Herman G. van der Wilt, *The Continuous Quest for Proper Modes of Criminal Responsibility*, 7 J. INT'L CRIM. JUST. 307, 307–08 (2009) (identifying the challenges in choosing the correct mode of criminal responsibility).

71. See Nollkaemper, *supra* note 66, at 290 (noting that principles of joint liability from tort and criminal law have not been incorporated into international law).

72. *Id.* at 295.

73. See *id.* at 283 (noting that when it comes to responding to the world's most pressing problems, such as environmental cooperation or mass killings, individual states will often be incapable of making much of a difference).

1. *Cholera & Allocating Responsibility.*—“Cholera is an acute diarrhoeal infection caused by ingestion of food or water contaminated with” the Cholera bacteria.⁷⁴ Most infected people display only mild symptoms and recover with minimal treatment.⁷⁵ However, in some infected individuals the disease can lead to severe dehydration and death if treatment is not promptly administered.⁷⁶ The WHO estimates that every year there are approximately 1.3 to 4 million cases of Cholera and an estimated 21,000 to 143,000 deaths worldwide.⁷⁷

In October 2010, Cholera tragically reemerged in Haiti for the first time after a century. Following the outbreak, the U.N.’s Panel of Independent Experts found that its peacekeepers and its failure to establish proper sanitation systems in its camps were not the but-for causes of the epidemic. Instead, the organization blamed “water and sanitation and health care system deficiencies . . . coupled with conducive environmental and epidemiological conditions” for allowing Cholera to spread.⁷⁸ The U.N. blaming conditions in Haiti—which has prompted it to repeatedly intervene in the country for the spread of the epidemic—is illuminating. This is especially so when one considers that reconstruction efforts following the earthquake neglected the importance of reviving and building robust institutions aimed at the detection, prevention, and control of communicable diseases.

Scholars have criticized the U.N.’s response for being both a public relations and public health disaster.⁷⁹ A U.S.-based NGO working with lawyers in Haiti sent a petition to the U.N. Secretary General with 5,000 signatures presenting a number of legal arguments.⁸⁰ After over a year, the U.N. responded by dismissing those arguments as “not receivable” given the organization’s immunity under the General Convention on the Privileges and Immunities of the United Nations.⁸¹ Three separate class action lawsuits were also brought in New York against the U.N.⁸² Its response in the face of these

74. *Cholera Fact Sheet*, *supra* note 2.

75. *Id.*

76. *Id.*

77. *Id.*

78. CRAVIOTO ET AL., *supra* note 15, at 4.

79. See, e.g., Jose Alvarez, *The United Nations in the Time of Cholera*, 108 AJIL UNBOUND 22, 22 (2014) (“The United Nations’ handling of the allegations that its peacekeepers in Haiti are responsible for the largest number of Cholera cases and deaths in the world is a public relations as well as public health disaster.”).

80. Petition for Relief from Mario Joseph, Brian Concannon, Jr. & Ira Kurzban, Attorneys for Petitioners, to Chief, Claims Unit, MINUSTAH 18, 36 (Nov. 3, 2011), <http://ijdh.org/wordpress/wp-content/uploads/2011/11/englishpetitionREDACTED.pdf> [<https://perma.cc/4EU4-E9JD>].

81. Letter from Patricia O’Brien, Under Sec’y-Gen. for Legal Aff., United Nations, to Brian Concannon, Jr., Dir., Inst. for Justice & Democracy in Haiti (July 5, 2013), <http://www.ijdh.org/wp-content/uploads/2013/07/20130705164515.pdf> [<https://perma.cc/QQM6-XYM6>].

82. Class Action Complaint, *Laventure v. United Nations*, 279 F. Supp. 3d 394 (E.D.N.Y. 2017) (No. 14-CV-1611), *appeal docketed*, No. 17-2908 (2d Cir. Sept. 18, 2017); Class Action Complaint,

claims is heartbreaking but unsurprising.⁸³ On September 26, 2018, Haitian human rights lawyers requested an emergency injunction before the Tribunal de Première Instance de Port-au-Prince against the State of Haiti, which would compel it to trigger the creation of a standing claims commission.⁸⁴ If created, the commission could potentially address claims arising from the Cholera epidemic in Haiti. A standing claims commission is envisioned as the primary means for the settlement of disputes based on the Status of Forces Agreement in effect between the United Nations and Haiti.⁸⁵

To date, the U.N. has continued to skirt responsibility⁸⁶ and has not compensated those harmed for its role in enabling the spread of Cholera in Haiti. A potential remedy to this responsibility gap is the International Law Commission's proposal to make states responsible in certain situations where they delegate authority to an international organization, which then violates rights.⁸⁷ The proposal would hold states responsible even where the injury was solely attributable to the international institution.⁸⁸ The International Law Commission has also proposed that an institution can be responsible in connection with the wrongful acts of states where, for example, the organization adopts a decision that requires states to commit acts that contravene international obligations.⁸⁹

Notably, the Draft Articles on the Responsibility of International Organizations recognizes that in situations of internationally wrongful acts where there is concerted action between international organizations and states, both the states and the organizations have shared responsibility.⁹⁰ The Draft Articles also provide for shared responsibility between international

Georges v. United Nations, 84 F. Supp. 3d 246 (S.D.N.Y. 2015) (No. 13-CV-7146), *aff'd*, 834 F.3d 88 (2d Cir. 2016); Complaint, Jean-Robert v. United Nations, No. 14-CV-1545 (S.D.N.Y. Mar. 6, 2014) (dismissed Jan. 26, 2015).

83. Alvarez, *supra* note 79, at 24 (noting that national courts in the United States and elsewhere always recognize the U.N.'s comprehensive immunity).

84. Press Release, Institute for Justice and Democracy in Haiti, Le Dossier des Victimes du Choléra en Attente D'ordonnance du Juge des Référés, <https://www.ijdh.org/2018/10/projects/le-dossier-des-victimes-du-cholera-en-attente-dordonnance-du-juge-des-referes/> [<https://perma.cc/RXD5-BPS3>].

85. Agreement Between the United Nations and the Government of Haiti Concerning the Status of the United Nations Operation in Haiti, U.N.-Haiti, art. 55, July 9, 2004, 2271 U.N.T.S. 235.

86. Devika Hovell, *Due Process in the United Nations*, 110 AM. J. INT'L L. 1, 30–31 (2016).

87. See Int'l Law Comm'n, Rep. on the Work of Its Sixty-First Session, U.N. Doc. A/64/10, at 162–76 (2009) [hereinafter Rep. on the Work of Its Sixty-First Session] (proposing that states shoulder the responsibility for the wrongful acts of international organizations).

88. *Id.* at 162–63.

89. Int'l Law Comm'n, Rep. on the Work of Its Sixty-Third Session, Draft Articles on Responsibility of International Organizations, U.N. Doc. A/66/10, at 107–09 (2011) [hereinafter Draft Articles on Responsibility of International Organizations].

90. See *id.* at 111 (“This chapter is without prejudice to the international responsibility of the State or international organization which commits the act in question, or of any other State or international organization.”).

organizations.⁹¹ While the Draft Articles potentially improve upon the status quo, they still fail to account for cumulative action. They also do not clarify how responsibilities are to be allocated amongst multiple actors.⁹² For example, international institutions increasingly also have public–private partnerships and rely on private actors, especially in the field of global public health.⁹³ It is unclear how responsibility is to be apportioned in instances of violations of the right to health with public–private partnerships. Furthermore, the Draft Articles do not yet have the status of law. Even if they are interpreted as binding, most international organizations and private actors, like corporations, may not necessarily be bound by international law obligations or even soft law in many areas, and if they are, their obligations may not be the same as those of states.

Relatedly, the regime governing jurisdiction over international institutions is meek—they are immune from suit domestically, and typically, no court has jurisdiction. International organizations like the U.N. have been found to have legal personality,⁹⁴ which enables them to make claims and to have claims made against them. Under the current regime, international organizations are legally responsible only for the wrongs they choose to be responsible for.⁹⁵ Thus, notwithstanding the clear, causal relationship between the action of an identifiable actor that is one of its agents, the U.N. has refused to accept its legal, moral, and political responsibility for the resulting harm of the Cholera epidemic in Haiti.⁹⁶ Responsibility should not turn on whether an organization assents to jurisdiction or not.⁹⁷

91. *See id.* at 144–45 (“Where an international organization and one or more States or other international organizations are responsible for the same internationally wrongful act, the responsibility of each State or organization may be invoked in relation to that act.”).

92. For further discussion, see Nollkaemper & Jacobs, *supra* note 64, at 396–97 (“It would seem that if joint responsibility is to be a useful concept in international law, it should likewise be defined in terms of what injured parties, or international institutions, can demand of each of the responsible states.”).

93. *See generally, e.g.*, Kent Buse & Andrew M. Harmer, *Seven Habits of Highly Effective Global Public-Private Health Partnerships: Practice and Potential*, 64 *SOC. SCI. & MED.* 259 (2006) (discussing the effects of public–private partnerships on global public health).

94. *See* Reparation for Injuries Suffered in the Service of United Nations, Advisory Opinion, 1949 *I.C.J. Rep.* 174, 185 (Apr. 11) (holding that the U.N. possesses an “objective international personality” with capacity to bring international claims).

95. *See, e.g.*, Kornhauser, *supra* note 17, at 141 (discussing how international institutions have internal procedures to process grievances from employees and third parties).

96. *See, e.g.*, Alston, *supra* note 14, at 1 (explaining that the U.N. authorities “contested the proposition that the peacekeepers had been responsible” for Cholera’s appearance in Haiti).

97. *See* Hovell, *supra* note 86, at 37 (arguing that the U.N. “must look beyond legal boundaries” when determining the scope of its responsibilities); *see also* Anthony F. Lang, Jr., *Shared Political Responsibility* (locating political responsibility in specific agents and actions for the construction of new arrangements), in *DISTRIBUTION OF RESPONSIBILITIES IN INTERNATIONAL LAW*, *supra* note 17, at 62, 65.

Indeed, numerous actors can be considered responsible for the release of the deadly Cholera epidemic in Haiti. First, the Nepalese military deployed personnel to Haiti using a problematic medical screening process, which failed to detect or prevent Cholera in the deployed troops and can be considered directly causally responsible for the transmission of Cholera into the population.⁹⁸ Additionally, the U.N. had inadequate sanitary facilities for treatment of waste at the camp and insufficient monitoring of its bases and contractors.⁹⁹ As such, the U.N. was either vicariously liable through its mission's failure or more indirectly causally responsible for the Cholera epidemic by failing to provide adequate guidelines.¹⁰⁰ Also, a Haitian contractor disposed of waste improperly near the base and at the river¹⁰¹ and is causally responsible for the resulting Cholera epidemic. In addition, the Haitian government did not have proper procedures in place to trigger an early warning system and, more generally, failed to provide a secure and safe system for providing drinking water.¹⁰² As a result, the Haitian government is also causally responsible for the Cholera epidemic.

How is responsibility allocated amongst these various actors?¹⁰³ The most common answer is that no actor is held responsible.¹⁰⁴ An alternative would be to have only the state actors be jointly and severally responsible for the resulting harm irrespective of their own contributions. However, the law of responsibility does not allow for this possibility. Another is that one state actor is held responsible for the harm irrespective of the size of the individual contribution of the Haitian or Nepalese governments. Conduct is attributable to the Nepalese state under the law of responsibility because it was committed by an organ or agent of the government, as the military personnel were on the base. Alternatively, the Haitian government is responsible because it failed to exercise due diligence and take necessary measures to prevent harm. The analysis above illustrates the state-centric nature of allocating responsibility under the conventional paradigm.

98. See CRAVIOTO ET AL., *supra* note 15, at 8, 12–13 (describing U.N. troop practices to support the hypothesis that the U.N. Stabilization Mission in Haiti's camp was the direct source for the Cholera outbreak).

99. Kornhauser, *supra* note 17, at 149.

100. *Id.*

101. See CRAVIOTO ET AL., *supra* note 15, at 22–23; see also JONATHAN M. KATZ, THE BIG TRUCK THAT WENT BY: HOW THE WORLD CAME TO SAVE HAITI AND LEFT BEHIND A DISASTER 228–31 (2013) (reporting that residents saw contractors engaging in unauthorized feces dumping).

102. Kornhauser, *supra* note 17, at 149.

103. See Anne van Aaken, *Shared Responsibility in International Law: A Political Economy Analysis* (noting that it is unclear how responsibility is apportioned among states for international wrongful acts), in *DISTRIBUTION OF RESPONSIBILITIES IN INTERNATIONAL LAW*, *supra* note 17, at 153, 156.

104. See discussion *supra* subpart II(B) (discussing responsibility gaps in international law).

The current proposals for international organizational responsibility contemplate making states responsible where they delegate authority to an international organization that then violates rights.¹⁰⁵ For one or more states to assume vicarious responsibility, when some actors were acting through international organizations, hardly seems satisfactory here. Penalizing states for delegations of authority to international organizations that result in international law violations does not sufficiently account for the independent actions of international institutions. Another proposal for responsibility of international organizations concerns situations of internationally wrongful acts where there is concerted action between international organizations or between international organizations and states.¹⁰⁶ This proposal also fails to capture the actions of the U.N. in Haiti. There is no evidence of a prior plan or agreement between the actors to introduce Cholera into Haiti. The failure to provide for cumulative but nonconcerted action by multiple actors potentially allows states, and especially nonstate actors, to engage in blame avoidance and blame shifting for harmful consequences of highly-infectious diseases and to shield themselves from responsibility.¹⁰⁷

The Cholera epidemic in Haiti illustrates why the allocation of responsibility is critical for successful implementation of the right to health and for bridging the gap between law, policy, and reality. The traditional doctrine relies on a narrow conceptualization of causation and would lead to inappropriately discounting the role of actors that have contributed indirectly to the epidemic in Haiti. Under traditional principles, responsibility cannot be determined for some, and other actors would be judgment proof.¹⁰⁸ It is also not possible to bring an effective claim against the collective.

Due to the challenges discussed above, where massive violations result—like the avoidable deaths during the Cholera epidemic—injured parties will be without redress. The state-centric nature of the law of responsibility means that the legal requirements are not met for some actors implicated in the Cholera epidemic. One of the underlying principles of attributing responsibility is that every legal injury deserves a remedy to ensure justice to victims. The Cholera epidemic in Haiti indicates that much more needs to be done to reform how international actors are held responsible for highly-infectious diseases. The traditional framework of responsibility is

105. Rep. on the Work of Its Sixty-First Session, *supra* note 87, at 163–66.

106. Draft Articles on Responsibility of International Organizations, *supra* note 89, at 111, 144–45.

107. Nollkaemper, *supra* note 66, at 298 (describing blame strategies that actors use to “diffuse responsibility” and protect themselves from claims).

108. Both the Nepalese government and the Haitian government have limited available resources to compensate those victimized while not suffering significant reductions in the provision of socioeconomic rights to people within its territory, making them *de facto* judgment proof. *See, e.g.*, Kornhauser, *supra* note 17, at 151 n.71 (discussing the limited resources of the Nepalese and Haitian governments).

inadequate because it only apportions blame to culpable actors narrowly defined and ignores broader conceptualizations of culpability. Also, if it is not possible to hold culpable actors responsible in clear cases of but-for and proximate causation for any resulting violations of public health, as occurred with the Cholera epidemic in Haiti, what happens when the lines of causation are even more fraught, as with the Ebola epidemic in West Africa?

2. *Ebola & Allocating Responsibility.*—Ebola is an infectious disease that manifests as a severe hemorrhagic fever, which is often fatal without proper clinical care, such as providing fluids and maintaining blood pressure and oxygen levels.¹⁰⁹ Because the early symptoms resemble common diseases like malaria, many do not realize they are infected and do not seek treatment at a hospital.¹¹⁰ The virus is spread in humans through direct contact with broken skin, blood, bodily fluids, or contaminated objects, and possibly through sexual contact.¹¹¹ The full toll of the epidemic in West Africa is still being uncovered, with reports showing that Ebola can linger in survivors' eyes, causing painful disease, cataracts, and potential blindness in the young and old.¹¹² Ebola first appeared in 1976 in separate outbreaks in South Sudan and the Democratic Republic of Congo.¹¹³ Whatever the biological or ecological origin of the virus in West Africa, it was the sociopolitical and legal landscape that influenced whether the virus would lead to a couple of isolated cases or become a full-scale outbreak.¹¹⁴ This subsection seeks to foreground the indirect factors—the human-made laws, policies, actions, and omissions that gave rise to the Ebola epidemic. It does so to expose the fallacy of infectious diseases as purely biological or naturally occurring events¹¹⁵ by focusing on one of the *many* factors that contributed

109. *Ebola Virus Disease*, WORLD HEALTH ORG. (Feb. 12, 2018), <http://www.who.int/news-room/fact-sheets/detail/ebola-virus-disease> [<https://perma.cc/T9FF-WZY9>] (noting that Ebola is often fatal if untreated and that rehydration and treatment of specific symptoms improves survival rates).

110. *Id.*; see also Annie Wilkinson & Melissa Leach, *Briefing: Ebola—Myths, Realities, and Structural Violence*, 114 AFRICAN AFF. 136, 145 (2015) (noting that many people infected with Ebola have found themselves “fearful or unable to access hospitals”).

111. Ctrs. for Disease Control, *Ebola Virus Disease Transmission* (May 22, 2018), <http://www.cdc.gov/vhf/ebola/transmission/index.html> [<https://perma.cc/Y8GR-E8VS>].

112. Denise Grady, *Ebola's Legacy: Children with Cataracts*, N.Y. TIMES (Oct. 19, 2017), <https://www.nytimes.com/2017/10/19/health/ebola-survivors-cataracts.html> [<https://perma.cc/CJ48-NLF3>].

113. *Ebola Virus Disease*, *supra* note 109.

114. See Bausch & Schwarz, *supra* note 20, at 3–4 (“Biological and ecological factors may drive emergence of the virus from the forest, but clearly the sociopolitical landscape dictates where it goes from there—an isolated case or two or a large and sustained outbreak.”).

115. See Susan Marks, *Human Rights and the Bottom Billion*, 2009 EUR. HUM. RTS. L. REV. 37, 47 (“[N]atural disasters are never purely natural, and social misfortunes are never purely misfortunes.”).

to the spread of the epidemic.¹¹⁶ This subsection illuminates the role of “structural adjustment” reforms in undermining already compromised health systems in the subregion.¹¹⁷

Structural adjustment refers to the loan conditionalities imposed by the International Monetary Fund (IMF) and the World Bank. Structural adjustment aims to contract certain areas of the formal sector with an eye towards improving specific macroeconomic indicators.¹¹⁸ The structural adjustment of an economy occurs through compliance with the conditions embedded within the terms of loans, like reducing budget deficits, devaluing currency, reducing domestic credit expansion, freeing controlled prices and interest rates, reducing trade barriers, and privatizing state enterprises.¹¹⁹ These well-known austerity measures aim to cut budget deficits and improve the balance of payments, which often entails budget ceilings and wage caps.¹²⁰ The IMF has been active in West Africa for decades with its structural adjustment programs. For example, its first loan in Liberia began in 1963,¹²¹ and since 1984, the IMF has given consistent support to Sierra Leone and Guinea.¹²² The IMF’s structural adjustment programs prioritized short-term macroeconomic objectives over longer term investments in public health, and the result predictably hollowed out the flailing health sector.¹²³

116. For further discussion, see Sirleaf, *supra* note 22, at 481 (“[T]he international legal architecture facilitates the conditions for global health inequities, and in particular for infectious diseases to reach epidemic levels in the Global South.”).

117. See Brook Baker, *The Impact of the International Monetary Fund’s Macroeconomic Policies on the AIDS Pandemic*, 40 INT’L J. HEALTH SERVICES 347, 348–49 (2010) (arguing that structural adjustments are one of several IMF policies that have “intensified the global health crisis in general and the AIDS pandemic in particular”).

118. See William Easterly, *IMF and World Bank Structural Adjustment Programs and Poverty* (noting that structural adjustment packages usually require some formal-sector activities to contract and thus adjust a few highly visible macroeconomic indicators), in *MANAGING CURRENCY CRISES IN EMERGING MARKETS* 361, 363 (Michael P. Dooley & Jeffrey A. Frankel eds., 2003).

119. *Id.* at 364.

120. Baker, *supra* note 117, at 350.

121. *Liberia: History of Lending Arrangements as of November 30, 2013*, IMF (July 29, 2017), <http://www.imf.org/external/np/fin/tad/extarr2.aspx?memberKey1=600&date1key=2013-11-30> [<https://perma.cc/B57N-FVWX>].

122. See *Guinea: Transactions with the Fund from May 01, 1984 to August 31, 2017*, IMF (July 29, 2017), <http://www.imf.org/external/np/fin/tad/extrans1.aspx?memberKey1=380&endDate=2017-08-31> [<https://perma.cc/K87S-VXT6>]; *Sierra Leone: Transactions with the Fund from May 01, 1984 to August 31, 2017*, IMF (July 29, 2017), <http://www.imf.org/external/np/fin/tad/extrans1.aspx?memberKey1=850&endDate=2017-08-31> [<https://perma.cc/9M2C-X6FH>].

123. See David Stuckler & Sanjay Basu, *The International Monetary Fund’s Effects on Global Health: Before and After the 2008 Financial Crisis*, 39 INT’L J. HEALTH SERVICES 771, 773 (2009) (addressing the adverse financial effects that IMF loan policies had on the development of the health sector within developing countries); see also CTR. FOR GLOB. DEV., *DOES THE IMF CONSTRAIN HEALTH SPENDING IN POOR COUNTRIES? EVIDENCE AND AN AGENDA FOR ACTION 15* (2007), http://www.cgdev.org/doc/IMF/IMF_Report.pdf [<https://perma.cc/78UZ-L554>] (noting the criticism directed at the IMF’s macroeconomic programs for “unduly constrain[ing] a scaling-up of health expenditures to respond to the population’s health needs”).

For example, an independent evaluation of the IMF's structural adjustment programs surveyed twenty-nine countries in sub-Saharan Africa between 1999 and 2005 and found that 37% of all annual aid increases were diverted to beefing up currency reserves, with another 37% going to repay debts in line with the dictates of structural adjustment—leaving only 27% for health and other pressing developmental needs.¹²⁴

Irrespective of the labeling that the IMF used to describe its programs—from structural adjustment, to good governance, to poverty reduction—the underlying logic and macroeconomic policies remained the same.¹²⁵ Although the IMF has attempted to respond to the criticism leveled against it, it continues to prioritize “macroeconomic stability” above all else.¹²⁶ Indeed, prior to the Ebola outbreak, although all three countries had successfully met the IMF's macroeconomic policy prescriptions, they all failed to meet targets for social spending, including health.¹²⁷ This would render the health systems in Liberia, Sierra Leone, and Guinea ill-equipped to arrest the spread of Ebola when the outbreak began in 2014.

Moreover, to keep government spending low, the IMF placed limitations on public-sector wages, which meant money to employ and remunerate doctors, nurses, and other health care professionals was limited.¹²⁸ As health care employment opportunities lessened, health care quality and a capable health care workforce concomitantly decreased.¹²⁹ Additionally, depressed wages in the public health system contributed to the brain-drain problem in the health sector (where indigenous talent leaves for

124. See INDEP. EVALUATION OFFICE, INT'L MONETARY FUND, *THE IMF AND AID TO SUB-SAHARAN AFRICA* 42 (2007) [hereinafter *THE IMF AND AID TO SUB-SAHARAN AFRICA*], <https://www.imf.org/external/np/ieo/2007/ssa/eng/pdf/report.pdf> [https://perma.cc/P5JN-NUQP] (displaying the average percentages of aid increases used for different categories of spending in sub-Saharan Africa between 1999 and 2005).

125. See Daniel W. Muriu, *The Imperial–Emancipatory Paradox of International Human Rights: How Useful Is the Right to Health in Sub-Saharan Africa?*, 9 INT'L COMMUNITY L. REV. 387, 401 (2007) (noting several key policies of international economic institutions in sub-Saharan Africa).

126. Baker, *supra* note 117, at 356 (concluding that the IMF continues to prioritize macroeconomic stability above other concerns despite criticism).

127. See generally IMF, *Guinea: Letter of Intent, Memorandum of Economic and Financial Policies, and Technical Memorandum of Understanding* (Feb. 2014) (detailing the structural reforms needed to meet the year's spending goals); IMF, *Liberia: Third Review Under the Extended Credit Facility Arrangement and Request for Waiver of Nonobservance of Performance Criterion and Modification of Performance Criteria*, Country Report No. 14/197 (July 2014) (same); IMF, *Sierra Leone: First Review Under the Extended Credit Facility Arrangement, Request for Modification of Performance Criteria, and Financing Assurances Review*, Country Report No. 14/171 (June 2014) (same).

128. See *THE IMF AND AID TO SUB-SAHARAN AFRICA*, *supra* note 124, at 15 (discussing critics' view that the IMF's policies are undermining these countries' social sectors).

129. *Id.*

greener, more prosperous pastures).¹³⁰ For instance, even before the Ebola epidemic began in 2014, in a survey of health care workers for every 1,000 persons found, Guinea could only count 0.097 doctors, Liberia, 0.023, and Sierra Leone, 0.024.¹³¹ In Sierra Leone, the structural adjustment policies of the IMF between 1995 and 1996 required the reduction of public employment, which resulted in the retrenchment of 28% of governmental employees, with limits on wages continuing into the 2000s.¹³² This directly affected health, as a study provided by the WHO shows a reduction in community health workers from 0.11 per 1,000 population in 2004 to 0.02 in 2008.¹³³ While it is impossible to isolate how much of the lack of health workers was caused by structural adjustment, it seems plausible that these reform policies were at least a substantial factor in producing this result.¹³⁴ Accordingly, the effect of structural adjustment reforms—by insisting on cuts in health spending to manage public expenditures—was detrimental to the supply of health services. Thus, when the outbreak occurred in 2014, not enough trained health workers were readily available to help combat the spread of Ebola.

Additionally, structural adjustment reforms also had a negative impact on the demand for health services by reducing household income, leaving people with less money for health. Due to the IMF's structural adjustment policies, public health was transformed into a "commodity and an individual responsibility."¹³⁵ For example, in Sierra Leone, despite the government's

130. See Karen McColl, *Fighting the Brain Drain*, 337 BRIT. MED. J. 958, 958 (2008) (noting the factors causing the brain-drain problem for health-care workers in Sub-Saharan Africa); David McCoy et al., *Salaries and Incomes of Health Workers in Sub-Saharan Africa*, 371 THE LANCET 675, 680 (2008) (noting that IMF limits on wage bills prevent healthcare needs from being met); ERIC FRIEDMAN, PHYSICIANS FOR HUMAN RIGHTS, AN ACTION PLAN TO PREVENT BRAIN DRAIN: BUILDING EQUITABLE HEALTH SYSTEMS IN AFRICA I (2004), <http://allafrica.com/download/resource/main/main/idatcs/00010242:21e6b22646882263f8b7aa73a71c810c.pdf> [<https://perma.cc/JP8Y-T64Z>] (discussing brain drain for health-care workers in sub-Saharan African countries and its causes).

131. *Global Health Observatory Data Repository: Density per 1,000, by Country*, WHO (Feb. 2, 2017), <http://apps.who.int/gho/data/view.main.92100> [<https://perma.cc/F8G7-HTMT>] (noting data for Guinea in 2005, Liberia in 2008, and Sierra Leone in 2010).

132. Alexander Kentikelenis et al., *The International Monetary Fund and the Ebola Outbreak*, 3 LANCET GLOBAL HEALTH e69, e69 (2015). For more information on the IMF's review of Sierra Leone, see generally IMF, *Sierra Leone: 2006 Article IV Consultation, First Review Under the Three-Year Arrangement Under the Poverty Reduction and Growth Facility, Financing Assurances Review, and Request for Waiver of Nonobservance of Performance Criterion* (Feb. 2007); IMF, *Sierra Leone: Midterm Review Under the Second Annual Arrangement Under the Enhanced Structural Adjustment Facility and Request for Waiver of Performance Criteria* (Sept. 1996).

133. Kentikelenis et al., *supra* note 132, at e69.

134. See McColl, *supra* note 130, at 958 ("Government spending on health workers' pay has been constrained by macroeconomic factors, such as the recruitment freezes and limits on the public sector wage bill that were often part of structural adjustment programmes imposed as a condition of loans from the World Bank.").

135. Wilkinson & Leach, *supra* note 110, at 142.

introduction of a free health care initiative, health care providers continued to charge fees for services, thereby limiting access.¹³⁶ It was likely influenced by the IMF's admonition to "carefully assess the fiscal implications" of providing free health care services.¹³⁷ Indeed, studies have shown that the IMF's policies have slowed down improvements in, or worsened, the health status of people in countries implementing them.¹³⁸ Given this, it is not difficult to see how the depletion of investment in health services contributed towards higher incidences of Ebola in the subregion. In the 2000s in Guinea, the IMF promoted fiscal and administrative decentralization, which made it difficult to plan a coordinated response to Ebola. Five years after Guinea complied with IMF dictates to transfer budgetary responsibilities from the central government to the local level,¹³⁹ an IMF mission to the country found governance problems, ineffective decentralization, and deterioration of the quality of health-service delivery.¹⁴⁰ While the IMF programs cannot be blamed entirely for this result, it nonetheless indicates that the collective effects of the structural adjustment programs potentially made survival from an epidemic in the impacted countries less likely. IMF programs made it more likely that individuals would rely on communities of care as opposed to public health systems, which in turn impeded the ability to have a coordinated approach to Ebola.

The IMF belatedly recognized the connection between its policies and the outbreak. IMF Director Christine Lagarde said at a meeting on Ebola in 2014, "It is good to increase the fiscal deficit when it's a matter of curing the people, of taking the precautions to actually try to contain the disease. The

136. See generally AMNESTY INT'L, AT A CROSSROADS: SIERRA LEON'S FREE HEALTH CARE POLICY (2011) (describing how Sierra Leone's health system still charged for services despite a free health care initiative).

137. IMF, *Sierra Leone: Sixth Review Under the Arrangement Under the Extended Credit Facility, Request for Waiver for Nonobservance of a Performance Criterion, Request for a Three-Year Arrangement Under the Extended Credit Facility, and Financing Assurances Review*, Country Report No. 10/176, at 10 (May 2010).

138. See David Stuckler et al., *International Monetary Fund Programs and Tuberculosis Outcomes in Post-Communist Countries*, 5 PLOS MED. 1079, 1086 (2008) (showing the connection between IMF programs and the worsening of tuberculosis mortality rates). But see IMF Survey: *IMF Casts Doubt on TB Study*, IMF (July 23, 2008), <https://www.imf.org/en/News/Articles/2015/09/28/04/53/sores072308a> [<https://perma.cc/LJT8-WWBF>] (criticizing the study).

139. See IMF, *Guinea: Staff Report for the 2002 Article IV Consultation, the First Review Under the Poverty Reduction and Growth Facility, Requests for Waiver of Performance Criteria, Second-Year Program Under the Poverty Reduction and Growth Facility, and for Additional Interim Assistance Under the Enhanced Initiative for Heavily Indebted Poor Countries*, at 49–69 (July 2002) (detailing the results of Guinea's first review); IMF, *Guinea: Staff Report for the Request for a Three-Year Arrangement Under the Poverty Reduction and Growth Facility*, at 46–65 (Apr. 2001) (noting compliance).

140. IMF, *Guinea: Staff Report for the 2007 Article IV Consultation and Requests for Three-Year Arrangement Under the Poverty Reduction and Growth Facility and for Additional Interim Assistance Under the Enhanced Heavily Indebted Poor Countries Initiative*, at 5–7 (Dec. 2007).

IMF doesn't say that very often."¹⁴¹ Indeed, the IMF had been requiring the exact opposite for decades preceding.

The IMF's structural adjustment programs are illustrative of how action by international institutions can facilitate epidemics and how the temporal distance between the initial action and the resulting outbreak can lead to the disremembering of structural factors. For example, the Ebola epidemic in West Africa was the result of historical vulnerability from slavery, colonialism, neocolonialism, bad governance, and neoliberal reform policies like structural adjustment, amongst others. When institutions like the IMF contribute to indivisible harms as witnessed with Ebola, the dominant paradigm of responsibility is unable to provide redress and fails to capture these violations.

The conventional law of responsibility depends on a clearly identifiable actor who acts to produce injury.¹⁴² However, the traditional approach typically fails to capture the harms caused by highly-infectious diseases due to the multiplicity of actors causally contributing directly and indirectly to the harm. Thus, the increased rates of morbidity and illness from infectious diseases like Ebola are unaccounted for. This makes it incredibly "difficult to secure effective legal measures for prevention, restitution, and redress"¹⁴³ for epidemics using the traditional framework of responsibility.

The law of responsibility is inept. It privileges the status quo and directs attention towards individual claims against specific actors for identifiable proximate harms and away from broader conceptualizations and concepts of shared responsibility.¹⁴⁴ It is inadequate for combating highly-infectious diseases because it focuses on state actors often to the exclusion of international organizations and other important nonstate actors. The analysis above indicates that a reexamination of the current doctrine of responsibility is needed more generally and especially as applied to combating highly-infectious diseases.

141. Christine Lagarde, Managing Dir., Int'l Monetary Fund, Remarks on the Impact of the Ebola Crisis: A Perspective from the Countries (Oct. 9, 2014), <http://www.worldbank.org/en/news/speech/2014/10/09/transcript-event-impact-ebola-crisis-perspective-countries> [<https://perma.cc/MD7E-GDCE>].

142. See Draft Articles on Responsibility of States, *supra* note 60 ("The justification for attributing to the State . . . the conduct of 'parastatal' entities lies in the fact that the internal law of the State has conferred on the entity in question the exercise of certain elements of governmental authority.").

143. ROB NIXON, SLOW VIOLENCE AND THE ENVIRONMENTALISM OF THE POOR 9 (2011).

144. See generally Nollkaemper & Jacobs, *supra* note 64 (discussing the reluctance of states to accept responsibility for acts other than their own).

C. *Reconceptualizing Responsibility: Whither the Responsibility to Protect*

A rival principle that challenges the traditional view of state responsibility is the emerging norm of the responsibility to protect. This section examines what the norm entails and demonstrates why R2P offers an incomplete vision for reconceptualizing responsibility. The foundational principles of R2P provide that the state has the primary responsibility for protecting its people, but if a state is unwilling or unable to stop or prevent war crimes, genocide, and crimes against humanity, the principle of nonintervention in the internal affairs of states is to yield to the international responsibility to protect.¹⁴⁵ R2P is not settled law, and the extent to which it influences state behavior is sporadic at best.¹⁴⁶

The U.N. Secretary General has indicated that there are three components of implementing R2P. Pillar I emphasizes that states have the primary responsibility to protect their own populations and suggests ways states can improve their capacity to do so.¹⁴⁷ Pillar II focuses on the responsibility of the international community to assist states in building capacity to protect their populations through development assistance, preventative deployments, rule-of-law aid, and similar peaceful measures.¹⁴⁸ Lastly, Pillar III stresses the responsibility of the international community to

145. U.N. Secretary General, *Implementing the Responsibility to Protect*, ¶ 11, U.N. Doc. A/63/677 (Jan. 12, 2009) [hereinafter *Implementing the Responsibility to Protect*]; see, e.g., Constitutive Act of the African Union art. 4(h), July 11, 2000, 2158 U.N.T.S. 3 (stating that the African Union has the right “to intervene in a Member State” regarding “grave circumstances,” including “war crimes, genocide, and crimes against humanity”); G.A. Res. 60/1, ¶ 138 (Sept. 16, 2005) (“Each individual State has the responsibility to protect its populations from genocide, war crimes, ethnic cleansing and crimes against humanity. This responsibility entails the prevention of such crimes We accept that responsibility and will act in accordance with it.”); S.C. Res. 1674, ¶ 4 (Apr. 28, 2006) (reaffirming the “responsibility to protect populations from genocide, war crime . . . and crimes against humanity”); ALEX J. BELLAMY, *RESPONSIBILITY TO PROTECT: THE GLOBAL EFFORT TO END MASS ATROCITIES* 67 (2009) (noting that the 2005 World Summit Outcome “provide[s] a mandate for a wide range of institutional reforms and international activities aimed at protecting people from . . . mass atrocities”).

146. Draft Articles on Responsibility of States, *supra* note 60, at 114 (acknowledging that it is ambiguous “whether general international law at present prescribes a positive duty of cooperation” to end serious breaches of preemptory norms presented by R2P situations and that its statements to the contrary are aspirational and geared towards the “progressive development of international law”); *id.* at 112–13 (including a nonexhaustive list of examples of preemptory norms, such as the prohibition against genocide, war crimes, aggression, torture, and slavery, amongst others); see also GARETH EVANS, *THE RESPONSIBILITY TO PROTECT: ENDING MASS ATROCITY CRIMES ONCE AND FOR ALL* 55 (2008) (noting the continued resistance to the concept); Carsten Stahn, *Responsibility to Protect: Political Rhetoric or Emerging Legal Norm?*, 101 AM. J. INT’L L. 99, 108–09 (2007) (outlining the moral and political concepts of R2P and its derivative responsibilities to prevent, react, and rebuild).

147. *Implementing the Responsibility to Protect*, *supra* note 145, ¶ 11.

148. *Id.*; see also Lloyd Axworthy & Allan Rock, *R2P: A New and Unfinished Agenda*, 1 GLOBAL RESP. TO PROTECT 54, 59 (2009) (describing the R2P toolbox of peaceful interventions).

take timely and decisive action to prevent genocide, ethnic cleansing, war crimes, and crimes against humanity when a state is manifestly failing to protect its population.¹⁴⁹ Pillar III has effectively overshadowed Pillar II in practice. It also seems useless to extricate Pillar II from the rest of the doctrine because, if the objective is to assist states in building capacity, this could be achieved without the rest of R2P's baggage.

Most of the debate on R2P centers less on what satisfies the duty to cooperate¹⁵⁰ and more on fears of its misapplication. The International Law Commission states that cooperation in R2P situations can take place through international organizations or be noninstitutionalized.¹⁵¹ The institutionalized form of R2P is most often affiliated with the United Nations Security Council (Council)¹⁵² or regional organizations. The role of the Council in implementing R2P¹⁵³ must be approached with trepidation as it could improperly exceed its mandate and potentially violate respect for state sovereignty. The noninstitutionalized form of R2P is also potentially subject to misuse by powerful states, since they can use R2P as a pretext for military intervention and to sustain global hierarchies.¹⁵⁴ Because R2P assigns duties

149. *Implementing the Responsibility to Protect*, *supra* note 145, ¶ 11; *see also* Axworthy & Rock, *supra* note 148, at 60.

150. The International Law Commission's Draft Articles on State Responsibility provide that all states shall cooperate to bring an end through lawful means to serious breaches of peremptory norms. Draft Articles on Responsibility of States, *supra* note 60, at 112–16. Peremptory norms of general international law are norms that are “accepted and recognized by the international community of States as a whole as a norm from which no derogation is permitted and which can be modified only by a subsequent norm of general international law having the same character.” Vienna Convention on the Law of Treaties art. 53, May 23, 1969, 1155 U.N.T.S. 331.

151. *See* Draft Articles on Responsibility of States, *supra* note 60, at 112 (citing the Vienna Convention's description of the peremptory norm in explicating the concept).

152. *See* R2P REPORT, *supra* note 25, at 52 (emphasizing that decisions on intervention should be made by the Council); *see also* Rep. of the High-Level Panel on Threats, Challenges and Change, transmitted by Letter Dated 1 December 2004 from the Chair of the High-Level Panel on Threats, Challenges and Change Addressed to the Secretary-General, ¶ 206, U.N. Doc. A/59/565 (Dec. 2, 2004) (echoing the International Commission on Intervention and State Sovereignty's recommendations and calling on the Council to adopt and agree on a set of guidelines to maximize the possibility of consensus on when it is appropriate to use coercive action).

153. *See, e.g.*, U.N. Secretary-General, *We the Peoples: The Role of the United Nations in the 21st Century*, ¶ 219, U.N. Doc. A/54/2000 (Mar. 27, 2000) (stating the Council's moral duty to act on behalf of the international community); R2P REPORT, *supra* note 25, ¶ 52 (explaining the importance of the Council's responsibility); Louise Arbour, *The Responsibility to Protect as a Duty of Care in International Law and Practice*, 34 REV. INT'L STUD. 445, 453 (2008) (positing that the Council holds a heavier responsibility than other states to ensure the protection of all civilians).

154. *See, e.g.*, Alex J. Bellamy, *Whither the Responsibility to Protect? Humanitarian Intervention and the 2005 World Summit*, 20 ETHICS & INT'L AFF. 143, 161 (2006) (“[T]he responsibility to protect [should] not be used as a pretext to undermine the sovereignty, independence, and territorial integrity of states.” (internal quotation marks omitted)); Stahn, *supra* note 146, at 102 (noting that one can simply recharacterize the responsibility to protect into a legally undesirable right to intervene for humanitarian reasons); Jane Stromseth, *Rethinking Humanitarian Intervention: The Case for Incremental Change* (“Humanitarian justifications—particularly the

to all outside states with little differentiation, it faces some of the same challenges with undistributed duties not being discharged that the law of responsibility does.

In sum, R2P offers an insufficient shift in reconceptualizing responsibility. As one of the most radical challenges to traditional principles of responsibility, it still falls into predictable hierarchies that privilege civil and political rights over and above economic and social rights. R2P is a modest improvement on the completely state-centric nature of the law of responsibility because it hints at responsibility beyond the state. However, R2P embeds state-centricity in other ways, for example, by pretending as if the conditions that give rise to crimes against humanity, war crimes, and genocide in any given state are divorced from international actors. It also fails to adequately distribute responsibility and comes with the additional danger of exploitation and advancing imperialistic tendencies of powerful states. The next subsection demonstrates why R2P is flawed as applied to combating highly-infectious diseases.

The Inappropriateness of the Responsibility to Protect for Combating Epidemics.—R2P’s original conceptualization was much broader. For example, the International Commission on Intervention and State Sovereignty argued that it included protection from starvation.¹⁵⁵ Some scholars argue for a return to first principles, beyond R2P’s historical association with crimes against humanity, war crimes, and genocide.¹⁵⁶ This expanded approach would theoretically allow for R2P to have broader significance and address serious socioeconomic violations caused by structural processes.¹⁵⁷ This author is unconvinced that R2P can be rehabilitated or expanded in meaningful ways.¹⁵⁸

claim of necessary action in the face of humanitarian catastrophe—have become more central, moreover, to how states justify and evaluate military options.”), in HUMANITARIAN INTERVENTION: ETHICAL, LEGAL, AND POLITICAL DILEMMAS 232, 246–47 (J.L. Holzgrefe & Robert O. Keohane eds., 2003).

155. See R2P REPORT, *supra* note 25, at VIII (defining the “Responsibility to Protect” as a nation’s responsibility to protect its citizens from avoidable catastrophes such as mass murder, rape, and starvation).

156. See generally Lindsey N. Kingston & Saheli Datta, *Strengthening the Norms of Global Responsibility: Structural Violence in Relation to Internal Displacement and Statelessness*, 4 GLOBAL RESP. PROTECT 475 (2012) (arguing that sovereignty as responsibility demands broader protection of human rights by addressing structural problems).

157. See Axworthy & Rock, *supra* note 148, at 56–57 (advocating for the expansion of R2P principles beyond violence prevention to address systematic human rights violations).

158. *But see* E. Tendayi Achiume, *Syria, Cost-Sharing, and the Responsibility to Protect Refugees*, 100 MINN. L. REV. 687, 745 (2015) (arguing that, despite its flaws, R2P provides a valuable framework for shared responsibility among international actors); Jay Butler, *Responsibility for Regime Change*, 114 COLUM. L. REV. 503, 510 (2014) (positing that R2P should extend to intervenor-states involved in regime change).

First, it does not appear that R2P has any real utility for responding to highly-infectious diseases. For example, applying the R2P framework to epidemics would mean that each state would be expected to reduce the number of highly-infectious diseases within its borders; the international community would be expected to assist states towards meeting its goals; and where a state or other actors are unable or unwilling to do their part toward fulfilling or supporting a state's duty to protect its population from highly-infectious diseases,¹⁵⁹ the state and/or other actors could be subject to serious consequences. However, states are not self-sufficient, and the distribution of highly-infectious diseases is fundamentally conditioned in part by transnational actors and global institutions.¹⁶⁰ Accordingly, an expanded conceptualization of R2P would still problematically place primary responsibility on countries that are the least equipped to combat epidemics effectively.

Thus, for R2P to have any relevance for altering the conditions that led to underlying structural issues,¹⁶¹ it must be permanently divorced from the blunt coercive measures utilized under it. Given R2P's primary association with the use of force,¹⁶² its value in combating epidemics is inherently suspect. Indeed, the use of force to arrest epidemics would lead to more damaging socioeconomic consequences.¹⁶³ Allowing for potentially selective military enforcement is a precarious method for preventing the spread of diseases. And, even with a Council authorization, military intervention would still only aggravate direct and structural harms. Changing the underlying systems, institutions, laws, and policies that facilitate epidemics would not be furthered by allowing for military intervention.

159. For further discussion on the problem of determining unwillingness versus lack of capacity, see discussion *infra* subsection III(B)(2)(b).

160. See, e.g., Frank J. Garcia, *Why Trade Law Needs a Theory of Justice*, 100 PROC. AM. SOC'Y INT'L L. 376, 377 (2006) (discussing wealth distributions in the global economy).

161. See Iris Young, *From Guilt to Solidarity: Sweatshops and Political Responsibility*, DISSENT, Spring 2003, at 39, 39–40, 44, <https://www.dissentmagazine.org/article/from-guilt-to-solidarity> [<https://perma.cc/HG2Y-G4CW>] (“[M]any structural processes do not recognize national boundaries, and they often produce more widespread and long-term harms than do particular actions or policies.”).

162. See R2P REPORT, *supra* note 25, at 55 (noting that if the Council fails to “discharge its responsibility in conscience-shocking situations crying out for action, then it is unrealistic to expect that concerned states will rule out other means and forms of action to meet the gravity and urgency of these situations”); see also G.A. Res. 60/1, *supra* note 145, ¶ 139 (“[W]e are prepared to take collective action, in a timely and decisive manner, through the Security Council . . . and in cooperation with relevant regional organizations as appropriate . . .”); Monica Hakimi, *Distributing the Responsibility to Protect* (remarking on the historic association of R2P with the use of force), in DISTRIBUTION OF RESPONSIBILITIES IN INTERNATIONAL LAW, *supra* note 17, at 265, 271.

163. See Alison Agnew, *A Combative Disease: The Ebola Epidemic in International Law*, 39 B.C. INT'L & COMP. L. REV. 97, 124–25 (2016) (examining the dangers of militarizing disease outbreaks and prescribing alternative international disease-control strategies).

Additionally, economic sanctions as a means of addressing highly-infectious diseases and global health inequities also seem particularly unfitting. Economic isolation would only exacerbate the problems of countries with epidemics in attempting to marshal resources to provide treatment and to prevent further contagion.¹⁶⁴ Such measures will prove counterproductive and increase tensions at a time when greater international cooperation is needed.

Problematically, there is no limiting principle within R2P that would prevent the Council or other international actors from utilizing one of these unsuitable means to implement R2P as opposed to more pacific measures. Accordingly, R2P might allow for sovereignty incursions whether states in the Global South want or need health assistance and could open the floodgates for pretextual interventions.¹⁶⁵

Finally, because the international community has not been able to successfully deal with problems of direct mass personal violence in R2P situations, it may be even less equipped and willing to address problems presented by epidemics. Given the above considerations, R2P is patently unsuitable for addressing challenges posed by pandemics. Accordingly, the next Part demonstrates why the CBDR framework offers a more compelling vision of shared responsibility and why it will more effectively address epidemics than extant regimes.

III. Common but Differentiated Responsibility and Epidemics

A. *Understanding Common but Differentiated Responsibility*

1. *CBDR in Theory.*—CBDR reflects the effort to achieve equity between richer countries in the Global North and poorer states in the Global South.¹⁶⁶ Under it, richer countries agree to take on higher obligations to combat environmental concerns to reflect consumption and production patterns, as well as the unequal distributions of risks that result in more

164. See Marcella David, *Rubber Helmets: The Certain Pitfalls of Marshaling Security Council Resources to Combat AIDS in Africa*, 23 HUM. RTS. Q. 560, 574 (2001) (emphasizing that economic sanctions serve to isolate target states and thereby strain resources available for disease control efforts).

165. See *id.* at 571 (warning against the risk that wealthier nations may rely on health interventions as a pretense to pursue national interests in less powerful regions).

166. See generally Christopher D. Stone, *Common but Differentiated Responsibilities in International Law*, 98 AM. J. INT'L L. 276 (2004) (exploring the increased adoption of common but differentiated responsibilities and the circumstances under which differentiation is desirable).

devastating environmental consequences for poorer countries.¹⁶⁷ It is based in part on the principle of solidarity¹⁶⁸ and reflects the role of the Global South in shaping international law by demanding more equitable rules.¹⁶⁹

The first step in understanding the CBDR framework requires clarity on the meaning of “common.” The principle of CBDR in international environmental law evolved from resources that were considered part of the “common heritage” or of common concern to humans.¹⁷⁰ The rhetoric of “common interest,” “common concern,” and “common heritage of mankind” was originally conceived to deal with deep seabed resources and issues of the utilization of outer space.¹⁷¹ The aim of these treaties was to further conservation and protection efforts.¹⁷² The use of “common” in the CBDR

167. See, e.g., Paris Agreement to the United Nations Framework Convention on Climate Change, Dec. 13, 2015 [hereinafter Paris Framework] (“This Agreement will be implemented to reflect equity and the principle of common but differentiated responsibilities and respective capabilities, in the light of different national circumstances.”), in Rep. of the Conference of the Parties on the Twenty-First Session, U.N. Doc. FCCC/CP/2015/10/Add.1, annex (2016); United Nations Framework Convention on Climate Change art. 3, May 9, 1992, S. TREATY DOC. No. 102-38, 1771 U.N.T.S. 107 (enumerating the principles of common but differentiated responsibilities by which treaty signers are expected to abide); see also United Nations Climate Change, *Paris Agreement—Status of Ratification*, http://unfccc.int/paris_agreement/items/9444.php [<https://perma.cc/T3E5-9PH9>] (noting that 197 signatories and 175 state parties have so far ratified the agreement, including China).

168. U.N. Conference on the Human Environment, *Stockholm Declaration on the Human Environment*, U.N. Doc. A/CONF.48/14/Rev.1 (June 1972) (explaining in Principle 24 that states are obliged in the spirit of solidarity to cooperate in preventing transboundary pollution).

169. Paris Framework, *supra* note 167, arts. 4(1), 4(2) (noting that obligations are subject to CBDR). Transitioning economies are also subjected to differential treatment under the Convention. *Id.* art. 4(6).

170. See, e.g., Convention on Biological Diversity pmbl., June 5, 1992, 1760 U.N.T.S. 79 (noting that conserving “biological diversity is a common concern of humankind”); Convention for the Protection of Cultural Property in the Event of Armed Conflict with Regulations for the Execution of the Convention 1954, pmbl. May 14, 1954, 249 U.N.T.S. 240, <http://unesdoc.unesco.org/images/0018/001875/187580e.pdf> [<https://perma.cc/P749-JMWK>] (“Being convinced that damage to cultural property belonging to any people whatsoever means damage to the cultural heritage of all mankind, since each people makes its contribution to the culture of the world.”); International Convention for the High Seas Fisheries of the North Pacific Ocean pmbl., May 9, 1952, 4 U.S.T. 380, 205 U.N.T.S. 65 (categorizing conservation efforts towards tuna as serving the common interest of mankind).

171. See, e.g., Treaty on Principles Governing the Activities of States in the Exploration and the Use of Outer Space, Including the Moon and Other Celestial Bodies arts. 1, 11, Jan. 27, 1967, 18 U.S.T. 2410, 610 U.N.T.S. 205 (referring to outer space as the “province of all mankind” and noting that the “moon and its natural resources are the common heritage of mankind”).

172. See, e.g., Convention Concerning the Protection of the World Cultural and Natural Heritage art. 6, Nov. 23, 1972, 27 U.S.T. 37 (imposing a duty on the international community to protect “world heritage”); Convention on Wetlands of International Importance Especially as Waterfowl Habitat pmbl., Feb. 2, 1971, T.I.A.S. No. 11,084, 996 U.N.T.S. 245 (characterizing waterfowls as an “international resource”).

framework suggests that certain resources “affect and are affected by every nation on earth.”¹⁷³

The second part of understanding the CBDR framework necessitates precision on the meaning of “differentiated responsibility.” This element of CBDR in international environmental law focuses on a range of different burden-sharing arrangements that take into account each nation’s particular circumstances,¹⁷⁴ especially “each State’s contribution to the evolution of a particular problem and its ability to prevent, reduce and control the threat.”¹⁷⁵ CBDR focuses on the state’s historical contributions to environmental degradation and takes this into account when fashioning legal commitments.¹⁷⁶ The idea of differentiated responsibilities in environmental law was aimed at promoting “substantive equality between developing and developed States within a regime, rather than mere formal equality.”¹⁷⁷

2. *CBDR in Practice.*—CBDR reflects the belief that while all states are responsible for global environmental problems like ozone depletion, some states are more responsible than others.¹⁷⁸ In light of this principle, countries in the Global North have committed to joint projects in developing

173. Stone, *supra* note 166, at 276.

174. See, e.g., International Treaty on Plant Genetic Resources for Food and Agriculture art. 7.2(a), Nov. 3, 2001, T.I.A.S. No. 17-313, 2400 U.N.T.S. 303 (entered into force June 29, 2004) (directing international cooperation to establish and strengthen the capabilities of developing countries and economies in transition); *id.* art. 8 (requiring parties to promote the provision of technical assistance to developing countries and economies in transition); Convention to Combat Desertification in Those Countries Experiencing Serious Drought and/or Desertification, Particularly in Africa arts. 3, 5–6, June 17, 1994, S. TREATY DOC. No. 104-29, 1954 U.N.T.S. 3 (calling for the full consideration of the special needs and circumstances of affected developing countries, particularly the least among them); Convention on Biological Diversity, *supra* note 170, arts. 8(m), 9(e) (mandating all parties to cooperate in the provision of financial and other support to developing countries for conservation); *id.* art. 20 (noting that developed countries must provide financial resources to developing countries to enable them to implement the Convention).

175. CBDR: ORIGINS AND SCOPE, *supra* note 26; see also Stockholm Convention on Persistent Organic Pollutants pmbl., May 22, 2001, S. TREATY DOC. No. 107-5, 2256 U.N.T.S. 119 (entered into force May 17, 2004) (noting the respective capabilities of developed and developing countries and the CBDR of states); *id.* art. 4(7) (providing that parties take due account of the special circumstances of developing countries as well as transitioning economies in deciding whether to grant exceptions); *id.* art. 12(2) (recognizing that parties are required to provide technical assistance to developing and transitioning countries to assist them with their obligations); PHILLIPE SANDS, PRINCIPLES OF INTERNATIONAL ENVIRONMENTAL LAW 286 (2d ed. 2003) (overlying the concept of CBDR with the 1992 Climate Change Convention).

176. SANDS, *supra* note 175, at 218, 287–89.

177. CBDR: ORIGINS AND SCOPE, *supra* note 26.

178. Christopher C. Joyner, Professor of Gov’t., Georgetown University, Remarks on Common but Differentiated Responsibility (Mar. 13–16, 2002), in *Introduction*, 96 PROC. OF THE ANN. MEETING (AM. SOC’Y INT’L L.) 358, 358.

countries to assist with issues like emissions reductions.¹⁷⁹ Developed countries have also been asked “to take the lead” in mobilizing finance for tackling environmental challenges.¹⁸⁰ These initiatives recognize that developing countries will need major assistance from developed countries if they are to mitigate the detrimental effects of ozone depletion and climate change.

CBDR in international environmental law is premised on the logic that the countries responsible for polluting the global commons should utilize the resources gained from those activities and have primary responsibility for cleaning up the environment, as well as help other countries adapt clean-development technologies.¹⁸¹ For example, the most recent climate-change-mitigation effort, the Paris Agreement, acknowledges the specific needs and concerns of developing countries arising from implementation measures.¹⁸² Under the Paris Agreement, each party makes self-determined emissions reductions with climate change adaptation plans that are to be in place by 2020.¹⁸³ CBDR is still reflected in many aspects of the treaty, from the preamble¹⁸⁴ to the differentiation between developing and developed countries in the Annex, as well as provisions that stress the importance of financing and technology transfer for developing nations.¹⁸⁵

179. See, e.g., Kyoto Protocol to the United Nations Framework Convention on Climate Change art. 12, Dec. 11, 1997, 2303 U.N.T.S. 162 [hereinafter Kyoto Protocol] (committing developed nations to share proceeds of clean-power technology with developing nations). Initially, under the Kyoto Protocol, developed countries made certain commitments to reduce greenhouse gas emissions, economies in transition had lesser commitments, and developing nations made no commitments toward reduction of greenhouse gas emissions. See *id.* arts. 3(1), (5).

180. E.g., Paris Framework, *supra* note 167, art. 9(3); see also Adoption of the Paris Agreement, Dec. 12, 2015 (clarifying, under the section labeled “Decisions to Give Effect to the Agreement,” that developed countries will implement “meaningful mitigation actions”), in Rep. of the Conference of the Parties on the Twenty-First Session, ¶ 54, U.N. Doc. FCCC/CP/2015/L.9/Rev.1.

181. See Lindsay Wiley, *Moving Global Health Law Upstream: A Critical Appraisal of Global Health Law as a Tool for Health Adaptation to Climate Change*, 22 GEO. INT’L ENVTL. L. REV. 439, 488 (2010). But see Christopher C. Joyner, *Burning International Bridges, Fuelling Global Discontent: The United States and Rejection of the Kyoto Protocol*, 33 VICTORIA U. WELLINGTON L. REV. 27, 27, 36 (2002) (discussing the reluctance of the United States and other chief emitters like China to participate in agreements like the Kyoto Protocol to the Climate Change Convention).

182. U.N. Framework Convention on Climate Change, Rep. of the Conference of the Parties on Its Eighteenth Session, U.N. Doc. FCCC/CP/2012/8/Add.1, at 21 (2013); see also *The Paris Agreement: Frequently Asked Questions*, UNITED NATIONS (Sept. 12, 2016), <https://www.un.org/sustainabledevelopment/blog/2016/09/the-paris-agreement-faqs/> [<https://perma.cc/EK6U-LM2A>] (describing the Paris Agreement “as an important tool in mobilizing . . . support and capacity building for developing countries”).

183. *The Paris Agreement: Frequently Asked Questions*, *supra* note 182.

184. See, e.g., Paris Framework, *supra* note 167, pmbl. (calling for cooperation by all countries in accordance with their “common but differentiated responsibilities”).

185. E.g., *id.* arts. 4, 9–10.

The principle of CDDR is also reflected in the ozone protection regime. Important developing countries like China and India were initially not members of the Montreal Protocol on Substances that Deplete the Ozone Layer.¹⁸⁶ They argued that they had not caused the problem and were unwilling to forgo using cheaper products with ozone-depleting substances, or to use more expensive substitutes to enrich the industry responsible for the problem.¹⁸⁷ Legal obligations in conventions reflecting CDDR are not just based on differentiated mitigation actions for developing and developed states.¹⁸⁸ For example, the London Amendment to the Montreal Protocol of 1991 incorporates the principle of CDDR through the creation of a Multilateral Fund, which provided for differing contributions to adaptation measures for developed and developing states.¹⁸⁹ The ozone treaty regime reflects the equity arguments made by developing countries and provides additional incentives for developing countries to ratify and comply with their obligations under the treaty. The ozone regime is one of the biggest success stories in international law. Since 2005, the ozone hole has been shrinking.¹⁹⁰ By 2014, the ozone treaties had resulted in the phasing out of 98% of all ozone-depleting substances.¹⁹¹ Scientists anticipate that the hole in the ozone will close completely by around 2060.¹⁹²

186. See *Status of Montreal Protocol on Substances that Deplete the Ozone Layer*, UNITED NATIONS TREATY COLLECTION, https://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtdsg_no=XXVII-2-a&chapter=27 [<https://perma.cc/7NC2-58RB>] (noting that China and India did not accede to the 1987 treaty until 1991 and 1992, respectively). The Protocol was part of a series of overlapping treaty arrangements that make up the ozone regime. The regime was formulated to reduce ozone-depleting chemicals, which have many industrial uses. Yet, utilizing these substances created a hole in the ozone layer, which allowed more ultraviolet radiation to reach the earth's surface, harming human, animal, and plant health. Montreal Protocol on Substances that Deplete the Ozone Layer pmbl., art. 2, Sept. 16, 1987, 1522 U.N.T.S. 29 [hereinafter Montreal Protocol].

187. JEFFREY DUNOFF ET AL., *INTERNATIONAL LAW: NORMS, ACTORS, PROCESS: A PROBLEM-ORIENTED APPROACH* 637 (4th ed. 2015).

188. See, e.g., Montreal Protocol, *supra* note 186, art. 5(1); Amendment to the Montreal Protocol on Substances that Deplete the Ozone Layer, June 29, 1990 [hereinafter London Amendments] (amending the Montreal Protocol to make a special provision to meet the needs of developing countries, including the provision of financial resources and access to relevant technologies, as well as granting them a ten-year grace period for compliance), in *Report of the Second Meeting of the Parties to the Montreal Protocol on Substances that Deplete the Ozone Layer*, arts. 5, 10, U.N. Doc. EP/OzL.Pro.2/3 (1990).

189. See London Amendments, *supra* note 188, art. 10 (describing the operation of the Multilateral Fund).

190. Susan E. Strahan & Anne R. Douglass, *Decline in Antarctic Ozone Depletion and Lower Stratospheric Chlorine Determined from Aura Microwave Limb Sounder Observations*, 45 *GEOPHYSICAL RES. LETTERS* 382, 382, 388 (2018) (noting that a decline in ozone-depleting chemicals has resulted in 20% less depletion since 2005).

191. DUNOFF ET AL., *supra* note 187, at 644.

192. Samson Reiny, *NASA Study: First Direct Proof of Ozone Hole Recovery Due to Chemicals Ban*, NASA (Jan. 4, 2018), <https://www.nasa.gov/feature/goddard/2018/nasa-study-first-direct-proof-of-ozone-hole-recovery-due-to-chemicals-ban> [<https://perma.cc/YBK8-PV6M>].

The principle of CBDR has met with mixed results in mitigating climate change but has been usefully applied to address ozone depletion in practice. While the ozone regime has served to mostly eliminate the production and use of ozone-depleting substances, the climate-change regime has produced only modest steps at stabilizing greenhouse gases. However, climate change is a vastly more complex problem than ozone depletion. It involves virtually every form of human activity that contributes to greenhouse gases and presents more difficult distributional and equity issues than ozone depletion. Overall, the analysis above indicates that CBDR has continued vitality.

B. Expanding the Common but Differentiated Responsibility Framework

This section develops and expands the theory underlying the framework of CBDR. It applies this framework to the Cholera and Ebola epidemics, which in turn yields important implications for the theory of CBDR. This section fleshes out aspects of the CBDR framework that are undertheorized. It does this by drawing on concepts of criminal law and tort law, as well as corrective justice and remedies. The below subsections set out the case for expanding “common” and the case for expanding “differentiation” based on need, culpability, and capacity within the CBDR framework.

1. The Case for Expanding “Common.”—The first element of CBDR, “common,” conventionally describes the shared obligations of two or more states towards the protection of an environmental resource.¹⁹³ But, there is no reason why “common” could not apply to other resources that are shared, like global public health, either because the resource is not sufficiently under the control of a state, or is under the sovereign control of a state but subject to a common legal interest.¹⁹⁴ Indeed, the ordinary meaning of “common” highlights the public aspect of the term and defines it as “of or relating to a community at large.”¹⁹⁵ Similarly, legal definitions also indicate that, when used as an adjective, “common” is something that is “shared amongst several” or “owned by several jointly.”¹⁹⁶ Thus, we could conceive of the shared good of environmental protection being akin to the shared good of protection from disease.

193. CBDR: ORIGINS AND SCOPE, *supra* note 26.

194. *See, e.g., SANDS, supra* note 175, at 286 (describing a common responsibility as applying when a “resource” is subject to a common legal interest but is not under the exclusive jurisdiction of a single state).

195. *Common*, MERRIAM-WEBSTER ONLINE DICTIONARY, <http://www.merriam-webster.com/dictionary/common> [<https://perma.cc/D3KW-3DWH>].

196. *Common*, LAW DICTIONARY, <https://thelawdictionary.org/common/> [<https://perma.cc/M9EB-WKEP>].

Both environmental protection and protection from disease are global public goods¹⁹⁷ that are subject to common legal interests. Certainly, disease eradication has been identified as a “weakest link global public good” because international cooperation can be undermined by a single weak link or uncooperative actor.¹⁹⁸ Yet, disease eradication shares several similarities with aggregate effort public goods, like ozone layer protection, in that participation of all states is required for effective provision. Despite the different typology for conceptualizing disease eradication and ozone protection as public goods, the two areas have much more in common than the weakest-link and aggregate-effort public good categories indicate.¹⁹⁹ Namely, aggregate efforts like ozone fortification “can be undermined by weak links,” and for public goods like “disease eradication, efforts short of total success will still yield benefits, meaning that . . . aggregate effort matters.”²⁰⁰

States are beginning to recognize that highly-infectious diseases pose severe risks for the entire world.²⁰¹ States have also recently recognized that highly-infectious diseases present serious challenges to developmental goals.²⁰² In addition, states have acknowledged that certain “diseases and other emerging health challenges require a sustained international response.”²⁰³ Stakeholders are also starting to identify the linkages between infectious disease and climate change given the anticipated escalating costs of addressing infectious diseases known to be climate sensitive, such as Cholera, malaria, Dengue fever, and other viral diseases.²⁰⁴ Certainly, warmer weather linked with climate change allows mosquitos and other insects to breed and transmit diseases faster. This means that new diseases will show up in places that they have not been, like Zika, and that other

197. See SANDS, *supra* note 175, at 277 (citing the *Beef Hormones* case, where the European Community prohibited the import of beef from the United States and Canada because of potential health concerns regarding the use of artificial hormones, as an example of the precautionary principle); see also J. Samuel Barkin & Yuliya Rashchupkina, *Public Goods, Common Pool Resources, and International Law*, 111 AM. J. INT’L L. 376, 381 (2017) (arguing that disease eradication and climate change are examples of public goods that show the overlap between “weakest link” goods and “aggregate effort” goods).

198. SCOTT BARRETT, WHY COOPERATE? THE INCENTIVE TO SUPPLY GLOBAL PUBLIC GOODS 47 (2007).

199. Barkin & Rashchupkina, *supra* note 197, at 381.

200. *Id.*

201. The Council unanimously adopted Resolution 2177, which states “that the unprecedented extent of the Ebola outbreak in Africa constitutes a threat to international peace and security.” S.C. Res. 2177, pmb. (Sept. 18, 2014).

202. G.A. Res. 60/1, *supra* note 145, ¶ 57 (noting the significant effects that HIV/AIDS, malaria, tuberculosis, and other diseases have on health).

203. *Id.*

204. See REG’L OFFICE FOR SOUTH-EAST ASIA, WORLD HEALTH ORG., REGIONAL STRATEGY FOR PROTECTING HEALTH FROM CLIMATE CHANGE 62–63 (2013) (projecting the costs of managing additional climate change-related cases of certain diseases).

established infectious diseases will continue to grow in places where they have been.²⁰⁵ In the United States alone, the number of insect-borne illness cases that individuals reported to the Centers for Disease Control and Prevention tripled from 2004 to 2016.²⁰⁶ The increase in the number of reported cases may simply reflect the increase in testing and reporting or the increase in jet travel that facilitates the easy transmission of diseases, but the influence of a warming climate on these trends cannot be easily discounted. Indeed, studies have shown that warmer weather is assisting the spread of infectious diseases in other wealthy countries as well.²⁰⁷ When facing common risks in other contexts, states have recommended that all actors “cooperate in a spirit of global partnership.”²⁰⁸ Thus, a CDR framework for highly-infectious diseases is a logical conceptual expansion and provides a method for addressing mutual risks posed by epidemics.

2. *The Case for Expanding “Differentiation.”*—The second element of CDR is “but differentiated responsibility.” The plain meaning of “but” is “except for the fact,”²⁰⁹ while the ordinary meaning of “differentiate” is “to mark or show a difference.”²¹⁰ Legal definitions of “responsibility” speak to “the obligation to answer for an act done, and to repair any injury it may have caused.”²¹¹ Reading all the definitions of the component parts of CDR together yields: something relating to a community at large or that is shared amongst several, except for the fact to mark or show a difference in the obligation to answer for an act done, and to repair any injury it may have caused. Nothing warrants restricting this definition to the realm of international environmental law.²¹² In fact, the second element of the

205. For further discussion, see Nick Watts et al., *The Lancet Countdown on Health and Climate Change: From 25 Years of Inaction to a Global Transformation for Public Health*, 391 LANCET GLOBAL HEALTH 581, 589 (2018) (analyzing the health effects of climate change and the health implications of the Paris Agreement’s implementation).

206. Ronald Rosenberg et al., *Vital Signs: Trends in Reported Vectorborne Disease Cases—United States and Territories, 2004–2016*, MORBIDITY & MORTALITY WKLY REP. 496, 498 (2018), <https://www.cdc.gov/mmwr/volumes/67/wr/mm6717e1.htm> [<https://perma.cc/539G-YHVQ>].

207. See Watts et al., *supra* note 205, at 589 (finding that climate change influences infectious disease emergence and incidence globally).

208. Rep. of the World Summit on Sustainable Development, U.N. Doc. A/CONF.199/20, at 51 (Sept. 2, 2002), *modified*, U.N. Doc. A/CONF.199/20/Corr.1 (2003).

209. *But*, MERRIAM-WEBSTER’S COLLEGIATE DICTIONARY 168 (11th ed. 2006).

210. *Differentiate*, MERRIAM-WEBSTER’S COLLEGIATE DICTIONARY 348 (11th ed. 2006).

211. *Responsibility*, LAW DICTIONARY, <https://thelawdictionary.org/responsibility/> [<https://perma.cc/V3NL-VTK2>].

212. See, e.g., United Nations Convention on the Law of the Sea pmbl., Dec. 10, 1982, 1833 U.N.T.S. 397 (accounting for the interests and needs of developing countries); General Agreement on Tariffs and Trade art. XXXVI(8), Oct. 30, 1947, 61 Stat. A-11, 55 U.N.T.S. 194 (noting that when granting concessions developed countries should not demand that developing countries reciprocate).

principle of CBDR is reflected in many areas of international law. For example, under the General Agreement on Tariffs and Trade, the enabling clause inculcates a system of preferences wherein “parties may accord differential and more favourable treatment to developing countries, without according such treatment to other contracting parties.”²¹³ Additionally, the Agreement on Sanitary and Phytosanitary Measures allows developing countries to request time-limited exemptions from their obligations geared towards food safety and animal and plant health, and it requires developed countries to consider providing technical assistance to exporting countries in order to allow them to meet any standards set by the importing developed country.²¹⁴ Differential obligations are also found in the intellectual property regime to address public health problems posed by epidemic diseases. For example, the Doha Declaration reaffirms the commitment of countries in the Global North to provide incentives to corporations and other institutions to promote and encourage technology transfer to countries in the Global South.²¹⁵ The Declaration also allowed for the phasing in of obligations under the Trade-Related Aspects of Intellectual Property Rights Agreement²¹⁶ with respect to pharmaceutical products for the least-developed country members until January 1, 2016, without prejudice to their right to seek further extensions.²¹⁷ Consequently, the second element of the CBDR framework is already influential in many areas of law and is ripe for further development.

Undoubtedly, there are several norms underpinning the differentiated-responsibility element of CBDR that need elaboration. Particularly instructive is the Rio Declaration on the Environment and Development, which states that developed countries shall acknowledge the “special situation and needs of developing countries, particularly the least developed

213. Decision on Differential and More Favourable Treatment, Reciprocity and Fuller Participation of Developing Countries, Nov. 28, 1979, GATT (Doc. L/4903) B.I.S.D. (26th Supp.), at 203–18 (1980).

214. Agreement on the Application of Sanitary and Phytosanitary Measures pmbl., arts. 9–10, Apr. 15, 1994, 1867 U.N.T.S. 493.

215. World Trade Organization, Ministerial Declaration on the TRIPS Agreement and Public Health of 14 November 2001 ¶ 7, WTO Doc. WT/MIN(01)/DEC/2, 41 ILM 755 (2002) [hereinafter Doha Declaration].

216. See Agreement on Trade-Related Aspects of Intellectual Property Rights art. 65(2), Apr. 15, 1994, 1869 U.N.T.S. 299 [hereinafter TRIPS Agreement] (granting extra implementation time to developing countries); *id.* art. 66(1) (delaying indefinitely implementation for the least-developed countries); *id.* art. 66(2) (obliging developed countries to provide incentives to “enterprises and institutions in their territories” for technology transfer to developing countries to “enable them to create a sound and viable technological base”).

217. Doha Declaration, *supra* note 215, ¶ 7.

and those most environmentally vulnerable, [and that they] shall be given special priority.”²¹⁸ The Declaration provides that:

In view of the different contributions to global environmental degradation, States have common but differentiated responsibilities. The developed countries acknowledge the responsibility that they bear in the international pursuit of sustainable development in view of the pressures their societies place on the global environment and of the technologies and financial resources they command.²¹⁹

The Declaration mentions three distinct normative bases for differentiation: need, culpability, and capacity. The next subsections will take up and develop each axis of differentiation and make the case for expansion of the CBDR framework to global public health.

a. Differentiation Based on Need.—The first rationale for differentiation in the Rio Declaration distinguishes the needs of developing, the least developed, and vulnerable countries from developed countries.²²⁰ Expanding this rationale of differentiation to combat highly-infectious diseases means there would be disparate levels of responsibility for addressing epidemics, which would correspond with varying levels of social, economic, and health needs.

Undeniably, need-based claims for differentiation are hardly new; much legal and philosophical ink has been spilled on claims grounded in the duty to rescue.²²¹ The normative justification for differentiation on this ground is straightforward—morally, we have a responsibility to help those in need. Need-based claims often run headfirst into the so-called slippery slope, in that vulnerable countries are faced with many needs, not just risks posed by epidemics. If need-based claims for differentiation were accepted, the practical implications for law-and-policy making in global public health would be substantial, but surmountable, as the status quo distribution of need

218. U.N. Conference on Environment and Development, *Rio Declaration on Environment and Development* princ. 6, U.N. Doc. A/CONF.151/26/Rev.1 (Vol. I), annex I (Aug. 12, 1992) [hereinafter Rio Declaration].

219. *Id.* princ. 7.

220. *Id.* princ. 6.

221. See generally, e.g., Lawrence O. Gostin, *Why Rich Countries Should Care About the World's Least Healthy People*, 298 J. AM. MED. ASS'N 89 (2007) (highlighting national interests and ethics as reasons why wealthy countries should be concerned with global health); Bhikhu Parekh, *Cosmopolitanism and Global Citizenship*, 29 REV. INT'L STUD. 3 (2003) (discussing the ethical obligations individuals have to those inside and outside of their communities); Thomas W. Pogge, *Responsibilities for Poverty-Related Ill Health*, 16 ETHICS & INT'L AFF. 71 (2002) (contending that those involved in upholding institutions that contribute to illness around the world have a responsibility to prevent and mitigate it). But see Mathias Risse, *What We Owe to the Global Poor*, 9 J. ETHICS 81 (2005) (denying the existence of far-reaching redistributive duties to the global poor).

is avoidable under a more just international order. Although the political appetite may be low, the effort to do so would be minimal. For example, a mere 0.1% of the gross national income of sixty-six high-income economies is all that would be needed to meet the core obligations of the right to health.²²² Certainly, eliminating deprivation globally is achievable collectively, as substantial improvements in the living conditions in the Global South are possible at small opportunity costs to those in the Global North.²²³

The countries where the Cholera and Ebola epidemics occurred certainly meet the criterion of need. In the aftermath of the conflicts in Guinea, Liberia, and Sierra Leone and before the 2010 earthquake in Haiti hit, many vital state institutions were nonexistent or significantly weakened.²²⁴ The epidemics were able to wreak such havoc in large part because these are some of the poorest countries in the world.²²⁵ For example, even though Liberia and Sierra Leone had some of the highest growth rates globally, the vast majority of people's lived experiences were defined by continued or growing poverty prior to Ebola.²²⁶ Liberia ranks 177 out of 188 countries on the U.N. Development Program's Human Development Index (HDI)²²⁷ for 2014, in front of Sierra Leone at 181 and Guinea at 182.²²⁸ Comparatively, prior to the Cholera epidemic in Haiti in 2010, the HDI

222. E.g., G. Ooms & R. Hammonds, *Taking Up Daniels' Challenge: The Case for Global Health Justice*, 12 HEALTH & HUM. RTS. 29, 37 (2010).

223. "Doubling the wealth of all in the bottom two quintiles would take only 1.55 percent of the wealth of the top 1 percent of the human population." Thomas Pogge, *Growth Is Good! – But What Growth?*, in SOCIAL JUSTICE, GLOBAL DYNAMICS: THEORETICAL AND EMPIRICAL PERSPECTIVES 77, 87 (Ayelet Banai, Mirian Ronzoni & Christian Schemmel eds., 2011); see also Robert Beaglehole et al., *Prevention of Chronic Diseases: A Call to Action*, 370 LANCET GLOBAL HEALTH 2152, 2152 (2007) (finding that a small set of interventions in twenty-three low-income and middle-income countries in 2005 would have cost approximately USD 5.8 billion to achieve the global goal for prevention and control of chronic diseases).

224. See SUSAN E. RICE & STEWART PATRICK, BROOKINGS INST., INDEX OF STATE WEAKNESS IN THE DEVELOPING WORLD 3, 39 (2008) [hereinafter INDEX OF STATE WEAKNESS] (ranking all 141 developing countries according to their performance in four key areas—economics, politics, security, and social welfare). It ranked Liberia ninth, Haiti twelfth, Sierra Leone thirteenth, and Guinea twenty-third (with a lower ranking representing poorer performance). *Id.* at 10, 39.

225. See UNITED NATIONS DEV. PROGRAM, HUMAN DEVELOPMENT REPORT 2015: WORK FOR HUMAN DEVELOPMENT 228–29 (2015) [hereinafter HD REPORT 2015] (noting that between 2004 and 2014, 52.9% of the population lived below the national poverty line in Sierra Leone, 55.2% did in Guinea, 58.5% in Haiti, and 63.8% in Liberia).

226. See INT'L MONETARY FUND, WORLD ECONOMIC OUTLOOK: RECOVERY STRENGTHENS, REMAINS UNEVEN 69, 186 (2014) (classifying Liberia, Sierra Leone, and Guinea as low-income countries as determined by GDP, consumer prices, current account balance, and unemployment).

227. The HDI assesses health deprivations by considering life expectancy, but it also examines health outcomes like infants lacking immunizations and deaths due to certain infectious diseases like malaria and tuberculosis, as well as measuring HIV prevalence.

228. HD REPORT 2015, *supra* note 225, at 210.

ranked Haiti 145 out of 169 countries.²²⁹ The level of susceptibility in all four countries to infectious diseases when the outbreaks occurred was dismal. The percentage of public health expenditures relative to gross domestic product that all four countries spent on health prior to the epidemics paled in comparison to countries with the highest human development.²³⁰ Examining the relative deprivation and susceptibility to outbreaks in all countries prior to the Cholera and Ebola epidemics reveals a key insight for the theory of CBDR. The CBDR framework must also consider relative health needs, that is, a determination of the resources (or lack thereof) to mitigate the risks from epidemics, as opposed to simply focusing on absolute need.

Differentiation based on need within the CBDR framework would mean that states, international organizations, and other nonstate actors would have a moral and undoubtedly contested legal duty to recognize and act upon the threats posed by epidemics like Cholera and Ebola. This legal duty as applied to highly-infectious diseases could be based in part on norms of international cooperation that already exist in international law. Arguably, the U.N. Charter requires member states to provide international assistance and cooperation. Under Article 56 of the Charter, members are “to take joint and separate action in cooperation with the Organization for the achievement of the purposes set forth in Article 55.”²³¹ And Article 55 provides that the U.N. shall promote “solutions of international economic, social, health, and related problems; and international cultural and educational cooperation.”²³² Article 55 also provides in relevant part that the U.N. should promote higher standards of living and conditions of economic and social progress and development as well as universal respect for and observance of human rights.²³³ Reading these provisions together provides a basis to argue that states are obligated under the Charter to cooperate with the U.N. and other actors to prevent, detect, and arrest pandemics. Several scholars are of the view that the Charter does not legally empower the U.N. to force member

229. UNITED NATIONS DEV. PROGRAM, HUMAN DEVELOPMENT REPORT 2010: THE REAL WEALTH OF NATIONS: PATHWAYS TO HUMAN DEVELOPMENT 150 (2010) [hereinafter HD REPORT 2010].

230. *Compare* UNITED NATIONS DEV. PROGRAM, HUMAN DEVELOPMENT REPORT 2016: HUMAN DEVELOPMENT FOR EVERYONE 226, 229 (2016) (noting that in 2014, Norway and Australia ranked the first and second in human development, respectively spending 8.3% and 6.3% of their GDP on public health, while Liberia ranked 177 and spent 3.2%, Guinea ranked 183 and spent 2.7%, and Sierra Leone ranked 179 and spent 1.9%), *with* UNITED NATIONS DEV. PROGRAM, HUMAN DEVELOPMENT REPORT 2013: THE RISE OF THE SOUTH: HUMAN PROGRESS IN A DIVERSE WORLD 162, 164 (2013) (noting that in 2010, Norway and Australia ranked first and second for human development, respectively spending 6.4%–8.0% and 5.4%–5.9% of their GDP on public health, while Haiti spent 1.5%–1.7% of its GDP, Liberia spent 1.3%–3.9%, Guinea spent 0.6%–0.7%, and Sierra Leone spent 1.1%–1.5%).

231. U.N. Charter art. 56.

232. *Id.* art. 55(b).

233. *Id.* art. 55(a), (c).

states to aid.²³⁴ That states are not subject to compulsion, however, does not mean that they are not under an obligation to act.

Notwithstanding the ostensible lack of binding obligations, there are promising recent developments that reflect the expanded CBDR approach. For instance, the Global Health Security Agenda was created in 2014 in the midst of the Ebola epidemic and endorsed by the Group of Seven Nations (G-7).²³⁵ Its goal is to “advance a world safe and secure from infectious disease threats, to bring together nations from all over the world to make new, concrete commitments, and to elevate global health security as a national leaders-level priority.”²³⁶ Membership in the GHSA is open to all countries, and currently nearly 50 nations are members,²³⁷ along with international organizations like the WHO, the Economic Community of West African States, and the European Union, as well as nongovernmental stakeholders.²³⁸ It is a completely voluntary initiative wherein countries endeavor to make commitments to prevent, detect, and respond to threats whether naturally occurring, deliberate, or accidental that arise from highly-infectious diseases. One of the key aspects is the external evaluation tool’s ability to highlight gaps and needs for current and prospective donors, as well as to inform and assist country-level planning and priority setting.²³⁹

The GHSA differentiates based on need. The countries most impacted by Ebola—Liberia, Sierra Leone, and Guinea—joined and have experienced improvement.²⁴⁰ For example, during the Ebola epidemic in Sierra Leone in November of 2015, only 35% of health facilities reported to their respective districts.²⁴¹ By September 2016, with the help of the GHSA, this increased to 96% of health facilities.²⁴² Early indications similarly show the initiative’s

234. See Malcolm Langford et al., *Extraterritorial Duties in International Law* (describing one scholar’s view that the Charter serves to promote rather than to enforce), in *GLOBAL JUSTICE, STATE DUTIES: THE EXTRATERRITORIAL SCOPE OF ECONOMIC, SOCIAL AND CULTURAL RIGHTS IN INTERNATIONAL LAW* 51, 54–55 (Malcolm Langford et al. eds., 2013).

235. GHSA *About*, *supra* note 29.

236. *Id.*

237. *Id.*; see also *Membership*, GLOB. HEALTH SEC. AGENDA [hereinafter *Membership*], <https://www.ghsagenda.org/members> [<https://perma.cc/8ZEK-J8DF>] (listing current member-states). Notably, Haiti only recently became a member of the GHSA, joining Liberia, Sierra Leone, and Guinea.

238. GHSA *About*, *supra* note 29.

239. *Assessments & JEE*, GLOB. HEALTH SEC. AGENDA, <https://www.ghsagenda.org/assessments> [<https://perma.cc/G8JH-5T55>].

240. *Membership*, *supra* note 237; see, e.g., WORLD HEALTH ORG., JOINT EXTERNAL EVALUATION OF THE REPUBLIC OF LIBERIA: MISSION REPORT 4, 16 (2016) (indicating that Liberia has made significant structural improvements in the wake of the Ebola epidemic).

241. GLOB. HEALTH SEC. AGENDA, ADVANCING THE GLOBAL HEALTH SECURITY AGENDA: PROGRESS AND EARLY IMPACT FROM U.S. INVESTMENT 7 [hereinafter *ADVANCING THE GLOBAL HEALTH SECURITY AGENDA*], <https://www.ghsagenda.org/docs/default-source/default-document-library/ghsa-legacy-report.pdf?sfvrsn=12> [<https://perma.cc/TLM5-SLHQ>].

242. *Id.* at 7.

impact in Liberia. Prior to the 2014 Ebola outbreak, Liberia had very few trained “disease detectives,” but with the initiative’s support at the end of 2016, it had approximately 115 trained “detectives” covering all fifteen counties and ninety-two health districts.²⁴³ This progress will likely assist with early detection of epidemic diseases in the sub-region. The GHSA incorporates an important aspect of the CBDR framework.

Differentiating based on relative health needs makes intuitive sense because while public health risks are distributed across all nations, some nations are more needful of assistance than others and are especially vulnerable to epidemics. Differentiating responsibility based on need makes clear that the basis for obligations of international assistance and cooperation does not depend on whether an actor has contributed to the resulting harm. At the same time, meeting the global need required to address epidemic diseases requires more than the resources of any one state, as such obligations to cooperate must be shared and differentiated not only based on need²⁴⁴ but also based on culpability and capacity. The next subsections take up both in turn.

b. Differentiation Based on Culpability.—The second rationale for differentiation in the Rio Declaration recognizes countries’ responsibility for different contributions to global environmental degradation.²⁴⁵ Expanding this rationale to global public health affords a basis for differentiation based on an assessment of those who contributed to highly-infectious diseases and calls for a concomitant apportionment of responsibility to repair the harm caused. Under a CBDR framework to combat epidemics, dissimilar levels of responsibility would be allocated based on the culpability of actors.

Under a culpability analysis, the emphasis changes from a focus on the obligations to succor to the conditions that created the epidemic. Differentiating based on culpability would not leave states solely responsible for addressing health inequities that exist, in part because of the structuring of the international system like other frameworks.²⁴⁶ CBDR would necessitate determining the culpability of international actors in facilitating global health inequities. This is particularly important when one considers that a fundamental norm that is being violated with epidemic diseases is the failure to comply with an obligation to assist and cooperate internationally.²⁴⁷ Accordingly, a culpability analysis under CBDR should look to such factors

243. *Id.* at 10.

244. Margot E. Salomon, *How to Keep Promises: Making Sense of the Duty Among Multiple States to Fulfill Socio-Economic Rights in the World*, in *DISTRIBUTION OF RESPONSIBILITIES IN INTERNATIONAL LAW*, *supra* note 17, at 366, 381.

245. Rio Declaration, *supra* note 218, princ. 7.

246. *Cf.* discussion *supra* subsection III(B)(2)(a) (discussing the U.N. Charter’s obligation).

247. Salomon, *supra* note 244, at 373.

like the power an actor wields to influence international affairs and its ability or inability to shape the international trade, investment, finance, intellectual property, development, and global public health regimes, among others, that create conditions for epidemics to spread.

The culpability analysis should be wide-ranging. As such, it cannot be limited to situations where it is the actor's purpose or conscious objective to perform an action that causes harm. Additionally, it cannot simply contemplate situations where an actor has knowledge that its conduct will cause a result, but the actor is indifferent to that result. Nor can the analysis be restricted to reckless actors that are aware of the strong possibility that their behavior will produce harm but discount the risks and proceed. A thorough culpability analysis must also account for situations of negligence where the actor is unaware and inadvertently creates a substantial and unjustifiable risk of harm. Objectively, negligent actors are deemed responsible because they fail to perceive risks, and their failure is a gross deviation from the standard of care that a reasonable actor in the same situation would exercise. A culpability analysis that accounts for the above mental states will sufficiently capture direct and indirect action witnessed with structural harms like epidemics.

Notably, the broad culpability analysis proposed herein is not a method for imposing a form of strict liability that merely requires an action and a harmful result. Strict liability is an exceptional form of responsibility domestically and internationally, reserved for actors who act without a culpable mental state. Strict liability may seem attractive because it is a method of ensuring that an individual actor's behavior complies with the law and causes no harm to others. But it is unduly harsh and runs against the main purpose of the framework by allocating responsibility for every harm without distinction. Embedded within differentiating responsibility based on culpability is the implicit understanding that more culpable or blameworthy actors should be assigned more responsibility, and less blameworthy actors should be assigned less responsibility. Thus, strict liability is inapposite because it fails to distinguish between levels of culpability.

There may still be trepidation that increasing culpability in this manner may create perverse disincentives for actors to render voluntary assistance or consent to more robust responsibility norms. However, the conclusion that a more wide-ranging conception of culpability should not be imposed does not follow from this concern. That is, society may be better off when more care is taken in the provision of public benefits like aid.²⁴⁸ Accordingly, an expanded CBDR framework that causes negligent and other culpable actors to internalize the detrimental effects of external costs imposed would be better overall for society because it would incentivize more careful policies and actions.

248. Kornhauser, *supra* note 17, at 142.

The following subsections address two related issues: the need to account for the multiplicity of actors causing an epidemic and the need to account for historical culpability.

i. Culpability and Too Many Hands.—CBDR must consider the multiplicity of actors that may or may not act in concert to produce an epidemic. Instances of concerted and independent but cumulative action are termed “the problem of too many hands” to characterize the difficulty that arises when too many actors are involved in the process that caused the harm.²⁴⁹ The problem of “too many hands” may also lead to challenges in identifying what actor is responsible for what due to lack of information or knowledge about a given situation.²⁵⁰

A narrow reading of causation would stop at the following inquiry: if the actor refrained from action, would the result have occurred anyway? However, causation so narrowly understood cannot offer the primary basis for attributing responsibility under this framework, especially because epidemics involve structural causes. Due to overdetermination, different questions apply than the traditional but-for test. Instead, the inquiry should consider the following:

- (1) whether the actors’ actions were a substantial factor in producing the result, regardless of whether the outcome might have occurred anyway;
- (2) whether the actors’ actions hastened the result; or
- (3) whether the actors’ actions make survival less likely as a result.²⁵¹

These queries are important because without examining them one would tend to stop at the first-level question—whether the result would have occurred but for the actors’ actions.

The avoidable deaths and the infringement of the right to health that took place during the Cholera epidemic were the result of cumulative action from too many hands.²⁵² If the traditional but-for test is used, it appears the outcome would have occurred regardless of most actors’ actions. Such a causal analysis would consider the Nepalese government for the actions of its military personnel, the U.N. for insufficient monitoring of its bases and contractors, the Haitian contractor for disposing of waste improperly near the

249. See, e.g., Dennis F. Thompson, *Moral Responsibility of Public Officials: The Problem of Many Hands*, 74 AM. POL. SCI. REV. 905, 905 (1980) (noting the “problem of too many hands” where several public officials contribute to a decision and it becomes “difficult in principle to identify who is morally responsible for political outcomes”).

250. See Nollkaemper, *supra* note 66, at 296 (examining the problem of the information gap between parties when assigning responsibility).

251. JENS OHLIN, CRIMINAL LAW: DOCTRINE, APPLICATION, AND PRACTICE 192, 198 (2016).

252. For further discussion, see *supra* section II(B)(1) (discussing the causal actors responsible for the Cholera epidemic in Haiti).

base, and the Haitian government for failing to provide a safe system for providing drinking water. Under a superficial but-for analysis, perhaps only the Nepalese government is determined to be the but-for cause. The substantial actions of the U.N., Haitian government, and contractor seemingly made no difference to the resulting epidemic. That analysis would elide the realities of highly-infectious diseases. Instead, considering whether the above actors' actions were a substantial factor in producing or hastening the result, or made survival less likely, regardless of whether the outcome might have occurred anyway, are more appropriate inquiries. Because epidemic diseases are characterized by overdetermination, it is critical to delve deeper than when ordinarily conceptualizing causation. Failure to ask the right queries may lead to inaccuracies in identifying what actors are responsible.²⁵³ Similarly, simply focusing on the bad governance of countries or the recent history of conflicts in the West African subregion may obscure the role of international actors who championed neoliberal reform policies like structural adjustment, which contributed to the Ebola epidemic amongst others.²⁵⁴ This legacy, concomitant with narrow post-conflict reconstruction efforts, combined to marginalize the health sector and undermine state capacity to respond to epidemic diseases.²⁵⁵

When determining responsibility, causation cannot be established if the result is so remote that it makes holding the actor accountable illegitimate.²⁵⁶ The requirement of a direct causal link that is foreseeable or proximate to hold an actor responsible for an injury is a fundamental principle of international law.²⁵⁷ Direct factors that should be relevant under an expanded CBDR framework include the contribution that an actor has made to the emergence of an epidemic. A thorough culpability analysis also considers the direct actions or omissions—be they international or internal with extraterritorial effect—that had reasonably foreseeable consequences—that resulted in an epidemic. For instance, it was clearly foreseeable that Cholera would result from the Nepalese government's failure to properly screen its troops for Cholera before deployment, the U.N.'s inadequate supervision of contractors and insufficient monitoring at its base, the Haitian contractor's

253. Cf. Nollkaemper, *supra* note 66, at 289–97 (addressing the ways in which there can be a gap in responsibility because of the difficulties in apportioning responsibility among multiple actors).

254. For further discussion, see *infra* subsection III(B)(2)(b)(ii); see also Sirleaf, *supra* note 22, at 495–97 (analyzing how policies like structural adjustments “have slowed down improvements in, or worsened, the health status of people in countries implementing them”).

255. Muriu, *supra* note 125, at 401–02 (describing how private actors are taking over areas traditionally reserved to the state, resulting in the state's diminished ability to adequately provide for its citizens' health and economic well-being).

256. OHLIN, *supra* note 251, at 209.

257. See Draft Articles on Responsibility of States, *supra* note 60, at 91–93 (noting that the requirement of a causal link is not the same for every international obligation but that a sufficient causal nexus is a general requirement).

improper disposal of waste, and the Haitian government's failure to provide safe drinking water. Accordingly, it is fair to find the above actors as proximate causes for Cholera in Haiti and hold them responsible. The broader conceptualization of culpability articulated above allows for responsibility to be attributed to multiple actors.

ii. Lengthening the Historical Gaze of Culpability.—The CBRD framework must also necessarily lengthen the causal gaze temporally to fully account for historical harms, as opposed to pretending that the status quo distribution of highly-infectious diseases is simply due to erratic nature or bad luck. This approach would assign contemporary obligations not only because of today's harms but also based on historical responsibility for past exploitation, as well as the persistence of the deprivation of the right to health. “While undeniably the spread of [epidemics] is due to a combination of domestic factors,” both current and historical, “the tendency has been to focus almost exclusively on local actors and [more contemporary] factors as a way to distance, differentiate, and other the spread of disease.”²⁵⁸

This subsection demonstrates how international actors are historically responsible for the vulnerability of the West African subregion that enabled the spread of Ebola.²⁵⁹ Following the implementation of structural adjustment programs beginning in the 1980s, NGOs overtook most of the basic welfare functions of public health provision.²⁶⁰ The beleaguered health systems enabled by structural adjustment were further degenerated following conflicts in the subregion. U.N. agencies, donor countries, and several international NGOs spearheaded the post-conflict recovery process in the subregion in the 2000s. They neglected restructuring the economic and social sectors in the subregion, which rendered already fragile countries ill-equipped to deal with Ebola and indirectly facilitated its spread. The United Nations missions in Liberia and in Sierra Leone led the loose coalition of organizations, which became responsible for managing the state and the health care sector.²⁶¹

258. Sirleaf, *supra* note 22, at 512 (citing Obijiofor Aginam, *International Law, HIV/AIDS, and Human Rights in Africa: A Post-Colonial Discourse*, 100 PROC. AM. SOC'Y INT'L L. 350, 351 (2006) (discussing the rhetoric on HIV/AIDS as a unique problem to “[s]avage” African cultures that encourage promiscuity, male domination, polygamous relationships, infidelity, and wife inheritance”).

259. For further discussion, see Sirleaf, *supra* note 22, at 500–03 (tying West Africa's fractured healthcare system to failed international post-conflict reconstruction attempts).

260. See Tsung-Ling Lee, *Making International Health Regulations Work: Lessons from the 2014 Ebola Outbreak*, 49 VAND. J. TRANSNAT'L L. 931, 972 (2016) (“[T]he World Bank's involvement in health and economic projects in Africa contributed to the diminishing role of the state as the primary provider of healthcare and other basic social welfare.”).

261. See Sharon Abramowitz, *How the Liberian Health Sector Became a Vector for Ebola*, CULTURAL ANTHROPOLOGY (Oct. 7, 2014), <https://culanth.org/fieldsights/598-how-the-liberian->

In many ways, this network voluntarily assumed care and functioned as the de facto government during post-conflict reconstruction. The fragility of this system of health care provision was apparent in 2007 when Doctors Without Borders left Liberia following the conflict. The lack of the vital services they provided resulted in the immediate closure of regional and urban hospitals.²⁶² This, concomitant with the closure of thirty NGO-run clinics in the country, undermined the already teetering system.²⁶³ Following the conflicts, aid organizations delivered more and more services to the poor because some of the governments in the subregion were shrinking their spending on public health.²⁶⁴ This meant that prior to the epidemic, public health facilities were regarded as places to be avoided and even resisted in the subregion.²⁶⁵

This fractured system of health care delivery created conditions that facilitated Ebola's spread by accelerating the harm caused by the virus and/or reducing the likelihood of survival due to the lack of resilient health systems. The counterargument is that one can never know what would have happened if international actors had not intervened in the subregion. On this view, it is possible the epidemic might have been much worse but for structural adjustment or post-conflict reconstruction efforts. It is futile to attempt to disprove a counterfactual given the impossibility of knowing what would occur in this alternative universe and the inability of conducting a social experiment. More importantly, it seems clear that these interventions were at least substantial factors in producing the increased susceptibility to Ebola in the subregion and contributing to serious adverse consequences.

A crucial theoretical insight gleaned from the analysis above is that epidemics require more than simply a tort- or criminal-law evaluation of causation. Accordingly, the theoretical framework developed herein considers a global historical perspective, as well as moral and political evaluations of responsibility.²⁶⁶ A nonexhaustive list of factors that should be

health-sector-became-a-vector-for-ebola [https://perma.cc/GHW3-L8TZ] (chronicling international involvements in the post-conflict Liberian healthcare system).

262. *Id.*

263. *Id.*

264. See United Nations Dev. Program, *Human Development Data 1990–2015*, <http://hdr.undp.org/en/data> [https://perma.cc/95GX-4FX3] (noting that Liberia decreased its percentage of GDP dedicated to public health expenditures from 3.9% in 2011 to 3.2% in 2014 (the year the Ebola epidemic occurred), Sierra Leone decreased from 2.6% in 2011 to 1.9% in 2014, and Guinea increased from 2.0% in 2011 to 2.7% in 2014).

265. See Wilkinson & Leach, *supra* note 110, at 142 (discussing the causes and consequences of government underfunding of the health-care system).

266. See, e.g., Christopher L. Kutz, *Shared Responsibility for Climate Change: From Guilt to Taxes* (taking up the debate between historical- and future-based allocation of responsibility in both an ethical and empirical dimension), in *DISTRIBUTION OF RESPONSIBILITIES IN INTERNATIONAL LAW*, *supra* note 17, at 341, 342.

considered in determining historical responsibility includes whether the harmful effects of past actions are traceable to current epidemics and/or whether the external actor gained unjust enrichment or benefit as the result of its past misdeeds.

Unsurprisingly, actors in the Global South will be the most vocal proponents of historical responsibility as a ground of differentiating culpability,²⁶⁷ while actors in the Global North will tend to be the most hostile or ambivalent to it. There are numerous studies that have demonstrated the long-term detrimental consequences of the legacies of slavery and colonialism on the current economic performance and position of countries in the Global South.²⁶⁸ For actors in the Global South, the way things are—the status quo—remains the key issue.²⁶⁹ While in practice former colonial powers tend to direct international assistance towards former colonial territories,²⁷⁰ it is not evident that this is out of a sense of historical responsibility for the position of former colonies. A common argument against claims of corrective justice is that the actors of today should not be held responsible for the sins of their predecessors. However, history must be owned. As far as historical responsibility can be traced to a common lineage, the bearers of that lineage must face the “future in the shadow of the collective past.”²⁷¹

To the extent that more backward-looking arguments for differentiating based on historical culpability are likely to meet resistance, a more forward-looking approach might be more appealing. The alternative normative basis for differentiation based on historical responsibility would be to deter actors from engaging in harmful action in the future. Normative support can be located in the principle that actors should not benefit from their wrongdoing and should compensate those that have been harmed as a result of their actions.²⁷² It may be easy for actors in the Global North to assert that bygones

267. See, e.g., G.A. Res. 41/128, Declaration on the Right to Development (Dec. 4, 1986) (concluding that the elimination of human rights violations against those peoples affected by colonialism and other forms of discrimination “would contribute to the establishment of circumstances propitious to the development of a great part of mankind”).

268. See generally, e.g., Graziella Bertocchi, *The Legacies of Slavery In and Out of Africa*, 5 IZA J. MIGRATION, no. 24, 2016, at 1 (illustrating the long-term consequences of the slave trade on contemporaneous socioeconomic outcomes); Babacar M’baye, *The Economic, Political, and Social Impact of the Atlantic Slave Trade on Africa*, 11 EURO. LEGACY 607 (2006) (explaining how the slave trade began “the systemic and continuous process of economic exploitation and social and political fragmentation that Europeans later institutionalized through colonization”); Nathan Nunn, *The Long Term Effects of Africa’s Slave Trades*, 123 Q.J. ECON. 139 (2008) (examining the relationship between Africa’s slave trade and its current underdevelopment).

269. Stone, *supra* note 166, at 293.

270. Salomon, *supra* note 244, at 375.

271. Kutz, *supra* note 266, at 355.

272. See Salomon, *supra* note 244, at 375 (arguing that those states responsible for causing harms are duty-bound to remedy them); Dinah Shelton, *Describing the Elephant: International*

should be bygones when they continue to benefit from those bygones, while the detrimental consequences are experienced primarily elsewhere in the Global South. For example, countries in the industrialized North have contributed to huge disparities in historic emissions, which has led to substantial environmental degradation that is forecasted to increase if the current rate of emissions continues. The damage from a warming climate includes the increase in epidemics, as well as the exacerbation of already established infectious diseases. It is unjust for actors to benefit from the production and consumption of greenhouse gases and then diffuse the external harms. While the increased incidence of epidemics affects both industrialized and developing states, the detrimental consequences of these diseases will be more severe in the Global South. If the objective is to contribute to global justice,²⁷³ then we must create proper incentives and disincentives for actors such that they do not benefit from unjust enrichment.²⁷⁴ In some sense, historical responsibility as a basis for differentiation requires that actors internalize the detrimental effects that they impose on others.²⁷⁵ A deterrence rationale posits that it is only when actors take responsibility for their actions that future harm is likely to be avoided. Indeed, detrimental action without consequences does not usually get the incentives right.²⁷⁶

In sum, the framework developed herein accounts for direct, indirect, and multiple causal factors, as well as historical responsibility as bases for culpability. Differentiation based on culpability shifts the framework from what the vulnerable need to an analysis of the actors that caused the contagion. This section demonstrates why differentiating responsibility based on culpability is justified. However, under international human rights law, states are under a positive obligation to act towards the fulfillment of socioeconomic rights irrespective of issues of causation.²⁷⁷ States also have

Justice and Environmental Law (“If such relations [between rich and poor countries] are unjust, moral reciprocity may require extensive redistribution of wealth.”), in *ENVIRONMENTAL LAW AND JUSTICE IN CONTEXT* 55, 61 (Jonas Ebbesson & Phoebe Okowa eds., 2009).

273. There are several common objections to global justice claims. One view contends that global justice is meaningless because there is not a global social contract to make the concept enforceable. Another objection questions the existence of a normative consensus to support truly global perspectives on justice.

274. See, e.g., Kornhauser, *supra* note 17, at 121–22 (providing examples of how society can create incentives and disincentives for actors).

275. For further discussion, see generally, for example, R.H. Coase, *The Problem of Social Cost*, 3 *J.L. ECON.* 1 (1960) (discussing how externalities can be internalized in the absence of transaction costs).

276. See, e.g., van Aaken, *supra* note 103, at 186 (discussing the trade-off between the different goals of state responsibility).

277. See ICESCR, *supra* note 39, art. 2(1) (mandating that each party to the Covenant take steps, “to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant”).

a duty to address epidemics in global public health law, irrespective of a causal link. As such, a CBDR framework is warranted not only based on culpability but also based on capacity.

c. Differentiation Based on Capacity.—The final rationale for differentiation in the Rio Declaration disaggregates states with distinct capacities.²⁷⁸ Expanding CBDR in this vein would necessitate diverse levels of responsibility based on capacity to combat highly-infectious diseases. Capacity as used in this framework refers to the ability of an actor to detect, prevent, and control communicable diseases, as well as assist others in accomplishing these objectives. Differentiating based on capacity is reflected in human rights and global public health law. The normative justification for differentiation of responsibilities based on capacity is intuitive—if we want a reduction in epidemics, then we should allocate responsibility to those that are best placed to do so.²⁷⁹ Thus, under a CBDR approach, stakeholders in the Global North would be expected to take on special leadership roles based on their industrial development, experience with public health protection policies, greater wealth, technical expertise, and capacity to influence global decision-making.

An expanded CBDR framework should encapsulate prospective obligations to cooperate in the provision of international aid.²⁸⁰ The International Covenant on Economic, Social and Cultural Rights stipulates that it is the obligation of all state parties, especially those with economic and technical capacity, to take steps towards the full realization of rights in the Covenant individually and through international assistance and cooperation.²⁸¹ The Committee responsible for interpreting this Covenant has emphasized that “States parties should recognize the essential role of international cooperation and comply with their commitment to take joint and separate action to achieve the full realization of the right to health.”²⁸² It asserts that states have an obligation subject to the availability of resources to “facilitate access to essential health facilities, goods and services in other countries, wherever possible, and [to] provide the necessary aid when required.”²⁸³ Additionally, this Committee has found that states have a “joint

278. Rio Declaration, *supra* note 218, princ. 7.

279. See, e.g., David Miller, *Distributing Responsibilities*, 9 J. POL. PHIL. 453, 460–61 (2001) (“If we want bad situations put right, we should give the responsibility to those who are best placed to do the remedying.”).

280. Cf. discussion *supra* subsection III(B)(2)(a) (discussing the U.N. Charter’s obligation).

281. See ICESCR, *supra* note 39, arts. 2(1), 22–23 (establishing the obligation of the parties to take steps toward achieving full recognition of the rights laid out in the Covenant and discussing how these steps can be taken).

282. General Comment No. 14, *supra* note 37, ¶ 38.

283. *Id.* ¶ 39.

and individual responsibility,” under international law, “to cooperate in providing disaster relief and humanitarian assistance in times of emergency.”²⁸⁴ It has also found that states should contribute to this task to the maximum of their capacity, and should prioritize the provision of international medical aid, distribution and management of resources, and financial aid to the “most vulnerable or marginalized groups of the population.”²⁸⁵ Thus, the enforcement body responsible for ensuring compliance with the Covenant on Economic Social and Cultural Rights explicitly recognizes parts of the CBDR framework, namely differentiation based on need and capacity. The following subsections address three related issues—the affected state’s capacity, external states’ capacity, and global capacity.

i. The Affected State’s Capacity.—Ideally, the affected state would have the most capacity to respond to epidemics. Global public health law provides states with a couple of years to make this ideal a reality. For example, the International Health Regulations require that each state party develop, strengthen, and maintain the capacity to detect, assess, notify, and report certain diseases within five years of its entry into force.²⁸⁶ States not able to meet their capacity obligations must show good cause and, in exceptional circumstances, are to receive an extension of up to four years.²⁸⁷ States are to develop capacities seemingly by fiat—“utiliz[ing] existing national structures and resources to meet their core capacity requirements.”²⁸⁸ States also have specific public health response capacities to develop under the International Health Regulations (IHR). This includes rapidly determining the control measures to prevent the domestic and international spread of disease; providing support and logistical assistance; providing an efficient means of communication with relevant stakeholders; and establishing, operating, and maintaining a public health emergency response plan.²⁸⁹ In 2005, the WHO found that health capacities were nowhere near “a path to timely implementation worldwide.”²⁹⁰ By 2013, prior to the Ebola outbreak, no African state had fully implemented the IHR’s core capacity

284. *Id.* ¶ 40.

285. *Id.*

286. INTERNATIONAL HEALTH REGULATIONS, *supra* note 31, art. 5(1).

287. *Id.* art. 5(2).

288. *Id.* Annex I(A) ¶ 1.

289. *Id.* Annex I(A) ¶ 6.

290. HARVEY FINEBERG, WORLD HEALTH ORG., REPORT OF THE REVIEW COMMITTEE ON THE FUNCTIONING OF THE INTERNATIONAL HEALTH REGULATIONS (2005) AND ON PANDEMIC INFLUENZA A (H1N1) 2009 (2011), http://www.who.int/ihr/WHA64_10_HVF_2011.pdf [<https://perma.cc/6XC3-L26A>].

requirements.²⁹¹ These gaps in core capacities were especially pronounced in the Ebola-affected countries.²⁹²

Even in circumstances where states lack capacity, like with Ebola²⁹³ or Cholera,²⁹⁴ states still have obligations under human rights law. These obligations include monitoring the nonrealization of the right to health and devising strategies to promote the right,²⁹⁵ as well as protecting persons within their jurisdictions from infringement of the right to health by third parties.²⁹⁶ The determination of whether a state has taken all adequate and reasonable steps towards the progressive realization of the right to health includes the affected state seeking international cooperation to ensure the protection needed from highly-infectious diseases.²⁹⁷ All of the affected governments sought international assistance for combating Cholera²⁹⁸ and Ebola.²⁹⁹ Accordingly, the Haitian, Liberian, Sierra Leonean, and Guinean states met their human rights obligations relating to epidemics. The determination regarding the affected state's inability or unwillingness to take steps to prevent, treat, and control epidemics should not be overstated—its legal relevance goes to the affected state's failure to meet its primary human rights obligations.³⁰⁰ It is not dispositive as to the assignment of secondary duties to external states, which is to be determined by the failure of the

291. See Hoffman, *supra* note 21, at 239 (stating that many countries did not meet 2012 requirements and requested extensions).

292. See discussion *supra* subsection III(B)(2)(a) (discussing the limited capacity and susceptibility to outbreak of Ebola-affected countries prior to the Ebola epidemic). For further discussion, see Sirleaf, *supra* note 22, at 491–97 (analyzing how underdevelopment shaped the trajectory of sub-Saharan Africa with respect to disease-outbreak vulnerability).

293. Margaret Chan, Director-General of the WHO, asserted that Ebola-affected countries simply do not have the capacity to manage an outbreak of this size and complexity on their own and urged the international community to provide support. See Sarah Boseley, *Ebola: Government Cuts to the WHO Aided Delays in Dealing with Outbreak*, GUARDIAN (Oct. 9, 2014), <https://www.theguardian.com/world/2014/oct/09/ebola-who-government-cuts-delays-in-dealing-with-outbreak> [<https://perma.cc/TE2L-Z5UF>].

294. See discussion *supra* subsection III(B)(2)(a).

295. Comm. on Econ., Soc. and Cultural Rights, General Comment No. 3: The Nature of States Parties' Obligations (Art. 2, Para. 1, of the International Covenant on Economic, Social and Cultural Rights) ¶ 11, U.N. Doc. E/1991/23 (Dec. 14, 1990).

296. General Comment No. 14, *supra* note 37, ¶ 51.

297. Comm. on Econ., Soc. and Cultural Rights, An Evaluation of the Obligation to Take Steps to the “Maximum of Available Resources” Under an Optional Protocol to the Covenant, ¶¶ 8, 10, U.N. Doc. E/C.12/2007/1 (Sept. 21, 2007) (providing for the assessment of whether the measures taken by a state were adequate or reasonable).

298. See, e.g., *Cholera*, U.S. AGENCY FOR INT'L DEV., <https://www.usaid.gov/haiti/cholera> [<https://perma.cc/R28A-DPVQ>] (noting that the Haitian government requested the U.S.'s assistance during the Cholera outbreak after confirming cases of the disease in 2010).

299. For further discussion on how affected governments responded to the Ebola epidemic, see Sirleaf, *supra* note 22, at 503–12.

300. Salomon, *supra* note 244, at 370.

rightsholders to exercise their rights.³⁰¹ In other words, “the principles governing the determination of responsibility are irrelevant for the determination of attribution of obligations.”³⁰²

ii. External Actors’ Capacity.—The responsibility of international actors to protect people from gross violations of human rights presented by pandemics is triggered by the manifest failure of national authorities to afford that protection, and not whether that failure is due to a government’s incapacity or unwillingness. International action to prevent, treat, and control epidemic diseases by actors other than the affected state, where required, is based on a subsidiary duty in circumstances where the primary duty bearer lacks capacity or is unwilling to fulfill its obligations.³⁰³ This secondary duty is best understood as complementary to those of the rightsholder’s own state because any other reading would render meaningless the duty to cooperate in order to realize socioeconomic rights.³⁰⁴

Thus, the proper inquiry once we have attributed the obligation to cooperate to an external actor is whether it had the capacity to abide by this obligation.³⁰⁵ If the external actor had the capacity to do so and failed to cooperate, then it can be held responsible. For example, the United States became the single largest government donor responding to Ebola by appropriating USD 5.4 billion in emergency funding, “the greatest amount of emergency funding ever provided by Congress for an international health emergency.”³⁰⁶ Almost all of this funding (USD 3.7 billion) was directed toward international activities for both the initial response and ongoing recovery and rebuilding efforts.³⁰⁷ When the Zika epidemic occurred, a significant amount of U.S. Ebola assistance was clawed back and repurposed for Zika.³⁰⁸ Despite the reduction of Ebola aid, this example is illustrative of an external state with capacity acting to cooperate towards combating a

301. See Leif Wenar, *Responsibility and Severe Poverty* (arguing that even if a primary responsibility-holder is blameworthy, secondary responsibility can still be located in the person that can most easily bear that responsibility), in *FREEDOM FROM POVERTY AS A HUMAN RIGHT: WHO OWES WHAT TO THE VERY POOR?* 255, 265 (Thomas Pogge ed., 2007).

302. VANDENBOGAERDE, *supra* note 42, at 218.

303. Salomon, *supra* note 244, at 370.

304. *Id.* at 371.

305. VANDENBOGAERDE, *supra* note 42, at 218.

306. JEN KATES ET AL., HENRY J. KAISER FAMILY FOUND., *THE U.S. RESPONSE TO EBOLA: STATUS OF THE FY2015 EMERGENCY EBOLA APPROPRIATION 8* (2015), <http://files.kff.org/attachment/Issue-Brief-The-US-Response-to-Ebola-Status-of-the-FY2015-Emergency-Ebola-Appropriation> [<https://perma.cc/5DYL-VLA2>].

307. *Id.* at 3.

308. *E.g.*, Editorial Board, Opinion, *Stealing from Ebola to Fight Zika*, N.Y. TIMES (May 19, 2016), <https://www.nytimes.com/2016/05/20/opinion/stealing-from-ebola-to-fight-zika.html?emc=eta1> [<https://perma.cc/3WF8-NJPK>].

highly-infectious disease. It is emblematic of the special responsibility that economically developed states in the Global North have to assist poorer states in the Global South with epidemics.³⁰⁹ Indeed, the International Covenant on Economic Social and Cultural Rights provides that special duties rest with actors that have more influence to conclude treaties and to make recommendations that can help to galvanize international action towards the achievement of socioeconomic rights.³¹⁰

A preliminary objection to this special responsibility is the problem of “insatiable entitlements.” Differentiating based on capacity may require social spending “long past the point where additional spending will do much good” and under circumstances where a claim can never be satisfied.³¹¹ This would present challenges where a state has not broadly secured the right to health at home but is expected to take steps to fulfill the right to health abroad. Nonetheless, highly-infectious diseases like Cholera and Ebola are not characterized by problems of too much spending. Limited resources for health, given other commitments, are already built into the current framework for socioeconomic rights. One way of addressing the “insatiable entitlements” problem is to require that any country that has realized the minimum essential levels of health domestically is then duty-bound to contribute to the realization of the same standard elsewhere before attempting to achieve the next highest attainable standard of health at home.³¹² Another solution would place the duty earlier, requiring any state that has not met the minimum levels of health domestically to comply with its obligations to others elsewhere so long as there are, objectively, resources to do so, and no retrogression as to the rights of people within its territory occurs as a result of foreign assistance.³¹³

iii. Global Capacity.—The treaty-body responsible for interpreting the Covenant on Economic, Social and Cultural Rights has stressed that because some diseases are “easily transmissible beyond the frontiers of a [s]tate, the international community has a collective responsibility to address this problem.”³¹⁴ Responsibility for remedying highly-infectious diseases through the CBDR framework should take the form of capacity building (research and information sharing), technical assistance (training and the

309. See, e.g., General Comment No. 14, *supra* note 37, ¶ 40.

310. ICESCR, *supra* note 39, art. 23.

311. Mark S. Stein, *Nussbaum: A Utilitarian Critique*, 50 B.C. L. REV. 489, 500 (2009).

312. See Ooms & Hammonds, *supra* note 222, at 36 (recognizing that if rich countries were to assist foreign countries only after optimal assistance had been achieved domestically, obligations to poorer countries may never become fulfilled).

313. See Salomon, *supra* note 244, at 380 (suggesting a test whereby a state would be required to comply with obligations if sufficient resources were available, even though that state had not met minimum socioeconomic standards within its own state).

314. General Comment No. 14, *supra* note 37, ¶ 40.

provision of expertise), and financial and material assistance through special funds with contributions from members to help defray costs. Private foundations and public-private partnerships will also be instrumental in capacity-building efforts. These initiatives are especially needed where states lack the infrastructure necessary to address epidemics domestically.

The West African Ebola epidemic provides several illustrations of international actors demonstrating capacity to fulfill their collective responsibility. For example, the U.N.'s General Assembly called on "Member States, relevant United Nations bodies and the United Nations system to provide their full support to the United Nations Mission for Ebola Emergency Response,"³¹⁵ which was an attempt to coordinate the response to the epidemic through a unified international structure.³¹⁶ This was the institution's first system-wide, emergency health mission. Its primary objective was to contain and prevent the spread of Ebola through case management and safe burial services, to treat infected individuals, and to provide services to affected communities.³¹⁷ The U.N. praised it as an innovative approach, which will likely increase "as the nature of global responses are reshaped to meet the complex challenges of this century."³¹⁸

During the peak of the Ebola epidemic, the Global Health Security Agenda was also created to facilitate collaborative capacity-building efforts.³¹⁹ These efforts were aimed at achieving specific targets tied to the core capacities under the International Health Regulations.³²⁰ While the Regulations require the 196 state parties to cooperate to help build health capacities,³²¹ they do not articulate how this is to work in practice. The GHSA fills in this lacuna by creating a system for countries to address their commitments. There are eleven action packages that are designed to help build state capacity to prevent, detect, and respond to threats posed by

315. G.A. Res. 69/1, ¶ 3 (Sept. 19, 2014).

316. U.N. Secretary-General, *Statement by the U.N. Secretary-General on the Establishment of the United Nations Mission for Ebola Emergency Response* (UNMEER) (Sept. 19, 2014), <https://www.un.org/sg/en/content/sg/statement/2014-09-19/statement-secretary-general-establishment-united-nations-mission> [<https://perma.cc/M75K-D9W3>].

317. *U.N. Mission for Ebola Response* (UNMEER), GLOBAL EBOLA RESPONSE, <http://ebolaresponse.un.org/un-mission-ebola-emergency-response-unmeer> [<https://perma.cc/8RS3-Q4L9>].

318. *UN Mission for Ebola Response Highlights New Type of UN Operation—Chef de Cabinet Tells UNMEER Staff*, UNITED NATIONS (Oct. 20, 2014), <https://www.un.int/news/un-mission-ebola-response-highlights-new-type-un-operation-chef-de-cabinet-tells-unmeer-staff> [<https://perma.cc/3DL6-DUT5>].

319. See discussion *supra* subsection III(B)(2)(a).

320. See INTERNATIONAL HEALTH REGULATIONS, *supra* note 31, Annex I(A).

321. *Id.* Annex I(A)(3) ("State parties and WHO shall support assessments, planning and implementation processes . . .").

highly-infectious diseases.³²² Under the GHSA, member countries can utilize a tool that helps to assess baseline national health security capacity. An action plan can then be tailored with a five-year target for states to meet, along with a set of indicators to measure progress and activities to support successful implementation.

The GHSA reflects the CBDR framework by differentiating based on need,³²³ as well as capacity. Under it, member countries can reach their commitments by building capacity in their own nation, regionally, or globally. For example, the United States made a commitment to assist thirty-one countries and the Caribbean Community.³²⁴ The United States has invested \$1 billion in resources across seventeen of these countries, which need the most assistance with capacity building to detect and respond to future infectious disease outbreaks.³²⁵ The United States' rationale for participating is simple: "[T]he most effective and least expensive way to protect Americans from diseases and other health threats that begin abroad is to stop them before they spread to our borders."³²⁶ There is evidence suggesting that investments in promoting protective and primary care services in the Global South lead to large improvements in public health, generating benefits for other states like containment of epidemic diseases.³²⁷ Additional donors, including the G-7 and G-20 leaders, as well as other donor countries and organizations, have provided a collective commitment to assist seventy-six countries to reach the capacities outlined in the International Health Regulations.³²⁸ The GHSA is based on the view that "[g]lobal health security is a shared responsibility that cannot be achieved by a single actor or sector of government."³²⁹ However, neither the GHSA nor the Regulations determine how responsibility for capacity building should be allocated.³³⁰ The CBDR framework can step in to fill in these gaps.

322. The prevention action packages cover antimicrobial resistance, zoonotic diseases like Ebola, biosafety and biosecurity, and immunization. *Action Packages*, GLOB. HEALTH SEC. AGENDA, <https://www.ghsagenda.org/packages> [<https://perma.cc/X5KV-YJSN>]. The detection action packages address national laboratory systems, real-time surveillance, reporting, and workforce development. *Id.* The response packages focus on emergency operations centers, linking public health with law and multisector rapid response, and medical countermeasures and personnel deployment. *Id.*

323. *See* discussion *supra* subsection III(B)(2)(a).

324. ADVANCING THE GLOBAL HEALTH SECURITY AGENDA, *supra* note 241.

325. *Id.*

326. *Id.* at 10.

327. Agnew, *supra* note 163, at 119.

328. *See* INTERNATIONAL HEALTH REGULATIONS, *supra* note 31, Annex I(A), app. I.

329. GHSA *About*, *supra* note 29.

330. *See* Laurence O. Gostin & Eric A. Friedman, *Ebola: A Crisis in Global Health Leadership*, 384 LANCET GLOBAL HEALTH 1323, 1323 (criticizing the WHO for its failure to allocate responsibility for capacity building prior to the Ebola outbreak).

Significant theoretical insights for the framework can be drawn from the analysis above. A nonexhaustive list of the factors that should be considered in distinguishing the capacity of actors includes economic, technical, and technological capacities and available resources, but also influence and ability to impact international decision-making.³³¹ An additional factor that should be considered when differentiating capacity is the geographic distance of the external actor from the affected state.³³² Thus, relative capacity, as opposed to absolute capacity, to act will be crucial in determining responsibility.

This subsection makes the normative case for differentiating responsibility based on capacity. Differentiating based on capacity makes intuitive sense and is derived from human rights and global public health law. As with the other bases for differentiation examined above, this subsection maintains that capacity should not be considered in a vacuum when determining responsibility.

IV. Theoretical and Policy Implications of Expanding CBDR to Combat Epidemics

This Part resolves the inter- and intra-axis conflicts within the framework and explores the limits of diffusion, as well as the issues raised with operationalizing CBDR in hard and soft law.

A. *Differentiating Within CBDR*

1. Resolving Inter-Axis Conflicts.—It is not clear which axis of differentiation, if any, should be determinative when allocating responsibility. Does one have precedence over the others? For example, if capacity alone was determinative, then actors that are especially capable would carry more burden even if their involvement to address a given epidemic would lack legitimacy. Action to remedy the harm caused by the Cholera epidemic in Haiti would be viewed as more sociologically legitimate were it to be the U.N. paying financial compensation to victims as opposed to say the EU, which has a more tenuous causal link to the Cholera epidemic. Should culpability have superiority? It may be nonsensical to privilege one axis for all time and in all places. Yet, leaving the framework entirely

331. ETO CONSORTIUM, MAASTRICHT PRINCIPLES ON EXTRATERRITORIAL OBLIGATIONS OF STATES IN THE AREA OF ECONOMIC, SOCIAL AND CULTURAL RIGHTS princ. 31 (2013), https://www.etoconsortium.org/nc/en/mainnavigation/library/maastrichtprinciples/?tx_drblob_pi1%5BdownloadUId%5D=23 [<https://perma.cc/3A3H-4NQU>] (suggesting that states have the obligation to fulfill extraterritorial rights commensurate to each state's capacity in several given factors).

332. *Cf.* Application of Convention on Prevention and Punishment of Crime of Genocide (Bosn. & Herz. v. Serb. & Montenegro), Judgment, 2007 I.C.J. Rep. 43, ¶ 430 (Feb. 26) (“This capacity itself depends, among other things, on the geographical distance of the State concerned from the scene of the events . . .”).

indeterminate may lead to similar problems with allocating responsibility witnessed with the conventional law of state responsibility and R2P.

Accordingly, it is essential that further elaboration take place on whether the framework envisions a hierarchy. To this end, differentiating based on capacity must take precedence over other methods of differentiation. Differentiating based on capacity reflects obligations under human rights and global public health law. The positive duties that states have under both bodies of law to combat highly-infectious diseases are not based on a causal link or culpability. Differentiating based on culpability is secondary. The law of responsibility depends on a formal determination of culpability.³³³ However, the CBDR framework does not, due to the numerous limitations for seeking redress internationally for violations experienced during epidemics through formal channels. For example, finding a venue with jurisdiction over actors implicated in pandemics that can exercise authority over relevant actors will be challenging in the best of circumstances. This is not to mention the difficulty that victims will have in recovering from respondents when seeking accountability for instances of shared responsibility. For instance, the contractor that improperly disposed of waste in Haiti likely did not have deep pockets, rendering it functionally judgment-proof for its share of responsibility. The Cholera epidemic in Haiti indicates that not all culpable actors will be capable. Additionally, this framework is not simply concerned with the allocation of responsibility as a theoretical matter. The objective is to further legal and institutional reform, rather than responsibility being purely punitive or even restorative. As such, culpability may be sufficient but not necessary for invoking CBDR.

The culpability framework envisioned herein is extensive, going beyond what is legally required. It is not evident that this expansion of culpability to account for direct, indirect, and multiple causal factors, as well as historical culpability, will gain traction with stakeholders given propensities for blame avoidance and blame shifting. Yet, the aim is to involve not only those held legally responsible but also a wider community of culpable actors. The framework is deeply concerned with the practicalities of combating highly-infectious diseases. Culpability as a secondary basis of differentiation reflects that normative judgment.

The status of each axis of differentiation in law helps to impose hierarchy on the CBDR framework. As such, differentiation based on need is ranked last due to the hyper-contested nature of these duties. The normative justification for differentiation based on need is morally clear and sound. However, the legal duty to render aid or rescue has not been widely accepted. Differentiating based on need is also logistically difficult since the need may be acute in many places. Indeed, what of situations where there is capacity to

333. See VANDENBOGAERDE, *supra* note 42, at 39 (discussing the limitations of state responsibility and the responsibility of international organizations).

act to combat a highly-infectious disease, but the need is not yet acute? Differentiating based on need should not be used as a straitjacket to limit preventative actions that could forestall greater calamity. Such a restrictive view may undermine capacity-building efforts aimed at the development of a comprehensive public health system with the surveillance needed for epidemic prevention. For example, the Global Health Security Agenda provides a useful model that incorporates both need and capacity as means of differentiation, while singling out Ebola and other highly pathogenic infectious diseases as its focus.³³⁴ As such, considering both the need to act, as well as another axis of differentiation will be instructive moving forward.

The above analysis presents significant insights for the theoretical framework. Mainly, all the bases of differentiation should be considered cumulatively together. To this end, actors with capacity will be allocated the most responsibility towards combating highly-infectious diseases, then actors with culpability. Actors with capacity and culpability are to direct their efforts at combating highly-infectious diseases where there are the greatest health needs. The more capacity and culpability actors have, the more responsibility for combating epidemics and vice versa. Additionally, need is the only form of differentiation that should be paired with another aspect of the framework in practice. This is because the details of which actor(s) has the most responsibility for a given epidemic and how inter-axis conflicts should be resolved will necessarily be context-dependent.

2. *Resolving Intra-Axis Conflicts.*—Another area for elaboration is how to resolve intra-axis conflicts within the framework. For example, it may be more socially desirable and legitimate for actors that have high capabilities (but are not the most capable globally) to act to remedy the harm caused by an epidemic disease. Otherwise, requiring action from only the *most* capable actors could reify geopolitical hierarchies in ways that allow for powerful actors to exercise oversight over programs aimed at highly-infectious diseases because they have more capacity than less powerful actors. This could serve to immunize more well-resourced actors from necessary health interventions, which would sustain a problematic role between countries in the Global South and Global North. To protect actors from unwarranted sovereignty incursions, the framework should require state consent for the provision of external assistance, with a stipulation that states cannot withhold consent without good cause.³³⁵ There is a rich foreign-aid literature that

334. GHSAG *About*, *supra* note 29.

335. See, e.g., Int'l Law Comm'n, Rep. on the Work of Its Sixty-Eighth Session, Draft Articles on the Protection of Persons in the Event of Disasters, U.N. Doc. A/71/10, at 59 (2016) [hereinafter Draft Articles on the Protection of Persons in the Event of Disasters] (suggesting a mandate that the provision of external assistance require consent).

discusses the mismatch between donor and recipient countries' priorities, with aid supplanting local needs.³³⁶ Donor governments and NGOs often direct aid to specific health projects and diseases through vertical projects like the Global Fund to Fight AIDS, Tuberculosis, and Malaria.³³⁷ The role of the affected state in being able to articulate its needs and priorities is crucial.³³⁸

Consequently, the framework must be flexible and sensitive to local conditions and should not be applied in a rigid fashion. The framework must be cognizant of local priorities for combatting epidemics to formulate contextually appropriate responses. Much more experimentation needs to be done to determine how the framework would work in practice.

B. *Diffusing CBDR to Combat Epidemics*

The Limits of Diffusion.—The policy diffusion literature is vast.³³⁹ Policy diffusion describes the phenomenon where policy choices made in one place are influenced by the policy choices made elsewhere,³⁴⁰ which aptly

336. See Shoba Shukla, *The Mismatch Between Donor Priorities and Global Health Needs*, CITIZEN NEWS SERV. (Feb. 2013), <http://www.citizen-news.org/2013/02/the-mismatch-between-donor-priorities.html> [<https://perma.cc/WD3B-CVV5>] (providing statistics on which countries need the most aid and comparing them to statistics on which countries receive the most aid). For further discussion on foreign aid, see generally, for example, PETER BURNELL, *FOREIGN AID IN A CHANGING WORLD* (1997) (arguing that the political value of aid to donors can “easily be overestimated” in part, for example, because donors pursue multiple competing objectives); BEN RAMALINGAM, *AID ON THE EDGE OF CHAOS: RETHINKING INTERNATIONAL COOPERATION IN A COMPLEX WORLD* (2013) (inquiring into the “black box” of foreign aid and arguing that aid agencies are increasingly operating within constraints through which they were not designed to navigate).

337. See Wilkinson & Leach, *supra* note 110, at 140 (“Vertical programmes, such as the Global Fund to Fight AIDS, Tuberculosis, and Malaria, have undermined commitments to horizontal health system strengthening.”).

338. See, e.g., Draft Articles on the Protection of Persons in the Event of Disasters, *supra* note 335, at 15 (affected states have the “primary role in the direction, control, coordination, and supervision of . . . relief assistance”).

339. See, e.g., Erin Graham et al., *The Diffusion of Policy Diffusion Research in Political Science*, 43 BRIT. J. POL. SCI. 673, 673 (2013) (noting that between 1958 and 2008, over eight hundred articles have been published in the field of political science on policy diffusion alone).

340. Compare policy diffusion to legal transplants, which were originally defined as “the moving of a rule or a system of law from one country to another, or from one people to another.” ALAN WATSON, *LEGAL TRANSPLANTS: AN APPROACH TO COMPARATIVE LAW* 21 (1974). The legal transplant literature is wary of the notion that the law can be transplanted to further policymaking and legal reform efforts without regard to context. See Daniel Berkowitz et al., *The Transplant Effect*, 51 AM. J. COMP. L. 163, 168, 171 (2003) (observing that “the social, economic and institutional context often differs remarkably between origin and transplant country” and that “transplants either adapted the law to local conditions and/or had a population that was familiar with the transplanted law”). This Article does not advocate a simple cut-and-paste of a principle from one area of law to another. Indeed, Part III went through great length to develop and expand the framework sensitive to the uniqueness of highly-infectious diseases. As such, the expanded

characterizes the expansion of CBDR proposed herein. The policy diffusion literature cautions against the tendency to adopt policies from the “leaders even in the absence of evidence of the efficacy of those policies.”³⁴¹ Yet, there are several reasons to be cautiously optimistic about the value of CBDR as a policy matter.

First, disease eradication and ozone protection have similar problem-and-solution structures. One of the reasons for the ozone regime’s success is because it involved a handful of chemicals with a small number of producers located primarily in the U.S. and Europe. These chemical companies quickly developed reasonably priced substitutes for ozone-depleting substances because the ozone treaties banned their trade and required their phasing out.³⁴²

Similarly, disease eradication efforts should also target the producers. The global pharmaceutical market is expected to reach USD 1.3 trillion by 2020,³⁴³ mostly from revenue generated and controlled from companies with headquarters in the Global North. The international intellectual property regime’s grant of monopoly rights to pharmaceuticals for twenty years³⁴⁴ impedes pharmaceutical research and the development process for highly-infectious diseases that are not profitable. Pharmaceutical companies depend on charging monopoly prices to recover their investment in experimental drugs and technologies. This system does not incentivize the development of drugs to treat diseases that disproportionately impact people in the Global South.

framework of CBDR is not a “classic transplant” and should not suffer from problems associated with them. For example, when transplants are not adapted to local conditions, a “transplant effect” happens, wherein less effective legal institutions persist when compared to the origin country. *See* Karen J. Alter, Laurence R. Helfer & Osvaldo Saldías, *Transplanting the European Court of Justice: The Experience of the Andean Tribunal of Justice*, 60 AM. J. COMP. L. 629, 634–35 (2012) (discussing the contention of Berkowitz et al., *supra*, that a mismatch between local institutions and the transplanted law arises absent adaptation to local needs).

341. Beth A. Simmons et al., *Introduction: The Diffusion of Liberalization* (discussing why the policy choices of rich, large, and proximate countries are emulated regardless of consequences), in *THE GLOBAL DIFFUSION OF MARKETS AND DEMOCRACY* 1, 35 (Beth A. Simmons et al. eds., 2008); *see also* KATERINA LINOS, *THE DEMOCRATIC FOUNDATIONS OF POLICY DIFFUSION: HOW HEALTH, FAMILY AND EMPLOYMENT LAWS SPREAD ACROSS COUNTRIES* 4, 14–15 (2013) (discussing why the policy choices of rich, large, and proximate countries are emulated regardless of consequences).

342. Montreal Protocol, *supra* note 186, art. 2 (listing specific ozone-depleting substances and targets for phasing them out); *id.* art. 3 (regulating both production and consumption of ozone-depleting substances); *id.* art. 4 (banning state parties from importing or exporting these substances to non-parties); *see also* London Amendments, *supra* note 188, art. 2 (accelerating the phasing out of existing substances and adding new substances).

343. PRICEWATERHOUSECOOPERS, *PHARMA 2020: THE VISION—WHICH PATH WILL YOU TAKE?* 5 (2007).

344. TRIPS Agreement, *supra* note 216, art. 33.

Patent holders charge varying prices in different jurisdictions. The intellectual property regime places limits on parallel importation, which occurs where parties purchase goods in one state and then resell them in a second state without the patent holder's consent.³⁴⁵ This prevents countries in the Global South from accessing essential medicines at more affordable prices. The flexibilities in the intellectual property regime that allow for compulsory licensing are also insufficient.³⁴⁶ Indeed, compulsory licensing is of little use to states with limited-to-no manufacturing capabilities to produce essential generic drugs at more affordable prices for their home markets.³⁴⁷

Changing the incentive structures for the research and development of drugs, as well as making generic and affordable versions of drugs more widely available, should aid efforts to eradicate highly-infectious diseases. The ozone regime indicates that changing the incentive structures prompted companies to develop cheaper substitutes, and with these substitutes, more countries stopped using ozone-depleting substances and traded in products that contained them. For example, the ozone treaty regime was initially focused on sharing information and scientific research.³⁴⁸ Later, the obligations became more stringent with strict timetables for phasing out dependence on harmful ozone-depleting substances, as well as adding new substances to be phased out.³⁴⁹ In the future, it is possible that the CBDR framework to combat highly-infectious diseases might develop along the same lines. Thus, there is reason to be enthusiastic about the potential efficacy of an expanded CBDR framework for combating epidemics.

Furthermore, CBDR may resonate more in global public health than in the international environmental regime. While environmental problems like

345. See *International Exhaustion and Parallel Importation*, WORLD INT'L PROP. ORG., http://www.wipo.int/sme/en/ip_business/export/international_exhaustion.htm [<https://perma.cc/A8PH-RSZ6>] (defining parallel importation as the importation "of goods outside the distribution channels contractually negotiated by the manufacturer").

346. The TRIPS Agreement, *supra* note 216, art. 31, permits compulsory licensing, but only where the proposed user makes efforts to obtain authorization from the patent holder on reasonable commercial terms and conditions, which must be unsuccessful for a reasonable period. The requirement can be waived where there is a state of national emergency or other circumstance of extreme urgency in cases of public noncommercial use. The Doha Declaration sought to clarify that the TRIPS Agreement does not and should not prevent members from taking measures to protect public health and that it should be interpreted as compatible in a manner that promotes access to medicines. Doha Declaration, *supra* note 215, ¶ 4.

347. The Doha Declaration recognized this and asked the TRIPS Council to find solutions. Doha Declaration, *supra* note 215, ¶ 6.

348. See Vienna Convention for the Protection of the Ozone Layer art. 2, Mar. 22, 1985, 1513 U.N.T.S. 293 (creating a group to form a protocol that addresses updated scientific and economic research).

349. London Amendments, *supra* note 188, art. 2A–2E (setting forth a timetable for phasing out use of ozone-depleting substances and identifying new substances to be phased out).

climate change can be slow-moving with the most harmful effects predicted for generations from now, epidemic diseases tend to engender visceral fear in the present. Indeed, the tendency for some pandemics to take on a hyper-visible or spectacular quality means that an expanded CBDR approach may be especially useful for highly-infectious diseases. For example, the Global Health Security Agenda was shaped during the height of the Ebola epidemic not only to combat that disease but also other “highly pathogenic infectious diseases.”³⁵⁰ The success of this initiative indicates that state practice is evolving to recognize the importance of a coordinated response to highly-infectious diseases. Thus, it is likely that the specter of other epidemics may similarly galvanize actors towards additional international action.

C. Operationalizing CBDR Utilizing Hard and Soft Law

1. Towards a Comprehensive Treaty Regime.—Concerns about the usefulness of CBDR may be heightened because its status as binding law is robustly debated.³⁵¹ Whether a customary international law norm³⁵² has formed on CBDR—separate from treaty law—or whether CBDR is a form of soft law that is nonbinding is irrelevant for this project. This Article draws inspiration from the under-theorized norm of CBDR in international environmental law and substantially develops it as a framework to inform progressive developments in global public health. Thus, clarity on the legal status of CBDR in international environmental law is unnecessary for its expansion, development, and application.

Although a CBDR framework for combating highly-infectious diseases might seem attractive on a theoretical level, skeptics may believe that it is impossible for this approach to be operationalized. First, there are few treaties regulating infectious diseases.³⁵³ Also, states seem to have little appetite for

350. GHSA *About*, *supra* note 29.

351. Susan Biniak, Assistant Legal Advisor, U.S. Dep’t of State, Remarks on Common but Differentiated Responsibility (Mar. 13–16, 2002) (citing four reasons for why the CBDR principle has not been helpful), in *Introduction*, 96 PROC. OF THE ANN. MEETING (AM. SOC’Y INT’L L.) 358, 361.

352. See RESTATEMENT (THIRD) OF FOREIGN RELATIONS LAW § 102 (AM. LAW INST. 1987) (defining customary international law as requiring a state to follow its generalized practice out of a sense of legal obligation).

353. See generally, e.g., International Sanitary Regulations, May 25, 1951, 7 U.S.T. 2255 (standardizing international quarantine regulations regarding Cholera, yellow fever, and plague); International Sanitary Convention for Aerial Navigation, Dec. 15, 1944, 59 Stat. 991, 16 U.N.T.S. 247 (protecting against the spread of disease via air travel); International Convention for Mutual Protection Against Dengue Fever, July 25, 1934, 177 L.N.T.S. 59 (resolving to take steps against the spread of dengue fever); International Agreement Relating to Facilities to be Accorded to Merchant Seamen in the Treatment of Venereal Diseases, Dec. 1, 1924, 78 L.N.T.S. 351 (agreeing

additional treaty-making in global public health as compared to the international environmental regime.³⁵⁴ In addition, due to the responsibility gaps discussed above,³⁵⁵ many of the relevant nonstate actors would fall outside of any potential treaty regime and would not be bound by any such obligations.

Additionally, if the climate change regime's negotiations on emissions levels are an indication, resulting decisions would be based on what was politically feasible and would have little to do with ethical or scientific considerations.³⁵⁶ As such, treaty negotiations for an expanded CBDR framework would likely lead to a lowest common denominator not necessarily reflective of scientific best practices. It may be that linking the three bases of differentiation erects a substantial hurdle to subsequent legal adoption. Thus, one might expect any deliberations concerning diffusing the CBDR framework to privilege the status quo, given the international community's limited willingness to mandate the redistribution of economic resources as a political matter. Accordingly, this Article does not advocate for the development of a treaty regime as an initial matter. However, because so much of the expanded CBDR framework is derived from existing law, a comprehensive treaty to implement the framework may not be necessary.

2. *Towards a Soft-Law Regime.*—A myriad of explanations exists as to why a soft-law regime makes sense as a starting place. First, operationalizing the framework through norms of conduct understood as legally *nonbinding*, or soft law, is achievable in the immediate future. Soft-law commitments may be more politically realistic because they do not require that all actors be incorporated into a single treaty. Soft law also does not necessarily have to accommodate the varying positions of different actors. When there are disagreements among states or uncertainties about how to achieve an agreed-upon goal, a comprehensive treaty regime could result in a race to the bottom to get the most parties on board, while a soft-law approach would not.

Moreover, soft-law commitments also offer significant advantages, such as flexibility and adaptability, when compared to comprehensive treaty regimes. Because the expanded CBDR framework is still in its infancy, a soft-law approach can act like a “trial balloon.” Soft law allows actors to maintain some freedom of action should situations change, since soft law can be easily amended and adapted to meet the needs of parties. For instance, soft law is far less cumbersome than the treaty amendment process. The treaty

to provide medical treatment in ports where seamen might be treated for venereal diseases); INTERNATIONAL HEALTH REGULATIONS, *supra* note 31.

354. Compare sources cited *supra* note 353, with sources cited *supra* notes 165–73.

355. See discussion *supra* subpart III(B).

356. See, e.g., Kyoto Protocol, *supra* note 179, arts. 3, 10, annex I (explaining that Annex I states have differentiated targets based on negotiated outcome).

negotiation process can be long and unwieldy with lags in the development of implementation mechanisms. Yet, because soft law does not require formal domestic approval or ratification, discussions can be less contentious than treaty making, which requires the approval of domestic actors. Thus, soft-law commitments can develop quite rapidly and be used quickly to address highly-infectious diseases immediately.

The normative underpinnings of the CBDR framework have been expressed in soft law in the pledge to “leave no one behind,” the central theme of the 2030 Agenda, which seeks to place an obligation on everyone to reach those in situations of conflict, disaster, vulnerability, and risk.³⁵⁷ CBDR has also been referenced in World Health Assembly committee meetings regarding the health effects of air pollution.³⁵⁸ The most concrete instantiation of the CBDR framework is reflected in the Global Health Security Agenda, discussed above.³⁵⁹ The GHSA has been operating since 2014 and capitalizes on the more participatory nature of soft law. Conventionally, formal treaty making and customary-law creation in international law are both state-centric enterprises. Soft law allows for the participation of nonstate actors, which would be highly desirable for addressing epidemics due to the significant role that nonstate actors play in global public health. The GHSA reflects soft law’s quick adaptability to respond to highly-infectious diseases, given its formation during the Ebola outbreak.

Also, soft law could work to create expectations that influence the actions of state and nonstate actors towards compliance. The main disadvantage presented by relying on soft law is that there could be less credible commitments by states since it is nonbinding. The framework can be shaped to reflect, and hopefully help form, a standard of appropriate conduct. Soft law would allow participants to determine what aspects of the framework are worth keeping and what needs to be modified before the expanded CBDR framework is completely memorialized.

The informality of soft law presents both an opportunity and a challenge for progressive development. Powerful actors can apply and enforce their preferred aspects of the framework to try to push the development of the law in one direction. This can occur even without a clear consensus on which aspects of the framework are favorable or unworkable. However, if the CBDR framework develops as soft law only, this may hinder the development of binding obligations because actors may be disincentivized to do more when they can do less. It is not evident that adopting a CBDR

357. Secretary-General of the World Humanitarian Summit, *One Humanity: Shared Responsibility*, ¶ 72, U.N. Doc. A/70/709 (Feb. 2, 2016).

358. World Health Organization, Summary Records of Committees from the Sixty-Eighth World Health Assembly, U.N. Doc. WHA68/2015/REC/3, at 83 (2015).

359. See discussion *supra* subsections III(B)(2)(a), III(B)(2)(c).

framework for combating epidemics would necessarily lead to that outcome. Indeed, it could also create expectations that impact the activities of actors in a way that fosters commitments without treaties, or treaty bodies, to coerce compliance.

Most optimistically, the CBDR framework could eventually induce meaningful change in the behavior of relevant stakeholders, which could lay the groundwork for a comprehensive treaty or the development of a customary international law obligation. Otherwise, at a minimum, compliance can be obtained through the framework via cooperative, interactive processes of justification, discourse, and persuasion. Whether the law will develop along the lines proposed is an open question. Notwithstanding, this Article demonstrates that an expanded CBDR framework for combating epidemics is worthy of progressive development in law and practice.

V. Conclusion

Epidemics are the result of the actions of multiple actors, which necessitates the comprehensive allocation of responsibility. Yet, the traditional framework for responsibility and the emerging norm of R2P are inadequate for addressing highly-infectious diseases. First, both the traditional principles of responsibility and R2P perpetuate the fallacy that states can cope on their own with structural problems, including the increased incidence of epidemics. Conventional approaches to responsibility are untenable for the realities of today's world wherein responsibility needs to be distributed to several states and nonstate actors.³⁶⁰ The traditional framework is also wanting due to its narrow conception of causality. Moreover, the traditional responsibility doctrine is too state-centric in terms of both account holders and power wielders.³⁶¹ The state-centric nature of R2P similarly fails to recognize that the structural conditions that give rise to R2P situations are not divorced from the "international community." R2P also privileges direct harms occasioned by civil and political violations over and above structural harms occasioned by socioeconomic violations. Moreover, both the traditional principles of responsibility and R2P fail to adequately distribute responsibility.

Given the limitations of the law of responsibility and R2P, this Article argues for a new vision of responsibility. It develops the theory underlying CBDR and makes the case for expansion of the framework to the challenges posed by epidemics. This Article articulates the distinctive normative bases for differentiating responsibilities based on need, culpability, and capacity. This framework better distributes responsibility and is less state-centric than

360. See VANDENBOGAERDE, *supra* note 42, at 40 (discussing the limitations of international responsibility).

361. See *id.* at 41.

rival norms of responsibility. It accounts for structural inequality in ways that other frameworks do not. It also does not reify the false hierarchy between civil and political rights and economic and social rights that exists in other areas. Moreover, it recognizes and accounts for the significant role of nonstate actors and provides a basis for holding such actors responsible, as opposed to pretending that only states are responsible for the increased incidence of epidemics. The CBDR framework is superior for dealing with highly-infectious diseases. It does not come with R2P's baggage or the risks of the extraordinary responses utilized under R2P. Furthermore, the CBDR framework distributes responsibility far more comprehensively than extant regimes.

The expanded CBDR framework represents “part of a broader normative” push that “requires action on the part of those in a position to assist.”³⁶² CBDR also hints at an emerging requirement for states to coordinate their efforts with each other to effectively “discharge their respective obligations to cooperate.”³⁶³ The expanded CBDR framework is significant for the progressive development of global public health law. It also shifts the conceptualization of responsibility in fundamental ways.

There are valid concerns about diffusing this framework from addressing environmental problems to combating epidemics. States are not consistently adhering to capacity-building commitments in international environmental law. This generates uneasiness because it may be that they will be even less willing to address problems presented by epidemics through the framework. In the end, it may be that state and nonstate actors are roused to address highly-infectious diseases, not necessarily because of an acknowledgement of the need. Undeniably, the idea that actors should help others in need is not new.³⁶⁴ Mobilization in the Global South has taken place for years to get actors in the Global North to address global inequities in health and other areas.

Moreover, actors may not even necessarily be motivated to action because of a recognition of culpability for an epidemic. This has certainly been witnessed with the U.N. in Haiti. Yet, motivation may similarly be lacking to combat epidemics even with the recognition of capacity to act and ameliorate harm. Certainly, actors in the Global North routinely reject an

362. Salomon, *supra* note 244, at 378 (internal quotations omitted).

363. *Id.* at 378–79.

364. *See, e.g.*, U.N. High Commissioner for Human Rights, Rep. on the Relationship Between Climate Change and Human Rights, ¶¶ 84–85, U.N. Doc. A/HRC/10/61 (Jan. 15, 2009) (calling for the cooperation of the international community to address climate change); Michael Marmot et al., *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health*, 372 LANCET 1661, 1665 (2008) (singing the praises of “intersectoral action for health—coordinated policy and action among health and non-health sectors”).

obligation to provide foreign assistance,³⁶⁵ irrespective of capacity. For example, while states express support in principle for the notion that 0.7% of their GNI should routinely go towards development assistance, few states meet that goal.³⁶⁶ Given this, there may be skepticism about the traction the expanded CBDR framework will have with relevant stakeholders.

Nonetheless, there is reason for cautious optimism about the prospects of success of this framework. CBDR is consistent with theoretical and existing foundations of law where responsibility is tethered to an actor's conduct and relationship to the harm through culpability. However, the framework does not treat the culpability model as a legal straitjacket and envisions a broad understanding of causation—direct, indirect, and historical. Additionally, the framework differentiates based on capacity, which is derived from human rights and global public health law. It also draws on extralegal incentives, building on moral and political conceptualizations of responsibility towards those in need. In this way, the approach functions as a three-headed dragon, with multiple methods of galvanizing action to attack epidemics.

Through interactive processes, the norms underlying the CBDR framework can be invoked, interpreted, and elaborated in ways that generate pressure for compliance through soft law. Most hopefully, a CBDR approach to combating epidemics could be accepted as a normative framework that could serve as a precursor for the later creation of “hard” or binding international law.³⁶⁷ The world is contending with the increasing incidence and severity of a wide range of highly-infectious diseases. The ease with which these diseases can spread in the wake of disasters *and without* makes

365. See, e.g., Comm'n on Human Rights, Rep. of the Open-Ended Working Group to Consider Options Regarding the Elaboration of an Optional Protocol to the International Covenant on Economic, Social and Cultural Rights on its Second Session, ¶ 76, U.N. Doc. E/CN.4/2005/52 (Feb. 10, 2005) (reporting that the United Kingdom, the Czech Republic, Canada, France, and Portugal did not believe that international cooperation and assistance was a legal entitlement); Philip Alston, *Ships Passing in the Night: The Current State of the Human Rights and Development Debate Seen Through the Lens of the Millennium Development Goals*, 27 HUM. RTS. Q. 755, 777 (2005) (noting the pattern among developed countries to reject obligations for providing foreign assistance).

366. See, e.g., MILLENNIUM DEVELOPMENT GOAL GAP TASK FORCE, UNITED NATIONS, THE GLOBAL PARTNERSHIP FOR DEVELOPMENT: MAKING RHETORIC A REALITY 9–10 (2012) (finding that out of twenty-three countries, only Sweden, Norway, Luxembourg, Denmark, and the Netherlands met the 0.7% development assistance goal).

367. This has happened multiple times in human rights, of which the most prominent example is the nonbinding Universal Declaration of Human Rights. See generally G.A. Res. 217 (III) A, Universal Declaration of Human Rights (Dec. 10, 1948) (enumerating thirty universal human rights and setting international standards of achievement). It led to the conclusion of two separate treaties—the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights. Compare *id.*, with ICCPR, *supra* note 38 (recognizing certain civil rights as foundational and internationally protected), and ICESCR, *supra* note 39 (extending the principles of the Universal Declaration of Human Rights to cover the economic, social, and cultural rights of every human being).

it likely that state and nonstate action will be stimulated in this area out of a common self-interest. The GHSA is currently harnessing states' shared self-interest to work to address the threats posed by highly-infectious diseases and is differentiating based on capacity and need. As such, a CBDR approach to epidemics is already functioning in practice. The findings from this Article will hopefully be used to help inform wider discussions in this area to aid with developing law and policy governing responsibility for, and risk reduction of, pandemic diseases.