

Perspective and Case Studies on Battling Contagions Like Covid-19 Under the Legal Framework of International Law

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ABSTRACT

Coronavirus disease 2019 (COVID-19) is an infectious disease caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). The disease was first identified in December 2019 in Wuhan, the capital of China's Hubei province, and has since spread globally, resulting in the ongoing 2019–20 coronavirus pandemic. Common symptoms include fever, cough, and shortness of breath. Other symptoms may include muscle pain, sputum production, diarrhoea, sore throat, loss of smell, and abdominal pain. While the majority of cases result in mild symptoms, some progress to viral pneumonia and multi-organ failure. As of 4 April 2020, more than 1,118,921 cases of have been reported in more than two hundred countries and territories, resulting in over 58,937 deaths. More than 226,769 people have recovered. Legal framework for this type of virus is poor. Many countries have law but it does not have any implementation.

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INTRODUCTION

Coronavirus disease (COVID-19) is an infectious disease caused by a newly discovered coronavirus. Most people infected with the COVID-19 virus will experience mild to moderate respiratory illness and recover without requiring special treatment. Older people, and those with underlying medical problems like cardiovascular disease, diabetes, chronic respiratory disease, and cancer are more likely to develop serious illness. The best way to prevent and slow down transmission is be well informed about the COVID-19 virus, the disease it causes and how it spreads. Protect yourself and others from infection by washing your hands or using an alcohol based rub frequently and not touching your face.

The COVID-19 virus spreads primarily through droplets of saliva or discharge from the nose when an infected person coughs or sneezes, so it's important that you also practice respiratory etiquette (for example, by coughing into a flexed elbow). At this time, there are no specific vaccines or treatments for COVID-19. However, there are many ongoing clinical trials evaluating potential treatments. WHO will continue to provide updated information as soon as clinical findings become available (WHO, 2020). How easily a virus spreads from person-to-person can vary. Some viruses are highly contagious (spread easily), like measles, while other viruses do not spread as easily. Another factor is whether the spread is sustained, spreading continually without stopping (Chinazzi, 2020).

According to the World Health Organization (WHO), viral diseases continue to emerge and represent a serious issue to public health. In the last twenty years, several viral epidemics such as the severe acute respiratory syndrome coronavirus (SARS-CoV) in 2002 to 2003, and H1N1 influenza in 2009, have been recorded. Most recently, the Middle East respiratory syndrome coronavirus (MERS-CoV) was first identified in Saudi Arabia in 2012. In a timeline that reaches the present day, an epidemic of cases with unexplained low respiratory infections detected in Wuhan, the largest metropolitan area in China's Hubei province, was first reported to the WHO Country Office in China, on December 31, 2019. Published literature can trace the beginning of symptomatic individuals back to the beginning of December 2019. As they were unable to identify the causative agent, these first cases were classified as "pneumonia of unknown etiology." The Chinese Center for Disease Control and Prevention (CDC) and local CDCs organized an intensive outbreak investigation program. The etiology of this illness is now attributed to a novel virus belonging to the coronavirus (CoV) family, COVID-19.

On February 11, 2020, the WHO Director-General, Dr. Tedros Adhanom Ghebreyesus, announced that the disease caused by this new CoV was a "COVID-19," which is the acronym of "coronavirus disease 2019". In the past twenty years, two additional coronavirus epidemics have occurred. SARS-CoV provoked a large-scale epidemic beginning in China

and involving two dozen countries with approximately 8000 cases and 800 deaths, and the MERS-CoV that began in Saudi Arabia and has approximately 2,500 cases and 800 deaths and still causes as sporadic cases. This new virus seems to be very contagious and has quickly spread globally. In a meeting on January 30, 2020, per the International Health Regulations (IHR, 2005), the outbreak was declared by the WHO a Public Health Emergency of International Concern (PHEIC) as it had spread to 18 countries with four countries reporting human-to-human transmission. An additional landmark occurred on February 26, 2020, as the first case of the disease, not imported from China, was recorded in the United States.

Transmission

Because the first cases of the CoVID-19 disease were linked to direct exposure to the Huainan Seafood Wholesale Market of Wuhan, the animal-to-human transmission was presumed as the main mechanism. Nevertheless, subsequent cases were not associated with this exposure mechanism. Therefore, it was concluded that the virus could also be transmitted from human-to-human, and symptomatic people are the most frequent source of COVID-19 spread. The possibility of transmission before symptoms develop seems to be infrequent, although it cannot be excluded. Moreover, there are suggestions that individuals who remain asymptomatic could transmit the virus. This data suggests that the use of isolation is the best way to contain this epidemic.

As with other respiratory pathogens, including flu and rhinovirus, the transmission is believed to occur through respiratory droplets from coughing and sneezing. Aerosol transmission is also possible in case of protracted exposure to elevated aerosol concentrations in closed spaces. Analysis of data related to the spread of SARS-CoV-2 in China seems to indicate that close contact between individuals is necessary. The spread, in fact, is primarily limited to family members, healthcare professionals, and other close contacts.

Based on data from the first cases in Wuhan and investigations conducted by the China CDC and local CDCs, the incubation time could be generally within 3 to 7 days and up to 2 weeks as the longest time from infection to symptoms was 12.5 days (95% CI, 9.2 to 18). This data also showed that this novel epidemic doubled about every seven days, whereas the basic reproduction number (R_0 - R naught) is 2.2. In other words, on average, each patient transmits the infection to an additional 2.2 individuals. Of note, estimations of the R_0 of the SARS-CoV epidemic in 2002-2003 were approximately.

History

The clinical spectrum of COVID-19 varies from asymptomatic or paucisymptomatic forms to clinical conditions characterized by respiratory failure that necessitates mechanical ventilation and support in an intensive care unit (ICU), to multiorgan and systemic manifestations in terms of sepsis, septic shock, and multiple organ dysfunction syndromes (MODS).

In one of the first reports on the disease, Huang et al. illustrated that patients (n. 41) suffered from fever, malaise, dry cough, and dyspnea. Chest computerized tomography (CT) scans showed pneumonia with abnormal findings in all cases. About a third of those (13, 32%) required ICU care, and there were 6 (15%) fatal cases (Deng, 2020).

The case studies of Li et al. published in the *New England Journal of Medicine* (NEJM) on January 29, 2020, encapsulates the first 425 cases recorded in Wuhan. Data indicate that the patients' median age was 59 years, with a range of 15 to 89 years. Thus, they reported no clinical cases in children below 15 years of age. There were no significant gender differences (56% male). Clinical and epidemiological data from the Chinese CDC and regarding 72,314 case records (confirmed, suspected, diagnosed, and asymptomatic cases) were shared in the *Journal of the American Medical Association* (JAMA) (February 24, 2020), providing an important illustration of the epidemiologic curve of the Chinese outbreak.

There were 62% confirmed cases, including 1% of cases that were asymptomatic, but were laboratory-positive (viral nucleic acid test). Furthermore, the overall case-fatality rate (on confirmed cases) was 2.3%. Of note, the fatal cases were primarily elderly patients, in particular those aged ≥ 80 years (about 15%), and 70 to 79 years (8.0%). Approximately half (49.0%) of the critical patients and affected by preexisting comorbidities such as cardiovascular disease, diabetes, chronic respiratory disease, and oncological diseases, died. While 1% of patients were aged 9 years or younger, no fatal cases occurred in this group.

INTERNATIONAL LAW

The no-harm principle

The no-harm principle has been articulated in seminal cases such as *Alabama*, *Trail Smelter*, *Nuclear Weapons* and *Pulp Mills*, as well as in the work of the ILC on the 2001 Draft Articles on the Prevention of Transboundary Harm ('Draft Articles on Prevention'). It requires States to prevent, stop and redress significant transboundary harm to other States or their populations originating from or crossing their territory or any other area under their jurisdiction or control (Islam, 2020).

As other due diligence duties, the no-harm principle does not require States to actually prevent or stop the harm from happening. Instead, it requires them to *attempt* to do so, or to minimize the risk thereof, to the best of their abilities. The obligation arises from the moment States *know or should have known* about the harm or the risk thereof. Some measures that may be appropriate to discharge this duty include continuous monitoring or supervision, risk assessments, legislation, administrative policies and regulation, enforcement action and, most notably, international cooperation. To the extent States can employ these measures, they must do so. The no-harm principle requires States to act regardless of who is responsible for the harm: a State or a non-State entity. It covers both unlawful and lawful activities causing harm, such as an accident or a natural disaster. In this way, it differs from the so-called *Corfu Channel* principle, requiring States 'not

to allow knowingly its territory to be used for *acts contrary to the rights of other States*', which presupposes an internationally wrongful act (Von Bogdandy, 2020).

Crucially, although the no-harm principle has gained most traction in the environmental realm, where there has been a growing emphasis on prevention and precaution, it applies generally in international law (Von Bogdandy, 2020). Accordingly, States have the duty to prevent, halt and redress any significant transboundary harm emanating from their territories, regardless of who caused it or the lawfulness of the activity generating it. The COVID-19 outbreak ticks all those boxes: it is now scientifically proven and widely known that it causes widespread and disastrous health consequences which may lead to death beyond national borders. Thus, *all States*, regardless of whether the outbreak originated in their territory, have the obligation to exercise their best efforts, to the extent permitted by their capabilities, to stop the spread of coronavirus to other countries and prevent further outbreaks.

International Human Rights Law

It is no surprise that a crucial legal framework for assessing States' responses to an epidemic is international human rights law: after all, epidemics show their tangible effect on human beings. States not only have the ontological function to protect their citizens from entities or events that may harm them but also a binding legal duty to do so, codified in international treaties and crystallized in customary international law. In particular, it is self-evident that individuals' right to life and their right to health are most immediately endangered by the existence of an epidemic like the COVID-19 one (Islam, 2020).

The Right to Life

In the words of the International Covenant on Civil and Political Rights, every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life. Whilst violations of this right are most commonly associated with the arbitrary use of lethal force by the military or law enforcement authorities, these instances do not exhaust the range of possible violations of the right. State's acts and omissions with respect to health care policy may well constitute violations of the right to life. (Agiman, 2002).

States have a positive ('due diligence') duty to *protect* and *ensure* the right to life, i.e. adopt the measures necessary to safeguard the life of individuals under their jurisdiction, and thus to do all they can to prevent such individuals' life from being 'avoidably put at risk' (de Ruijter, 2020). The Human Rights Committee, more broadly, underlined that States' duty to protect life requires them to adopt 'appropriate measures to address the general conditions in society that may give rise to direct threats to life', including life-threatening diseases (de Ruijter, 2020).

Measures of this kind include not only guaranteeing access to food, water, medicines and other objects indispensable to survival, but also providing for

effective emergency health services, engaging in emergency response operations and organizing contingency and emergency management plans, or the adoption of a regulatory framework for hospitals and other health-related structures which is capable of ensuring the protection of patients' lives (Ahsah ullah, 2016). Thus, the positive duty to protect human life involves advance planning and immediate responses to prevent, stop or at the very least mitigate the spread of life-threatening diseases like COVID-19 (Islam, 2020).

The Right to Health

Even more evident is the relevance of human being's right to health in the case of an epidemic such as the COVID-19 pandemic. According to Article 12(1) of the International Covenant on Economic, Social and Cultural Rights (ICESCR), 'States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.' Article 12(2) makes explicit what was already possible to read into the preceding provision, namely that 'the steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for [...] (b) The improvement of all aspects of environmental and industrial hygiene; (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases; (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.'

With similar language, the right to health is recognized *inter alia* in Article 11 of the European Social Charter, in Article 16 of the African Charter of Human and Peoples' Rights and in Article 10 of the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights. A number of due diligence obligations can be derived from this legal framework (von Bogdandy, 2020).

Most notably, to comply with these provisions, the Committee on Economic, Social and Cultural Rights (CESCR) explains that States are obliged to establish 'prevention and education programs for behavior-related health concerns', which could reasonably include educational, professional and social activities which carry a greater risk of transmission of COVID-19 (Islam,2020). In other words, adopting social distancing policies, reducing working hours etc. are measures required not only by wisdom and medical necessity, but by law — in order to protect individuals' health from the risk posed by the contact with infected (even if asymptomatic) persons. Although the duty to ensure the right to health is one of 'progressive realization', it presupposes, at the very least, an obligation to behave proactively and to put in place an effective system of *urgent* medical care which could cope with life-threatening situations such as an epidemic of the proportions we are experiencing now.

In addition, according to the CESCR, States have an obligation to control diseases, both individually and through international cooperation, by acting in order to, among other things, 'make available relevant

technologies, using and improving epidemiological surveillance and data collection on a disaggregated basis, the implementation or enhancement of immunization programs and other strategies of infectious disease control'. COVID-19 warranted compliance with such obligations from its very early stages, and States which do not promptly share relevant information and technology may be in breach of their international obligations — in the same way as those that do not expeditiously adopted policies aimed at slowing down the outbreak. Delays in adopting adequate containment measures may have also caused unacceptable and unlawful discrimination against those most vulnerable to the disease, like the elderly and persons with disabilities, whose rights may have effectively been sacrificed on the altar of the 'business-as-usual' attitude. In addition, 'censoring, withholding or intentionally misrepresenting health-related information' may also amount to a violation of the duty to protect the right to health (von Bogdandy, 2020). Whilst the realization of the right to health is subject to the technical and economic capabilities of each state, this is not an excuse for non-compliance. According to Art 2(1) ICESCR, States must take deliberate, concrete and targeted steps towards the full realization of the right to health, including for cases like an epidemic. The core content of the right encompasses, *inter alia*, the duty to 'adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population', and the duty to 'take measures to prevent, treat and control epidemic and endemic diseases'. States which are in a position to assist other States who struggle to meet their core obligations have, in turn, an obligation to render such assistance.

CASE STUDIES UNDER THE LEGAL FRAMEWORK OF IRAN Iran Battling Contagions like COVID 19

The official death toll in Iran from the coronavirus disease has risen to 1,135, after 147 new deaths were reported in the past 24 hours. Another 1,192 cases have also been confirmed, bringing the total to 17,361 - the third highest in the world. Despite that, the deputy health minister warned that some Iranians were still not taking the disease seriously. The World Health Organization's (WHO) Middle East chief has called on countries to share more information. Dr Ahmed Al Mandhari said the agency's teams had observed "uneven approaches across the region", adding that much more ought to be done. The countries that have made the most progress are those that have engaged all ministries and sectors effectively," he told a briefing in Cairo. "They are the ones that are providing accurate, transparent and timely information for their people about the current status of the pandemic, the actions being taken, and the measures individuals can take themselves. He warned that the disease could only be controlled if experts had the information that allowed them to understand its dynamics in the region. "Unfortunately, even today, as the situation is becoming critical, information on cases is insufficiently communicated by countries to WHO," he said.

Dr Mandhari said a total of 18,000 confirmed cases of Covid-19 and more than 1,100 related deaths had been reported across the WHO's Eastern Mediterranean Region, which comprises 21 member states and the Palestinian territories. Almost all of the cases and deaths have been reported by Iran or been linked to it. At a televised news conference on Wednesday, Iranian Deputy Health Minister Alireza Raisi lamented the response of some people to the outbreak.

"Now everyone knows about this disease, and what is very strange is that some don't take it seriously," he said. "If people help, we can control it, and if not, then expect it to last more than two months." The official statistics issued by Iran's health ministry about the coronavirus pandemic, which report 23,049 people infected and 1,812 deaths across the country as of March 23, are brutal enough. But there's every reason to believe the real figures are much higher. Last Thursday, Kianush Jahanpur, an Iranian health ministry spokesman, tweeted that 50 people on average contract the virus in Iran almost every hour, and the fatality rate is one person every 10 minutes or six people per hour. That sobering comment reflected earlier warnings by other Iranian health officials that the real tally of coronavirus infections and deaths is "definitely" higher than the government admits. Rick Brennan, an emergency director for the World Health Organization who recently visited Iran, said on March 17 that the actual overall COVID-19 toll could be five times higher than official statistics.

It's indisputable that Iran, a country of around 83 million people, is one of the pandemic's epicenters. Why exactly the crisis acquired such massive proportions in Iran is more complicated to address, but responsibility mainly lies with Tehran's botched response, details of which are only now starting to come to light. There are growing indications that the Iranian government knew about the outbreak even as it avoided doing anything to stop it—or even inform the public about it. Meanwhile, the government's judgment continues to be marred by a combination of cynicism and religious ideology. As the coronavirus got officially underway in China through January with an ever-rising death toll, Iranian officials did nothing to stem travel between the two countries, in a seeming attempt to maintain strong diplomatic ties. In an interview on Feb. 4, Bahram Parsaei, a ranking member of parliament from Shiraz, complained that despite a government decision on Jan. 31 to supposedly suspend all Iran-China flights, some Iranian airlines not only carried on business as usual but also helped transfer China-bound passengers in other countries. He added that even Turkey had "canceled all China flights out of care for people's lives" notwithstanding its heavy economic reliance on tourism, including Chinese tourists. Yet Mahan Air pressed on with Tehran-Beijing flights until as late as Feb. 23. On Feb. 19, the Iranian government publicly confirmed two deaths caused by COVID-19 in the religious city of Qom, which has a population of 1.2 million. International public health experts found it curious that Iran's first official acknowledgment of the outbreak came in the form of a death, rather than any announcement of infection, which

necessarily must have preceded. This suggests the virus may have already spread quite widely at the time of the announcement—and that Iranian officials may have known as much.

Giving further credence to that theory is the fact that on Feb. 15, four days before Iran officially reported its first coronavirus cases, Supreme Leader Ali Khamenei had a customary meeting with a group of religious eulogists, but unlike in past years, his security detail did not permit them to approach Khamenei and kiss his hand. “They didn’t let us kiss aga’s hand,” the eulogist Nariman Panahi later clarified, using a local appellation to refer to the supreme leader. “Why? [Does this mean] aga ignored us? No. Protection of aga’s life is obligatory for us.” Thus while the Iranian government cared for the life of the supreme leader and took extra precautions to protect him from the coronavirus as early as mid-February, it failed to care for the lives of 83 million Iranians and prioritized its partnership with China over the nation’s public health.

Is Iran taking necessary steps to control COVID 19?

BAGHDAD as coronavirus spreads across the globe, the number of infected people in Iraq is still manageable. Though the country has taken strict measures to reduce infections, Iraqi officials are worried that the situation could deteriorate, and announced that other tight measures to prevent the virus' spread will be taken soon (Mikhael, 2020).

“We are still the best country in the world in terms of preventive measures against the coronavirus,” Iraqi Minister of Health Jaafar Allawi said. He still expressed concern that “in the event of the high spread of the disease, as in other countries, we do not have the means to face it.” The minister announced a new series of “strict measures [to last] up to three weeks to avoid danger.” To ensure the implementation of decisions, Iraqi authorities created a crisis unit composed of the ministers of health, environment, immigration, education, higher education and interior, among others. The goal is to develop a comprehensive program to limit the spread of the virus. Every governorate will have its own unit linked to the central unit in Baghdad. The crisis unit announced March 7 that flights from Iran and Italy would be halted; public stores will be closed, including cafes, restaurants, swimming pools, malls, cinemas and parks. Schools and universities will also be closed until further notice. Working hours will be suspended or reduced as needed, except for health and security institutions, which will continue to work full time. The Iraqi Cabinet held a special meeting March 17 to announce a curfew in Baghdad starting that same day, as well as directing authorities to disinfect certain districts; authorizing governors to impose curfews; and banning travel between Iraqi provinces.

To implement these measures, the minister of health has conducted field visits alongside judiciary, religious and security officials, to galvanize efforts. During his meeting with Allawi, Faiq Zaidan, the head of the Supreme Judicial Council, said that the judiciary will impose fines and “penalties on those who spread false information about the disease, take

reckless measures or encourage people to gather in any form. People who fail to abide by the strict measures will be arrested in cooperation with the police, which follows up on the implementation of the curfew.” Zaidan’s statement came after several religious groups expressed opposition to closing shrines and preventing community prayers and other religious gatherings. Security forces prevented several religious processions from entering holy cities to visit the shrines.

Meanwhile, Ayatollah Sayyed Hussein al-Sadr, an influential Shiite cleric in Baghdad, met with Allawi and said he supported the unit's decisions. He said Iraqis need to abide by the health authorities' directives and to practice social distancing and not hold public gatherings. He urged everyone to take preventive measures to reduce the spread of coronavirus and avoid customs and traditions, such as kissing shrines that “only lead to more injuries.” Supreme Shiite cleric Ali Sistani also supported the halt of religious community gatherings and the closing of holy shrines. Meanwhile, Muqtada al-Sadr criticized the closing of religious shrines and the disruption of prayers since such moves affect people's morale, he said. In tandem with the central government's measures, Iraq’s governorates are taking additional measures, depending on their circumstances, to counter the virus.

Khaled Burhan Razouqi, the director of the Salahuddin governorate health department, deemed the central government's measures insufficient. He called for tight controls on border crossings and banning the entry of foreigners, especially those from areas with significant coronavirus outbreaks, in reference to Iran. Razouqi said, “All forms of gatherings should be banned, especially religious gatherings, in addition to raising awareness to warn of the exacerbation of the disease and its transformation into a pandemic.” No cases of coronavirus have been documented in the Salahuddin governorate due to the early and strict preventive measures taken by local authorities. Ammar Hekmat, the deputy governor of Salahuddin, criticized the “poor coordination between Baghdad and the rest of the governorates,” stressing the need to “secure funds to support the security services, civil defense and health institutions.” Hekmat told Al-Monitor, “A curfew law has been in force from March 18 until 21, subject to extension.” Razouqi expressed concern about the rise in infections given Iraq's poor medical infrastructure. Hospitals will not be able to accommodate large numbers of patients and do not have adequate space for quarantine.

CASE STUDIES UNDER THE LEGAL FRAMEWORK OF SPAIN COVID-19: Spain

As the COVID-19 disease spreads outside of China, countries like Italy, Iran and Spain are leading the world in new corona virus cases. Corona virus cases in Spain began to climb at the end of February, as other European countries also began to see substantial rises. While Spain continues to see similar rises in case numbers compared to other European countries, many believe the country is more prepared to handle the influx of hospitalizations

than Italy and the U.S. Recently, a Spanish official stated they were prepared for over 80 percent of people in the capital city of Madrid to contract the virus at some point. Total cases of COVID-19 have quickly increased in Spain, with a peak of 112,065 as of April 2. Daily new cases have remained steady since their peak of 8,271 on March 26, dropping slightly to 6,120 new cases reported on April 2. The death toll in the country has skyrocketed to 10,348 as of April 2, the second-most in the world behind Italy. Overall, the recovery rate is climbing, and was reported at 70.7 percent of all cases in Spain as of April 2 (Togarro, 2020).

Madrid: Two planes packed with protective equipment arrived to restock Spain's overloaded public health system on Wednesday (Apr 1) as its confirmed coronavirus cases rose beyond 100,000 and it recorded its biggest one-day death toll from the outbreak. Barring Italy, the virus has killed more people in Spain than anywhere else, triggering a lockdown that has brought economic activity to a virtual standstill. A survey showed Spain's manufacturing sector is heading for a slump after shrinking in March at its steepest pace since 2013 (Toharro, 2020).

Is Spain taking necessary steps to control COVID 19?

Establishing temporary hospitals and reducing infections

One of the first priorities is to tackle infections within healthcare structures and treating people with COVID-19 in a manner that would contribute to reducing the risk for patients with other illnesses from getting infected. The second priority aims to decongest hospitals and healthcare centers by setting up temporary hospitals for people with mild and moderate symptoms of COVID-19 so that intensive care units can focus on treating people with severe symptoms. Following the green light from Madrid's Regional Government, MSF set up a 100-bed temporary hospital to accommodate people with moderate symptoms at the University of Alcalá de Henares, located 31 kilometers east of the capital. Treatment of patients will be handled by the staff of the nearby Hospital Príncipe de Asturias, relieving pressure on the hospital's emergency department, where severe patients that require hospitalization in the intensive care unit will be sent to. We have established another temporary hospital in a sports centre near the Hospital Severo Ochoa in Leganés, 11 kilometers southwest of Madrid. Discussions with local health authorities are also ongoing in identifying other locations to set up temporary hospitals in Catalonia.

Helping to protect the elderly and vulnerable

The third priority looks outside of healthcare facilities, where we are providing advice to the steering committees of nursing homes for the elderly. Our teams are working on risk assessments and implementation of hygiene and protection measures to reduce transmission of the corona virus within residences, as well as improving patient care. All of these activities, in coordination with national and local health authorities, are essential to increase treatment capacity, reduce mortality and prevent infections.

PRESENT CORONA SITUATION IN U.S.A.

Novel Corona virus is now a major threat to the entire world. Meanwhile we all know about that it is a pandemic virus. Near about 204 countries have been affected by this deadly virus. U.S. is one of them and their current situation is really awful. In February, the Centers for Disease Control and Prevention warned that the United States should brace for a domestic coronavirus outbreak. Throughout the month of March, the number of confirmed cases of COVID-19 in the U.S. has risen dramatically, and the U.S. now has the highest confirmed case count in the world. As of Wednesday morning, at least 188,247 people across every state, Washington, D.C., and four territories have tested positive for the disease. Globally, more than 868,100 cases of COVID-19 have been reported in 171 countries, with at least 43,010 deaths so far. In March, the World Health Organization officially declared COVID-19 a pandemic, and President Trump declared a national state of emergency. As of Wednesday morning, more than 3,900 American patients with the virus have died (Ghinai, 2020).

Many new coronavirus cases have been confirmed in the U.S.

As of April 1, there were at least 188,247 confirmed cases of COVID-19 in the U.S., and at least 3,921 patients with the virus had died. However, officials have warned that due to delays in testing in many areas, the total number of infected individuals is likely much higher. Over the last week, the rate of diagnosis has accelerated dramatically as a number of states have expanded their testing capacity; New York State, which has been testing aggressively, has been announcing thousands of new cases every day. Yet the New York Times reports that there's still huge variation in the rates of testing among states.

New York has had by far the largest outbreak in the country, with at least 76,030 confirmed cases and 1,552 deaths as of Wednesday. New Jersey is also among the states that have been hardest hit by the virus, along with California and Michigan. Washington State had some of the country's earliest confirmed cases, with 37 deaths from the virus linked to an outbreak of COVID-19 at a long-term care facility, the Life Care Center, in Kirkland, Washington. Louisiana experienced a sudden spike in confirmed COVID-19 cases last week, which experts suspect could be linked to Mardi Gras celebrations, which concluded on February 25.

Government take some necessary measures are being taken to limit the spread of coronavirus

As the number of confirmed cases of COVID-19 has continued to rise, a growing number of states have announced drastic measures to slow the spread of the virus. As of April 1, officials in 33 states have urged residents to stay at home, including Alaska, Arizona, California, Colorado, Connecticut, Delaware, Hawaii, Idaho, Illinois, Indiana, Kansas, Louisiana, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oregon, Rhode Island, Tennessee, Vermont, Virginia,

Washington, West Virginia, and Wisconsin, as well as Washington, D.C., and Puerto Rico. These “stay-at-home” orders require residents to stay in their homes except for essential activities, which include buying food, seeking medical treatment, and exercising outdoors, provided they stay six feet away from anyone not part of their household. Medical professionals, caregivers, public-safety officials, sanitation workers, and other essential workers, such as those who work in grocery stores and pharmacies, are exempt.

A number of cities have also announced stay-at-home orders, and Pennsylvania and Nevada have ordered all nonessential businesses in their states to close. According to the *New York Times*, as of Wednesday, more than three-quarters of the U.S. population has been urged or ordered to stay at home. The widespread lockdowns have had serious economic consequences, and record numbers of Americans have filed for unemployment claims. Though President Trump had previously questioned whether the economic toll of stay-at-home orders was worth it, on Sunday he announced that Americans must continue to avoid nonessential travel, going to work, eating at bars and restaurants, and gathering in groups of more than ten for at least another month, and possibly until June. Dr. Deborah Birx, who is coordinating the nation’s coronavirus response, said Tuesday that strict adherence to social-distancing guidelines, like statewide stay-at-home orders, is the most effective way to slow the spread of the virus. However, even with such restrictions, the estimated death toll in the U.S. is between 100,000 and 240,000. Speaking Tuesday, President Trump told Americans to brace themselves for a “very, very painful two weeks.” As of Friday, schools in 46 states were closed entirely. In New York City, the largest school district in the country, public schools will remain closed until at least April 20, though Mayor Bill de Blasio said there was a strong chance they would not reopen before the end of the school year. The mayor said that some schools will reopen as “enrichment centers” to provide services to vulnerable children, including homeless students and those with special needs, and that the city would open centers to provide child care for the children of health-care and emergency workers.

Governor Andrew Cuomo has warned that the New York outbreak may still be weeks away from its peak, and that the state’s hospital system may soon be overwhelmed by the number of coronavirus cases. This week in New York, a 68-bed field hospital was erected in Central Park, a naval hospital ship docked in Manhattan, and a 1,000-bed emergency hospital opened at the Javits Convention Center. Additionally, more than 500 paramedics, 2,000 nurses, and 250 ambulances from across the country are headed to New York to assist with the city’s health-care response. Both Cuomo and de Blasio have criticized the federal government for not taking sufficient action to provide needed medical equipment and supplies, including face masks and ventilators. Although President Trump said on Thursday that he thought the need for ventilators may have been exaggerated, on Friday, he invoked the Defense Production Act to order General Motors to ramp up their manufacture.

The federal government doing to fight coronavirus

In February, President Donald Trump put Vice-President Mike Pence — a man with a frankly dismal track record in public health — in charge of the coronavirus response, assuring the public that the White House is “very, very ready for this.” In March, President Trump declared a national emergency over the coronavirus pandemic, effectively freeing up to \$50 billion in federal funds to help states and territories fight the spread of the virus, which he said would include expanding access to testing. Still, there have been many issues with the availability of the coronavirus test. Some people say they’ve been denied tests, and even though Pence announced on March 3 that anyone in the country can be tested for coronavirus, subject to doctor’s orders, the rate of testing still varies widely from state to state. The *Times* reported last week that the U.S. was performing 65,000 tests a day a huge rise from even a week earlier. However, public-health experts say about 150,000 tests a day is needed to identify infected patients and slow the spread of the virus. On Friday, however, the FDA approved a five-minute coronavirus test that should ship this week, allegedly delivering 50,000 tests daily by April 1.

On March 19, Secretary of State Mike Pompeo announced that the U.S. would close its borders with Canada and Mexico, barring entry to all nonessential travelers. The announcement was the latest in an increasing list of travel restrictions. President Trump has also barred entry of all foreign nationals who have been in high-risk countries, including China, Iran, and much of Europe, within the last 14 days. As of March 13, American citizens and permanent residents who are returning to the U.S. from those areas are required to fly through one of 13 airports, listed here, though Pompeo has said that U.S. citizens traveling abroad “should arrange to return immediately,” unless they plan to remain out of the country for an extended time.

The State Department has also issued a Level 4 “do not travel” advisory, the most serious advisory at its disposal, asking United States citizens to avoid any global travel. It has also advised Americans, especially those who are older or have existing medical conditions, to avoid cruises at this time. On Saturday, the CDC issued a travel advisory for residents of New York, New Jersey, and Connecticut, asking them to “refrain from non-essential domestic travel” for 14 days. On Friday, President Trump signed a \$2 trillion stimulus plan, the largest in modern American history. The plan will send direct payments of around \$1,200 to millions of Americans who earn less than \$99,000, along with an additional \$500 per child. The plan will also substantially expand unemployment benefits, including extending eligibility to freelance and gig workers, and provide aid to businesses and companies in distress. Last week, Treasury Secretary Steven Mnuchin extended the tax-filing deadline to July 15. President Trump has also signed a relief package to establish paid emergency leave for some American workers, expand food assistance, medical aid, and unemployment benefits, and offer free coronavirus testing. The U.S. House and Senate recently

reached a deal to provide \$8.3 billion in emergency funding to stop the spread of the coronavirus. According to the *Washington Post*, the money will go toward the development of a vaccine, public-health funding, medical supplies, and research of coronavirus in other countries. Meanwhile, the World Health Organization has said it will take around 18 months to develop a vaccine for COVID-19.

CASE STUDY ON UNITED KINGDOM

Introduction & Historical Background of Contagions Diseases in Europe

Although the modern public health system was not established until the nineteenth century, the roots of thinking and practice on trans-border health risks lie much farther back. The earliest recorded official efforts to deal with human disease associated with mobile populations date from the introduction of leprosy in Europe circa 350 B.C. and its subsequent spread by the Romans to most of the continent. Without means of preventing or curing the disease, local officials isolated and limited the movement of infected individuals to control its spread. Other measures adopted were mandatory inspection of selected travelers arriving in Britain, known as *Leprechaun*, and a system of public health warning (*Lazarus Bell*) to others of an infected individual.

The bubonic plague spread from central Asia to Europe, arriving in Italy in the 1340s. The resultant high levels of morbidity and mortality prompted the introduction of quarantine practices. As with leprosy, despite the lack of scientific knowledge, vagaries of diagnosis and practical means of controlling the disease, there was an intuitive desire to separate the local community from external sources and victims of the health risk. Quarantine became regularly used over the next four centuries and became standard practice throughout the trading world whenever ships and their passengers were suspected of posing an infectious risk to local populations. Along with plague, other diseases (e.g. cholera) were gradually added to the list of quarantine able conditions.

There is, of course, no novelty in the observation of a link between transcontinental movements of people and associated impacts on the health of both travelers and local populations in destination and return countries. Although such impacts were doubtless experienced from the migration of *Homo erectus* from Africa around 1 million BC, a landmark event in this context is what has been termed the “Columbian exchange” following 1492. The subsequent introduction into the New World of diseases such as smallpox, malaria, yellow fever, cholera and bubonic plague (Crosby 1972) heralded the emergence of true pandemics. Embryonic attempts to protect resident populations from health risks associated with international travel actually pre-date this, with the concept of quarantine emerging as standard maritime practice in parts of Europe from the fourteenth century. While acknowledging the long established historical connection between human travel and health, there are features of the current scale of population mobility that have particular implications for human health. The enormous

growth in population mobility across a number of categories in recent decades suggests that there is something both quantitatively and qualitatively different from previous eras, and that trans-border health risks assume a new salience.

Legal Overview on the Powers to Prevent the Spread of Disease in United Kingdom

A report published in 2003 from the House of Lords recommended that the roles and responsibilities of the groups involved in the fight against infectious disease be more clearly defined. The result of this report was the development of Emergency Planning Guidance of The National Health Service (NHS), which was first published in 2005. This guidance provides general principles on how NHS organizations should handle major incidents, which are defined to encompass “big bang” incidents, such as an infectious disease epidemic. The primary piece of legislation that addresses public health emergencies is the Public Health (Control of Disease) Act 1984. This Act served to consolidate a number of pieces of legislation from the nineteenth century, much of which was “directly derived from Victorian antecedents.” The laws were based on the scientific knowledge and social circumstances of those times and, therefore, did not address modern risks, such as contamination from chemicals or radiation. As a result of these concerns, the government enacted the Health and Social Care Act 2008, which repealed a large number of provisions in the Public Health (Control of Disease) Act 1984. The amendments aimed to bring the provisions concerning infections up to date and take into account other concerns, such as radiation and chemical contamination. The updated provisions of the 1984 Act provide two areas under which regulations may be made in relation to diseases. The first relates to in-country provisions and the second to England’s international borders.

Under section 45C of the Health and Social Care Act 2008, the Secretary of State may make regulations to prevent, protect against, control, and provide a public health response to an incident or to the spread of infection or contamination in England, even if the threat originated from outside the country. The Law provides examples of powers that the Secretary of State may exercise by regulation, including-

- i. imposing or enabling restrictions or requirements on individuals in the event of, or in response to, a threat to public health; or
- ii. providing local authorities with functions to monitor public health risks.

According to this section, The restrictions may include keeping a child away from school, prohibitions or restrictions on events or gatherings, a “special restriction or requirement” or “Part 2A order,” or requirements with regard to the handling and treatment of dead bodies. Under section 45D of the Health and Social Care Act 2008, any restriction imposed under the provisions of this Act must be proportionate with the aim that it is trying to achieve, in order to comply with human rights principles adopted in the UK.

Section 45E of this Act of 2008 stated that the Secretary of State may not make regulations requiring that a person receive medical treatment, including vaccinations. However, if there is a serious and imminent threat to public health any special requirements and restrictions may require “medical examinations, removal to or detention in a hospital or other establishment, or isolation or quarantine.”

The statute limits the powers and penalties the regulations may confer which is describe in section 45F & 45M of this Act of 2008. The regulations can

- i. confer functions on local authorities and other persons;
- ii. create offenses, although these cannot be punishable with imprisonment or a fine of more than £20,000 (approximately US\$35,000);
- iii. enable courts to order that anyone convicted of an offense under the regulations take or pay for remedial action;
- iv. make regulations that apply to different areas of the country;
- v. provide for the execution and enforcement of restrictions or requirements imposed;
- vi. provide for a system of appeals from and reviews of decisions made under the regulations;
- vii. allow or prohibit charges to be levied;
- viii. permit or require the payment of incentive payments, compensation, and expenses; and/or
- ix. provide for the resolution of disputes.

To prevent the spread of infection or contamination, the Public Health (Control of Disease) Act provides that Justices of the Peace may impose restrictions and requirements on individuals, premises, groups, and objects through orders, known as “Part 2A Orders.” Only local authorities may apply to a Justice of the Peace for a Part 2A Order, and these orders may, in certain circumstances, be made without notifying the individual affected by the Order. And section 45G to section 45O of this Act of 2008 derived every fact relating to this orders. Such an order may require that an individual,

1. submit to medical examination;
2. be removed to a hospital or other suitable establishment;
3. be detained in a hospital or other suitable establishment (unless otherwise stated, for a maximum period of twenty-eight days);
4. be kept in isolation or quarantine (unless otherwise stated, for a maximum period of twenty-eight days);
5. be disinfected or decontaminated;
6. wear protective clothing;
7. provide information or answer questions about their health or other circumstances;
8. have their health monitored and the results reported;
9. attend training or advice sessions on how to reduce the risk of infecting or contaminating others;
10. be subject to restrictions on where they go or with whom they have contact; and

11. abstain from working or trading.

The Justice of the Peace may issue the order only if he/she is satisfied that a person may be infected or contaminated, could present significant harm to human health, and there is a risk the person may infect or contaminate others. The Justice of the Peace may also order that the suspected infected or contaminated person provide information about the identity and location of other individuals that may be infected or contaminated who pose a risk to others, to enable “contact tracing” of these individuals.

For items, the order may impose a number of restrictions or requirements, including that the thing be seized; retained; isolated; quarantined; disinfected; decontaminated; destroyed; disposed of; or, in case of dead bodies, it would be cremated or buried. For premises, the order may impose restrictions or requirements, including that the premises be closed, disinfected, decontaminated, or destroyed. For conveyances or other moveable structures, the order may require that they be detained. To enable contact tracing to help prevent the spread of infection or contamination, the order may require the owner or person in control of the thing or premises to provide information or answer questions about the thing or premises. All of these mentioned facts are stated in section 45G to 45I of the Act of 2008.

Under section 45K of the Health and Social Care Act 2008, The Justice of the Peace may also issue additional orders to include “such other restrictions or requirements as the justice considers necessary for the purpose of reducing or removing the risk in question.” The order may be conditional; for example, if a person refuses to be decontaminated, he/she must remain in isolation until the risk of contamination or infection has passed.

Covid-19 and United Kingdom

The government published its coronavirus action plan on 3 March. On 10 February, the Secretary of State for Health and Social Care, Matt Hancock, announced strengthened legal powers to protect public health. The Health Protection (Coronavirus) Regulations 2020 have been put in place to reduce the risk of further human-to-human transmission in this country by keeping individuals in isolation where public health professionals believe there is a reasonable risk an individual may have the virus. The government's action plan for dealing with the virus involves three phases – contain, delay and mitigate. After trying to contain the disease, the country moved to the “delay” phase on March 12, 2020 to stop the wider spread of the virus (Islam, 2020). In this phase, the aim is to slow spread of virus with providing the option of “Ask those with minor symptoms to self-isolate”, “Limit Large gathering”, “Encourage home working”, “close educational institution”.

In spite of these, the government faced difficulties to tackle the outbreak of Covid-19 due to their slow and late proceedings. The government has faced criticism over a shortage of testing, including the

inability to test NHS staff who have symptoms but are unsure if they have the virus. As a result the risk of Covid-19 to the UK has been raised to high. On 3 April 2020, total 173,784 people have been tested, of which 38,168 were confirmed positive and 3,605 have died. Even the British Prime Minister Boris Johnson had tested positive for coronavirus.

CONCLUSION

Yet, any vaccines were invented for this particular virus. So, we must follow the preventive measures to prevent the virus from spreading massively. The World Health Organization (Who) has already introduce some effective basic preventive measures which must be followed by all of us and already followed by every country. The basic protective measures against the new coronavirus are as follows:

1. Wash your hands frequently;
2. Maintain social distancing;
3. Avoid touching eyes, nose and mouth;
4. Practice respiratory hygiene;
5. Stay informed and follow advice given by your healthcare provider.

Poorer countries may be unable to deal with both the health and economic fallout of this pandemic on their own. The global effort that is already underway is essential, because COVID-19 knows no borders. No country is safe until every country is safe. Social distancing will slow the spread of COVID-19, but it will not win the war. So, our best hope lies in finding a vaccine. While there may be 41 candidates of varying promise in the pipeline. Too often, governments have sequestered vaccines in the countries where they were manufactured. They must ensure that when an effective vaccine becomes available, it is accessible to anyone who needs it, not just the rich and fortunate few. We are not yet near the end of the beginning of the COVID-19 crisis. Every country of the world weather developed or not, must use what precious time we all the people has to bolster their weakest health systems and economies. But shoring up their defenses is not enough. They must go on the offensive by making the development and global distribution of a vaccine our highest priority. Lastly, it is said that “Law without execution is impotent”. So, every country must ensure that their enacted laws for preventing or battling the outbreak of Covid-19 are imposed correctly and effectively.

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