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This report reviews legal developments during the year 1996 in the field of public international health law. The report summarizes developments in: international agreements; judicial decisions by international and foreign bodies; international and regional organizations activities; as well as U.S. legislation and agency actions. The primary focus is on the international control of disease, *e.g.*, tobacco, as well as AIDS, and other emerging and reemerging infectious diseases.

I. International Tobacco Control

At its January 1996 meeting, the World Health Organization (WHO) Executive Board[1] recommended that the World Health Assembly (meeting in May 1996) adopt a resolution—that urges all WHO Member States (and where applicable agencies of the United Nations system and other international organizations) to implement progressively comprehensive tobacco control strategies that include comprehensive, multisectoral, long-term tobacco control strategies.[2] The resolution also requested the WHO Director General: (1) to initiate the development of a framework convention for tobacco control in accordance with Article 19 of the WHO Constitution; and (2) to include as part of this framework convention a strategy to encourage Member States to move progressively towards the adoption of comprehensive tobacco control policies and also to address tobacco control issues that transcend national boundaries.

II. Judicial Decisions by International and Foreign Bodies

A. INTERNATIONAL COURT OF JUSTICE

Legality of Use of Nuclear Weapons in Armed Conflict[3] (Request for Advisory Opinion by the World Health Organization)[4]

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1. An international framework convention for tobacco control, EB97.R8, Jan. 23, 1996.

2. Such strategies are to be consistent with resolutions adopted by the World Health Assembly, *i.e.*, Resolutions WHA39.14 and WHA43.16.

3. Reference should be made to the report of the International Courts Committee.

4. Legality of the Use of Nuclear Weapons in Armed Conflict, 1996 I.C.J. No. 95 (Advisory Opinion of July 8, 1996).

On July 8, 1996, the International Court of Justice issued an advisory opinion concerning the legality of the use of nuclear weapons in armed conflict.[5] The ruling followed a plea by both the United Nations General Assembly and the WHO. Of significance from a health perspective is the Court's companion opinion, handed down on the same day, which held that WHO lacked standing to request such an advisory opinion.[6] The companion opinion was unprecedented in that the Court had never before refused to consider the request of a specialized agency of the United Nations for an advisory opinion.[7]

The Court began by stating that its power to issue an advisory opinion is exercisable upon three conditions: (1) the agency requesting the opinion must be duly authorized under the United Nations Charter[8] to request advisory opinions; (2) the opinion requested must address a legal question; and (3) the question must be one arising within the scope of the activities of the requesting agency.[9] The Court concluded that WHO had met the first two conditions, but not the third.

The entire Court readily acknowledged that WHO is duly authorized to deal with the effects on health of the use of nuclear weapons.[10] However, the majority determined that WHO's request related to the ***general legality*** of using nuclear weapons, as opposed to the ***health effects*** of such use.[11] Because the issue of the general legality of using nuclear weapons was found to be outside the scope of WHO's specialized activities, the Court held that WHO lacked standing to request an advisory opinion.[12]

Three judges dissented with the majority. Judge Shahabuddeen stated that the majority had misinterpreted the fundamental question submitted by WHO.[13] In his view, WHO's question was more reasonably interpreted as whether use of nuclear weapons would violate WHO's Constitution[14]—not whether use was illegal in general.[15] Judges Weeramantry and Koroma also felt that the majority had misconstrued WHO's question as merely concerning general legality.[16] In their collective opinion, WHO's request directly related to WHO's activities in at least three specific areas: (i) State obligations in regard to health; (ii) State obligations in regard to the environment; and (iii) State obligations under WHO Constitution.

All of the dissenters expressed additional concern over the Court's abrupt departure from its longstanding practice of routinely granting requests for advisory opinions, unless compelling circumstances to decline exist.

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5. *Id.*
6. Request for Advisory Opinion from the World Health Organization on the Legality of the Use of Nuclear Weapons in Armed Conflict, 1996 I.C.J. No. 96/22 (July 8).
7. *Id.* at 3 (Weeramantry, J., and Koroma, J., dissenting).
8. U.N. Charter, art. 96, ¶ 2.
9. 1996 I.C.J. 96/22 at 1 (Majority Opinion).
10. *Id.*
11. *Id.* at 5.
12. *Id.* at 5-6.
13. *Id.* at 2 (Shahabuddeen, J., dissenting).
14. Constitution of the World Health Organization, *opened for signature* July 22, 1946, 62 Stat. 2679, T.I.A.S. No. 1808, 14 U.N.T.S. 185.
15. 1996 I.C.J. 96/22 at 2 (Shahabuddeen, J., dissenting).
16. *Id.* at 2-3 (Weeramantry, J., and Koroma, J., dissenting).

B. COURT OF JUSTICE OF THE EUROPEAN COMMUNITIES

1. *United Kingdom v. E.C. Commission*[17]

Re: Emergency Measures to Protect Against Bovine Spongiform Encephalopathy (BSE), a/k/a "Mad Cow" Disease.

On March 20, 1996, an independent advisory body to the government of the United Kingdom issued a statement that exposure to bovine spongiform encephalopathy (BSE), the so-called mad cow disease, was the most likely cause of a recently discovered variant of Creutzfeld-Jacob disease (an incurable disease causing death) in humans.[18] In response to this statement, on March 27, 1996, the E.C. Commission adopted Decision 96/239, pursuant to which a worldwide ban on the export of British beef and beef products was immediately imposed.[19] (On June 11, 1996, the preventive measures imposed by Commission Decision 96/239 EC were partially relaxed [Decision 96/362 EC], but the worldwide ban on beef exportation for human consumption was continued.)[20]

In or about May 1996, the United Kingdom applied for interim suspension of the worldwide ban, pending the hearing of its application for the annulment of Decision 96/239.[21] On July 12, 1996, the European Court of Justice denied the U.K.'s interim application.[22]

The Court was required to consider three factors in connection with the U.K.'s application. The first factor was whether a prima facie case for the suspension of Decision 96/239 existed.[23] The second factor was whether interim relief was urgent and necessary to avoid serious and irreparable harm to the United Kingdom.[24] The third factor was whether the balance of competing interests favored the United Kingdom.[25] In rendering its opinion, the Court held that all three factors weighed against the United Kingdom.

Among other things, the United Kingdom claimed that a prima facie case for suspension existed because: (1) Decision 96/239 discriminated against the United Kingdom, (2) Decision 96/239 was motivated solely by improper economic objectives, and (3) the Commission was without legal authority to impose a worldwide ban.[26] The Court disagreed on all counts. It was unpersuaded by the discrimination argument, noting that 97.9 percent of all BSE cases in Europe originated in the United Kingdom.[27] It rejected the "improper motive" argument, finding that the primary objective of Decision 96/239 was to protect public health in light of the perceived link between BSE and Creutzfeld-Jacob disease.[28] Finally, the Court held that the Commission did not appear to have overstepped its jurisdictional bounds in imposing a worldwide ban, but, in any event, the question of whether the Commission has the inherent power to impose a worldwide ban is a complex legal question not capable of resolution on an interim application.[29]

17. Case 180/96R, United Kingdom v. E.C. Commission (E.C. Council intervening), 3 C.M.L.R. 1 (1996).
18. *Id.* at 2.
19. *Id.*
20. 1996 O.J. (C239) (1996).
21. United Kingdom v. E.C. Commission, 3 C.M.L.R. at 2.
22. *Id.* at 3.
23. *Id.* at 13-15.
24. *Id.*
25. *Id.*
26. *Id.* at 15-16.
27. *Id.* at 18
28. *Id.* at 19-20.
29. *Id.* at 21.

As to the element of irreparable harm, the Court acknowledged that the British beef industry was being adversely affected by the BSE scare.[30] However, the Court reasoned that there was no evidence that Decision 96/239—as opposed to pre-existing bans on British beef imposed by other member states and nonmember countries—was the direct and proximate cause of these damages.[31]

Finally, in balancing the respective interests, the Court concluded that any alleged harm to the United Kingdom did not outweigh the serious harm to public health which could be caused by suspension of Decision 96/239.[32] In this regard, the Court stated:

> Scientists have as yet only an imperfect knowledge of Creutzfeld-Jacob disease and, more particularly, its recently discovered variant. Its fatal consequences were reiterated several times at the hearing. There is at present no cure for it. Death ensues several months after diagnosis. Since the most likely explanation of this fatal disease is exposure to BSE, there can be no hesitation. Whilst acknowledging the economic and social difficulties caused by the Commission's decision in the United Kingdom, the Court cannot but recognize the paramount importance to be accorded to the protection of health.[33]

A ruling on the U.K.'s application for the annulment of Decision 96/239 is not expected until at least late 1997. However, the Court's denial of the U.K.'s request for interim relief is a fair indication that it will continue to place paramount importance on the issue of public health, notwithstanding the possibility of serious adverse economic consequences.

2. *United Kingdom v. E.C. Commission*[34]

Re: 48-Hour Working Time Directive[35]

In 1993, the EU Council of Ministers adopted a 48-Hour Working Time Directive for all member states (Directive).[36] Among other things, the Directive prescribed: (1) a ceiling of 48 hours, including overtime, on the average working week; (2) a minimum daily rest period of 11 consecutive hours; (3) a minimum uninterrupted rest period of 24 hours each week, including, "in principle," Sunday; (4) a maximum average shift of 8 hours for night workers; and (5) a minimum of 4 weeks' paid leave per year. The implementation date of the Directive was November 23, 1996.[37]

The United Kingdom was the only member state to apply for annulment of the Directive. In an opinion handed down on November 12, 1996, the European Court of Justice denied the U.K.'s application virtually in its entirely.[38] Finding that the EU Council of Ministers was fully empowered to impose the Directive, and adopting a broad interpretation of the terms "health" and "safety," the Court upheld the U.K.'s challenge only to the limited extent of ruling that the minimum weekly rest period of 24 hours prescribed by the Directive need not include Sunday.[39]

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30. *Id.* at 22.
31. *Id.*
32. *Id.* at 23.
33. *Id.*
34. Case C-84/94, United Kingdom v. E.U. Council, 3 C.M.L.R. 671 (1996).
35. Reference should be made to the report of the International Employment Committee.
36. *Id.*
37. Council Directive 93/104 of Nov. 23, 1993, Concerning Certain Aspects of the Organization of Working Time, 1993.
38. Case C-84/94, United Kingdom v. E.U. Council, 3 C.M.L.R. 671 (1996).
39. *Id.* at 701.

The United Kingdom advanced several arguments in support of its application for annulment. The primary argument was based upon the alleged absence of a demonstrable link between the Directive and health or safety.[40] In light of such alleged absence, the United Kingdom claimed that the Directive should have been adopted under a separate EU protocol on social policy from which Great Britain is exempt.[41]

The Court flatly rejected the U.K.'s arguments. It ruled that the terms "working environment," "safety," and "health" are to be broadly construed.[42] It held that there is nothing to indicate that these concepts should "be interpreted restrictively, and not as embracing all factors, physical or otherwise, capable of affecting the health and safety of the worker in his working environment."[43] The Court thus adopted the definition of "health" contained in the preamble of the Constitution of the World Health Organization, *i.e.*, "a state of complete physical, mental and social well-being that does not consist only in the absence of illness or infirmity."[44]

C. Foreign Courts

Canada

On June 13, 1996, the Canadian Human Rights Tribunal ruled that its federal government and other federally regulated industry must provide medical and dental benefits to partners of gay and lesbian employees.[45] A three-member, independent panel said it is "crystal clear" that the denial of spousal benefits to same-sex partners is illegal.[46]

The Tribunal ordered the federal government to supply an inventory of all federal laws, regulations, and directives that discriminate against same-sex couples.[47] The Tribunal further ordered the federal government to stop applying provisions in all federal collective agreements and health plans which deny gays and lesbians the same benefits as opposite-sex couples.[48]

The Tribunal's ruling was made retroactive prior to a 1992 Ontario Court of Appeals decision which determined that sexual orientation is a prohibited ground for discrimination under the Canadian Human Rights Act.[49]

III. Emerging and Reemerging Infectious Diseases

A. Introduction

Since the 1992 publication of *Emerging Infections: Microbial Threats to the United States* by the Institute of Medicine of the U.S. National Academy of Sciences,[50] awareness of the threats posed by emerging and reemerging infectious diseases to the United States has grown rapidly. The U.S. Centers for Disease Control and Prevention (CDC) and the WHO define emerging and reemerging infectious diseases as "emerging infectious diseases" (EIDs), which are "diseases of infectious origin whose incidence in humans has increased within the past two decades or

40. *Id.* at 680.
41. *Id.* at 691.
42. *Id.* at 685.
43. *Id.* at 710.
44. *Id.* at 711.
45. *Id.*
46. *Id.*
47. *Id.*
48. *Id.*
49. *Id.*
50. Institute of Medicine, Emerging Infections: Microbial Threats to Health in the United States (Joshua L. Lederber et al. eds., 1992).

threatens to increase in the near future."[51] EIDs were an important topic of political and public health concern again in 1996 as infectious disease outbreaks in the United States[52] and around the world[53] demonstrated that EIDs are a serious problem in international relations. In its 1996 annual report, WHO stated that infectious diseases now constitute a "world crisis."[54]

The problem posed by EIDs to the United States and the rest of the world also began to attract the attention of international law scholars and practitioners.[55] The International Health Law Committee sponsored a program entitled *Law and Emerging and Reemerging Infectious Diseases* at the ABA Annual Meeting in 1996 to help raise awareness about the many international, national, and local legal issues and challenges raised by the growing global threat of EIDs.[56] Presented below are some of the international legal highlights produced by states attempting to come to grips with the EID threat.

1. *International Agreements*

a. Multilateral Agreements

In May 1995, the World Health Assembly[57] requested the Director-General of WHO to begin a process for revising the International Health Regulations (IHR) in light of the EID threat; and to submit the revised IHR to the World Health Assembly in accordance with Article 21 of the WHO Constitution.[58] The IHR constitute the "only international health agreement on communicable diseases that is binding on [WHO] member states."[59] In December

51. U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION, ADDRESSING EMERGING INFECTIOUS DISEASE THREATS: A PREVENTION STRATEGY FOR THE UNITED STATES 1 (1994); WORLD HEALTH ORGANIZATION, WORLD HEALTH REPORT 1996: FIGHTING DISEASE, FOSTERING DEVELOPMENT 15 (1996) [hereinafter WORLD HEALTH REPORT 1996].

52. A few examples of infectious disease outbreaks in the United States during 1996 include the importation of the Ebola Reston strain through infected research monkeys from the Philippines, outbreaks of illness in the United States from consumption of imported raspberries infected with the cyclospora parasite, and sickness caused by apple juice contaminated with the bacteria *E. coli* 0157:H7.

53. Examples of infectious disease outbreaks around the world in 1996 include outbreaks of *E. coli* 0157: H7 in Japan and Germany, Ebola outbreaks in Gabon and the movement of Ebola to South Africa via a Gabonese physician seeking treatment, and the controversy caused within the European Union by growing evidence of a link between "mad cow" disease in British cattle and the human Cruetzfeld-Jacob disease.

54. WORLD HEALTH REPORT 1996, *supra* note 51, at 1.

55. *See, e.g.*, David P. Fidler, *Globalization, International Law and Emerging Infectious Diseases*, 2 EMERGING INFECTIOUS DISEASES 77 (1996); David P. Fidler, *Mission Impossible? International Law and Infectious Diseases*, 10 TEMPLE INT'L & COMP. L. J. ___ (1996); Bruce Jay Plotkin, *Mission Possible: The Future of the International Health Regulations*, 10 TEMPLE INT'L & COMP. L. J. ___ (1996); Bruce Jay Plotkin and Ann Marie Kimball, Designing the International Policy and Legal Framework for Emerging Infection Control: First Steps (draft manuscript); Allyn L. Taylor, *Controlling the Global Spread of Infectious Diseases: Toward a Reinforced Role for the International Health Regulations*, 32 HOUSTON L. REV. (forthcoming 1997); and David P. Fidler, *Return of the Fourth Horseman: Emerging Infectious Diseases and International Law*, 81 MINN. L. REV. (forthcoming 1996).

56. *See* PROGRAM MATERIALS FOR LAW AND EMERGING AND RE-EMERGING INFECTIOUS DISEASES, Aug. 1996. Although not focused on law, the National Health Policy Forum also sponsored a seminar on EIDs in 1996. *See* EMERGING AND REEMERGING INFECTIOUS DISEASES: A MAJOR PUBLIC HEALTH CHALLENGE NATIONAL HEALTH POLICY FORUM, ISSUE BRIEF No. 686 (1996).

57. WHO doc. WHA 48.7 (May 12, 1995).

58. World Health Assembly, *Revision and Updating of the International Health Regulations*, WHO Doc. WHA 48.7 (May 12, 1995).

59. World Health Organization, *Division of Emerging and Other Communicable Diseases Surveillance and Control, Emerging and Other Communicable Diseases Strategic Plan Outline 1996-2000* (WHO/EMC/96.1), at 10 [hereinafter EMC Strategic Plan].

1995, an informal WHO working group made recommendations on revising the IHR.[60] In 1996, WHO's new Division of Emerging and Other Communicable Diseases Surveillance and Control (EMC) made revision of the IHR part of its mandate.[61] EMC began in 1996 to develop substantive initiatives on revising the IHR and to develop a timetable for completing the revision.[62] Currently, EMC projects that the revision of the IHR will be completed by the end of 1997.[63]

The importance of the EID threat also received emphasis within other multilateral fora in 1996. The members of the Group of Seven industrialized countries included a statement on the need for international cooperation on infectious diseases in the final Lyon summit statement.[64] The participating states in the Asia Pacific Economic Cooperation (APEC) forum established a working group on EIDs in 1996.

b. U.S. Bilateral Efforts

The United States was also active in 1996 incorporating cooperation on EIDs into bilateral agreements and relationships with other countries. Working groups on EIDs have been established under (1) the United States–European Union Trans-Atlantic Agenda, and (2) the United States–Japan Common Agenda. Both of these agendas involve multiple issues, including, among other things, security, trade, environmental protection, and health. Cooperative work on EIDs is now becoming expressly part of these wide-ranging diplomatic efforts. The action plan on EIDs in the U.S.-EU Trans-Atlantic Agenda includes: (1) establishing a task force to develop and implement an effective global early warning system and response network for infectious diseases; (2) increased training and professional exchanges on infectious diseases; (3) coordination of activities with WHO and other relevant international organizations; and (4) bilateral and multilateral cooperation on health-related matters (*e.g.*, AIDS and other communicable diseases).[65] The U.S.-Japan EID working group first met in August 1996 and has plans to meet again early in 1997. The United States and Japan hope that their bilateral effort grows into a Pacific Rim initiative, perhaps in synergy with APEC's efforts.

The United States also launched EID projects with South Africa and Russia in 1996. The United States would like to see South Africa play a larger role in the global surveillance system for infectious diseases, and South Africa has expressed serious interest in playing an enhanced regional and global role. With respect to Russia, the United States and Russia are seeking to broaden their cooperation on infectious disease control and surveillance from a focus on diphtheria into the wider threats posed by EIDs.

60. World Health Organization, *Division of Emerging and Other Communicable Diseases Surveillance and Control, The International Response to Epidemics and Applications of the International Health Regulations: Report of a WHO Informal Consultation* (Dec. 11-14, 1995) (WHO/EMC/IHR/96.1) [hereinafter *Report of WHO Informal Consultation*].

61. EMC STRATEGIC PLAN, *supra* note 57, at 4.

62. Informal Working Group Discussion on the Revision of the International Health Regulations, Sept. 11, 1996 (Unpublished manuscript by EMC Director, on file with authors).

63. *Id.*

64. *Toward Greater Security and Stability in a More Cooperative World,* June 29, 1996, *available in* LEXIS, News Library, Curnws File.

65. *The New Transatlantic Agenda, available at* <http://europa.eu.int/en/agenda/tr06ap2.html#ii7>.

2. *International and Regional Organizations' Activities*

a. WHO

WHO was very busy with EID issues during 1996. WHO's 1996 annual report, *Fighting Disease, Fostering Development*, focused on the world infectious disease crisis.[66] WHO's new division (EMC) dedicated to the surveillance and control of infectious diseases adopted its first strategic plan in 1996.[67] EMC also began taking steps to achieve its four strategic goals: (1) to strengthen the global surveillance of infectious diseases; (2) to strengthen the national and international infrastructure necessary to recognize, report, and respond to EIDs; (3) to strengthen national and international capacity for the prevention and control of infectious diseases; and (4) to support and promote infectious disease control research.[68] WHO rapid response teams—part of EMC's effort to strengthen national and international infectious disease control—have frequently been in action in 1996, most notably dealing with Ebola outbreaks in Gabon.

The World Health Assembly decided in 1996 that the last remaining samples of the smallpox virus shall be destroyed in 1999, formally ending one of the great international public health crusades of this century. The World Health Assembly also designated that EIDs will be the focus of the World Health Day in 1997.

b. PAHO

Meeting in June 1996, the Executive Committee, of the Directing Council, Pan American Health Organization (PAHO) (which is also the WHO Regional Office for The Americas) adopted Resolution CE118.R13, concerning hemispheric measures for the control of *Aedes aegypti* (a type of mosquito infesting many major cities especially in the Americas) as a means of controlling dengue (a severe influenza-like illness) and urban yellow fever (a mosquito-borne virus disease occurring in tropical regions of South America, causing fever, prostration, nausea, and vomiting).[69]

c. European Union

(Proposal to Establish Community Infectious Disease Surveillance System) On March 7, 1996, the European Commission submitted a proposal for European Parliament and Council decision to create a network for the epidemiological surveillance and control of communicable diseases in the European Community.[70] A Commission Communication on communicable disease surveillance networks in the European Community accompanied the proposal.[71] The Communication provides a review of existing infectious disease surveillance in the European Community. The European Commission's "proposal seeks to establish a system of close cooperation and effective coordination between Member States in the field of surveillance, both routine and emergency, with a view to improving the prevention and control of a certain number of serious communicable diseases which necessitate introduction of measures for the protection of

66. World Health Report 1996, *supra* note 51.

67. EMC Strategic Plan, *supra* note 51.

68. *Id.* at 2.

69. Final Report, Executive Committee, of the Directing Council, Pan American Health Organization (PAHO), 118th Meeting, Washington, D.C., June 1996, CE118/FR (Eng.), 27 June 1996, at pages 31-33.

70. 1996 O.J. (No. C 123) 10 (1996).

71. Commission Communication Concerning Communicable Diseases Surveillance Networks in the European Communities, COM (96) final at 78 (Mar. 7, 1996).

populations."[72] Article 1 of the proposal states that "[a] general network for the epidemiological surveillance and control of communicable disease shall be set up in the European Community."[73]

On November 16, 1996, the Health Ministers of the European Union discussed at their Council meeting the European Commission's proposal to establish a Community-wide infectious disease surveillance network. According to press reports, the Health Ministers "showed reluctance" in their discussions about the proposal, which "led only to an agreement that the issue should be discussed at more length . . . in the first half of next year."[74]

On November 21, 1996, the European Parliament made amendments to the Commission's proposal.[75] According to press reports, members of the European Parliament requested that the network for communicable disease control also include early warning and that the communicable disease effort be more centralized.[76] French European Parliament member Christian Cabrol stated that "subsidiarity must give way to security" in the public health context.[77] The European Parliament amendments and arguments will be taken up when the Council takes up the issue again in 1997.

3. *U.S. Legislation and Agency Actions*

a. Agency Actions

In 1994, the CDC published a major strategic plan for the United States on addressing the EID threat.[78] In 1995, in response to the CDC's report, the United States government interagency Working Group on Emerging and Reemerging Infectious Diseases (CISET Working Group) was formed and published another major report with recommendations for the United States' strategy to combat EIDs.[79] In April 1996, the CISET Working Group established four subcommittees to develop implementation strategies for the CISET Report's recommendations.[80] The work of the subcommittees has been progressing throughout 1996.

The work of the CDC and CISET Working Group received a significant boost in June 1996 when Vice President Gore announced the Clinton administration's new infectious disease policy, which elevated national and international infectious disease control and prevention on the U.S. political and public health agenda. Much of the Clinton administration's new infectious disease policy seeks to develop a global surveillance and response system to detect, control, and prevent EIDs.[81]

Eventually, the work of the CDC and the CISET Working Group and the Clinton administra-

72. *Id.*

73. 1996 O.J. (C 123) 10.

74. *Health Ministers Discuss Disease Network and EU Health Card*, European Europe, Nov. 16, 1996, *available in* LEXIS, News Library, Curnws File.

75. *See EP Modifies Proposals on a Network for Surveillance of Communicable Diseases and AIDS in Developing Countries*, Agence Europe, Nov. 22, 1996, *available in* LEXIS, News Library, Curnws File.

76. *Id.*

77. *Id.*

78. U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION, ADDRESSING EMERGING INFECTIOUS DISEASE THREATS (1994).

79. NATIONAL SCIENCE AND TECHNOLOGY COUNCIL COMMITTEE ON INTERNATIONAL SCIENCE, ENGINEERING, AND TECHNOLOGY WORKING GROUP ON EMERGING AND RE-EMERGING INFECTIOUS DISEASES, INFECTIOUS DISEASES—A GLOBAL HEALTH THREAT (1995) [hereinafter CISET REPORT].

80. The four subcommittees are addressing respectively surveillance and response issues, research and research training, capacity building, and outreach.

81. *See* Al Gore, Address Before the National Council for International health (June 12, 1996); FACT SHEET: ADDRESSING THE THREAT OF EMERGING INFECTIOUS DISEASES, WHITE HOUSE OFFICE OF SCIENCE AND TECHNOLOGY POLICY (June 12, 1996).

tion's new infectious disease strategy will produce proposals for specific legislative actions as the recommendations move towards actual implementation.

b. U.S. Legislation

Although major legislative activity may be forthcoming in 1997, Congress passed some legislation related to the global EID problem in 1996. The U.S. Government adopted in 1996 new rules on federal meat inspection largely in response to outbreaks of *E. coli* 0157:H in the United States in the early 1990s.[82] The United States also issued new regulations dealing with the domestic and international shipment of etiologic agents that have potential for biological warfare or bioterrorism.[83] Congress also included in the new immigration legislation vaccination requirements for all immigrants for a specified list of diseases to reduce the threat of disease importation.[84]

IV. AIDS

A. Introduction

An estimated 30.6 million people have been infected with Human Immunodeficiency Virus (HIV) since the Acquired Immune Deficiency Syndrome (AIDS) was first recognized as a disease.[85] Responses of international, national, and local organizations over the years have ranged from compassion to hysteria. Major developments in 1996 demonstrate, at least in theory, that responses to AIDS should be made within a public health framework that respects the human rights of those affected by HIV. First, the United Nations undertook a major reform when it established UNAIDS, a coordinated mechanism to fight HIV by, among other measures, emphasizing the human rights of persons affected by HIV. Second, it is becoming generally accepted that various human rights instruments should extend to persons affected by HIV and AIDS. Third, medical developments in protease inhibitors announced at the 1996 International AIDS Conference held in Vancouver have turned the public perceptions of AIDS from being only an inevitably fatal disease to being a disease that may, with access to new medicines, be treated as a chronic illness. Although this development in AIDS treatment is not a legal development, it may shape future legislation and litigation on AIDS until the emergence of new strains of HIV that may be resistant to protease inhibitors.

B. UNAIDS Established to Coordinate the International Fight Against AIDS

AIDS has always presented a complex matrix of scientific, political, social, and legal issues. In recognition of these and other complex aspects of HIV, the U.N. undertook a major reform of its own efforts against the disease. In January of 1996, a new Joint U.N. Program on HIV/AIDS (UNAIDS) became operational. UNAIDS did more than replace the World Health Organization's Global Program on AIDS, which was itself a replacement of the World Health Organization's Special Program on AIDS. The new organization, UNAIDS, is a common effort of six institutional cosponsors: the United Nations Children's Fund (UNICEF), the United Nations Development Program (UNDP), the United Nations Population Fund (UNFPA), the

82. 21 U.S.C. § 624.
83. 42 U.S.C. § 300.
84. 42 U.S.C. § 13206-7.
85. The Global AIDS Policy Coalition, AIDS in the World II: Global Dimensions, Social Roots, and Responses 11 (Jonathan Mann and Daniel Tarantola eds. 1996).

United Nations Educational, Scientific and Cultural Organization (UNESCO), the World Health Organization, and the International Bank for Reconstruction and Development (the World Bank).

UNAIDS may be seen as a unique international initiative for at least three reasons. First, UNAIDS is the first strategic partnership program of its kind in the U.N. system to coordinate a variety of efforts against a common health threat. Second, UNAIDS is the first U.N. program to include nongovernmental organization representation on its governing body, the Program Coordinating Board.[86] The board is comprised of 22 U.N. Member States (including donor and recipient nations), representatives of the six institutional cosponsors (UNICEF, UNDP, UNFPA, UNESCO, WHO, and the World Bank), nongovernmental organizations, and persons living with HIV.[87] The importance of including persons with HIV recognizes that programs can only be successful if they involve those directly affected by the problem. Third, the coordinated structure of UNAIDS allows the agency to promote human rights as a guiding principle.[88] As the influence of UNAIDS and its emphasis on human rights becomes an accepted part of effective national response programs, the protection of human rights will remain a paramount consideration.

The creation of UNAIDS may be viewed as a response to calls to streamline the U.N. system in this post–Cold War era. UNAIDS promises to be more than a model of reform, however. UNAIDS is poised to create support for coordinated responses to prevent further transmission of HIV, to provide care and support to persons already infected, and to reduce the vulnerability of individuals and communities who may be affected by HIV.

C. Human Rights Instruments Protect Persons with HIV and AIDS as "Other Status"

UNAIDS has stated that: "People are entitled to enjoy all human rights without discrimination, including discrimination based on HIV infection status. These [rights] include the right to health, travel, and privacy, the right to freedom from sexual violence and coercion, and the right to the information and means to prevent infection."[89] In the first decade of the AIDS pandemic, most lawyers, legislators, and public health advocates generally discounted international human rights instruments as a framework to consider the rights of persons affected by HIV.[90] A common misperception was that public health considerations outweigh the individual human rights of persons affected by HIV. Although there are still many exceptions, it was gradually recognized that the public health could be protected without violating individual human rights. In the year 1996, there is growing evidence that human rights instruments provide a paradigm to promote both human rights and public health.

An example is seen in the August 1996 deliberations of the Sub-Commission on Prevention of Discrimination and Protection of Minorities, a Sub-Commission of the U.N. Commission on Human Rights. In its resolution on discrimination in the context of HIV or AIDS, the Sub-Commission recognized that discrimination based on "AIDS or HIV infection, actual or

86. UNAIDS, *Fact Sheet* (May 1996) (visited Dec. 5, 1996) <http://www.unaids.org/highband/press/factunen.html>.

87. *Id.*

88. *See, e.g.*, Commission on Human Rights, Report of the Secretary-General on Human Rights and HIV/AIDS, E/CN./44 (1996).

89. UNAIDS, *Fact Sheet, supra* note 86.

90. *See* Robert M. Jarvis, *Advocacy for AIDS Victims: An International Law Approach*, 20 U. Miami Inter-Am. L. Rev. 1 (1988).

presumed, is a violation of fundamental rights and freedoms" and that "persons suffering from disadvantaged socioeconomic or legal status, such as women, children, indigenous peoples, minorities, refugees, migrants, sex workers, men who are homosexual, injecting drug users and prisoners, are more vulnerable to the risk of HIV infection owing to limited or no access to education, health care and social services, and that they suffer disproportionately from the economic and social consequences of the HIV/AIDS epidemic."

With these and other concerns in mind, the Sub-Commission made two legal pronouncements of significant interest. First, the Sub-Commission confirmed "that discrimination on the basis of HIV or AIDS status, actual or presumed, is prohibited by existing international human rights standards and that the term 'other status' in nondiscrimination provisions in international human rights texts should be interpreted to cover health status, including HIV/AIDS." Second, the Sub-Commission confirmed "that it is appropriate to consider HIV/AIDS as a disability for purposes of protection against discrimination."

The Sub-Commission's first pronouncement that the term "other status" includes persons affected by HIV applies to documents such as the *Universal Declaration of Human Rights*,[91] which provides that all persons are "entitled to all of the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, *or other status.*"[92] Similar "other status" language is found in Article 2(2) of *the International Covenant on Economic, Social, and Cultural Rights*[93] and in Article 2(1) of the *International Covenant on Civil and Political Rights*.[94] Analogous language can also be found in documents such as the *American Declaration of the Rights and Duties of Man*[95] which provides that "[a]ll persons are equal before the law and have the rights and duties established in this Declaration, without distinction as to race, sex, language, creed *or any other factor.*"[96] Although countries initially signed the *American Declaration* as a nonbinding declaration of human rights aspirations and political principles, the *Declaration* has since evolved into a binding source of international obligation related to a country's membership in the Organization of American States.[97]

The Sub-Commission's observation made this year that the term "other status" should include persons affected by HIV builds on the U.N. Commission on Human Rights' 1995 Resolution on HIV/AIDS which confirmed that discrimination based on "AIDS or HIV status, actual or presumed, is prohibited by existing international human rights standards, and that the term 'or other status' in non-discrimination provisions in international human rights texts

91. G.A. Res. 217 A (III), U.N. GAOR, 3rd Sess., at 71, U.N. Doc. A/810 (1948), *reprinted in* RICHARD B. LILLICH AND HURST HANNUM, INTERNATIONAL HUMAN RIGHTS—DOCUMENTARY SUPPLEMENT 17 (1995).

92. *Id.* art. 2 (emphasis added).

93. Dec. 16, 1966, *entered into force* Jan. 3, 1976, 999 U.N.T.S. 3, *reprinted in* LILLICH, *supra* note 91, at 23, 24.

94. Dec. 6, 1966, *entered into force* Mar. 23, 1976, 999 U.N.T.S. 171, *reprinted in* LILLICH, *supra* note 91, at 33, 34.

95. O.A.S. Res. XXX, *adopted by* the Ninth International Conference of American States, Bogota (1948), OEA/Ser. L./V/II.23/doc. 2 rev. 6 (1979), *reprinted in* LILLICH, *supra* note 91, at 137 (1995).

96. *Id.* art. II.

97. *See* Interpretation of the American Declaration of the Rights and Duties of Man within the Framework of Article 64 of the American Convention on Human Rights, Advisory Op. OC-10/89 of July 14, 1989, Ser. A, No. 10 (Inter-Am. Ct. Hum. Rts. 1989); Mark E. Wojcik, *Using International Human Rights Law to Advance Queer Rights: A Case Study for the American Declaration of the Rights and Duties of Man*, 55 OHIO ST. L.J. 649, 653 (1994).

can be interpreted to cover health status, including HIV/AIDS."[98] It also reconfirms the Sub-Commission's Resolution last year that the "other status" term "*should be interpreted* to cover health status, including HIV/AIDS."[99]

The Sub-Commission's second observation from the document circulated in 1996 states that "it is appropriate to consider HIV/AIDS as a disability for purposes of protection against discrimination." This pronouncement may implicate, on an international level, documents such as the *Vienna Declaration* from the World Conference on Human Rights. Although the *Vienna Declaration* was ostensibly silent on the rights of persons affected by HIV, it does contain two provisions on persons with disabilities.[100] Indeed, the *Vienna Declaration* has been described as "a quarry whose resources have [yet] to be tapped."[101] The disability provisions of the *Vienna Declaration*, for the first time in 1996, can be read to extend to persons affected by HIV. Such a result can be seen as a natural development for countries such as the United States,[102] Canada,[103] and Australia[104] where disability laws have already been applied to persons affected by HIV.

D. Medical Developments in 1996 May Change the Course of Future Legislation and Litigation

A major development in drug treatments for persons affected by AIDS may change the course of governmental responses to the pandemic. Clinical trials released in 1996 showed that protease inhibitors, when combined with AZT and other antiviral drugs, can reduce a patient's level of HIV to "undetectable" levels.[105] "No one can call AIDS an inevitably fatal disease anymore," exclaimed Peter Piot, director of UNAIDS.[106] Although this treatment can be made available to many, most persons with HIV live in the developing world where they will not have access to these drugs. The treatment is also, at the present time, very exact. A person's failure to comply with the strict regime of drug therapy may thwart the treatment by an entire

98. U.N. Commission on Human Rights, Resolution on HIV/AIDS, Res. 1995/44, adopted Mar. 3, 1995, *reprinted in* UN DP Regional Project on HIV and Development (New Delhi, India), HIV Law, Ethics and Human Rights 377, 380 (D.C. Jayasuriya, ed., 1995) (emphasis added).

99. U.N. Sub-Commission on Prevention of Discrimination and Protection of Minorities, *Resolution on Discrimination in the Context of Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)*, Res. 1995/21, *adopted* Aug. 24, 1995, *reprinted in* UN DP Regional Project on HIV and Development (New Delhi, India), HIV Law, Ethics and Human Rights 384, 386 (D.C. Jayasuriya, ed., 1995) (emphasis added).

100. Vienna Declaration and Programme of Action (paras. 63-64), World Conference on Human Rights, U.N. Doc. A/Cont. 15724 (1993).

101. Koen Davidse, *The Vienna World Conference on Human Rights: Bridge to Nowhere or Bridge over Troubled Waters?*, 6 Touro Int'l L. Rev. 239, 257 (1995).

102. Under U.S. law, the Americans with Disabilities Act (ADA) defines the "disability" of individuals as "(A) a physical or mental impairment that substantially limits one or more of the major life activities of such individual; (B) a record of such impairment; or (C) being regarded as having such an impairment." 42 U.S.C. § 12102(2) (1994). Persons affected by HIV have been found to be "disabled" under the ADA, *see, e.g.*, Doe v. Kohn, Nast & Graf, 862 F. Supp. 1310 (E.D. Pa. 1994); under the Federal Rehabilitation Act of 1973, *as amended, see, e.g.*, Doe v. District of Columbia, 796 F. Supp. 559 (D.D.C. 1992); and under various state statutes, *see, e.g.*, Raintree Health Care Ctr. v. Illinois Human Rights Comm'n, 672 N.E.2d 1136 (Ill. 1996).

103. *See, e.g.*, Ontario Human Rights Board to Hear Discrimination Case, 6 AIDS Pol'y & Law (BNA), at 6 (Aug. 7, 1991).

104. *See, e.g.*, X v. Department of Defence, No. H94/98 (Australian Human Rights and Equal Opportunity Comm'n, June 29, 1995), *as reported in Sacked Army Recruit Wins HIV Discrimination Case*, 6 HIV/AIDS Legal Link (No. 3), at 7 (Sept. 1995) (interpreting the Australian Disability Discrimination Act).

105. *See, e.g.*, H.R. Sheperd, *Still Needed: An AIDS Vaccine*, Wall St. J., Dec. 3, 1996, at A22.

106. *Id.*

class of protease inhibitors. As persons fail to comply with this regime, it is possible that new strains of HIV may develop resistance to protease inhibitors, just as some strains now are resistant to the drug AZT. If this happens, the "cure" described in 1996 will be short-lived.

Until that time, however, nations where persons can afford the expense of protease inhibitors and related drugs may find a need to adjust their national laws. A person on disability leave, for example, may find the strength to return to work following a successful treatment. The disability laws, however, may impede a person from returning to work if that would endanger health insurance benefits. Persons with HIV can have more productive lives with this treatment, but the expense will bankrupt many individuals and local governments. If that happens, a person forced to stop treatment with protease inhibitors may develop strains that are resistant to further treatment. If the mutated virus spreads to others, treatment with protease inhibitors may be futile. The potential danger of developing new, resistant strains of HIV should awaken governments to their own responsibilities to ensure that funds are available to pay for the treatments. That understanding, however, requires more attention to the problem than most legislators seem willing to give.