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Feature Articles

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International Focus at Loyola University Chicago School of Law

Curriculum

Loyola University Chicago School of Law provides an environment where a global perspective is respected and encouraged. International and Comparative Law are not studied only in theoretical, abstract terms but primarily in the context of values-based professional practice. In addition to purely international classes, courses in other disciplines – health law, child and family law, advocacy, business and tax, antitrust, intellectual property – have strong international and comparative components.

International Centers

The United Nations has designated Loyola Chicago School of Law as the home if its Children's International Human Rights Initiative. The Children's International Human Rights Initiative promotes the physical, emotional, educational, spiritual, and legal rights of children around the world through a program of interdisciplinary research, teaching, outreach and service. It is part of Loyola's Civitas ChildLaw Center, a program committed to preparing lawyers and other leaders to be effective advocates for children, their families, and their communities.

Study Abroad

Loyola's international curriculum is expanded by its foreign programs and field study opportunities:

International Programs

- A four-week summer program at Loyola's permanent campus in Rome, Italy, the John Felice Rome Center, focusing on international and comparative law.
- A 10-day program in Beijing, during the last 10 days of May in the format of a Field Study. Students must take the Introduction to Chinese Law #177 in the Spring Semester. While on the Field Study, students will earn one additional credit for the Spring course #177, with instruction by a leading Chinese Commercial Law expert.

International Field Study

- A ten-day, between-semester course in London on comparative advocacy, where students observe trials at Old Bailey, then meet with judges and barristers to discuss the substantive and procedural aspects of the British trial system. Students also visit the Inns of the Court and the Law Society, as well as have the opportunity to visit the offices of barristers and solicitors.
- A comparative law seminar on *Legal Systems of the Americas*, which offers students the opportunity to travel to Chile over spring break for on-site study and research. In Santiago, participants meet with faculty and students at the Law Faculty of Universidad Alberto Hurtado.
- A one-week site visit experience in San Juan, Puerto Rico, students have the opportunity to research the island-wide health program for indigents as well as focus on Puerto Rico's managed care and regulation.

– A global law seminar that uses a collaborative immersion approach to learning about the legal system of a selected country, including travel to that country over spring break. Countries of focus have included Tanzania, Thailand, India, Cambodia, Turkey, and Vietnam. Students work in research teams to produce papers of publishable quality.

The Annual Wing-Tat Lee Lecture in International and Comparative Law

This annual event brings to Loyola University Chicago School of Law leading practitioners and scholars to deliver a significant lecture in international and comparative law. The lecture is funded by a grant from the late Wing-Tat Lee, a businessman from Hong-Kong. Previous lecturers include George A. Berman, Karen J. Alter, Thomas Buergenthal, Stephen Schwebel and Eleanor Fox.

The Wing-Tat Lee Chair in International Law

The Wing-Tat Lee Chair in International Law was established to support a leading scholar of international recruited from an international search with a grant from the late Wing-Tat Lee, a businessman from Hong-Kong. The current holder of the chair is James T. Gathii who specializes in international law, international human rights and international trade law. He is also an editor of the American Journal of International Law among other leading journals in his field. He serves as an investor-state arbitrator in international investment and contract disputes. He has published over 80 articles and several books and frequently presents his work around the world.

International Moot Court Competition

Students hone their international skills in two moot competitions: the Phillip Jessup Competition, which involves a moot court argument on a problem of public international law, and the Willem C. Vis International Commercial Arbitration Moot, involving a problem under the United Nations Convention on Contracts for the International Sale of Goods. There are two Vis teams that participate each spring in an oral argument involving an international moot arbitration problem. One team participates in Vienna, Austria against approximately 300 law school teams from all over the world, and the other team participates in Hong Kong SAR, China, against approximately 95 law school teams.

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We would like to recognize friends and alumni of the law school who have contributed within the past year to our international law program at Loyola University Chicago by their support of the Willem C. Vis International Commercial Arbitration Moot Program:

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Utilizing Social Epidemiological Profiles in Health and Human Rights Assessments to Advance Public Health

Dhrubajyoti Bhattacharya, J.D., M.P.H., LL.M.*

Introduction

Traditional health and human rights assessments do not adequately advance public health. Popular frameworks espoused by scholars and practitioners, though well intentioned, narrowly focus on human rights concerns as a product of downstream risk factors and health outcomes. This approach particularizes the problem within an affected person, and by extension, the population, though its traits may neither be representative nor pressing in the context of unmet needs. In this manner, invoking a human rights violation would be akin to filing a class action, enabling all parties with a material interest in the case to be represented, regardless of any socioeconomic or other demographic barriers that may prohibit an individual claimant from bringing suit. Equity and efficiency become the hallmarks of this procedural device and appears quite attractive to advance a public health issue that, by definition, affects a number of persons who constitute the "population" of interest. Public health, however, is guided by efforts to prevent harm, and not merely to identify it in its most obvious, physical manifestation of a clinical diagnosis. Underlying this approach is the presumption that health is a social construct and any attempt to characterize the experience of

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illness must not relegate efforts to the clinical domain.[1] Rather, an explanation of the distribution and determinants of morbidity and mortality must necessarily identify factors further upstream, that is, within those components of social structure that are associated with health and well being. Bhattacharya's specific approach to enumerate the role of politics, epidemiology, ethics, economics, and law ("PEEEL" framework) influenced the draft revision of accreditation criteria for schools and programs in public health, which now specifically requires training in public health policy to encompass the precise inquiries into the disciplines of economics, ethics, and law.[2]

Incorporating social indicators into an epidemiological profile reifies a number of human rights principles, including their indivisibility, interdependence, and interrelatedness. Under the Universal Declaration of Human Rights, "[a]ll human beings are born free and equal in dignity and rights," yet securing fulfillment of human dignity through the satisfaction of unmet needs remains elusive.[3] A myopic approach that matches needs to rights removed from their social context may exacerbate health disparities and further marginalize those disproportionately affected by the burden of illness.

I propose a simplified, three-step framework: (1) constructing a social epidemiological profile of the affected population, (2) reviewing the legal landscape, including international, national, and sub-national law, and (3) drafting local policies through enacting novel, or amending the existing, laws and regulations. Parts I through III, discussed below, are dedicated to each of these steps, and utilize the experience of migrants in the U.S. as a case study to illustrate key themes and issues. By deliberating upon the people, problems, and possibilities, we may appreciate the utility of this approach, and identify future courses of action that simultaneously advance public health and human rights.

I. The Necessity of Constructing a Social Epidemiological Profile

The relevance and utility of international law in advancing public health should not to be relegated to a linear process of treaty ratification and subsequent enforcement of particular provisions. While this may seem at odds with prior (and even ongoing) efforts to advance the right to health, this traditional approach often distances itself from the practical constraints of public health policymaking and implementation. Moreover, this approach inaccurately assumes that observed effects vis-à-vis poor health outcomes or incidents of morbidity or mortality may be immediately traced to the absence of a statute, regulation, or an amendment. I have previously advanced a framework, captured by the mnemonic "PEEEL" to highlight the opportunities and challenges of public health policymaking by examining the role of politics, epidemiology, economics, ethics, and law. So while the law is a critical component of this broader framework, it

[1] Dru Bhattacharya, *Public Health Policy: Issues, Theories, and Advocacy*, vii (2013).

[2] Council on Education for Public Health, Proposed Curriculum Criteria Revisions, C.4, t-v (2015) *available at* http://ceph.org/assets/Draft_curriculum.pdf (last visited October 22, 2015).

[3] Universal Declaration of Human Rights, G.A. Res. 217 (III) A, at Article 1, U.N. Doc. A/RES/217(III) (December 10, 1948).

should not be examined in isolation because of the potentially confounding effects of the other elements.[4]

The benefits of this robust framework, however, extend beyond the seemingly inherent value of a comprehensive and interdisciplinary approach. Where a traditional legal inquiry might look for individual facts to support the potential violation of a right, a public health approach will scrutinize both the methods and information (or "data") acquired by such efforts. Ideally, it will also disaggregate the data across numerous indicators that have historically amplified issues unique to the population under study. Examples may include age, sex, socioeconomic status, occupational hazards, access to material factors (e.g., food, shelter), as well as social and environmental determinants. Additionally, a traditional legal approach is quite reflexive, invariably following some blatant manifestation of a harm or wrong. Reporting violence, for example, and particularly incidents of sexual harassment or assault, has historically received attention among researchers exploring the experiences of female migrant workers. Our approach, however, would prioritize measures to combat violence as part of a broader strategy to promote health and secure the dignity of women. So before letting the data guide the development of policy, there should be a determination that the data is consistent with the unmet needs of the community being served. Even the term "unmet need" requires clarification, as it can be narrowly construed to mean the absence of a particular service or the heightened morbidity and mortality associated with a spike in the incidence of an illness. Otherwise, the provision of services, albeit beneficial, may not alleviate the burden of illness or address other needs that enable debilitating trends to sustain.

A. The Inadequacy of Traditional Frameworks

The International Covenant on Economic, Social, and Cultural Rights (ICESCR) espoused the initial right to health, identifying four specific steps to achieve the full realization of this right: (1) forging a provision for the reduction of the stillbirth and infant mortality rates; (2) improving all aspects of the environment and industrial hygiene; (3) preventing, treating, and controlling epidemic, endemic, and occupational diseases; and (4) creating conditions which would ensure medical services and medical assistance.[5] Notably, the right to health in the ICESCR was not explicitly synonymous with the right as was conceived by the World Health Organization. In its Constitution, the WHO made explicit reference to physical, mental, and social health. The omission of a "social" dimension to health in the ICESCR later prompted the Committee on Economic, Social, and Cultural Rights (CESCR) to clarify the apparent snub within a general comment that provided, in part, that the "express wording of article 12.2 acknowledge that the right to health embraces a wide range of socio-economic

[4] Bhattacharya, *supra* note 1, at 431.

[5] International Covenant on Economic, Social and Cultural Rights, S. Treaty Doc. No. 95-19, 6 I.L.M. 360, 993 U.N.T.S. 3, at Article 12(2)(a)-(d) (Dec. 16, 1966).

factors. . .”[6] Embracing a myriad of factors in a subsequent commentary, however, is quite distinct from an explicit obligation to do so.

In practice, the translation of the right to health would lay a foundation for the health and human rights movement, which has gathered momentum. We have begun to see studies that highlight the linkages between social structure and health. A prominent example of this is Michael Marmot's depiction of three factors through which social structure influences health and well-being: 1) material, 2) occupational, and 3) social/environmental.[7] Jonathan Mann provided a related framework arguing that violations of human rights have foreseeable effects on health, as well as the policies that enabled such violations to remain/thrive.[8] Mann further argues that there is an inextricable linkage between health and human rights so that the promotion of one would invariably promote the other, thereby suggesting a synergistic effect between measures to secure health and rights. The WHO elaborated on these linkages in its health and human rights paradigm, identifying the utility of this framework to identify violations, reduce vulnerability, and promote health.[9]

Gostin and Mann[10] later proposed a 7-step framework for conducting a health and human rights assessment, followed by a comparable framework by Gostin and Lazzarini.[11] Although there are slight (albeit significant) differences between the frameworks, they are substantially consistent in their methodology and scope (summarized in Figure 1 below). We will attempt to match and review the corresponding steps, along with notable differences, to illustrate where and how our current approach departs from these traditional paradigms.

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

[7] Marmot, Michael, and Richard Wilkinson, eds, SOCIAL DETERMINANTS OF HEALTH (Oxford U. Press, 2005).

[8] Jonathan Mann et al., *Health and Human Rights*, HEALTH AND HUM. RIGHTS, 6-23 (1994).

[9] World Health Organization, *Linkages between Health and Human Rights*, *available at:* http://www.who.int/hhr/HHR%20linkages.pdf (last visited October 22, 2015).

[10] Lawrence Gostin & Jonathan N. Mann, *Toward the Development of a Human Rights Impact Assessment for the Formulation and Evaluation of Public Health Policies*, 1 HEALTH AND HUM. RIGHTS, 59, 61-77 (1994).

[11] LAWRENCE GOSTIN & ZITA LAZZARINI, HUMAN RIGHTS AND PUBLIC HEALTH IN THE AIDS PANDEMIC, 58-67 (1997).

Social Epidemiological Profiles

Figure 1. Gostin and Mann's vs. Gostin and Lazzarini's Frameworks

Gostin and Mann (1994)	Gostin and Lazzarini (1997)
1. Clarify the public health purpose 2. Evaluate likely policy effectiveness 3. Determine whether the public health policy is well-targeted 4. Examine each policy for possible human rights burdens 5. Determine whether the policy is the least restrictive alternative to achieve the public health objective 6. If a coercive public health measure is truly the most effective, least restrictive alternative, base it on the "significant risk" standard 7. If a coercive measure is truly necessary to avert a significant risk, guarantee fair procedures to persons affected	1. Find the facts 2. Determine if the public health purpose is compelling 3. Evaluate how effectively the policy would achieve the public health purpose 4. Determine whether the public health policy is properly targeted 5. Examine each policy for possible human rights burdens 6. Determine whether the policy is the least restrictive alternative that can achieve the public health objective 7. If a coercive measure is truly the most effective, least restrictive alternative, base it on the "significant risk" standard and guarantee fair procedures

The first step in Gostin and Mann's framework calls for clarifying the public health purpose. This is problematic because articulating goals presupposes a consensus on the problem. Gostin and Lazzarini correct this by requiring an initial fact-finding expedition, and point to the "sciences" of public health and healthcare (e.g., medicine, nursing, social services).[12] These suggestions, however, are medically centered sciences, and epidemiology is not a pure science but rather a set of methods to describe the distribution of morbidity and mortality, and their application to the control and prevention of disease. With the increasing appreciation of the role of social determinants, reliance on these "sciences" of public health would offer little insight into those factors (except for the discipline of social epidemiology, to which we shall return momentarily). While a single individual may be subject to a human rights violation, it is the systematic targeting of marginalized populations and the disproportionate burden they incur on account of social factors (e.g., religious beliefs, lower socioeconomic status, race/ethnicity, sex, etc.) that illustrates those populations disproportionately affected by the burden of illness. While a limit to the disciplines that we rely upon to characterize a public health problem is not necessary, the aforementioned fields are necessary, but insufficient.

The second step of Gostin and Mann's framework recommends evaluation of the likelihood of the policy's effectiveness. They elaborate on effectiveness by citing screening programs to demonstrate the importance of considering the context of interventions. Specifically, they cite the appropriateness and accuracy of tests, the likelihood of effective interventions, and the possibility of alternative approaches as criteria to be considered. This step essentially requires that a policy support interventions that are evidence-based and scrutinized to ensure minimal harm to affected populations (overlapping with steps 4 and 5). Given the

[12] *Id.* at 58.

varied strengths of epidemiological studies, acknowledging the precise evidentiary basis for interventions is a critical step and may be cited within a social epidemiological profile, as discussed below. A randomized control trial may be the gold standard to illustrate why one drug may be preferred to another, but it tells us nothing of the communities and the underlying causes of the burden of illness. The critical issue, therefore, is not merely the strength of a particular piece of evidence, but whether the evidence is related to the unmet needs of the community, thereby begging the question of scope rather than merely substance.

The second step of Gostin and Lazzarini's approach is different and requires determination that the public health purpose be compelling. Here, the description of the criteria conflates the data with its interpretation, as if the former would necessarily translate into the latter. A rate (or any other indicator that constitutes those "facts" accumulated under Step 1) cannot have an inherent purpose, though it may be used to fulfill a purpose. If the standard is simply an aggregate sum, or some predetermined threshold worthy of "population" significance, then locating a *compelling* reason to intervene is nothing more than a formality in attaching the label thereto. Herein lies a fundamental problem with both frameworks; we are never quite sure when a health issue is a public health issue. A utilitarian model would suggest that health issues affecting, or potentially affecting, a large number of individuals are worthy of being considered "public health" issues.[13] This myopic view of public health would do little to advance health education and health promotion activities, which may take time to prevent future harm, especially as it relates to chronic illness. The role of childhood obesity, for example, as it relates to the adult onset of diabetes and other chronic health problems may not be readily apparent by examining a sample of children and screening them for such ailments. Yet, the role of those risk factors, and the benefits of advancing protective factors, may be worthy of scrutiny. Now childhood obesity is an easy "fact" to screen for in and of itself, and has drawn enough public attention in both professional and political arenas to satisfy a compelling public health purpose. What are not, but perhaps ought to be, more compelling issues are the social determinants[14] that sustain such trends, notwithstanding the extensive edu-

[13] See infra, note 1.

[14] *See* World Health Organization, *What are Social Determinants of Health?* Available at: http://www.who.int/social_determinants/sdh_definition/en/ ("The social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels.")(emphasis in the original); *see also* Centers for Disease Control and Prevention, Determinants of Health, http://www.cdc.gov/nchhstp/socialdeterminants/definitions.html ("Factors that contribute to a person's current state of health. These factors may be biological, socioeconomic, psychosocial, behavioral, or social in nature.") There is considerable overlap in how we generally characterize social determinants of health. The following definitions provided by the World Health Organization, and the U.S. Centers for Disease Control and Prevention together show the degree of similarities. Beyond those similarities, however, are some notable points in how the organization might choose to utilize those definitions to address issues in public health. The WHO defines social determinants as conditions in which people are born, grow, live, work and age. It goes on, however, to pinpoint these determinants as being responsible for health inequities, or what it describes as unfair and avoidable differences in health status, whether it is within or between countries. The CDC definition captures the breadth of determinants across many different spheres, including biological, socioeconomics, psychosocial, behavioral, and social. The organization notes that these forces are shaped by economics, social policies, and politics, and focuses on five determinants that it claims

cational campaigns, and occasional targeted intervention (e.g., soda tax, removal of vending machines in schools) that are conveniently symbolic, perhaps even sustainable, but woefully distracting.

The social and behavioral sciences constitute a vital role in contextualizing facts, but they are not required indicators in a formal epidemiological investigation. This creates a potential gap that is critical and warrants elaboration to illustrate why this complexity must be identified and deliberately acted upon to tease out those indicators worthy of further scrutiny. The social patterning of health enables advocates to inquire into the broader societal context, the role and influence of social structure, and all those elements we have come to characterize as social determinants of health. Another important discipline is psychology, which has long been associated with mental health issues, but has come to encompass other areas including health psychology.

Sociological theories can be characterized into structural and social action theories, the latter of which is espoused by Max Weber. Of course, our understanding of illness and ascribing those accommodations are by no means simple, especially when we publicly treat individuals differently for the behaviors that may have contributed to those ailments. We have seen this historically with the use of alcohol, tobacco, perhaps the contraction of an infectious disease, most notably HIV/AIDS, and perhaps today with overweight and obesity.[15] So our response is by no means simple, and for conditions that we find entangled in a web of societal influences that may exacerbate the experience or disparities within a particular subgroup—along the lines of sex, age, race/ethnicity, or socioeconomic status—the opportunity and constraints to intervene become more elusive because of the myriad of options that vary across different levels and time.[16] The emphasis, however, is objectivity wherein these determinants may be measured within dimensions and components using precise indicators.[17] Globalization with respect to the geopolitical, economic, and environmental dynamics has only added another layer to this complexity. Therefore, we ought to refrain from reflexive judgment about a given issue until we have appreciated the breadth of factors that may contribute to the experience of illness.

When we look at the sphere of human behavior, we can identify a wide set of risk regulators. Glass and McAtee describe behavior as an emergent property of the interplay between opportunities and constraints emanating from the environ-

scientists have generally recognized: first, biology and genetics (such as sex and age); second, individual behavior (such as alcohol use, smoking, unprotected sex); third, the social environment (such as income, and discrimination); fourth, the physical environment (such as where a person lives); and finally, health services (such as access to care, and insurance coverage). The CDC also collects data on these determinants as being consistent with its mission to "reduce health inequities among populations most disproportionately affected by HIV, AIDS, STDS, TB, and hepatitis."

[15] *See, e.g.,* Ronald O. Valdiserri, *HIV/AIDS stigma: an impediment to public health.* 92(3) AM. J PUB. HEALTH 341 (2002).

[16] *See, e.g.,* Marilyn Metzler, *Social determinants of health: what, how, why, and now*. 4(4) PREVENTING CHRONIC DISEASE A85 (2007).

[17] *See, e.g.,* Marianne Hillemeier et al., *Data Set Directory of Social Determinants of Health at the Local Level*. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (2004).

ment.[18] Here, we detail that environment to include material conditions; discriminatory practices, policies and attitudes; neighborhood community conditions; behavioral norms, rules, and expectations; conditions of work; and laws, policies, and regulations.[19] How do we explore these factors? Social action theories, which emphasize subjectivity, require researchers to focus on focus groups, interviews, surveys, and related qualitative assessments to collect data on beliefs, attitudes, and practices. Let us return to our example of childhood obesity to demonstrate the complexity of the problem.

Skelton et al. reported that more U.S. children are becoming severely obese after conducting a survey of 12,000 U.S. children and adolescents, ages 2-19 (Severe obesity is a BMI = 99th percentile for age and gender, and they found that the prevalence tripled from 0.8% ('76-'80) to 3.8% ('99-'04)).[20] In the U.S., instituting a soda tax would easily satisfy either of the initial steps of the aforementioned frameworks owing to this scope and magnitude of childhood overweight and obesity, coupled with evidence from a meta-analysis that a tax on sugar sweetened beverages reduces the obesity rate.[21] But why is this approach any more compelling than efforts to intervene with stakeholders such as parents, children, or schools, as loci of reform? We can conceptualize parents with respect to their awareness and health and the role of the home setting and environment. With children specifically, we may refer to the role of activities such as video games, food choices, and adolescent awareness of weight status. And with schools, we may consider the time spent in school, food, the school's environment, opportunities for physical activity, and education as important factors that affect a child's health.

The home environment and role of parents is remarkable, as obese parents appear to be more likely to have overweight children. A study done by Trasande focused on 226 families and determined that 41% of 8-year-old daughters of obese mothers were themselves obese. In contrast, only 4% of girls were obese who had mothers of a normal body weight.[22] Parents may also lack confidence to implement healthy behavior changes for children. Taveras et al. conducted a survey of 446 parents of overweight children, aged 2-12, about how confident they felt in making changes aimed at television viewing, and reducing their children's consumption of fast food. The mean parental confidence was 13 on a scale of 0-24.[23] Moreover, parents with positive outlooks on team sports have more active

[18] Thomas Glass & Matthew J. McAtee, *Behavioral Science at the Crossroads in Public Health: Extending Horizons, Envisioning the Future*, 62 SOC. SCI. & MED. 1650, 1660 (2006) (opportunities and constraints constituting "structural contingencies").

[19] *Id.*

[20] Joseph A. Skelton et al., *Prevalence and Trends of Severe Obesity among U.S. Children and Adolescents*, 9 ACAD. PEDIATRICS 322-329 (2009).

[21] Maria A. Escobar et al., *Evidence that a Tax on Sugar Sweetened Beverages Reduces the Obesity Rate: a Meta-Analysis,* 13 BMC PUB. HEALTH 1072 (2013).

[22] Leonardo Trasande et al., *Effects of Childhood Obesity on Hospital Care and Costs, 1999–2005*, 28 HEALTH AFFAIRS w751-w60 (2009).

[23] Elsie Taveras et al., *Parental Confidence in Making Overweight-Related Behavior Changes*, 124 PEDIATRICS 151 (2009).

children. A study by Anderson and Hughes included a survey of 680 parents of 4th and 5th graders from 12 schools. Children were more physically active when parents conveyed the importance of high-intensity team sports.[24] Overweight mothers are also less likely to accurately identify their children's weight. A study by Warschburger and Kroller entailed a survey of 216 mothers of children, aged 3-6, and asked to assess the weight status of 36 gender-specific silhouettes representing different ages and body mass indices.[25] Only 64.5% identified the silhouettes correctly and only 48.8% associated overweight silhouettes with a health problem.[26] Infants cared for in another home are also likely to be heavier. Benjamin et al. conducted a study of 1,100 women while pregnant and assessed weight after assessing who was placed in some form of day care.[27] Children cared for in someone else's home were more likely to be heavier than if they were either at home or in day care.[28] And finally, parents' dietary restrictions may backfire. Anzman and Birch conducted a study of 200 non-Hispanic white females and parents at two-year intervals when the girls were ages 5-15. They measured the mothers' reports of girls' inhibitory control levels, girls' reports of parental restriction, girls' BMI, and found that girls with lower inhibitory control at age 7 had higher concurrent BMI, greater weight gain, and higher BMIs later.[29]

The behaviors and beliefs of adolescents are also compelling factors. Online games, for example, can influence food choices. Pempek and Calvert conducted a study of 30 children, age 9-10, to play a game that awarded points for selecting healthy foods; a second version rewarded selection of unhealthy foods.[30] They measured the children's choice of a snack after playing, and found that 90% of children who played the first game chose a healthy snack, while only 10% did the same in the second group.[31] Adolescents also frequently underestimate body weight. Wang et al. conducted a survey of 196 boys and 252 girls, 5th through 8th grades, about their body weight, body perception, and weight control behaviors.[32] They found that 36% of overweight boys and 21% of overweight girls

[24] Cheryl B. Anderson et al., *Parent–child Attitude Congruence on Type and Intensity of Physical Activity: Testing Multiple Mediators of Sedentary Behavior in Older Children*, 28 HEALTH PSYCHOL. 428, 436 (2009).

[25] Petra Warschburger & Katja Kröller, *Maternal Perception of Weight Status and Health Risks Associated with Obesity in Children*, 124(1) PEDIATRICS, 1 at e60-e68 (2009).

[26] *Id.*

[27] Sara E. Benjamin et al., *Early Child Care and Adiposity of Ages 1 and 3 Years*, 124(2) PEDIATRICS 555, 560 (2009).

[28] *Id.*

[29] Stephanie L. Anzman & Leann L. Birch. *Low Inhibitory Control and Restrictive Feeding Practices Predict Weight Outcomes*, 155(5) THE J. OF PEDIATRICS 651, 653 (2009).

[30] Tiffany A. Pempek & Sandra L. Calvert, *Tipping the Balance: Use of Advergames to Promote Consumption of Nutritious Foods and Beverages by Low-income African American Children*, 163(7) ARCHIVES OF PEDIATRICS & ADOLESCENT MED. 633-37 (2009).

[31] *Id.*

[32] Youfa Wang et al., *Measured Body Mass Index, Body Weight Perception, Dissatisfaction and Control Practices in Urban, Low-income African American Adolescents*, 9 BMC PUB. HEALTH 183, 186, 190-91 (2009).

reported that their weight was normal or underweight, and 43.4% reported attempting to lose weight, although those who said so did not eat healthier or appear more active than those who did not report attempting to lose weight.[33]

The role of schools has been instrumental in providing access to food for children for many decades. The Healthy, Hunger-Free Kids Act of 2000 funds a number of nutrition programs, including the National School Lunch program. Over 45% of U.S. youth participate in this program, which costs approximately $12 billion annually and serves 32 million children. The National School Lunch Program provides nutritionally balanced meals at either low or no cost, and can be traced back to 1946 when President Harry Truman signed the National School Lunch Act.[34] It operates in over 100,000 public and non-profit private schools and residential child care institutions.[35] The lunches have to meet the nutritional standards in the latest Dietary Guidelines for Americans, and there are set calorie limits based on grade levels and improvements based on gradual reductions in sodium content. For example, it includes targets that must be reached in future years. Local school food authorities ultimately choose the foods served to the children, and schools receive support in the form of a cash reimbursement for each meal served.[36] The program has encountered significant challenges amidst reports of wasted food and improper payments alongside continued rates of childhood obesity, prompting Congressional hearings on the matter.[37] There have also been reports in schools of children selling packets of sugar or other condiments in order to mitigate the bland taste of some foods.[38]

Against this backdrop, we can appreciate a far more complex landscape to address childhood overweight and obesity and the need to adopt a nuanced approach that appreciates the numerous stakeholders and points of intervention. The role of social and behavioral sciences in public health amplifies the social structure and behavioral determinants of health. Whether we choose to adopt theories grounded in social structure or social action theory, we find opportunities to clarify the experience of illness associated with factors that extend beyond the proximal risk factors of disease. As we see in the example of childhood obesity, the role of parents, children, and schools as a loci of reform, numerous challenges arise in identifying the precise level and time of intervention to alleviate the burden of illness among vulnerable populations. By recognizing the opportunities and constraints, however, we may take a more nuanced approach to craft-

[33] *Id.*

[34] Richard B. Russell National School Lunch Act, Pub. L. No. 79-396, 60 Stat.239 (codified as amended in scattered sections of 42 U.S.C.).

[35] United States Department of Agriculture, *National School Lunch Program Factsheet*, (September 2013), http://www.fns.usda.gov/sites/default/files/NSLPFactSheet.pdf.

[36] *Id.*

[37] Subcommittee on Early Childhood, Elementary, and Secondary Education, *Addressing Waste, Fraud, and Abuse in Federal Child Nutrition Programs* (May 19, 2015), *available at*: http://edworkforce.house.gov/calendar/eventsingle.aspx?EventID=398843 (last visited October 22, 2015).

[38] Subcommittee on Early Childhood, Elementary, and Secondary Education, *Child Nutrition Assistance: Looking at the Cost of Compliance for States and School*, (2015), *available at:* http://edworkforce.house.gov/uploadedfiles/payne_testimony.pdf.

ing and implementing interventions that will only increase our likelihood of obtaining marked improvements in health.

Subsequent steps to ensure that the policy is "well-targeted" in response to a "significant risk" is a low bar to meet because a policy that is not well-targeted would not be consistent with the evidence base, or at the very least, would reveal gaps in the epidemiological literature as to the representativeness of the samples used in the studies.

Additionally, it is unclear what constitutes a "significant" risk beyond a heightened probability of transmission, but locating the threshold of significance is not a dispositive issue. What is problematic with the standard is that it is an individual determination, albeit consistent with traditional human rights analyses, but inadequate for our purposes. We need a standard that does not utilize an individual as the object of an intervention, but rather the population. In doing so, we shift the frame of reference to scrutinize those factors that enable population wide disparities to remain. These considerations may therefore be folded into the prior discussion of the evidence-base.

Gostin and Mann introduced four criteria to assess a human rights burden (Steps 4 and 5): (1) the nature of the human right, (2) invasiveness of the intervention, (3) the frequency and scope of the infringement, and (4) its duration.[39] These criteria are consistent with assessments of overt acts, and are thereby appropriate for downstream determinations. Unfortunately, these considerations may be too late and ought to be complemented by an upstream determination of social structure. By adopting this broader perspective, we are no longer confined to those indicators predictably defined by the intervention, but can focus more on the underlying causes of the burden of illness. Consider a heightened incidence of chronic disease within a community. Enabling access to care, and the provision of basic medical services (e.g., treatment) is a somewhat obvious proposition. At the same time, these provisions do not reach the following questions: Why did this particular population become affected? Do they share characteristics that suggest that they were at a heightened probability of disease onset? If so, what protective factors—rather than risk factors—ought to be promoted within this community to reduce the likelihood of infection? To answer these questions, we have to first assess the broader unmet needs of the community. Notably, there is no human right to public health, and individuals must lean on governmental discretion as to which indicators are sufficiently relevant to warrant a particular course of action.

Determining whether the policy is the least restrictive alternative that can achieve the public health objective does not require elaboration. To do otherwise would simply be unethical. A more challenging proposition is determining the least restrictive alternative in modifying a social determinant. In practice, this entails discretion because we do not have a hierarchy of pathways from social structure to health and well-being. Marmot's classic framework articulates three

[39] Lawrence Gostin & Jonathan N. Mann, *Toward the Development of a Human Rights Impact Assessment for the Formulation and Evaluation of Public Health Policies*, 1 HEALTH AND HUMAN RIGHTS 59, 61-77 (1994).

pathways through material, occupation, and social/environmental factors; yet, consistent with the principles of indivisibility and interrelatedness of human rights, the interrelated dimensions of these social determinants as material factors may be affected by occupational factors, which in turn may be affected by social/environmental factors (and vice versa). An allocation of resources that targets these determinants ought to be informed by the weight of influence that the particular pathway has at a given time for a given population; that is, handled on a case-by-case basis that, again, may be folded back into a social epidemiological profile, which ought to capture the weight of those factors.

The final steps entail the provision of fair procedures to persons affected by coercive measures.[40] This is a fundamental right whose implications are less a matter of public health concern, since the health issue to be averted is supposedly accomplished by the restraint of the individuals. Insofar as they cannot escape from this restraint, the public health issue has been addressed, albeit crudely, and begs the question whether voluntary submission to this restraint would alter the criteria. For example, if an at-risk individual isolates himself, or an infected individual quarantines herself, securing access to counsel (whether through public or private assistance) is neither an exceptional nor health-promoting feat. The right of habeas corpus is perhaps among the select rights that may find consensus in any legitimate democracy, but it does not seem to add much value to our framework (save in the case of infectious diseases where an incubation period may be cited to inform the length of detainment. But again, this would be distinct from the general provision of legal counsel).

Together, these considerations suggest that the traditional frameworks are untenable, and we turn towards a more nuanced approach that simplifies the process, and advances public health through a more deliberate course of action.

B. Incorporating a Social Epidemiological Profile: Migrant Workers in California

A migrant worker is "a person who is to be engaged, is engaged or has been engaged in a remunerated activity in a State of which he or she is not a national."[41] Over 214 million people meet this definition, whose plight may have stemmed from political persecution, conflicts, natural disasters, poverty, or even the pursuit of education or employment.[42] Here, we introduce the utility of integrating a social epidemiological profile into health and human rights assessments.

The shortcomings of our traditional models are not limited to theoretical constructs, but severely limit our range of intervention to satisfy unmet needs. There is no singular definition of an unmet need, so we may define the term narrowly with respect to access to a particular service, or broadly with respect to underlying social conditions that may directly, or indirectly, be associated with the health

[40] Gostin, Mann, and Lazzarini, *supra* notes 10-11.

[41] International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families art. 2(1), Dec. 18, 1990, 2220 U.N.T.S. 93.

[42] Pia Oberoi et al., *International Migration, Health, and Human Rights*, 7 (2013).

and well-being of the target population. Therefore, scrutinizing the adequacy of measures to secure the right to health by effectively meeting an unmet need can be elusive. What balance ought to be struck between the provision of preventive and therapeutic measures? What benchmarks should be established and over what period of time? Historically, no explicit guidelines were issued vis-à-vis the conventions or general commentary on the right to health.

In practice, determining the unmet health needs is best accomplished by examining the characteristics of the affected communities. We may accomplish this by creating an epidemiological profile of a community and including precise calculations of health indicators and an assessment of the laws and policies that affect the distribution and determinants of those indicators. An epidemiological profile is a report of the distribution of an ailment within various populations in a defined geographic region. The creation of an HIV/AIDS epidemiological profile, for example, would include an assessment of characteristics of the general population, individuals infected with HIV, and individuals at risk of infection.[43] The profile would also include data on the effect of HIV/AIDS on that community with respect to socioeconomic, geographic, behavioral, and clinical factors.[44]

The standard epidemiological profile would fit neatly within the traditional frameworks above by providing facts that would be compelling by their sheer scope and magnitude. For illustrative purposes, we shall focus on migrant workers as a case study to demonstrate the utility of this approach. We will create a simple epidemiological profile, illustrated below, of migrant patients who attended 160 health centers, and highlight the burden of diabetes that disproportionately affects individuals of Hispanic ethnicity, age 45 and above.

Table 1. Traditional Epidemiological Profile of Migrants

	Most Frequent Visits by 1° Diagnosis	Visits per Patient	Hispanic Ethnicity	Adults > 45 enrollment	Overweight or obese dx
Migrants	Diabetes	3.09[45]	89.8%[46]	20.7%[47]	4th

Against this backdrop, implementing a lifestyle intervention that targets adult Hispanic migrants who are overweight or obese would reduce the risk of diabe-

[43] Centers for Disease Control and Prevention and Health Resources Services Administration, *Integrated Guidelines for Developing Epidemiologic Profiles*, (2004), *available at*: http://www.cdph.ca.gov/programs/aids/Documents/GLines-IntegratedEpiProfiles.pdf.

[44] *Id.* at 3.

[45] U.S. Dep't of Health and Hum. Servs., *National - Migrant Health Center – 160 Grantees, List of Grantees – 2011* 15 (2011), http://bphc.hrsa.gov/uds/doc/2011/National_mh.pdf (table 6A, line 9, visits per patient).

[46] *Id.* at 8 (table displaying patients by race).

[47] *Id.* (estimated 164,966 calculated from summing lines 30-38 and dividing by the total 795,808, yielding .207 or 20.7%).

tes.[48] Overweight and obesity are risk factors particularly for individuals, age 45 and above, who are at heightened risk of developing the illness.[49] Since Hispanic males constitute almost 90% of this population, identifying those individuals who are overweight or obese would satisfy the "significant risk," "compelling" health purpose, and "well-targeted" policy criteria.

A social epidemiological profile, however, is a critical addendum to this traditional approach that incorporates social and historical determinants.[50] While the specific variables will differ on a case-by-case basis, the types of indicators would be similar insofar as they highlight social determinants. Notably, these determinants may change over time. Back in 1938, Dr. Walter Dickie, the Medical Director of the California State Department of Public Health, issued a report on migrant health in the department's weekly bulletin.[51] Dr. Dickie noted that the migrant population at the time was 90% White with malnutrition and poor dietary habits among the chief health related concerns.[52] Low-calorie intake and the absence of essential nutrients and minerals were among the specific findings. Notably, migrant mothers were said to be "[not used to] preparing the variety of vegetables and fruits" available in the state, so the health department placed nutritionists alongside doctors and nurses, and they held classes to give individual instruction to mothers on food preparation.[53] The Department of Agriculture also provided food grants and commodities for these families whose health improved in the months after receiving this aid.[54] At that time, infectious diseases such as tuberculosis were prevalent but were no greater among the children of migrants than the local residents. The health department concluded that the greatest need in this population was "that of education in the hygiene of proper living."[55] It also requested a coordinated effort by social welfare, medicine, nursing, and public health across local, state, and federal agencies to bring this population within the "social life of California." The report concluded by recommending not merely services for the prevention of disease alone, but additional care, relief, and housing facilities. The laws did predicate access to county hospitals based upon legal residence, but when that was lacking, migrants were directed to private physicians with services paid for by the Agricultural Health and Medical Association.[56]

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[48] *See, e.g.,* Diabetes Prevention Program (DPP) Research Group, *The Diabetes Prevention Program (DPP): Description of lifestyle intervention*, 25(12) DIABETES CARE 2165-71 (2002).

[49] Mayo Clinic Staff, *Disease and Conditions: Type 2 Diabetes,* http://www.mayoclinic.org/diseases-conditions/type-2-diabetes/basics/risk-factors/con-20031902.

[50] Luis A. Avilés, *Epidemiology as Discourse: the Politics of Development Institutions in the Epidemiological Profile of El Salvador*, 55(3) JOURNAL OF EPIDEMIOLOGY AND COMTY. HEALTH 164-71 (2001).

[51] Walter M. Dickie, *Health of the Migrant*. WEEKLY BULLETIN, CAL. DEP'T OF PUB. HEALTH 81-87 (June 18, 1938).

[52] *Id.* at 81.

[53] *Id.* at 83.

[54] *Id.*

[55] *Id.* at 86.

[56] *Id.*

Social Epidemiological Profiles

Over the past 70 years, we have seen a shift in the demographic makeup and the unmet needs of the migrant community. Today, the Health Resources and Services Administration reports that 81% of migrants are at or below federal poverty level, 51% are uninsured, and 90% are Hispanic or Latino (See Table 2, above). Diabetes and hypertension rank highest among select medical conditions, and preventive and screening services related to women and maternal and child health are among the highest within that category.[57] Specific measures include contraceptive management, the PAP test, and health supervision of an infant or child. Nutritional deficiencies still abound, with overweight and obesity high among the primary diagnoses at a first visit with a healthcare provider.[58]

So we observe an expansion of unmet needs specific to female migrants in their roles as both women and mothers, and an additional element of race and ethnicity that must be accounted for given cultural, linguistic, and other related issues that may give rise to discrimination and barriers to access and care. There is no single or comprehensive data repository for this population with some estimates based on assessments conducted 10-15 years prior. Therefore, studies conducted by researchers become a valuable source of information to identify existent trends that may otherwise go undetected based on current reporting requirements and compliance with these requirements.

For purposes of illustration, the social epidemiological profile in Table 2 includes individuals living at or below the federal poverty level, insurance status, ethnicity, and a history of workplace harassment, painting a broader picture of the migrant experience.

[57] U.S. Dep't of Health and Hum. Servs., *National - Migrant Health Center – 160 Grantees, List of Grantees – 2011* 15 (2011), *available at*: http://bphc.hrsa.gov/uds/doc/2011/National_mh.pdf.

[58] *Id.*

Social Epidemiological Profiles

Table 2. Social Epidemiological Profile of Migrants

	Most Frequent 1° Diagnosis	At or below FPL	Uninsured	Hispanic Ethnicity	Medicaid enrollment	Workplace harassment
General Pop	Hypertension[59]	15%[60]	11.4%[61]	17.0%	22.5%[62]	25%[63]
Migrants	Hypertension[64]	81%	51.0%[65]	89.8%[66]	37.3%[67]	0%-97%[68]
Difference	—	+66%	+39.6%	+72.8%	+14.8%	+72%

Heart disease is the leading cause of death among all Americans, including Hispanics.[69] Although the most frequent number of *visits* were attributable to diabetes, hypertension—a risk factor for heart disease—was the most frequent primary diagnosis for all patients.[70] Individuals without insurance, or who have inadequate access to healthcare, have a heightened risk of developing cardiovascular disease.[71] This risk may be particularly pronounced among migrants who are more likely to be uninsured compared to the general population. Among migrant women, the magnitude of workplace harassment is particularly noteworthy. Harassment is a psychosocial stressor and studies have demonstrated that daily

[59] Centers for Disease Control and Prevention, *National Ambulatory Medical Care Survey:2010 Summary Tables*, 18 (2010), *available at*: http://www.cdc.gov/nchs/data/ahcd/namcs_summary/2010_namcs_web_tables.pdf (noting "essential hypertension" was the most commonly diagnosed condition for physical office visits).

[60] Kaiser Family Foundation, *Distribution of Total Population by Federal Poverty Level,* (2014), *available at*: http://kff.org/other/state-indicator/distribution-by-fpl/.

[61] Stephanie Marken, *U.S. Uninsured Rate at 11.4% in Second Quarter*, Gallup (July 10, 2015), *available at*: http://www.gallup.com/poll/184064/uninsured-rate-second-quarter.aspx.

[62] Kaiser Family Foundation, *Total Monthly Medicaid and CHIP Enrollment*, (2014), *available at*: http://kff.org/health-reform/state-indicator/total-monthly-medicaid-and-chip-enrollment/ (71,637,638 divided by national population of 318,900,000 = 22.5%).

[63] ABC News & Washington Post, *One in Four U.S. Women Reports Workplace Harassment*, (2011), *available at*: http://www.langerresearch.com/uploads/1130a2WorkplaceHarassment.pdf.

[64] Benjamin, *supra*, note 28, at 560.

[65] *Id.* at 10.

[66] *Id.* at 9.

[67] *Id.* at 10.

[68] Irma M. Waugh, *Examining the Sexual Harassment Experiences of Mexican Immigrant Farmworking Women*, 28 Violence Against Women 247 (2010) (notably, incidents of sexual assault, abuse, or related crimes were not included within HRSA's summary of health-related diagnoses. She interviewed over 150 Mexican female farmworkers, of which over 97% reported an experience of harassment from male co-workers or supervisors. These findings illustrate the breadth of unmet needs, which encompass traditional clinical ailments alongside social determinants in the occupational and social environments); *cf.* Don Villarejo, *The Health of California's Immigrant Hired Farmworkers*, 53(4) Am. J. Indus. Med. 387, 392 (2010) (did not report a single instance of workplace violence, but also did not measure harassment, which is not an interchangeable term).

[69] Centers for Disease Control and Prevention, *Know the Facts about Heart Disease, available at:* http://www.cdc.gov/heartdisease/docs/consumered_heartdisease.pdf.

[70] U.S. Dep't of Health and Hum. Servs., *National - Migrant Health Center – 160 Grantees, List of Grantees – 2011* 15, (2011), *available at*: http://bphc.hrsa.gov/uds/doc/2011/National_mh.pdf (table 6A, line 9, visits per patient).

[71] Am. Heart Ass'n, *Hispanics and Heart Disease, Stroke,* http://www.heart.org/HEARTORG/Conditions/More/MyHeartandStrokeNews/Hispanics-and-Heart-Disease-Stroke_UCM_444864_Article.jsp (last visited Oct. 26, 2015).

harassment and unfair treatment were significant predictors of *masked* hypertension, which is defined as a normal blood pressure in the clinic, but an elevated blood pressure outside of the clinic.[72] Moreover, masked hypertension is a risk factor for cardiovascular disease.[73] Of course, general estimates on workplace harassment do not imply that an intervention regarding the same would yield lower rates of masked hypertension and future cardiovascular disease in a specific population. Indeed, a follow up study on a specific migrant population should examine the outcomes for that particular population. Still, our breadth of understanding should give us pause. These considerations illustrate the rather arbitrary characterization of a public health problem devoid of its social context, and simultaneously demonstrate the simplicity and utility of the proposed framework. In this context, implementing interventions that simultaneously address the social and physical determinants of the health problem will alleviate the burden of illness experienced by the affected population.

The role of laws and policies that may give rise to inequalities in health should be discerned from a simultaneous review of the social epidemiological profile. An analysis that relies solely on applying principles of statutory interpretation to the text of a treaty, statute, or regulation would not necessarily correlate to the observed effect of the law in practice, and may even generate complacency based on the notion that the measure was evidence-based. The appeal of this traditional analysis is perhaps attributed to the assumption that the law is most relevant as a tool to promote public health through its coercive influence. In response to a recent outbreak of measles among children, numerous health professionals were quick to support legislation that mandated vaccination. In California, where the outbreak occurred, two legislators indicated their intent to introduce a bill that would remove the personal belief exemption that historically enabled parents to opt out of vaccinating their children based on religious or philosophical beliefs.[74] In a recent study on a pertussis (whooping cough) outbreak, researchers found that unvaccinated children were not driving the epidemic, but they did have a higher risk of pertussis infection than those who were vaccinated.[75]

Ironically, in another city within California, an outbreak of pertussis occurred despite high levels of vaccination within the affected community.[76] In that case, the outbreak was attributed to the waning effectiveness of the vaccine, which only affords 5 years of protection.[77] Although the effectiveness of vaccination is

[72] Antoinette M. Schoenthaler et al., *Daily Interpersonal Conflict Predicts Masked Hypertension in an Urban Sample*, 23(10) AM. J. HYPERTENSION 1082-88 (2010).

[73] Donald W. McKay et al., *Masked Hypertension: A Common but Insidious Presentation of Hypertension*, 22(7) CANADIAN J. CARDIOLOGY 617-620 (2006).

[74] S. 277, 2015 Leg. (Cal. 2015) (enacted), *available at*: http://www.leginfo.ca.gov/pub/15-16/bill/sen/sb_0251-0300/sb_277_bill_20150219_introduced.html.

[75] Bridget M. Kuehn, *Author Insights: Protection from Pertussis Vaccine Wanes Over Time*, News at Jama (November 27, 2012), *available at*: http://newsatjama.jama.com/2012/11/27/author-insights-protection-from-pertussis-vaccine-wanes-over-time/.

[76] The Associated Press, *State Whooping Cough Outbreak Shows Vaccine Weakness*, San Diego Union Tribune (February 8, 2015), *available at*: http://www.sandiegouniontribune.com/news/2015/feb/08/california-whooping-cough-outbreak-raises-vaccine/.

[77] *Id.*

a public health truism, the reflexive insistence on a coercive mandate to remedy the public health problem paints an incomplete picture of the role of law in public health. Beyond coercion, the necessity to educate the public and conduct ongoing surveillance and monitoring of trends to inform subsequent epidemiological studies ought to be welcomed within the broader legislative and executive framework. In this way, laws ought to be crafted with an eye towards health promotion and the reduction of vulnerabilities through an iterative review of how well our laws and policies comport with the observed health outcomes. A health and human rights paradigm is therefore a powerful framework that compels advocates to lean on population health studies and assessments to capture the experience of the burden of illness. This burden is not narrowly confined to the physical ailment, but to the social forces that may create, sustain, or exacerbate those experiences. We now turn to an assessment of international and U.S. laws and policies in response to these unmet needs.

II. Assessment of International and U.S. Laws and Policies

The human right to, and the interdependence of, health,[78] food, housing, and employment, are among the myriad of indicia that may guide an assessment of States' compliance with obligations under the respective international treaties. These measures are frequently invoked by treaty monitoring bodies and international organizations that may issue shadow reports to facilitate periodic review. An accounting of these rights, however, does not necessarily secure the conditions to promote health.

Even attempts to identify or infer elements of formal or substantive equality to advance *de jure* or *de facto* equality among the sexes do not necessarily translate into the realization of public health. The provision of healthcare services, for example, is necessary but insufficient, as well as the broader assurance of access to health insurance. At first blush, it may be tempting to attribute this shortcoming to the difference between healthcare and public health, a distinction that has in fact given rise to arguments for recognizing a unique right to public health. I do not belabor this distinction but rather draw upon a fundamental premise that health—whether actualized at the individual or population levels—is fundamentally a social construct, and as such, the right to health inheres in social determinants further upstream from the delivery of healthcare services. Increasing access to medications to control diabetes and examining social barriers to secure education, employment, and economic opportunity, ought to be part of a broader public health policy.

We begin with a review of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), two general recommendations issued by its treaty monitoring body, and a WHA resolution on migrant workers to identify the health indicators and rights language that may be helpful in shaping our domestic legislation and policies. I then examine U.S. federal law on migrant

[78] International Covenant on Economic, Social, and Cultural Rights, G.A. Res. 2200A (XXI), art. 12, U.N. Doc. A/RES/2200(XXI)A (Dec. 16, 1966).

workers and the potential availability of private rights of action to illustrate existing gaps.

A. CEDAW, General Recommendations, and WHA Resolution 61.17

CEDAW Article 12

The health provision in CEDAW was drafted narrowly to support (1) access to contraceptives and (2) care during the prenatal, delivery, and postnatal periods for expectant mothers.[79] The experience of female migrants across 160 health centers indicates that both of these measures are essential this population.[80] Over 102,000 visits occurred in 2011 for contraceptive management among 58,000 patients, averaging almost two visits per patient.[81] This was the fourth highest preventive service sought after by women following immunizations, the seasonal flu vaccine, and services related to the health supervision of the infant or child.[82] This latter service speaks to the second provision of CEDAW, which focuses on maternal and child health. In 2011, there were over 168,000 such visits among 108,000 patients, or a little over 1.5 visits per patient. Out of 14 selected diagnostic tests and preventive services, access to contraceptive management and maternal and child health were among the leading service categories for migrants. The health provision is therefore consistent with the data on unmet needs of female migrants as relates to women's health issues.

General Recommendations 24 and 26

In 1999, or twenty years following the Convention, the CEDAW Committee issued General Recommendation 24 to elaborate on the health provision.[83] Over 19 sessions of State Party reports, coupled with programs of action adopted at United Nations (U.N.) world conferences, the work of the World Health Organization (WHO), United Nations Population Fund (UNFPA), and numerous nongovernmental organizations (NGOs), contributed to the language of the recommendation. The Committee drew particular attention to societal factors and requested special attention to the needs of the most vulnerable and disadvantaged groups, and first on its list were migrant women. Specifically, the Committee requested future reports to demonstrate that health legislation, plans, and policies were based on scientific and ethical research and assessment of the health status and needs of women.[84] It also requested to take into account ethnic, regional, or community variations based on religion, tradition, or culture.[85] The Committee

[79] Convention on the Elimination of All Forms of Discrimination Against Women, G.A. Res. 34/180, art. 12, U.N. Doc. A/RES/34/180 (Dec. 18, 1979).

[80] U.S. Dep't of Health and Human Servs., *supra* note 71 at 15 (table 6A, line 9, visits per patient).

[81] *Id.*

[82] *Id.*

[83] Report of the Committee on the Elimination of Discrimination against Women, G.A. Res. A/54/38, U.N. Doc A/RES/54/38 (May 4, 1999).

[84] Report of the Committee on the Elimination of Discrimination against Women*, supra* note 84, §6.

[85] Id. at § 9.

highlighted the unequal power relationship between men and women in the home and in the workplace, which may negatively affect women's health. It specifically noted sexual abuse and violence against women, and cited the interconnection with other articles, particularly education.[86]

A decade later in 2008, the Committee issued General Recommendation 26[87] focusing on female migrant workers and limited to addressing those situations where women, as workers in low-paid jobs, may be at high risk of abuse and discrimination. Migrant farmworkers fell into those categories of women migrant workers who join their spouses or other members of their families who are also workers, as well as, undocumented workers. Common experiences included discrimination, xenophobia and racism, as well a lower wages than their male counterparts.[88] Environmental concerns were also noted for those populations working in factories or farms and subpar living conditions that may include overcrowding, the absence of running water, inadequate sanitary facilities, or lack privacy and hygiene.[89] The Committee reiterated its concerns of women being vulnerable to sexual abuse, sexual harassment, and physical violence and specifically noted the experience of migrant workers on farms as a worldwide problem.[90] In response, the Committee recommended the formulation of comprehensive gender-sensitive and rights-based policies; active involvement of migrant workers and NGOs; research, data collection, and analysis; legal protection; complaint mechanisms; access to remedies; and temporary shelters, among other measures.[91]

The Committee went to extensive lengths to expand upon interrelated rights and their effects on health, yet the non-binding nature of general recommendations raises issues concerning the authoritative adjudicator on questions of interpretation. At first blush, this may suggest an inquiry into the precise scope of interpretation. This kind of inquiry is not, in practice, so much a theoretical exercise in determining what the law is, but rather who says what it is. Gardiner cites the potential role of international organizations of general interpretative competence, such as international courts, tribunals, and national legal systems, among the most preeminent bodies.[92] Consider the issue of whether Art. 12 of CEDAW condones the provision of, and access to, abortions. I have argued elsewhere that this is somewhat of a moot point because the CEDAW Committee has already recommended access to therapeutic abortions to numerous States Parties in their deliberations upon States Parties' compliance with the treaty obligations.[93] A dis-

[86] Id. at §§ 12-13.

[87] General Recommendation No. 26 on Women Migrant Workers, CEDAW Res. C/2009/WP.1/R (Dec. 5, 2008).

[88] Id. at § 14.

[89] Id. at § 17.

[90] Id. at § 20.

[91] *Id.* at § 23.

[92] RICHARD GARDINER, TREATY INTERPRETATION 111-38 (Oxford U. Press 2008).

[93] Dhrubajyoti Bhattacharya, *The Perils of Simultaneous Adjudication and Consultation: Using the Optional Protocol to CEDAW to Secure Women's Health,* 31 WOMEN'S RTS. L. REP. 42 (2009).

tinct, but related, issue is to what extent an individual party may seek solace in invoking a right to seek out relief vis-à-vis a General Recommendation. There cannot be relief without a claimant, and neither the treaty nor the General Recommendations engender the urgency of procedural safeguards. The journey of perfecting an imperfect right through issuing general recommendations, engaging in treaty interpretation, and awarding relief to affected parties, are futile if the affected party cannot bring the claim forward. This is readily accomplished by ratifying an Optional Protocol, but will necessarily raise issues of State sovereignty and to what extend a State will engage an international tribunal to influence its domestic policy. As indicated, above, the absence of guidance on best practices is not, however, for lack of trying on the part of treaty monitoring bodies.

WHA Resolution 61.17

That same year (2008), the Sixty-First World Health Assembly issued a resolution on the health of migrants.[94] Unlike General Recommendation 26, discussed above, the resolution was a broader appeal to universal measures of monitoring and responding to the unmet health needs of migrants generally. The resolution did recommend the development of policies sensitive to the specific health needs of men, women, and children; and the promotion of equitable access to services without discrimination on the basis of gender. Still, the measure was neither intended nor capable of addressing the sex-specific issues affecting female migrant workers. Nonetheless, its issuance was consistent with a broader movement within the international law community to recognize the unmet health needs of migrants as a priority for health and human rights advocates.

B. U.S. Federal Law on Migrant Workers and Private Rights of Action

When we turn to domestic laws on migrant workers, particularly those employed within the agricultural industry, the relevance and value of international law becomes readily apparent. At the federal level, we have the Federal Migrant and Seasonal Agricultural Worker Protection Act[95] (AWPA) and the Victims of Trafficking and Violence Prevention Act. We will examine these statutes to review the scope of the health-related provisions and reporting mechanisms, particularly with respect to incidents of assault or sexual harassment.

Migrant and Seasonal Agricultural Worker Protection Act

Section 203(b)(1) of the AWPA requires certification by a state or local health authority or other agency to ensure satisfaction of applicable safety and health standards for occupancy by migrants for residential purposes.[96] As such, we do find that the local health department has a potential interest in structural safety

[94] World Health Assembly, *Health of Migrants,* WHA 61.17 (May 24, 2008).

[95] 29 U.S.C. § 1801 (1983).

[96] 29 U.S.C. § 203(b)(1) (1983).

and its health implications. Additionally, under Section 401(b)(2)(B), the act requires, "consistent with the protection of the health and safety of migrant," compliance with standards of motor vehicle safety as prescribed by regulations issued by the Secretary of Labor for transport of migrants to or from the place of work.[97] These provisions suggest that health promotion under the AWPA is thereby narrowly tied to measures of physical safety in the transportation of, and dwellings for, migrants. Relief is also available through a private cause of action related to these explicit provisions. For matters of abuse or harassment, however, the Victims of Trafficking and Violence Protection Act of 2000 provides a seemingly attractive avenue of redress.

Victims of Trafficking and Violence Protection Act of 2000

As indicated in Part I, by some estimates, over 80% of female migrant workers may have experienced sexual harassment, and this percentage increases to 97% within our sample from California. Fear of being harassed, deported, or subject to other measures stemming from an individual's legal status may potentially deter some victims from reporting incidents to law enforcement. This act enables the acquisition of a U-Visa to protect undocumented immigrants by creating temporary legal status to victims if they have suffered substantial physical or mental abuse and cooperate with the investigation.

Eligibility requires, under Section 101(a)(15)(U), a showing of "substantial physical or mental abuse," and of course, compliance by law enforcement to investigate the complaint and document the abuse.[98] Moreover, law enforcement must certify that the alien ''has been helpful, is being helpful, or is likely to be helpful'' in the investigation or prosecution of criminal activity described in Section 101(a)(15)(U)(iii).[99] It is unclear how many victims would avail themselves of this avenue of relief given the potential uncertainty of meeting the threshold of demonstrating "substantial" physical or mental abuse, the willingness of law enforcement to investigate a claim, and the lag time in acquiring certification of cooperation.

Consequently, what we might glean from this cursory review is a narrow scope of health as it relates to the migrants and limited protections or avenues of redress when it comes to potential violations of rights that have health-related consequences, including physical and mental abuse or harassment.

III. Drafting a Local CEDAW Ordinance for Female Migrant Workers

While we know that CEDAW, its general recommendations, and even a broad WHA resolution may help overcome those shortcomings, the U.S. has not ratified the Convention, notwithstanding becoming a signatory to the treaty and mul-

[97] 29 U.S.C. § 401(b)(2)(B) (1983).

[98] The *Victims of Trafficking and Violence Protection Act of 2000*, Pub. L. No. 106-386, § 1513(b)(3)(U)(i)(I) (2000)(amending Section 101(a)(15) of the Immigration and Nationality Act (8 U.S.C. 1101(a)(15)(as amended by Section 107 of the act)).

[99] *Id.* at 1513(b)(3)(U)(iii).

tiple Senate committee hearings on the same. This seemingly bleak picture does not conclude our analysis. Indeed, this is where the value of international law must not be restricted to formal obligations that States adopt at the international level. Ironically, it was a U.S. city ordinance that illustrates the potential to advance the application of a health and human rights approach to this particular community.

A. Precedent for Effectiveness: San Francisco CEDAW Ordinance

In 1997, the City of San Francisco passed an ordinance inspired by CEDAW to reduce sex discrimination and increase gender equity as relates to health, safety, and employment. In addition to making explicit the healthcare mandate of Art. 12 of CEDAW, the ordinance included two additional components that were lacking in the original treaty. First, it afforded definitional clarity and articulated an explicit method to address sex discrimination. Specifically, it defined "gender equity" as redress of discriminatory practices and establishment of conditions enabling women to achieve full equality with men, recognizing that needs of women and men may differ, resulting in fair and equitable outcomes for both. Moreover, it required a "gender analysis" as an examination of the cultural, economic, social, civil, legal and political relations between women and men within a certain entity. Notably, the recognition of those different components is consistent with a framework that incorporates social elements, and requires an interdisciplinary approach to effectively improve public health.

Beyond this framework, the specific measures incorporated elements that recognized the interdependence of rights to secure health, safety, and employment. Specifically, the ordinance required measures to (1) eliminate discrimination against women and girls in the City of San Francisco in employment and other economic opportunities, (2) to prevent and redress sexual and domestic violence, and (3) eliminate discrimination in the field of healthcare. Employment protections included: right to equal remuneration, health and safety in the workplace, including protection from violent acts at the workplace. The provision on violence was specifically geared towards vulnerable populations that would otherwise be reluctant or historically unable to engage law enforcement without fear of repercussions. The ordinance specifically mentions prostitutes as a population whose "legal status" tends to marginalize them and noted that it would be the goal of the City to develop and fund projects to assist those individuals who were victims of violence. The healthcare provisions were also a mirror image of Art. 12 of CEDAW.

B. Recommendations for Surveillance, Monitoring, and Intervention

There are a number of lessons that can be drawn from the San Francisco ordinance that could be applicable to migrants, and specifically farmworkers. First, it affords a robust package of protections across numerous spheres that affect health, namely, employment, access to care, and personal safety in the home and workplace. Beyond legislative reform that promotes access to care, the dual provision of safety and freedom from harassment in the home and workplace, and

accountability, become critical measures that would yield measurable health effects. It also provides enhanced protection for vulnerable populations without predicating redress upon legal status, which may exacerbate health disparities within this population owing to their potential reluctance to engage law enforcement, or otherwise draw attention to the perpetrators.

After documenting the findings from the gender analysis, the entity must adopt a concrete action plan to institute corrective measures. Under Section 4.K.12(b), the entity "shall develop an Action Plan that contains specific recommendations on how it will correct any identified deficiencies. . ." In this way, the ordinance secures two fundamental aspects of public health, namely, surveillance and monitoring, and intervention. It will not do to simply take an accounting of risk factors, and relegate the necessary remedial measures to an indeterminable future. Accountability is an essential component of the ordinance and is categorically imperative to secure the health and well-being of the affected individuals. In addition to general measures of accountability, a deterrent effect through fines or penalties associated with noncompliance would secure gaps that are otherwise corrected by formal ratification of the treaty and related measures.[100]

IV. Conclusion

Social determinants compel us to think of health as a social construct. In doing so, we are no longer limited in our choice of interventions. Specifically, we must move beyond a strictly medical model to treat ill health as an aberration from normal as defined by a medical diagnosis; but rather, identify and engage those root causes or determinants that are further upstream. The implications of incorporating social epidemiological profiles frameworks within health and human rights assessments are profound and make us realize that health is intertwined with other areas that often fall outside the purview of a health department, especially when it comes to education and development. Against a backdrop of political, legal, social, and fiscal constraints, it is imperative that as practitioners, we identify short- and long-term goals and recognize the work before us as part of a process that will implicate many public and private stakeholders. However, if we adopt a broader view of health, we will have already made progress and recognize that public health is truly what we, as a society, do to assure those conditions that secure population health. Incorporating a social epidemiological framework into formal health and human rights assessments would constitute a robust legal framework and guide best practices for stakeholders, including government (and specifically health) officials, law enforcement, women, and healthcare providers.

[100] CEDAW, *supra* note 80, art. 29 (requiring arbitration within six months for disputes arising among States Parties or subsequently refer the issue to the International Court of Justice). The treaty does not empower individuals to bring claims against their States for noncompliance with treaty obligations. Claims can be brought by citizens of States that have ratified the treaty's Optional Protocol, but this avenue of redress will be unavailable until the treaty has initially been ratified. Until the political landscape is amenable to ratification of the treaty, these proposed measures may afford some temporary relief to affected parties.

Adopting an International Convention on Surrogacy – A Lesson from Intercountry Adoption

Seema Mohapatra*

Introduction

Stories of scandals, stranded babies and parents, and stateless babies are becoming more and more common in the world of international surrogacy.[1] Surrogacy is having an identity crisis at the moment. There appears to have been a shift in public opinion about commercial surrogacy in the United States, and much of the world was already skeptical about this concept. In the United States, the entire concept of international surrogacy came into greater public attention in 2007 on the Oprah Winfrey Show when the Indian surrogacy example was touted as a "win-win" for both intended parents and Indian surrogates.[2] Just a few years

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[1] In this article, I use the term surrogacy to describe the arrangement whereby an intended parents or parents uses a paid surrogate to carry a child for them via in vitro fertilization of their own gametes or purchased gametes. Some have argued against the term "surrogacy," arguing that the gestational carrier, or surrogate, is a true mother and not a surrogate at all. Bioethicist Francois Baylis uses the term transnational contract pregnancy, following early researchers who used that term. *See* Baylis, Francoise, *Transnational Commercial Contract Pregnancy in India,* Int'l Inst. Of Soc. Studies in the Hague (Nov. 22, 2013, 7:04PM), http://www.iss.nl/fileadmin/ASSETS/iss/Guests/Adoption___surrogacy/Publications/Francoise_Baylis_Pub.pdf. (last visited Jan. 5, 2016). In this article and in previous works, I use the most commonly used phrasing "surrogacy" and thus I use it here. However, I have argued elsewhere for the need to improve conditions and rights of surrogates, and thus agree with the concern of those like Baylis who worry about the dignity of the surrogate. Seema Mohapatra, *Stateless Babies & Adoption Scams: A Bioethical Analysis of International Commercial Surrogacy*, 30 Berkeley J. Int'l L. 412, 442 (2012).

[2] Ling, Lisa, *Journey to Parenthood: Wombs for Rent*, OPRAH (Sept. 15, 2015, 7:20 PM), http://www.oprah.com/world/Wombs-for-Rent/2.

later, the realities of shady ethics, tabloid-worthy messes, and baby-selling, were exposed by countless newspaper articles, documentaries, and exposès such as the "Outsourcing Embryos" feature on HBO's *Vice*.[3] Although it is rarely a good idea to overreact with a legal solution or restriction to every sensational new story, a plethora of recent cases involving surrogacy demonstrate the need to protect the parties in surrogacy, particularly the child borne via surrogacy. Self regulation by surrogacy agencies is not realistic and not happening. Understandably, there is doubt about how effective an international convention on surrogacy would be, especially if many countries do not agree to be signatories. However, there is value in having a consensus about norms and standards in international surrogacy, especially if that comes from an esteemed organization such as the Hague Convention. Additionally, an international convention on surrogacy does not have to and should not have a normative position on surrogacy. Thus, countries that ban commercial surrogacy can still be part of such a convention. The convention could serve as notice to intended parents about which countries have a strong anti-surrogacy stance. I see a problem with countries that claim to be anti-surrogacy turning a blind eye to its residents leaving their border to seek international surrogacy arrangements. The tacit message seems to be "don't exploit our own women, feel free to exploit poor surrogates elsewhere. . ." Countries that "ban" commercial surrogacy need to have a plan of action when (not if) residents ignore their ban and seek surrogacy arrangements abroad. Such plans could be delineated in an international convention. This article is attempting to broaden how regulation is defined. There are other international conventions that seek to exist to define international norms. I suggest that it is time to consider the same for surrogacy. Coming to international consensus is an arduous and time-consuming process full of conflict and disagreement; for example, the convention on intercountry adoption discussed later took over fifty years to negotiate. The fatalistic tone in much commentary I have read and heard that "surrogacy is too controversial" ignores the reality that many subjects of international conventions are similarly divisive. Calling for an international convention does not mean that domestic law is perfect as is—in fact, much domestic law on surrogacy should be strengthened and made clearer. However, it is not an either-or proposition.

This article attempts to compare the effort to come up with an international convention on surrogacy to similar efforts that took place decades ago with intercountry adoption. Part I of this Article summarizes some recent surrogacy cases and dilemmas to emphasize the need for international action and provides an overview of the different ways surrogacy is regulated throughout the world to show the need for regulation. Part II of this Article attempts to discuss the similarities and differences between adoption and surrogacy and summarizes the critiques of inter-country adoption in general. The main point of this section is to show that inter-country adoption is controversial as well, yet has been governed by an international convention. Thus, surrogacy could similarly be governed by an international convention. Finally, Part III proposes what elements an Interna-

[3] Vice: *Lines in the Sand and Outsourcing Embryos* (HBO television broadcast March 27, 2015.)

tional Convention on ISAs should include. This Article proposes that surrogacy should be regulated similarly to adoption and outlines a potential surrogacy convention.

I. International Surrogacy: Definitions and Dilemmas

This section describes several recent scenarios that have arisen in international commercial surrogacy and defines the legal landscape in this arena. This background is helpful for understanding why it is imperative to have an international voice on commercial surrogacy.

A. Recent Controversies in International Surrogacy

Unfortunately, it seems that every month there is a new international surrogacy mess unfolding. In this section, I describe some recent cases that help demonstrate how domestic laws are not serving the needs of intended parents, surrogates, or the babies borne of a surrogacy arrangement.

Baby Gammy

In one of the most notorious surrogacy cases in recent years, an Australian couple was accused of abandoning their baby son, Baby Gammy, who has Down syndrome, with his Thai surrogate mother and returning home with his twin sister, who did not have Down syndrome. The conflict has resulted in a change in the surrogacy laws in Thailand and sparked an international debate about surrogacy. Pattaramon Chanbua is a Thai woman who was hired by an Australian couple, the Farnells, to be a surrogate for approximately $16,000.[4] Ms. Chanbua became pregnant with twins, and gave birth in December 2013.[5] During her pregnancy, it was discovered that one of the twins has Down syndrome.[6] The Farnells abandoned Gammy, their son that had Down syndrome, and took his healthy twin sister Pipah with them to Australia.[7] Ms. Chanbua decided to raise Baby Gammy as her own, along with her other two children, even though she is not genetically related to Baby Gammy.[8]

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[4] *Thai Surrogate Mother of a Baby with Down Syndrome Abandoned by Australian Parents Says She Cannot Afford Baby Gammy's Medical Treatment*, ABC NEWS (Aug. 1, 2014 7:00 PM), http://www.abc.net.au/news/2014-08-01/mother-of-thai-baby-abandoned-by-surrogate-parents-struggles-to/5642478.

[5] *Id.*

[6] *Id.*

[7] Samantha Hawley, *Baby Gammy, One-Year-Old at Centre of Thai Surrogacy Scandal, Granted Australian Citizenship*, ABC NEWS (Jan. 19, 2015 9:22 PM), http://www.abc.net.au/news/2015-01-20/baby-gammy-granted-australian-citizenship/6026600.

[8] *Thai Surrogate Mother of a Baby with Down Syndrome Abandoned by Australian Parents Says She Cannot Afford Baby Gammy's Medical Treatment*, *supra* note 4. (Along with Down syndrome, Gammy has a hole in his heart, which will require expensive surgery that Ms. Chanbua and her family would not be able to afford.) In January of 2015, Gammy, who turned one year old on December 23, 2014, was granted Australian citizenship after Ms. Chanbua applied for it. *Hawley*, supra note 7.

The Baby Gammy case has drawn attention to the lack of regulations in the international surrogacy process.[9] The intended Australian parents have participated in television interviews and stated that they initially sought a refund for the surrogacy services when they were told one of the twins had Down syndrome.[10] Statements like these are problematic and potentially dangerous. Assisted reproductive technologies ("ART") have allowed people who cannot "naturally" have children to become parents through in vitro fertilization and the use of surrogates who are implanted with an embryo of the intended parents' choosing. Some intended parents use the process of pre-implantation genetic diagnosis ("PGD") to "screen" embryos and choose to implant those without genetic anomalies. Such a practice, although controversial, is routine in ART. In the Baby Gammy case, it is evident that PGD was not used, yet somehow, the parents had an expectation of a perfect child and refused parentage of their perceived "imperfect" child. The Farnells have stated in interviews that if they had learned earlier in the pregnancy about the child having the disability, they would have asked that the pregnancy be aborted.[11] Regardless of the moral questions involved, one issue I see is in protecting surrogates in international surrogacy relationships. Here, Chanbua was willing to raise Baby Gammy, but in many past surrogacy dilemmas such as the infamous Baby Manji case in India, surrogates often are not willing to raise a genetically unrelated child.[12] Chanbua took to the media to get attention to her plight.

In most cases, a surrogate has agreed to carry the child for financial reasons only. An additional child is more of a financial burden, especially one with special needs. Further, there is no biological relationship, and Chanbua never anticipated having to raise this child. The surrogate is in a vulnerable position, and faces not being paid and being burdened with an additional child, or facing the guilt of abandoning a child she carried for nine months. An international convention should make clear that a contract for surrogacy might not condition payment on the birth of a healthy child. Even if a surrogate agrees to an abortion, she should still receive full payment. In too many cases, surrogates are held responsible for outcomes that have nothing to do with them. Without international protection, they are often in a vulnerable position.

Further, after the initial scandal of abandoning Gammy, it came to light that Mr. Farnell had been previously convicted and served time in prison for over twenty child sex offenses against girls as young as five years old.[13] This led to a

[9] *Thai Surrogate Mother of a Baby with Down Syndrome Abandoned by Australian Parents Says She Cannot Afford Baby Gammy's Medical Treatment*, *supra* note 4.

[10] Farrel, Paul, *Baby Gammy, Born into Thai Surrogacy Scandal, Granted Australian Citizenship*, THE GUARDIAN (Jan. 15, 2015 at 5:32 PM), http://www.theguardian.com/australia-news/2015/jan/20/baby-gammy-born-into-thai-surrogacy-scandal-granted-australian-citizenship.

[11] *Id.* ("It was late into the pregnancy that we learned the boy had Down [Syndrome]," David Farnell said. "They sent us the reports but they didn't do the checks early enough. If it would have been safe for that embryo to be terminated, we probably would have terminated it, because he has a handicap and this is a sad thing. And it would be difficult – not impossible, but difficult.").

[12] Mohapatra, *supra* note 1, at 419.

[13] *Id.*

public outcry that there should be some form of parental fitness requirement in surrogacy, similar to that in abortion. Yet, people who should not be parents for moral, financial, personal, and other reasons become parents every day. Just because someone is unable to have a child through traditional means does not mean they should be subject to policing. It is clear that Mr. Farnell's troubled history regarding child sex abuse is disturbing. However, it would be more harmful to discriminate against the hundreds and thousands of intended parents by setting forth a parental fitness test for surrogacy. This issue will be addressed in more detail in the proposed convention section of this Article. It is just one example of why every problem in international surrogacy does not need a regulatory fix. Countless examples exist of parents with predatory sexual behavior who gave birth to children "the natural way." The purpose of criminal law and family law is to protect children from unfit parents.

Thai Trafficking Concerns

Another disturbing Thai scandal that was publicized soon after the the Baby Gammy case was that of an alleged "baby factory" that has been created by a twenty-four year old Japanese businessman, who is the biological father of sixteen surrogate children and counting.[14] In Bangkok, police raided a home to find nine babies, each fathered by Mitsutoki Shigeta.[15] Though Shigeta claims his motives are benign, the babies were found in unfurnished rooms, which were not habitable for children.[16] According to investigators, both human trafficking and child exploitation charges are being explored as of the end of 2015.[17] Shigeta is said to have requested ten to fifteen babies per year from the fertility clinic, from now until the day he dies.[18] Shigeta claims that he simply wants a large family and he has the means to support it.[19] The Shigeta situation seems to be a case of a fertility clinic that is more interested in profit than the well being of the children borne via surrogacy. This type of situation seems to be one that could be avoided with the oversight of governmental entities in countries that allow commercial surrogacy.

[14] Kevin Rawlinson, *Interpol Investigates 'Baby Factory' as Man Fathers 16 Surrogate Children*, THE GUARDIAN (Aug. 23, 2014), http://www.theguardian.com/lifeandstyle/2014/aug/23/interpol-japanese-baby-factory-man-fathered-16-children.

[15] *Id.*

[16] *Id.*

[17] *Id.*

[18] *Id.* (discussing a conversation with the founder of the New Life clinic, a multinational fertility clinic).

[19] *Id.* (According to Shigeta's attorney, "These are legal babies, they all have birth certificates. There are assets purchased under these babies' names. There are savings accounts for these babies, and investments. If he were to sell these babies, why would he give them these benefits?").

Families in Transition

In light of these scandals, the Thai government outlawed commercial surrogacy in Thailand, and banned surrogacy for foreigners in its entirety.[20] The ban was supposed to exempt families who already had babies on the way via commercial surrogacy. Unfortunately, some families have been caught in the middle. Manuel Santos and Gordon Alan Lake, a couple from New Jersey, are fighting a legal surrogacy battle over their six-month old daughter, Carmen, who was born to a surrogate in Thailand.[21] The couple also has a two-year old son, Alvaro, who was born to a surrogate in India.[22] The legal issue concerning Carmen arose because the Thai surrogate backed out of her contract, and under current Thai law, Carmen belongs to the surrogate rather than to the couple.[23] The change in the Thai law exempts Lake and Santos, who were already in the midst of their surrogacy arrangement, but their legal issue exists because the surrogate changed her mind.[24] Under the parties' original agreement, the surrogate signed a consent form allowing Lake to put his name on the birth certificate, but the surrogate did not attend the last meeting at the U.S. Embassy to sign the proper paperwork.[25] Thus, even though Lake is the biological father and the parties' used a donor egg to facilitate the pregnancy, the family is still facing legal issues.[26] The couple's lawyers estimate that their chances of winning the legal battle against the surrogate are less than 10 percent.[27] This low estimate was given because Lake and Santos are a same-sex couple, which is not a legal union recognized under Thai law.[28] The United States State Department confirmed that the couple is subject to Thai law, and provided that "U.S. citizens in Thailand are subject to Thailand law. Pursuant to U.S. law, the Department cannot issue passports to minor children without the consent of the legal parent/s or guardian/s."[29] This again demonstrates the need for an international convention on surrogacy that addresses parentage and citizenship issues. The surrogate should not be named as a parent on the birth certificate when she is carrying the baby for the purposes of fulfilling

20 Nelson Groom, "*We're banning foreign couples from seeking surrogacy in our country': Thai parliament passes law banning 'rent-a-womb' tourism in wake of Baby Gammy saga*," DAILYMAIL.COM (Feb. 20, 2015, 11:36 AM), http://www.dailymail.co.uk/news/article-2961448/Thai-parliament-bans-surrogacy-wake-Aussie-baby-Gammy-saga.html.

21 Michael Sullivan, *A Thai Surrogacy Case, with a 6-Month-Old Girl Caught in the Middle*, NAT'L PUBLIC RADIO (July 15, 2015, 2:48 PM), http://www.npr.org/sections/parallels/2015/07/15/423188769/a-thai-surrogacy-case-with-a-6-month-old-girl-caught-in-the-middle.

22 *Id.*

23 *Id.*

24 *Id.* (Through an interpreter, the surrogate outlined some of her reasoning for changing her mind: "First of all, they are not natural parents in Thai society. . .They are same-sex, not like male and female that can take care of babies. Second thing is, when I tried to contact them to visit the baby, they didn't want to talk to me. And the third thing is, I was begging them to see the baby but they didn't allow me to see her. They treated me very badly and said I have no right to see the baby.")

25 *Id.*

26 Sullivan, *supra* note 21.

27 *Id.*

28 *Id.*

29 *Id.*

a surrogacy arrangement. In countries that sanction commercial surrogacy, the intended parents should be the parents on the birth certificate, not the surrogate.

Mennesson Case

Another recent case that demonstrates the importance of citizenship and parentage was the 2014 European Court of Human Rights (ECHR) ruling that France cannot refuse to grant legal parent-child recognition for children born to surrogates.[30] Two French families, the Mennessons and the Labassees, had children born to surrogates in the United States, and not France, where surrogacy is illegal.[31] The Mennessons' twins, Valentina and Fiorella were born via surrogacy in California in 2000, and Juliette Labassee was born in Minnesota in 2001.[32] All three children are American citizens, but the appellate court in France originally refused to grant citizenship status to the children.[33] The families appealed, and the ECHR ruled that this infringed on the children's respect to privacy rights, while still recognizing that France has a right to make surrogacy illegal.[34] The ECHR found that it "undermined the children's identity within French society," and took issue that the children's inheritance rights were not the same as French citizens.[35] The lawyer in the case estimated that at least 2,000 other children are in the same situation.[36] This ruling has two effects on the French stance on surrogacy. First, it prevents France from denying citizenship to children borne of surrogacy to French parents. Second, it allows France take a moral stance against commercial surrogacy, while effectively ignoring when its citizens go abroad and utilize commercial surrogacy. An international convention would force France and other countries to be more forthright about their position on surrogacy and would alert French citizens to what the effects of circumventing the French law would be.

Swiss Ruling

Further evidence demonstrating the problem of competing domestic laws on surrogacy and the need for an international convention is a recent case of two men from Switzerland who travelled to California in 2010 to obtain surrogacy services. The surrogacy agreement resulted in a child who is now four years

[30] *European Human Rights Court Orders France to Recognise Surrogate-Mother Children*, RADIO FRANCE INTERNATIONALE (June 26, 2014), http://www.english.rfi.fr/europe/20140626-european-human-rights-court-orders-france-recognise-surrogate-mother-children.

[31] *Id.*

[32] *Id.*

[33] *Id.*

[34] *European Human Rights Court Orders France to Recognise Surrogate-Mother Children*, *supra* note 30.

[35] *Id.*

[36] *Id.*

old.[37] A California court ruled in 2011 that both of the men's names could be on the child's birth certificate. However, the Swiss Supreme Court recently ruled that the child may not have two fathers.[38] The Court held that since the couple had circumvented Switzerland's surrogacy ban by obtaining surrogacy services in the United States, the United States birth certificate was not valid.[39] If the men had been aware of this situation, they may have decided an alternate route to parenthood. If Switzerland, as an anti-surrogacy country, was party to a neutral, international surrogacy convention, these men would have been aware that the birth certificate obtained where surrogacy is legal may not be upheld in their home country.

Each of these scenarios highlight the need for international regulation of surrogacy. The Hague Conference has indicated its desire and willingness to propose an international convention about cross border surrogacy, similar to its convention on intercountry adoption. In this Article, I introduce ways that this can be accomplished without impinging on the morals of those countries that are staunchly anti-surrogacy.

B. Legal Landscape

This section will describe from a macro level the wide variety of approaches to regulating surrogacy, and is meant to serve as an introduction to the law of surrogacy. Obviously, each country's specific surrogacy situation can be the topic of an entire Article. However, that is not the purpose of this paper. This brief overview should inform the reader about what major stumbling blocks are present when negotiating an international document. The majority of this Article focuses on commercial gestational surrogacy, not altruistic surrogacy. In an altruistic surrogacy, a surrogate agrees to carry a child that may or may not be genetically related to her to "help" other individuals.[40] In such surrogacy arrangements, there is no payment given to the surrogate. In contrast, commercial gestational surrogacy, the most common method of surrogacy in the world today, is describing a contractual relationship between the surrogate and the intended parents, where the surrogate is paid to carry the child with whom she has no genetic relationship.[41] In commercial gestational surrogacy arrangements, women are either employed through an agency or work independently. The majority of international surrogacy is transacted through agencies, and surrogates contract with these agencies. Given some of the questionable practices of certain agencies, as well as the low economic status of many surrogates involved, this surrogacy is the most controversial and is banned in most of Asia, Europe, and

[37] *Swiss Supreme Court Rules Boy Born to Surrogate Mother in US Can't Have 2 Legal Fathers*, ASSOCIATED PRESS (May 21, 2015, 12:38 PM), http://www.dailyjournal.net/view/story/80168b3db1b24d84878b2428c0572eb3/EU—Switzerland-Two-Fathers/.

[38] *Id.*

[39] *Id.*

[40] France Winddance Twine, OUTSOURCING THE WOMB: RACE, CLASS, AND GESTATIONAL SURROGACY IN A GLOBAL MARKET 13 (Routledge, 2d ed. 2015).

[41] *Id.* at 13-14.

the United States.[42] With traditional surrogacy, in contrast to gestational surrogacy, the woman is genetically related to the child.[43] This type of surrogacy may exist with or without a commercial transaction, as it can involve a family member providing surrogacy services altruistically, or a third party donating her eggs and selling her services in return for a fee.[44]

The legal confusion surrounding international surrogacy arises from the fact that there is no international regulation or agreement about either the surrogacy process itself, or about the national status of a child born to a surrogate in a different country than that of the intended parents.[45] There are many reasons why people seek international surrogacy arrangements.[46] First, domestic surrogacy may be prohibited by law or a surrogacy contract may not be enforceable in one's home country.[47] Second, the cost for domestic surrogacy could be much higher than a foreign surrogacy arrangement.[48] Third, a person or couple seeking to enter into a surrogacy arrangement could prefer the experience of a foreign surrogacy system, due to perceived better practices.[49]

Globally, there is no consensus about international surrogacy. Some countries, including Switzerland, Germany, Spain, France, Greece, and Norway, ban commercial surrogacy.[50] Others, like India and Ukraine, have actively tried to be seen as a commercial surrogacy destination.[51] Currently, sixteen countries ban all forms of surrogacy.[52] Ten countries allow non-commercial altruistic surrogacy.[53] Eight countries explicitly allow for both types of surrogacy.[54]

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[42] *Id.* at 14.

[43] *Id.*

[44] *Id.* (Under traditional surrogacy, the surrogate is the recognized legal mother of the child in most states in the United States until she relinquishes her rights by giving the child up for adoption. Under all three types of surrogacy, the person or couple that commissions the pregnancy is known as the intended parent(s), and usually is the party listed on the birth certificate).

[45] Charles P. Kindegran & Danielle White, *International Fertility Tourism: The Potential for Stateless Children in Cross-Border Commercial Surrogacy Arrangements*, 36 SUFFOLK TRANSNAT'L L. REV. 527, 532 (2013).

[46] Pamela Laufer-Ukeles, *Mothering for Money: Regulating Commercial Intimacy*, 88 IND. L.J. 1223, 1266 (2013).

[47] *Id.*

[48] *Id.*

[49] *Id.*

[50] Brock A. Patton, *Buying a Newborn: Globalization and the Lack of Federal Regulation of Commercial Surrogacy Contracts*, 79 UMKC L. REV. 507, 523 (2010).

[51] Mohapatra, *supra* note 1, at 431-37, 441-48.

[52] Twine, *supra* note 40, at 4. ("Austria, Belgium, Bulgaria, Canada (Quebec), France, Germany, Italy, Iceland, Norway, Sweden, Switzerland, Saudi Arabia, Turkey, Pakistan, China, Japan, and United States: Arizona, Indiana, Michigan, North Dakota").

[53] *Id.* at 5. ("Australia, Canada, Denmark, Greece, Hungary, Israel, the Netherlands, Spain, South Africa, United Kingdom, United States: New York, New Jersey, New Mexico, Nebraska, Virginia, Oregon, Washington").

[54] *Id.* ("Armenia, Belarus, Cyprus, Georgia, Mexico, Russian Federation, South Africa, Ukraine, United States: California, Florida, Illinois, Massachusetts, Texas, Vermont, Arkansas").

"Unlike either of these approaches, the United States has no national stance on surrogacy."[55] In fact, there are no federal laws or regulations related to surrogacy in the U.S.[56] Instead, each of the fifty states has its own approach to surrogacy-with some states embracing commercial surrogacy and others banning all types of surrogacy.[57] Currently, seventeen states permit surrogacy by law, but there are variations from state to state.[58] In twenty-one states, there are no laws applicable to surrogacy.[59] In five states, surrogacy contracts are void and cannot be enforced.[60] California currently has the most permissive law in the United States regarding surrogacy contracts.[61] Because surrogacy remains a controversial issue, many states may seek to find a middle ground.[62]

In both the United Kingdom and in Canada, commercial surrogacy is prohibited, and surrogacy agreements are unenforceable.[63] The rules about legal parenthood vary depending on the type of surrogacy involved.[64] Commercial surrogacy is also banned in Australia; however, some Australian states have lifted their ban on altruistic surrogacy.[65] Further, laws in Canada, France, Germany, and Japan make commercial surrogacy contracts illegal or unenforceable.[66] However other countries, such as India and Ukraine, have opened the door and become international centers for commercial surrogacy.[67]

India, in particular, has become a hotspot for people looking for surrogates.[68] Although historically, the law in India has been largely unclear and mostly accepting of commercial surrogacy, in 2013 the Indian government began to update its surrogacy regulations.[69] These proposed regulations include restrictions such

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55 Seema Mohapatra, *States of Confusion: Regulation of Surrogacy in the United States* in COMMODIFICATION OF THE HUMAN BODY: A CANNIBAL MARKET (Eds. J.D. *Rainhorn & S. El Boudamoussi) Editions de la Fondation Maison des Sciences de l'Homme, Paris, 2015.*

56 Yehezkel Margalit, *In Defense Of Surrogacy Agreements: A Modern Contract Law Perspective*, 20 WM & MARY J. WOMEN & L. 423, 424 (Winter 2014).

57 Patton, *supra* note 50, at 513-17.

58 Tamar Lewin, *Surrogates and Couples Face a Maze of Laws, State by State*, NEW YORK TIMES (Sept. 17, 2014), http://www.nytimes.com/2014/09/18/us/surrogates-and-couples-face-a-maze-of-laws-state-by-state.html.

59 *Id.*

60 *Id.*

61 *Id.*

62 *See id.* (comparing the Illinois surrogacy law that requires "medical and psychological screenings for all parties before a contract is signed and stipulates that surrogates be at least 21, have given birth at least once before and be represented by an independent lawyer, paid for by the intended parents.").

63 Erin Nelson, *Global Trade and Assisted Reproductive Technologies: Regulatory Challenges in International Surrogacy,* 41 J.L. MED. & ETHICS 240, 244 (2013).

64 *Id.*

65 *Id.*

66 Kindegran & White, *supra* note 45, at 527.

67 *Id.*

68 Trisha A. Wolf, *Why Japan Should Legalize Surrogacy*, 23 PAC. RIM L. & POL'Y J. 461, 478 (2014).

69 *Id.* at 479–81.

as a cap on the number of times a woman can act as a surrogate, the age requirements for the surrogate, and mandatory HIV testing.[70]

C. Legal Condrum

There is no clear accord about or whether to regulate surrogacy. I join those who believe that international regulation of this "truly international problem[ ]," is needed.[71] Although there are some that argue that this is really more of a family or citizenship law problem,[72] the reality is that some form of international acknowledgement is needed. There is a warranted concern that an increase in the regulation in the surrogacy context will result in exclusion and discrimination against some people (whether LGBT, single, old, or a whole host of other perceived parental fitness exclusions). If international regulation was designed without protections against such discrimination, many who seek surrogacy arrangements look for an alternative outside of the regulatory scheme, which could lead to further international legal issues.[73]

Domestic Law vs. International Law

The focus on international regulation does not mean domestic law should not be improved. Rather, I agree with scholars like Pamela Laufer-Ukeles, who has stated that jurisdictions should encourage domestic surrogacy, while still not outlawing international surrogacy arrangements.[74] Laufer-Ukeles argues that domestic surrogacy is preferable in many situations over an international arrangement, and therefore, jurisdictions should insure that domestic surrogacy is accessible. Although this is true, many countries will never legalize surrogacy arrangements. Individuals in such countries will seek out international arrangements as a last resort. While I agree with Laufer-Ukeles that criminalizing an international arrangement or refusing citizenship to the resulting child is harmful, I do not believe that staunchly anti-surrogacy countries will somehow allow surrogacy it is a realistic solution. Although criminalizing or refusing citizenship to the resulting child leads to stigmatization and often fails to protect the child's civil rights,[75] many countries will not change their stance on the moral turpitude of commercial surrogacy. Such countries should then sign on to an international convention on surrogacy as countries where surrogacy is illegal. This provides a strong signal to intended parents that are citizens of these countries that they are in a legal no-man's land should they seek international surrogacy services. One of the key problems in international surrogacy is that often agencies are assuring intended

[70] *Id.* at 480.

[71] Kristiana Brugger, *International Law in the Gestational Surrogacy Debate*, 35 FORDHAM INT'L L.J. 665, 682 (2012).

[72] Bruce Hale, *Regulation of International Surrogacy Arrangements: Do We Regulate the Market, or Fix the Real Problems?*, 36 SUFFOLK TRANSNAT'L L. REV. 501, 510 (2013).

[73] *Id.* at 509–10. ("In addition, as regulation pushes people out of the market, the risk of exploitation in the grey and black markets will increase with the increased demand.").

[74] Laufer-Ukeles, *supra* note 46, at 1277.

[75] *Id.* at 1276.

parents that the visa and legal concerns will be easy to deal with. If countries really wish to discourage surrogacy, they should be part of an international convention to make their position even more clear to intended parents. Such an argument has not previously been made in literature, and I think it is key to theorizing an international convention that would have more participation. In such an international convention, signatories would note whether their laws allow either domestic surrogacy or international surrogacy. There is no need for an international convention to be pro-surrogacy, even if there are countries that are pro-surrogacy as signatories. Countries like India will likely be party to such a convention as it appears to be courting international fertility tourists. On the other hand, countries like France, which has a strong anti-surrogacy stance, could be part of such a convention to discourage French intended parents from seeking international surrogacy arrangements.

Even in regimes with permissive surrogacy laws, often people seek surrogacy services abroad due to financial concerns. However, they may not realize that they are embarking on a path that may cause their baby to be stateless and potentially parentless. An international convention on surrogacy could spell out that the domestic family and citizenship law of the intended parents' home country would control any international surrogacy arrangement. This may dissuade those from anti-surrogacy countries seeking international surrogacy arrangements.

The Council on General Affairs and Policy for the Permanent Bureau of the Hague Conference on Private International Law is currently researching how to address the issues raised by international surrogacy[76] including legal parentage, the child's citizenship status and vulnerability, and concerns that are raised regarding exploitation of surrogates.[77] This research was prompted by controversies and issues arising from intended parents of international commercial surrogacy arrangements attempting to return to their home countries that prohibit surrogacy, such as the Menneson case previously discussed.[78] Refusal of travel documents, refusal to recognize a parent-child relationship, and rejection of citizenship for the child are all too common problems in international surrogacy.[79] Governmental schemes that prohibit surrogacy arrangements may also deny issuance of a passport or visa to the child, or refuse to recognize the intended parents as the legal parents of the child.[80] Often, not surprisingly, there is an incompatibility between the family and citizenship legal infrastructure amongst various countries.[81] There is also discrepancy among the penalties imposed in countries

[76] Hale, *supra* note 72, at 501.

[77] *Id.* at 501-02.

[78] Anika K. Boyce, *Protecting the Voiceless: Rights of the Child in Transnational Surrogacy Agreements*, 36 SUFFOLK TRANSNAT'L L. REV. 649, 663 (2013).

[79] Richard F. Storrow, *"The Phantom Children of the Republic": International Surrogacy and the New Illegitimacy*, 20 AM. U. J. GENDER SOC. POL'Y & L. 561, 598 (2012).

[80] *Id.*

[81] *But see* Hale, *supra* note 72, at 509–10 (suggesting that "[s]urrogacy itself may not be the real issue. Rather, the uncertainty with these arrangements is a symptom of a more general problem of irreconcilable family and citizenship laws at the international level. It is important to note that these legal issues may arise in cases that do not involve surrogacy.").

where commercial surrogacy is illegal.[82] Some laws deny citizenship to the child born from a surrogate, thus stigmatizing the child.[83] This harms the child borne of surrogacy and fails to protect that child's human rights.[84] Further, some laws criminalize the behavior of the surrogate, which stigmatizes the woman, but does nothing to resolve the issues with the institution itself.[85] Some have argued that countries that disapprove of international surrogacy may not deny citizenship or deny legal parentage for children born of surrogacy.[86] Although I agree with the normative conclusion, I do not think that realistically, an anti-surrogacy country is going to make it easy for parents who circumvented domestic laws. The solution I propose is not the "ideal" solution, but rather what I see as a practical or workable solution. Although it may not prevent all of the "legal limbo" about the legality of surrogacy arrangements or the legal parenthood of the intended parents, it may serve to at least have international acknowledgement of this problem, define the issue, and inform intended parents about their options.[87] The lack of international regulation has led to money being a corrupting influence in the global surrogacy market, especially with agencies and middlemen who stand to gain the most in these transactions.[88] An international convention will serve to rein in these influences in cross border surrogacy arrangements.

II. Adoption as a Model for Surrogacy

Surrogacy advocates often try to separate cross border surrogacy from inter-country adoption. By focusing on the needs and rights of the intended parents and the surrogate herself, there is often not a discussion of the child borne of surrogacy. There has been a resistance to likening surrogacy to adoption in part because the restrictions on inter-country adoption often resulted in discrimination against LGBT parents, single parents, and parents that did not otherwise fit the mold of the ideal adoptive parents. Advocates have theorized gestational surrogacy as a private issue between the intended parents and the surrogates, without the state being involved in determining the fitness of the intended parents. The assisted reproductive technology ("ART") community has advocated an open approach to access to ART and surrogacy. The theory is based on the belief that just as those who conceive "naturally" do not have a parental fitness test, neither should those who need ART assistance. Part II compares and contrasts adoption and surrogacy. As mentioned previously, little regulation exists in the surrogacy

82 April L. Cherry, *The Rise of the Reproductive Brothel in the Global Economy: Some Thoughts on Reproductive Tourism, Autonomy, and Justice*, 17 U. PA. J. L. & SOC. CHANGE 257, 287 (2014).

83 *Id.*

84 *Id.*; *see also* Pamela Laufer-Ukeles, *The Lost Children: When the Right to Children Conflicts with the Rights of Children*, 8 LAW & ETHICS HUM. RTS. 219, 251 (2014) ("not identifying parenthood status can create legally orphaned children. Frameworks for such children need to be created and their problematic status recognized.").

85 *See* Cherry, *supra* note 82, at 287.

86 Laufer-Ukeles, *supra* note 84, at 251.

87 Margalit, *supra* note 56, at 424–25.

88 Elizabeth Bartholet, *Intergenerational Justice for Children: Restructuring Adoption, Reproduction and Child Welfare Policy*, 8 LAW & ETHICS HUM. RTS. 103, 127-28 (2014).

context. However, adoption is highly regulated.[89] Just how much surrogacy regulation should reflect adoption regulations currently in place is a hotly contested issue.[90] Some who compare surrogacy to adoption embrace the view that the objectives of both adoption and surrogacy are substantially congruent, so adoption can be the appropriate "template" for surrogacy.[91]

A. Adoption versus Surrogacy

Similarities are found between the processes of both adoption and surrogacy for many reasons, including that both usually stem from infertility and offer an option for legal parentage absent biological relationships.[92] Therefore, both adoption and surrogacy target the same market.[93] Further, both processes involve third-party participation in the reproductive process.[94] Additionally, both adoption and surrogacy raise social issues, such as the debate about commodification of children and exploitation of women.[95] Although the pregnant woman may share less intimacy with the unborn child in surrogacy than with a woman who places her child up for adoption, there remains a comparably "high degree of intimate contact" between the surrogate, the fetus, and the prospective parents. Thus, like in adoption, where the birth mother has significant rights in international adoption law, in surrogacy, the rights of the surrogate should be protected, especially given her vulnerable position. Looking to the simple facts at the moment of delivery, "two women with newborn children that they will relinquish," some legislators look to apply existing adoption regulations to the surrogacy context.[96]

However, there are also important differences between surrogacy and adoption. In many cases, surrogacy is not subject to adoption statutes because there are recognized, fundamental differences between the two processes.[97] Some scholars also find surrogacy vastly different from adoption, and thus reject that the adoption framework is applicable in the surrogacy context.[98] One difference is that surrogacy stems out of a contractual relationship that begins the reproductive process, while the adoption process begins after a woman has become preg-

[89] Richard F. Storrow, *Rescuing Children from the Marriage Movement: The Case Against Marital Status Discrimination in Adoption and Assisted Reproduction*, 39 U.C. DAVIS L. REV. 305, 332 (2006).

[90] *Id.*

[91] *Id.*

[92] *Id.* at 333.

[93] Iris Leibowitz-Dori, Note, *Womb for Rent: The Future of International Trade in Surrogacy*, 6 MINN. J. GLOBAL TRADE 329, 329 (1997).

[94] Storrow, *supra* note 89, at 333.

[95] *Id.*

[96] Terry J. Price, *The Future of Compensated Surrogacy in Washington State: Anytime Soon?*, 89 WASH. L. REV. 1311, 1334 (2014).

[97] *See, e.g.*, Johnson v. Calvert, 851 P.2d 776, 784 (Cal. 2014) (assessing the contractual nature of the surrogacy agreement in that case, and finding it not subject to adoption statutes because the nature of the transaction did not bring it within the public policy reasons behind adoption law).

[98] Storrow, *supra* note 92, at 332.

nant.[99] With surrogacy, an intended parent may be biologically related to the child, while the same is not true in the adoption context with adoptive parents.[100] Adoption processes have also been in place longer than surrogacy, and thus have a more rigid structure.[101] Moreover, even if adoption law does influence surrogacy, existing laws are not sufficient to govern "all of the new rights and responsibilities created in the three adults and the child involved in IVF surrogacy."[102] Additionally, in IVF surrogacy, both the surrogate and the biological or intended parent can play a role in the reproductive process.[103]

Proponents of surrogacy agreements have attempted to distinguish adoption by highlighting that the child of a surrogate was never going to be her legal child.[104] The unborn child was always "to be the child of the intended parents, and legal parenthood would attach at birth."[105] Thus, they argue there is no need for adoption-like regulations in the surrogacy context.[106] I disagree with this notion, and believe such regulations would help avoid many of the surrogacy conflicts that have arisen recently.

One of the major issues about the way adoption is regulated is the use of the parental fitness test. I will discuss how this works in the adoption context and explain why it does not similarly apply in the surrogacy context. Prospective adoptive parents are heavily vetted via a "parental fitness test"[107] to protect the interests and rights of the adoptive child.[108] In the United States, adoption procedures vary state-to-state, but the processes are similar.[109] Prospective parents must file a petition with the appropriate court, and then the court looks to the parental fitness factors determined by the state.[110] Courts generally use one of

[99] *Id.* at 333.

[100] *See id.* at 333–34 ("The two are not equally valued by society, given the nearly overwhelming desire for and bias in favor of genetically-related children. . . . [T]he possibility of a genetic tie to a child born through assisted reproduction may make that choice appear more understandable and legitimate . . . .").

[101] *Id.* at 334 (discussing the different parental fitness tests in place and contrasting that in surrogacy, post-birth assessments do not take place like they do in adoption).

[102] Suzanne F. Seavello, *Are You My Mother? A Judge's Decision in In Vitro Fertilization Surrogacy*, 3 HASTINGS WOMEN'S L.J. 211, 212–13 (1992).

[103] *Id.* at 212.

[104] Price, *supra* 96, at 1335.

[105] *Id.*

[106] *Id.*

[107] Lynn D. Wardle, *Adult Sexuality, the Best Interests of Children, and Placement Liability of Foster-Care and Adoption Agencies*, 6 J.L. & FAM. STUD. 59, 97 (2004).

[108] Debora L. Spar, *As You Like It: Exploring the Limits of Parental Choice in Assisted Reproduction*, 27 LAW & INEQUALITY 481, 491 (2009) ("[N]o would-be parent in the United States can legally adopt a child without some outside authority (a child welfare office, licensed adoption agency, or court) deeming that the parent is fit and that the proposed adoption is in the best interests of the child.").

[109] Stella Lellos, *Litigation Strategies: The Rights of Homosexuals to Adopt Children*, 16 TOURO L. REV. 161, 168 (1999).

[110] *Id.*

three tests to determine parental fitness: (1) the best interests of the child test;[111] (2) the adverse impact test;[112] or (3) the nexus test.[113] Although the best interests of the child is the predominant screening device for adoptive parents, it is not applied uniformly.[114] Often there is a question about how the "best interests" test is balanced with "rights of individual adults to establish and maintain nurturing relationships with the child and to make decisions that promote their own goals for a happy and productive life."[115]

Adoptive parents have a more substantial burden to meet to become parents than so called "natural" parents.[116] Within the rigorous parental fitness test framework, there is a real possibility for discrimination against adoptive parents based on factors that have been employed by various jurisdictions. For example, courts have previously considered race,[117] and some courts consider factors such as sexual orientation,[118] weight,[119] and disabilities[120] in making the determination of parental fitness. The vague and unclear definition of "best interests" can lead to discriminatory results.[121]

In the United States, a prospective adoptive parent has to petition the state court to grant an adoption, and present evidence that they satisfy the jurisdictional standards.[122] Courts generally must make an official finding that a person

111 *Id.* at 168–69 (This test "examines the individual circumstances of the child in order to determine what is in the 'best interests of the person to be adopted.' ") (quoting Friederwitzer v. Friederwitzer, 432 N.E.2d 765, 767 (N.Y. 1982)).

112 *Id.* at 169 ("The adverse impact test considers the possible effect of any purported conduct or abnormal circumstances on the child, which must be demonstrated through a 'clear and convincing manner.' ").

113 *Id.* ("[T]he nexus test considers the possible effect of any purported conduct or abnormal circumstances on the child.").

114 Eleanor Willemsen & Michael Willemson, *The Best Interest of the Child*, SANTA CLARA UNIV. http://www.scu.edu/ethics/publications/iie/v11n1/custody.html. (last visited Sept. 20, 2015).

115 *Id.*

116 Brenda K. DeVries, *Health Should not be a Determinative Factor of Whether One Will Be a Suitable Adoptive Parent*, 6 IND. HEALTH L. REV. 137, 148–49 (2009).

117 *See* Kim H. Pearson*, Displaced Mothers, Absent and Unnatural Fathers: LGBT Transracial Adoption*, 19 MICH. J. GENDER & L. 149, 159 n.47 (2012).

118 *Id.*

119 Devries, *supra* note 116, at 148.

120 *Id.* at 147.

121 *Id.* at 143. One suggested solution specific to the sexual-orientation context is to change the legal definition of "parent." Sheryl L. Sultan, *The Right of Homosexuals to Adopt: Changing Legal Interpretations of "Parent" and "Family,"* 10 J. SUFFOLK ACAD. L. 45, 88 (1995). Other suggestions include an expansion of the considerations that the courts find controlling, to include factors such as the support system available to the prospective parents. Kimberly A. Collier, *Love v. Love Handles: Should Obese People Be Precluded from Adopting a Child Based Solely upon Their Weight?* 15 TEX. WESLEYAN L. REV. 31, 55 (2008). Further commentary suggests that states should adopt the standards employed by the Child Welfare League of America. DeVries, *supra* note 116 at 169. This framework imposes standards against discrimination in the evaluation process. *Id.* ("According to the Child Welfare League of America, '[a]pplicants should be accepted on the basis of an individual assessment of their capacity to understand and meet the needs of a particular available child at the point of the adoption and in the future' ").

122 *Adoption: An Overview,* LEGAL INFO. INST., https://www.law.cornell.edu/wex/adoption (last visited Mar. 14, 2015). Some states only permit one of the two types of adoption, others recognize both

is "acceptable" as an adoptive parent, and after weighing a number of factors, must approve an investigation report submitted by the applicable state agency.[123] However, "the law has begun to incorporate greater concern for children, [and] 'the law often seems to be lurching unwittingly in opposite directions.'"[124] Adoption carries stigma for many families, including labels such as being a family that is "not 'real' or 'natural,' solely because the legal, permanent, caretaking parents are not the adults who biologically produced the child."[125] This labeling can be detrimental for both the child and the adoptive parents.[126] With the adoptive parents, it can lessen confidence in parental ability, diminish satisfaction with parenting, and produce a want of secrecy within the adoptive family context about the biological origins of the child.[127] "All parents need social support to carry out their responsibilities most effectively, and the stigmatizing of adoptive families as deviant can make adoptive parents feel they are doing something bad rather than something that is supremely commendable."[128] Further, stigmatizing or discriminating in the adoption context can discourage participation, which can lead to less people engaging in raising children with whom they have no biological connection.[129]

Scholars like Dara Purvis have critiqued the court proceedings that govern whether the adoption is in the best interests of the child because there is no judicial test that must be met for "natural" parenthood to be created.[130] Purvis argues that the best interests test "can be a rigorous hurdle," due to the highly regulated nature of adoption proceedings and intense involvement on behalf of the state.[131] She argues that best interests test can introduce extrinsic factors that

open and closed adoptions. *Id.* An open adoption allows for the biological mother to select the adoptive parents, while a closed adoption results in a state administrative agency conducting the process. *Id.* Whether the biological mother in an open adoption retains visitation rights varies by jurisdiction. *Id.* The adoption process can be conducted through either a public or private agency. Jared C. Leuck, *The Best Interests of the Child in Adoption: An Article Overview*, 11 J. CONTEMP. LEGAL ISSUES 607, 609 (2000). Through this process, prospective parents work with the agency to complete the adoption formalities. *Id.* Adoption can also be independent, where the adoption is arranged between the biological and prospective parents. *Id.* Whether through agency or independent adoption, the prospective parents must still go through court proceedings, and accordingly have their parental fitness assessed. *Id.*

123 *See Adoption: An Overview*, *supra* note 122 ("These investigatory reports are tremendously detailed, including the petitioners' religious backgrounds, social history, financial status, moral fitness, mental and physical fitness, and criminal background. After weighing the factors, the agency makes a recommendation, which the court can accept or reject, with the court basing its decision on serving the best interests and welfare of the child.").

124 Dara E. Purvis, *Intended Parents and the Problem of Perspective*, 24 YALE J.L. & FEMINISM 210, 218 (2012).

125 James G. Dwyer, *First Parents: Reconceptualizing Newborn Adoption*, 37 CAP. U. L. REV. 293, 296–97 (2008).

126 *See Id.* at 297.

127 *Id.*

128 *Id.*

129 *Id.* ("Though there is no shortage of adults in the United States today wanting to adopt newborns, there would likely be an even larger surplus of applicants if the role were treated and viewed as normal parenthood. This could have spillover benefits for older children awaiting adoption, as to whom there is a shortage of applicants in some communities.").

130 *See* Purvis, *supra* note 124, at 215.

131 *Id.* at 216.

may disqualify a prospective parent from the adoption process.[132] For example, factors such as sexual orientation may be considered, although this does not truly affect parental fitness.[133] Thus, she has argued that parentage should be defined by statute, instead of by a judicial determination.[134] Further, if legislative identification of legal parentage is defined by statute, a parent would become the "legal parent" when the child is born, and would not be subject to such state intrusion.[135] In the United States, there is currently no documented parental fitness test in surrogacy that is comparable to the test employed in adoption.[136] I believe this is a good thing. Surrogacy is often a last resort that individuals face after a long and arduous infertility battle. Adding a parental fitness test here seems to add insult to injury.

However, other protections exist within the adoption framework which would work well in the surrogacy context, particularly against greedy agencies.[137] In the ART context, there are some countries like Israel that have extensive regulations, but that is the exception.[138] Naomi Cahn and others have argued that the best practices of adoption can be translated into the field of ART,[139] and notes four common issues that are present in both the adoption and ART context: (1) a need for a focus toward greater transparency in the process; (2) defining which parties are to benefit from the service and the implications for the future child; (3) ethical implications of heightened awareness regarding both types of families; (4) the need for regulations that enhance accountability and set parameters for services.[140] Although these points were about ART in general, the goals noted here are relevant and important for surrogacy - particularly transparency regarding what the agencies are being paid and what the surrogacy is being paid, the roles of the parties in the process-including the physician, the agency, the surrogate, and the intended parents; and the need for regulations to set guidelines for the practice of surrogacy, particularly citizenship and parenthood. There is a need to deter unethical conduct and safeguard individuals' right in the adoption context and the ART context.[141] Cahn notes that because ART and adoption services are

[132] *Id.*

[133] *Id.*

[134] *Id.* at 217.

[135] Purvis, *supra* note 124, at 217.

[136] Although the parental fitness test in the adoption context is "far from perfect," some scholars argue that the underlying principles could and should be applied to forms of assisted reproduction, including surrogacy. Spar, *supra* note 111, at 491. They argue that such principles could be used to monitor processes that carry risks to unborn children in the ART process. *Id.* Some countries that use the parental fitness test currently prohibit the use of assisted reproductive technology for parents who fail to meet the test's criteria. Elizabeth Bartholet, *Intergenerational Justice for Children: Restructuring Adoption, Reproduction and Child Welfare Policy*, 8 LAW & ETHICS HUM. RTS. 103, 111 (2014).

[137] *See* Naomi Cahn & Evan B. Donaldson Adoption Institute, *Old Lessons for a New World: Applying Adoption Research and Experience to ART*, 24 J. AM. ACAD. MATRIM. LAWS. 1, 4 (2011).

[138] *See id.* ("for instance, there are no legal limits on how many times an individual can provide gametes, so that a single sperm donor may father hundreds of children.").

[139] *See id.*

[140] *See id.* at 6–7.

[141] *Id.* at 17.

very expensive, the people who access the service tend to have significant resources, while those providing the service are less likely to have such financial resources.[142] Similarly, in surrogacy cases, intended parents are generally in a much more stable financial position than surrogates. Therefore, there is the risk of coercion and corrupting influence in a regulation free zone.

International adoption is regulated in participant countries by the Hague Convention, and a similar system can and should be developed for surrogacy agencies operating in countries that allow commercial surrogacy.[143] This would incentivize foreign jurisdictions to adhere to standards, and would "allow domestic jurisdictions to certify foreign surrogacy destinations."[144]

The comparison between adoption and ART/surrogacy has not been unchallenged.[145] The Hague Convention's focus is adoption, which is traditionally seen as an acceptable method of building a family.[146] , In contrast, surrogacy is illegal or discouraged in many countries. Due to individual national public policy stances, some scholars doubt that an acceptable international treaty regarding surrogacy could be effective.[147] I disagree. Most scholars who envision a surrogacy convention seem to be picturing a pro-surrogacy convention. In contrast, I believe there is a possibility of agreeing on a value-neutral description surrogacy convention that develops standards for those countries that engage in commercial surrogacy, but also notes the countries that are signatories that are staunchly anti-surrogacy. Such a document has real value in defining the positions of various countries and forcing them to articulate how they will deal with children borne of surrogacy. For example, France may be a signatory as an anti-surrogacy state, but would have to note that babies borne of surrogacy abroad to French parents would be able to gain French citizenship, as a result of the *Mennesson* decision. Obviously, the wrangling over the details of a convention will not be as simple. However, such effort has value because it protects individuals seeking surrogacy arrangements and the surrogates themselves. Although there are differences between ART and adoption, in many aspects ART, and surrogacy specifically, are similar to the state of adoption prior to international law in the adoption arena .[148] Additionally, there is a significant amount of research available regarding adop-

142 *Id.*

143 Laufer-Ukeles, *supra* note 46, at 1277.

144 *Id.* at 1278.

145 *See* Kindregan & White, *supra* note 45, at 528.

146 *Id.* at 623.

147 *Id.* at 623–24.

148 Cahn, *supra* note 137, at 28. Additionally, to model international surrogacy on the adoption framework, it presumes that the model is sound and that it can effectively be adapted for the issues in the surrogacy context. Tina Lin, *Born Lost: Stateless Children in International Surrogacy Arrangements*, 21 CARDOZO J. INT'L & COMP. L. 545, 567 (2013). Further, based on the current functions of the Hague Convention, people seeking that the agency regulate surrogacy agreements should be cautioned that a separate agency may need to be formed to regulate the process. Erica Davis, Note, *The Rise of Gestational Surrogacy and the Pressing Need For International Regulation*, 21 MINN. J. INT'L L. 120, 143 (2012).

tion and how it is regulated, which would be a useful platform to begin analyzing how to regulate assisted reproduction.[149]

B. Controversies in International Adoptions

This section responds to the critique by many scholars that an international convention in surrogacy is impossible because many countries oppose or ban commercial surrogacy. I want to highlight that there is a disparity of opinions about international adoption just as there is on surrogacy. This supports my position that a neutral convention on surrogacy is possible.

1. Arguments in Support of International Adoption

Nations that participate in the Hague Convention on Inter-Country Adoption agree that "the child, for the full and harmonious development of his or her personality, should grow up in a family environment, in an atmosphere of happiness, love and understanding," and that "intercountry adoption may offer the advantage of a permanent family to a child for whom a suitable family cannot be found in his or her State of origin."[150] The Convention has two main objectives: promoting intercountry adoptions and preventing abusive practices in this context.[151] In contrast, a surrogacy convention would not need to promote international surrogacy. Rather, it could simply serve to protect the parties that are involved in a surrogacy arrangement and put intended parents on notice about which countries may be better choices for them to seek surrogacy arrangements. If the convention has the effect of dampening the surrogacy industry, because intended parents will be nervous to seek surrogacy in a country that is on record as being anti-surrogacy, this will be a significant change to the current situation where third party brokers seem to assure intended parents that there will be no roadblocks in their path to parenthood. I believe surrogacy arrangements can be a win-win for all the parties involved, but that usually occurs when the regulations in the country or state are clear, the surrogates' and intended parents' interests are protected and represented by counsel, and there is not too much inequality in bargaining power between the parties. Following this test, the majority of international surrogacy arrangements would not pass. This is similar to the world of pre-Hague Convention Inter-country Adoption- where surrogacy was a corrupt business where stories of baby-selling scandals abounded. The Hague Convention, though decades in the making, curbed many of the evils in the Intercountry Adoption business.

Proponents of international adoption say that it plays an important role in protecting the parentless child,[152] and "makes a huge difference to each of those

[149] *See generally* Cahn & Donaldson, *supra* note 137.

[150] Lynn D. Wardle & Travis Robertson, *Adoption: Upside Down and Sideways? Some Causes of and Remedies for Declining Domestic and International Adoptions*, 26 REGENT U. L. REV. 209, 223 (2014).

[151] *Id.*

[152] *Id.* ("especially those in third-world countries").

children as well as future children."[153] The best interests of the child argument is also employed in the context of intercountry adoption in certain circumstances.[154] Proponents support the idea that regardless of the child's background, what should matter is that the adoptive parents will support the child unconditionally.[155] Further, supporters of international adoption argue that "research shows internationally adopted children do essentially as well as other adopted children."[156]

In the United States, restrictions can make domestic adoption "challenging" and thus make inter-country adoption attractive.[157] Foster adoption can be even more difficult because of the possibility the child may be reunited with the child's biological family. Additionally, many children in foster care are older, and some families may not be able to provide the special support that these children need.[158] Compared to a life confined to an orphanage, advocates argue that international adoption is the better solution.[159] Limiting international adoption would have adverse effects, including more institutionalized children for longer periods of time. This would result in developmental harm, and reduce the prospect of these children becoming a part of a permanent family.[160]

2. Arguments Against International Adoption

The opponents of the current processes involved in international adoption raise several concerns, including: human trafficking, coercion, lack of sufficient record-keeping, and the best interests of the child.[161] Human trafficking is arguably

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153 *Id.*

154 Joseph M. Isanga, *Surging Intercountry Adoptions in Africa: Paltry Domestication of International Standards*, 27 BYU J. PUB. L. 229, 249 (2012); *see id.* at 240 (this author argues that banning intercountry adoptions would only "negatively impact the best interests of otherwise adoptable children").

155 *Id.* at 251.

156 *See id*. ("Supporters even maintain that there is no evidence that children are genetically predisposed to a particular cultural identity.").

157 Lisa Milbrand, *Why International Adoption Matters*, GOODYBLOG (Jan. 2, 2013 2:11 PM), http://www.parents.com/blogs/goodyblog/2013/01/why-international-adoption-matters/ (discussing challenges such as the time frame involved, failed placements when the birthmother changes her mind, and the issues people may have with the "open adoption" which is prevalent in the United States).

158 *Id.*

159 *Id.* ("Institutional care is always subpar . . . [t]here is no replacement for a loving family . . . . Children in orphanages often have limited opportunities for education, and are sent out into the world as young as 14 years old, left to fend for themselves.").

160 Belinda Luscombe*, The Dark Side of Cleaning Up International Adoptions: Kids Are Left in Orphanages Longer*, TIME (Nov. 4, 2013), http://healthland.time.com/2013/11/04/the-dark-side-of-cleaning-up-international-adoptions-kids-are-left-in-orphanges-longer/ ("While there has been some rethinking on orphanages, studies are pretty conclusive that institutionalization of very young children can contribute to a range of lifelong effects that are almost impossible to undo, including behavioral, psychological and basic health issues.").

161 Elizabeth Long, *Where Are They Coming from, Where Are They Going: Demanding Accountability in International Adoption*, 18 CARDOZO J.L. & GENDER 827, 831–33 (2012); *see also* Isanga, *supra* note 154, at 239 ("Reports are rife of instances of 'child-buying, coercion of vulnerable birth parents, weak regulatory structures, and profiteering,' as well as a highly problematic fee structure. Humanitarianism can also mask abuse.") (citing Trish Maskew & Johanna Oreskovic, *Red Thread or Slender Reed:*

the greatest concern by the opponents of international adoption.[162] The demand for international adoption in the United States has led to couples paying up to $30,000 for one child, creating an incentive for the exploitation of orphaned children.[163] Further, in some countries, receiving payment for children is not per se illegal, and such payment is labeled a private business transaction.[164] Coercion has been called a "subdivision of human trafficking."[165] Sometimes poverty and social stigma are used to effectively coerce parents to give up their children.[166] Although the Hague Convention purportedly attempts to remedy this situation, such coercion is still present.[167] This is not to suggest that the Hague Convention is not doing anything. On the contrary, it is easy to imagine how much worse the situation would be without the benefit of an international convention.

Additionally, some critique the insufficient record-keeping and lack of an information sharing process[168] as leading to "often tragic failed attempts at finding homes for needy children."[169] Often prospective parents are not informed that their potential adoptive child has special psychological or medical needs.[170] Again, an international convention may not solve all the problems, but it at least addresses some of the most important issues. Similarly, should there be an international convention on surrogacy, one cannot expect every scandal or problem in international surrogacy to disappear. Rather, the goal should be to make the situation for intended parents, surrogates, and children borne of surrogacy better than it currently is.

Several additional concerns involve whether adoptive parents interests align with the best interests of the child. For some, there is concern that an adopted child's cultural identity will be lost by putting a child in a "non-traditional family structure."[171] This is often veiled discrimination against LGBT and single-led

Deconstructing Prof. Bartholet's Mythology of International Adoption, 14 BUFF. HUM. RTS. L. REV. 71, 79 (2008)).

[162] *See, e.g.*, Long, *supra* note 161, at 831.

[163] *Id.* at 831–32.

[164] *Id.* at 832 (the author specifically refers to Guatemala).

[165] *Id. See also* Rahul Sinha & Akshara Gyan, *Making Families or Selling Babies*, ACADEMIA, http://www.academia.edu/5301254/THEME-SURROGACY_AND_INTERCOUNTRY_ADOPTION_IN_INDIA_TITLE-MAKING_FAMILIES_OR_SELLING_BABIES_Author-Rahul_Sinha (calling this process "child laundering" whereby there is "illegal acquisition of children through monetary transaction, deceit, and/or force.").

[166] Long, *supra* note 161, at 832. ("A group of Romanian nuns profited by as much as $15,000 per child by persuading single mothers to relinquish their parental rights, possibly out of cultural shame for having a child out of wedlock.").

[167] *See* Sinha & Gyan, *supra* note 168.

[168] Long, *supra* note 161, at 832 ("between adoption agencies, potential parents, and sending and receiving countries.").

[169] *Id.*

[170] *Id.* (One of the main concerns in this arena is insufficient medical records for the children, specifically the lack of diagnosis for children suffering from psychological disorders requiring special care. *Id.* This is unforeseen to many adopting parents, leading to the need for extra time, money and attention that an adoptive parent may not be able to provide. *Id.* Further, there are no uniform requirements in place that would notify potential parents that these children could be "special needs adoptees.").

[171] *See* Isanga, *supra* note 154, at 240–41.

families. In adoption, the best interests analysis is used to protect an already living child. In surrogacy, the intended parents are choosing to go through the considerable time expense, financial overhead, and medical intervention to procure eggs and sperm in order to have a biologically related child. There are many people that have children "naturally" that are not subject to a best interests analysis. I believe that there is no need for a best interests analysis in the surrogacy context, and existing legal structures protect less-than-ideal family relationships that may result from a surrogacy arrangement.

Another common critique of inter-country adoption is that it puts the financial security of a transnationally adopted infant over other interests such as cultural heritage.[172] This critique is not directly relevant to surrogacy, as the child borne of surrogacy would typically share the race and culture of the intended parents and not that of the surrogate.

III. Ideas for Reform: Lessons for Surrogacy and a Plea to the Hague

Although there are many critiques of the Hague Convention on Inter-Country Adoption, the most common proposed solution is more stringent international legislation, not laxer regulations.[173] In the case of surrogacy, there is no international body or document that can even be considered as a starting point for any resolution of international surrogacy disputes. Even a weak surrogacy convention is better than none at all. The Hague Convention seems to be in the best position to facilitate international regulation in the developing global market for surrogacy.[174] A Preliminary Report by the Hague "calls for such regulation, particularly for the sake of children . . . some of whom have been left 'marooned, stateless and parentless' because of conflicting legal approaches to Inter-Country Surrogacy in different countries."[175] Similar to the Hague Convention on Inter-Country Adoption, a proposed Hague Convention on International Surrogacy would insure that surrogacy arrangements are recognized in the state where the child is born, as well as the state in which the child will live.[176] The Convention

[172] *Id.* at 243-45 ("Opponents argue that intercountry adoption forces the adopted child to assimilate into western society in a manner that is reminiscent of colonial attempts to indoctrinate indigenous peoples into European values and learning . . . [such that] the adopted child loses an essential aspect of the child's identity by being removed from his or her birth country.").

[173] *See e.g.*, Long *supra* note 161, at 831 ("The growing demand for foreign babies has led to dangerous results and the need for some form of multinational legislation to regulate the practice is clear.").

[174] Carolyn McLeod & Andrew Botterell, *A Hague Convention on Contract Pregnancy (or 'Surrogacy'): Avoiding Ethical Inconsistencies with the Convention on Adoption*, 7 INT'L J. OF FEMINIST APPROACHES TO BIOETHICS 219 (2014). International contract pregnancy is a term that the authors use as a substitute for "surrogacy" as a more morally neutral term. *Id.*; *see also id.* at 223–24 ("If a convention on contract pregnancy is to be neutral or unbiased with respect to what many call *surrogacy*, then it should adopt the term *contract pregnancy* instead. The latter is more neutral because it does not suggest that the woman who carries the child is merely a substitute for the real mother or real caregiver of the child.").

[175] *Id.* at 220-21 (citing Hague Conference on Private Int'l Law, *A Preliminary Report on the Issues Arising from International Surrogacy Arrangements*, Prel. Doc. No. 10 (March 10, 2012), http://www.hcch.net/upload/wop/gap2012pd10en.pdf.

[176] McLeod & Botterell, *supra* note 174, at 221 (In the case of countries like India, where no birth citizenship exists, either the rules must be amended for surrogacy or another acceptable solution must be sought).

on Intercountry Adoption satisfies these objectives, while still remaining neutral about states actually accepting inter-country adoption.[177] It would be appropriate for a convention on Inter-Country Surrogacy to adopt this same approach of neutrality. Using this approach, the two states involved in an international surrogacy arrangement could agree to the process without necessarily supporting Inter-Country Surrogacy, though for some countries, even a document mentioning surrogacy legitimizes the practice.[178] Because a proposed Convention should not "favor the one way of forming a family with children over the other . . . ."[179] and could actually explicitly have anti-surrogacy countries as signatories, some of the hesitation about such a document may dissipate.

Limited Scope

Because international surrogacy implicates ethical concerns that vary by viewpoint across countries, a regulation of all of the issues raised in international surrogacy is not currently feasible, especially as a first step.[180] Surrogacy involves numerous areas of law, both domestic and international, and it is therefore unlikely that a comprehensive, single instrument would gain enough political support to pass, especially if it takes a pro-surrogacy position.[181] If the surrogacy convention is drafted to define surrogacy and propose best practices for those countries that allow surrogacy, there may be more likelihood of such a document being adopted by several countries. If the document tries to address too many issues, it is unlikely that enough countries could come to an agreement on all of the questions involved to make the uniform regulation of international surrogacy possible.[182]

Although ideally an international convention would address all the different aspects of citizenship, parentage, and protection of surrogates I have discussed throughout the article, I acknowledge that this may be too ambitious a goal as a first step. Instead, an international document that agrees on the definition of commercial surrogacy may be the realistic first step, with the Palermo Protocol as an acceptable model. The main international instrument addressing issues with transnational organized crime is the United Nations Convention against Transnational Organized Crime, adopted by the UN in November 2000 in Pa-

[177] *Id.* (noting that the Convention on Adoption does not actually promote the practice or encourage any state to implement it, and further noting that "a Contracting State might never allow an adoption to proceed").

[178] *Id.* at 221–22. ("To expect that member States would all accept international contract pregnancy, which tends to be commercial rather than altruistic, is unrealistic. There is simply too much global opposition to this practice.").

[179] *Id.* at 222; *see also id.* at 5 ("It is still not obvious to us that the Hague Conference should support contract pregnancy—in particular by requiring that Contracting States accept it—while refusing to support adoption in the same way.").

[180] Kristiana Brugger, supra note 71, at 679-80.

[181] *Id.* at 680 (discussing the impact on family law, immigration law, adoption & citizenship law, abortion laws, labor laws, human rights laws, property laws, contract laws, and more).

[182] *Id.* at 684.

lermo, Italy.[183] The Convention is supplemented by three Protocols, commonly referred to as the "Palermo Protocols.,"[184] including the Protocol to Prevent, Suppress and Punish Trafficking in Persons, especially Women and Children, which became effective in December 2003.[185] This Protocol became the first international, legally-binding document that defined trafficking in persons.[186] The definition provides that:

> "Trafficking in persons" shall mean the recruitment, transportation, transfer, harboring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labor or services, slavery or practices similar to slavery, servitude or the removal of organs.[187]

The stated intent behind the definition is "to facilitate convergence in national approaches with regard to the establishment of domestic criminal offences that would support efficient international cooperation in investigating and prosecuting trafficking in persons cases."[188] Additionally, the Protocol seeks to protect the victims' of human trafficking basic human rights.[189]

Although the goals may be modest, the mere agreement of a definition of surrogacy and the convergence in national approaches with regard to the establishment of domestic surrogacy regulation that would support efficient international cooperation in cases of stateless or parentless babies borne of surrogacy would be a vast improvement compared to the black hole of international law that exists today. Some critics of the Palermo Protocol on human trafficking state that it "primarily serve(s) law enforcement goals, without sufficient provision for long-term protection of the victims."[190] This could be a concern for a value neutral surrogacy provision that includes anti-surrogacy countries. Advocates of a convention would want to ensure that it does more than criminalize surrogacy in anti-surrogacy countries and instead, actually helps prevent stateless and parentless babies. One issue to deal with in international surrogacy is that there may be conflict with existing international law. For example, the definition of trafficking has been interpreted differently by various jurisdictions, and few

183 United Nations Convention Against Transnational Organized Crime and the Protocols Thereto, art. 1, Dec. 12, 2000, T.I.A.S. 13127, 2225 U.N.T.S. 209.

184 *Id.*

185 *Id.*

186 *Id.*

187 United Nations Convention Against Transnational Organized Crime and the Protocols Thereto, *supra* note 183.

188 *Id.* (The United Nations Office on Drugs and Crime is charged with its implementation.).

189 *Id.* (The United Nations Office on Drugs and Crime is charged with its implementation.).

190 Martina Pomeroy, *Left Out in the Cold: Trafficking Victims, Gender, and Misinterpretation of the Refugee Convention's "Nexus" Requirement*, 16 MICH. J. GENDER & L. 453, 490 (2010).

have incorporated the Palermo Protocol's actual definition of "trafficking in persons" into legislation.[191] Thus, jurisdictions that forbid surrogacy arrangements could seek to use existing international legislation such as the Palermo Protocols to criminalize surrogacy as a form of human trafficking.[192] However, alternate routes are available for countries that disallow surrogacy, such as promoting agreements with states that do allow surrogacy by requiring the permissive states to actively prevent transactions by its citizens.[193]

Legal Representation of the Surrogate

In addition to the definition of surrogacy, an international document on surrogacy should delineate the best practices for commercial surrogacy in countries in which it is legal. Commercial surrogacy raises concerns about the commodification of the pregnancy, the surrogate, and the resulting child.[194] Moreover, there is a real risk of abuse with coercive conduct, exploitation, and human trafficking.[195] A problematic example is India, where under most surrogacy contracts, the fetus' health explicitly comes before the health of the mother.[196] Further, in India, surrogates often live in group homes during their pregnancies to monitor their health and progress, which may not include medical concerns, but does raise ethical and legal questions.[197] The entire life of the surrogate becomes gestating the child to complete the contract with the intended parents.[198] An international convention on surrogacy should address surrogate health and decision making, and should require that countries that allow commercial surrogacy require legal representation of the surrogate paid for by the intended parents. Such legal representation would ensure that the surrogate was in a position of understanding about what she had agreed to and the terms of her arrangement. In many current international surrogacy situations, the surrogate is the victim of a fertility clinic and middlemen recruiters, or even her own family. There are many states in the United States that require that surrogates have legal representation and even a mental health evaluation prior to undertaking a surrogate pregnancy. It may be

191 Jean Allain, *No Effective Trafficking Definition Exists: Domestic Implementation of the Palermo Protocol*, 7 Alb. Gov't L. Rev. 111, 122 (2014). Moldova is an example of a country with a very broad definition, and it has established that trafficking includes women acting as surrogates for reproductive purposes. *Id.* at 123. Additionally, both Israel and Azerbaijan have also established that exploitation includes surrogacy. Lauren A. McCarthy, *Human Trafficking and the New Slavery*, Ann. Rev. L. & Soc. Sci. 221, 223 (2014). *See* Allain at 126.

192 Yasmine Ergas, *Babies Without Borders: Human Rights, Human Dignity, and the Regulation of International Commercial Surrogacy*, 27 Emory Int'l L. Rev. 117, 172–73 (2013).

193 *Id.*

194 *Id.* at 176

195 *Id.*

196 *See* Laufer-Ukeles, *supra* note 46, at 1268 ("Apparently, under the terms of most surrogacy contracts in India, the surrogate mother and her partner agree that if the childbearing woman is injured or diagnosed with a life-threatening disease during advanced pregnancy, she is to be sustained with life support equipment to protect the fetus viability and insure a healthy birth on the genetic parents' behalf") (internal quotation marks omitted).

197 *Id.*

198 *Id.*

difficult to require a mental health evaluation in countries where mental health services are often lacking. However, legal representation can help ensure that surrogates are cognizant of the arrangement they are entering into, and are willingly a part of it. Legal representation may ensure that the financial and physical health of surrogates is being protected. Surrogates are often more vulnerable than birth mothers in inter-country adoption, because surrogates are being paid to carry a child for another and are separated from their support system while pregnant in some countries like India.

Parentage

Another issue raised is the legal confusion caused by situations like those in India, in which there is no regulation establishing legal parenthood in the context of surrogacy.[199] India bases its citizenship rules on the biological parents' citizenship, not birth citizenship. Therefore, there have been many scenarios where a baby borne to an Indian surrogate and foreign intended parents through donor gametes has been left stateless. Without better domestic rules to regulate surrogacy and an umbrella international convention to ensure parentage and citizenship are established, a child can be left without responsible care; a stateless, parentless baby.[200]

Implementation of an international surrogacy regulation that could cause a conflict of an international law with current domestic laws, the unlikely reform of domestic conflicting laws, and the possibility of political backlash will be difficult.[201] However, this should be the paramount goal of an international surrogacy convention. Some scholars have suggested that existing international organizations such as the World Trade Organization (WTO) or the International Labor Organization (ILO), may be good vehicles for regulating surrogacy.[202] Under the WTO, surrogacy arrangements could be regulated as "trade," through which a "surrogacy service instrument" could be formed that would require the enactment of domestic laws regarding surrogacy.[203] Alternatively, under the ILO, surrogacy could be regulated as "labor," because "legalized surrogacy is, indeed, paid labor (in the truest sense of the word)."[204] Although such arrangements are theoretically workable, a separate convention on surrogacy seems the most comprehensive and appropriate answer. Much of the dilemmas in surrogacy arise due to conflicts of laws issues.[205] International surrogacy has effects

[199] Kindregan & White, *supra* note 45, at 593.

[200] *Id.* at 593–94.

[201] Brugger, *supra* note 71, at 684.

[202] *See id.* at 685. ("The challenges to these approaches include (1) a lack of political will to push the boundaries of instrument creation into the surrogacy arena, and (2) a high risk of an imbalance in the protection given to various parties to a surrogacy arrangement. Both challenges ultimately derive from these two organizations' limited scope.").

[203] *Id.* at 691.

[204] *Id.* at 693–94 ("Simply stated, '[t]he ILO is the international organization responsible for drawing up and overseeing international labour standards.' ").

[205] *See* Hale, *supra* note 72, at 511.

on several fields of domestic law,[206] and rather than change domestic law, an international convention could address the relevant issues.[207] This could result in countries changing their surrogacy laws, or even cause intended parents to avoid the jurisdictions that would likely result in a struggle for citizenship or parentage.

Many doubt the feasibility of having an international uniform set of rules to regulate the commercial surrogacy industry. Although difficult, it may be possible for countries offering surrogacy services to adhere to guiding principles set forth via treatises.[208] A multilateral agreement may be the only effective way to resolve the issues concerning international surrogacy, because it leaves the power with those who have authority to change the contractual relations—the states.[209]

It may be possible, although not ideal, to address surrogacy via existing international treaties. There are three current human rights treaties that could incorporate surrogacy—the International Covenant on Economic Social and Cultural Rights, the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), and the Convention on the Rights of the Child (CRC).[210] None of these currently address surrogacy, but each of these treaties incorporate some of the same protections that are needed in surrogacy.[211] Although there is much doubt that there can be absolute agreement on all of the issues surrounding international surrogacy, such agreement is not necessary. For example, in the CRC, due to controversies between states about when life begins, "the drafters defined only an end-point of childhood (eighteen years), leaving the question of its beginning—whether at conception, birth, or some other stage—to each signatory's discretion."[212] For a provision on surrogacy, an agreement on the key issues- such as citizenship, parentage, and protection of surrogates would be satisfactory,[213]

Although some have suggested creating an agreement that delineates the relations between states and the acceptance of parentage documents, such a document would be even more difficult to negotiate.[214] This could be done through current international agreements, even though they are not specific to surrogacy.[215]

Amending existing treaties may work, but a separate convention on surrogacy would likely be more able to address all of the key issues related to surrogacy.[216]

206 *See* Nelson, *supra* note 63, at 248 (discussing "including family law, contract law, health law, and human rights law.").

207 *Id.*

208 Boyce, *supra* note 78, at 662.

209 Ergas, *supra* note 192, at 163.

210 Barbara Stark, *Transnational Surrogacy and International Human Rights Law*, 18 ILSA J. INT'L & COMP. L. 369, 371-72 (2012).

211 *Id.* at 372 (discussing "including the right to health, the right to support, the right to know one's origins, and the right to a family.").

212 Ergas, *supra* note 192, at 164.

213 *Id.*

214 Hale, *supra* note 72, at 502.

215 *Id.*

216 *Id.*

Because I propose that the international convention on surrogacy be value-neutral, anti-surrogacy states would also be able to be party to the convention. Anti-surrogacy states can make clear their domestic law and position on citizens that circumvent their surrogacy laws and seek surrogacy abroad. This will serve two purposes; first, the convention would serve as notice to prospective intended parents and protect intended parents from false assurances by clinics or other middlemen. Second, such declarations would serve as a test for anti-surrogacy states which are forced to admit that the babies borne of surrogacy may gain citizenship of their state (as in the case of France). This may be a first step in motivating countries to change their domestic surrogacy laws to be more consistent. This will avoid issues of abandonment because the agreement about the birth is enforceable and determined prior to conception.[217] In countries where commercial surrogacy is legal, an international convention could deem that those countries will ensure that their domestic laws will allow intended parents to be given parental rights at the time of the written surrogacy contract.[218] This would help safeguard that before the birth of the child, the surrogate and intended parents have accounted for the child's citizenship or nationality to prevent statelessness.[219] Another issue that should be addressed by a convention on surrogacy is requiring countries that allow surrogacy arrangements to create a central agency that is designated to monitoring the surrogacy process.[220] Such agencies would give security to intended parents, surrogates, and the country where the surrogacy arrangement takes place to ensure that stateless or parentless babies are not born.

Preventing Trafficking

As the Convention on Adoption expressly prohibits the sale and traffic of children,[221] the Convention on Inter-Country Surrogacy should contain similar language. Specifically, with regard to commercial surrogacy, a surrogate should be compensated regardless if her pregnancy results in a live child. Births begin to resemble a sale of children, instead of a contract pregnancy, "when [the surrogate] is paid only if there is a live child in the end."[222] This should be prohibited by a Hague Convention on International Surrogacy.[223]

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217 Sarah Mortazavi, *It Takes a Village to Make a Child: Creating Guidelines for International Surrogacy*, 100 GEO. L.J. 2249, 2290 (2012).

218 *See id.*

219 McLeod & Botterell, *supra* note 174, at 126.

220 *Id; but see* Hale, *supra* note 72, at 518 ("Central regulatory agencies specific to surrogacy would add unnecessary cost to the system.").

221 Hague Conference on Private International Law, Convention on Protection of Children and Cooperation in Respect of Intercountry Adoption, May 29, 1993, S. Treaty Doc. No. 105-51 [hereinafter Hague Convention], Preamble, Article 1 sub paragraph b, *available at https://assets.hcch.net/docs/77e12f23-d3dc-4851-8f0b-050f71a16947.pdf.*

222 McLeod & Botterell, *supra* note 174, at 126.

223 *Id.*; *See also id.* (Katarina Trimmings & Paul Beaumont *"International Surrogacy Arrangements: An Urgent Need for Legal Regulation at the International Level,"* 7 J. Private Int'l L. 627, 627–47 (2011) (who advocate that "instead that to prevent the sale of children, the convention should specify a 'remuneration maximum' . . . . No commercial contract pregnancy arrangements should exceed this maximum, in their view. However, such a measure would not eliminate the sale of children.").

Compensation of Surrogates

The question of what level of compensation should be allowed in an international convention is controversial. In comparing the current Hague Convention on Adoption language,[224] some scholars suggest that subsection (1) and (2) should be used in the Convention on International Surrogacy.[225] They suggest that the language should be amended to prohibit payment offers that are coercive.[226] In the context of International Surrogacy, subsection (4), and the second half of subsection (3), arguably present the most difficulty, as these sections involve withdrawal of consent.[227] Although I do not disagree with scholars who advocate such language and issues, I think more modest goals would result in an actual international convention. I believe that the international convention should be silent as to the payment to surrogates and withdrawal of consent. However, it is worthwhile to have countries who allow commercial surrogacy change their domestic laws to ensure that women be paid for their services in all circumstances, whether the surrogate pregnancy results in a live birth or not.[228]

Additional Issues

Just because the Hague Convention on Intercountry Adoption has a parental vetting requirement,[229] does not mean the proposed Convention on International Surrogacy should adopt the same position. Although some scholars disagree,[230]there is sufficient concern that parental vetting will discriminate against non-biological parents, LGBTQ parents, economically diverse parents, or non-married or single parents, just as it has been used in adoption. Criminal law and international law adequately deal with concerns about child trafficking. Too many people who would otherwise be good parents will be left out of the oppor-

[224] *Hague Convention*, *supra* note 221, at Article 4.

Article 4 sub-paragraph c) of the Convention on Adoption,

[a]n adoption within the scope of the Convention shall take place only if the competent authorities of the State of origin . . . have ensured that,

(1) the persons, institutions and authorities whose consent is necessary for adoption, have been counseled as may be necessary and duly informed of the effects of their consent, in particular whether or not an adoption will result in the termination of the legal relationship between the child and his or her family of origin,

(2) such persons, institutions and authorities have given their consent freely, in the required legal form, and expressed or evidenced in writing,

(3) the consents have not been induced by payment or compensation of any kind and have not been withdrawn, and

(4) the consent of the mother, where required, has been given only after the birth of the child.

[225] McLeod & Botterell, *supra* note 174, at 126.

[226] *Id.*

[227] *Id.*

[228] *Id.*

[229] *Hague Convention*, *supra* note 221, at Article 5. ("Article 5, sub-paragraph (a) states that "[a]n adoption within the scope of the Convention shall take place only if the competent authorities of the receiving State have determined that the prospective adoptive parents are eligible and suited to adopt.").

[230] McLeod & Botterell, *supra* note 174, at 126.

tunity to choose a surrogacy arrangement if a parental vetting requirement exists in any proposed convention.

Many commentators have suggested that any surrogacy convention must deal with the issue of whether anonymous gamete donations are allowed. Controversially, in adoption, there is a movement towards open adoption, and in many parts of the world, a trend towards "open ART" is also emerging. I take the position that although open ART may be a laudable goal, it will hinder the availability of donor gametes for infertile families and other intended parents that need to seek donor gametes. Thus, I suggest that the convention remain silent on whether donors need to be known.

There are numerous other issues that any international convention has the potential to address. However, it is urgent to develop some sort of international convention that can attract the most countries as signatories in order to protect the parties in commercial surrogacy transactions. It is not beneficial to forego any international agreement just because not every issue is dealt with. Although my proposed model may not be overly ambitious, it is pragmatic and realistic, especially because I propose that anti-surrogacy countries can and should be parties to the convention.

IV. Conclusion

This Article makes a case for why international surrogacy can and should be regulated. I use adoption as a model, but note that there are many differences in international surrogacy that warrant a new approach. In this Article, I attempt to make an argument that surrogacy should be regulated on an international level, similar to inter-country adoption. What makes the feasibility of such a convention a question is that, unlike inter-country adoption, where most countries are open to some form, many countries outright ban commercial surrogacy and would not want to be involved in theorizing how to make it legal. However, as I note, the proposed convention does not have to deem surrogacy a right or even make any moral judgments for or against surrogacy. The reality is that many citizens of countries that ban surrogacy are seeking surrogacy arrangements elsewhere, and thus, even those countries banning the practice, should be party to a convention which attempts to address this issue. The convention should address how to deter the breaking of the law, without harming children borne of such illegal arrangements. It would be great progress if countries could agree on a definition of international surrogacy and work towards best practices. We should not wait for all the issues in international surrogacy to be solved by one document. Rather, a convention that has modest goals is currently the best solution in giving notice to intended parents and the rest of the world about a countries' stance on surrogacy.

Fighting Against The Reemergence of Polio in the Federally Administered Tribal Areas of Pakistan

Basim Kamal

I. Introduction

In the backdrop of Pakistan's internal struggle to combat Islamic extremism, narrow the socio-economic inequality gap, and adequately care for over a million internally displaced people and refugees, another problem has quietly been brewing. The reemergence of polio in Pakistan has threatened to derail decades of work by the international community in eradicating the disease, and is on the verge of plunging Pakistan into another major public health crisis.

Since 2000, Pakistan has implemented over 130 polio-immunization campaigns.[1] Despite their efforts, Pakistan is one of the last reservoirs of Polio in the world, along with Nigeria and Afghanistan.[2] The Federally Administered Tribal Ares of Pakistan (FATA), a lawless, semi-autonomous region of Pakistan bordering Afghanistan, hosts a large percentage of the world's polio cases.[3] It is from this region that polio outbreak threatens to burst out of control. Pakistan now lags behind every other country in the world in eradicating polio, and without drastic measures, the surge in polio cases in Pakistan could threaten to create a global public health crisis.

[1] Zulfiqar A. Bhutta, *Polio Eradication Hinges on Child Health in Pakistan*, 511 Nature 285, 286 (2014).

[2] *Id.* at 285.

[3] Leslie Roberts, *Fighting Polio in Pakistan*, 337 Science 517, 519 (2012).

Fighting Against the Reemergence of Polio

This paper examines the rise of Polio in Pakistan and the international, national, and district level responses to combat its reemergence. Part II provides background information on the Federally Administered Tribal Regions of Pakistan and the global strategy to eradicate Polio in the country. Part III discusses in detail the roadblocks being faced by health workers in Pakistan in successfully implementing vaccination programs. Part IV analyzes the effectiveness and weaknesses of the current strategies being employed to eradicate polio in Pakistan, and Part V proposes a hybrid of solutions which allow for the effective monitoring and implementation of eradication proposals.

II. Background

A. Federally Administered Tribal Areas of Pakistan

Pakistan and Afghanistan share a rugged and porous border. The mountainous regions on both sides of the border are strife with Islamic extremism, and the area is often referred to as the 'grand central station of global Islamic militancy.'[4] The Federally Administered Tribal Areas of Pakistan (FATA), the area of Pakistan that borders Afghanistan, has become a safe-haven for Afghani and Pakistani militants.[5] Arguably, neither the Pakistani government nor the military have control over the area, and control of FATA is effectively managed by prominent Islamic Pushtun leaders.[6]

FATA's population is virtually entirely Pashtun.[7] FATA is divided into seven different administrative agencies, including Khyber, South Waziristan, and North Waziristan, where a majority of polio cases have arisen.[8] For over a hundred years, the area has been governed by its own set of colonial-era laws called the Frontier Crimes Regulation.[9] Laws passed by Pakistani Parliament do not apply in FATA, unless the president so directs, and FATA falls outside of the jurisdiction of Pakistan's Supreme and High Courts.[10] The Supreme Court, in recognizing the unique circumstances and traditions of the Pashtuns, noted that the laws for the area are "so that their inhabitants are governed by laws and customs with which they are familiar and which *suit their genius*."[11]

[4] Joshua A. Kurtzman, *Pashtunistan's Future: The Global Executive or a Regional Solution*, 21 IND. J. GLOBAL LEGAL STUD. 303, 308 (2014).

[5] Tayyab Mahmud, *Colonial Cartographies, Postcolonial Borders, and Enduring Failures of International Law: The Unending Wars Along the Afghanistan-Pakistan Frontier*, 36 BROOK. J. INT'L L. 1, 47 (2010).

[6] *See* Kurtzman, *supra* note 4, at 313.

[7] *See* Mahmud, *supra* note 5, at 55.

[8] *Id.* at 57.

[9] *Id.* at 55-56.

[10] *Id.* at 56.

[11] *Id.* at 57.

B. Polio Eradication in Pakistan

Against this backdrop, public health initiatives in FATA have been difficult, particularly with polio eradication. Polio causes "acute flaccid paralysis," affecting young children at an early age.[12] There is no cure for the polio disease, "which enters the body through the mouth, proliferates in the intestine then invades the central nervous system, destroying cells that activate muscles. . . caus[ing] irreversible paralysis."[13] There are three types of Polio: Type 1, Type 2, and Type 3.[14] Although Type 2 has been eradicated, Type 1 and Type 3 still linger.[15] Vaccines have been made that combat all three types of polio at once, though studies have shown that trivalent oral polio vaccines have "decreased effectiveness against individual strains."[16] As the virus is extremely contagious through the spread of contaminated fecal matter, a single case can put the entire world at risk.[17] In other words, if eradication fails in Pakistan, then the decades long campaign, in which over $10 billion has been spent, would have failed.[18]

To date, seven major eradication programs have been attempted against a variety of diseases, with only the fight against smallpox being successful in its total eradication.[19] The majority of developed nations largely eliminated traces of the polio virus by the 1970s.[20] By the late 1980s, 350,000 people in 125 countries were effected by the virus.[21] In 2010, 75% of the cases were in conflict-ridden areas, primarily in Pakistan, Afghanistan, and Nigeria.[22] By 2013, significant progress was made, as only 160 endemic cases were reported, with a majority of them originating in only Pakistan, Afghanistan, and Nigeria.[23]

The largest and most prominent international organization at the forefront of polio eradication has been the Global Polio Eradication Initiative, established in

12 April Chang et al., CTR. FOR STRATEGIC & INT'L STUD., ERADICATING POLIO IN AFGHANISTAN AND PAKISTAN 3 (2012), http://csis.org/files/publication/120810_Chang_EradicatingPolio_Web.pdf.

13 Jon Boone, *Pakistan's Polio-Busters Try to Contain Disease Despite Terrorist Opposition*, THE GUARDIAN (July 3, 2014, 11:12 AM), http://www.theguardian.com/world/2014/jul/03/pakistan-polio-busters-disease-terrorist-opposition.

14 Svea Closser, "*We Can't Give Up Now": Global Health Optimism and Polio Eradication in Pakistan*, 31 MED. ANTHROPOLOGY: CROSS-CULTURAL STUDIES IN HEALTH & ILLNESS 385, 392 (2012).

15 *Id.*

16 Tariq Khan & Javaria Qazi, *Hurdles to the Global Anti-polio Campaign in Pakistan: An Outline of the Current Status and Prospects to Achieve a Polio Free World*, 67 J. EPIDEMIOLOGY & CMTY HEALTH 696, 699 (2013).

17 *See* Roberts, *supra* note 3, at 517-518.

18 *Id.*

19 See Closser, *supra* note 14, at 385.

20 *Polio in Pakistan: Paralysis*, THE ECONOMIST (Oct. 15, 2011), http://www.economist.com/node/21532333.

21 *See* Bhutta, *supra* note 1, at 285.

22 *See* THE ECONOMIST *supra* note *20.*

23 Edna K. Moturi et al., *Morbidity and Mortality Weekly Report: Progress Toward Polio Eradication – Worldwide, 2013-2014*, CENTERS FOR DISEASE CONTROL AND PREVENTION, (May 30, 2014), http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6321a4.htm.

1988.[24] It has helped to reduce worldwide levels of polio by 99%, and has allowed over 10 million people to survive who otherwise would have been affected by the polio virus.[25] The Global Polio Eradication Initiative consists of a variety of stakeholders, including the World Health Organization, Rotary International, UNICEF, USAID, the Bill and Melinda Gates Foundation, and a multitude of non-governmental and donor agencies.[26] The organization focuses on four strategic pillars, which include "1) routing immunization, supplementary immunization, surveillance, and targeted 'mop-up' campaigns."[27]

For the period of 2013 – 2018, the Global Polio Initiative requires $5.5 billion to adequately address all aspects of their Pakistan program.[28] Its budget includes vaccinating 250 million children multiple times every year.[29] Specifically, the program calls for polio workers in Pakistan to routinely vaccinate children at birth, at six weeks, ten weeks, and at 14 weeks of ages for all children.[30] Teams go from door to door to administer vaccines.[31] Particularly for Pakistan, the Initiative's framework includes reducing the exposure of vaccinators to potential threats, enhancing cooperation between civilian and security services to provide local risk assessments, increasing community demand of the vaccinations, and providing religious leader advocacy at the local level to increase community involvement.[32]

Pakistan's anti-polio campaign is embodied in the National Emergency Action Plan for Polio Eradication, prepared by the government of Pakistan.[33] The plan establishes a multi-level organizational structure for implementing the polio initiative.[34] Essentially, the Prime Minister's office is the "main driving force" behind the anti-polio initiative in Pakistan.[35] Under the supervision of the Prime Minister, the focal person for polio eradication works in conjunction with the Prime Minister's Secretariat, the Office of the President, and the Ministry of Na-

[24] GLOBAL POLIO ERADICATION INITIATIVE, WORLD HEALTH ORG., STRATEGIC PLAN 2013-18, 1, 1 (2013), *available at* http://www.endpolio.com.pk/images/reports/polio-eradication-&-endgame-strategic-plan1-2013-2018.pdf [hereinafter STRATEGIC PLAN 2013].

[25] *Id.*

[26] Rafael Obregón et al., *Achieving Polio Eradication: A Review of Health Communication Evidence and Lessons Learned in India and Pakistan*, 87 WORLD HEALTH ORG., 624, 624 (2009).

[27] *See* Khan, *supra* note 16, at 696.

[28] *See* STRATEGIC PLAN 2013, *supra* note 24, at 10.

[29] *Id.*

[30] Jason Beaubien, *The Hidden Costs of Fighting Polio in Pakistan*, NPR, (July 29, 2014), *available at* http://www.npr.org/sections/goatsandsoda/2014/07/29/335388814/the-hidden-costs-of-fighting-polio-in-pakistan.

[31] *Id.* at 3.

[32] *See* STRATEGIC PLAN 2013, *supra* note 24, at 9.

[33] *See generally* NATIONAL EMERGENCY ACTION PLAN 2014 FOR POLIO ERADICATION, NAT'L TASK FORCE OF POLIO ERADICATION (2014), *available at* http://www.polioeradication.org/Portals/0/Document/InfectedCountries/Pakistan/2014_NEAP_Pakistan.pdf [hereinafter NATIONAL EMERGENCY ACTION PLAN].

[34] *See id.* at 17.

[35] *See* Chang, *supra* note 12, at 4.

tional Health Services.[36] There is also a National Steering Committee, a Polio Monitoring and Coordination Cell, Polio Control Rooms, and a Vaccine Management Committee.[37] Polio Control Rooms are in each province, while Deputy Commissioners act as administrative heads at the district levels, and each tehsil, or small administrative area, has its own polio eradication committee.[38]

The National Emergency Action Plan for Eradication has over sixteen key goals, touching on both supply-side and demand-side issues.[39] The demand-side issues "mainly involve a sense of vigilance among local residents against outside (particularly Western) influences, while the supply-side issues mainly involve the non-receptiveness of the communities to the female vaccinators."[40] The plan calls for 'Short Interval Additional Doses,' the goal of which is to "rapidly build up population immunity" by providing doses in quicker intervals, particularly for Pashtun communities residing outside of FATA.[41] To address migrant and unsettled populations in FATA, the plan calls for an extensive research effort in understanding migration patterns, including data collection and mapping.[42] The plan expressly calls for greater community partnerships with FATA, by engaging with community leaders at all levels, and for using religious leaders as partners for anti-polio initiatives.[43] In addressing incentives for aid workers, the plan calls for a 'Direct Disbursement Mechanism' as the only payment method for aid workers, in the hopes that workers are paid on time and in the full amount.[44]

III. Discussion

In 2011, Pakistan became known as the "global epicenter" of the polio disease, with the most cases in the world.[45] The rise of polio cases in Pakistan has been attributed to a "perfect storm of all the problems that are Pakistan: poverty and illiteracy; a health system in tatters; ethnic and sectarian violence; a government struggling to deal with corruption and dysfunction; huge population movements; and, especially since 9/11, rising extremism and [an] anti-Western view. . ."[46]

This has been compounded by recent large natural disasters, including earthquakes and flooding, along with persistent conflicts that have created a non-exis-

[36] *See* NATIONAL EMERGENCY ACTION PLAN, *supra* note 33, at 17.

[37] *Id.*at 18.

[38] *Id.* at 19.

[39] *See id.* (explaining that the National Action Plan broadly lists sixteen different goals for Pakistan's Anti-Polio initiative, many of which overlap; the relevant goals are discussed in this paper).

[40] Syed Q. Hassan et al*., Refusal of Oral Polio Vaccine in Northwestern Pakistan: A Qualitative and Quantitative Study*, 32 VACCINE, 1382, 1385-86 (2014).

[41] *See* NATIONAL EMERGENCY ACTION PLAN, *supra* note 33, at 30.

[42] *Id.*

[43] *See generally* NATIONAL EMERGENCY ACTION PLAN, *supra* note 33.

[44] *Id.*

[45] Roberts, *supra* note 3, at 517.

[46] *Id*. at 518.

tent public health infrastructure and the exposure of large populations to unsanitary conditions.[47]

By 2011, the majority of Pakistan's polio cases arose from a handful of distinct areas.[48] Since then, the outbreak of polio in Pakistan has been concentrated in four geographic areas: the city of Quetta in the province of Balochistan; the city of Peshawar in the province of Khyber Pakhtunkhwa; the city of Karachi in the province of Sindh; and the tribal areas of FATA.[49] Within these areas, there are 33 high-risk districts.[50] The tribal agency of North Waziristan, one of the seven tribal agencies of FATA, has more than half of the world's polio cases.[51]

Geographic and climate conditions have also not helped Pakistan, as "fecal-oral transmission of poliovirus is very efficient in Pakistan's hot climate, high population density, and poor water and sanitation infrastructure" conditions.[52] This problem contributes to low-dose efficiency in Pakistan, where children have to be vaccinated up to 10 times.[53] In FATA, high-levels of cross-border activity with Afghanistan, especially with refugees fleeing conflict, contributes to high levels of transmission.[54] The borders are a major problem for the transmission of polio with its lack of infrastructure, with nomads freely moving between both countries, and the lack of oversight by WHO and UNICEF officials due to no security arrangements in the area.[55] FATA's migrant Pashtuns, who comprise the majority of the population in FATA, are five times more likely to contract polio than other ethnic groups within Pakistan.[56]

The situation was not always so dire in Pakistan. Between 1994 and 2005, polio levels in Pakistan steadily dropped, and only began to spike in 2008.[57] To illustrate this, there were approximately 3000 cases of polio in Pakistan in 1980, and only 198 in 2011.[58] By 2011, the number of cases dangerously rose, in contrast to India which had only one reported case.[59]

Pakistan has had over 110 polio immunization campaigns since 1994.[60] Over 300 million doses are required annually to vaccinate Pakistani children.[61] For

[47] *See* Chang, *supra* note 12, at 6.

[48] *See* Roberts, *supra* note 3, at 519.

[49] Chang, *supra* note 12, at 4.

[50] *See* Roberts, *supra* note 3.

[51] *See* Boone, *supra* note 13.

[52] Closser, *supra* note 14, at 388.

[53] *Id.*

[54] *See* Chang, *supra* note 12, at 2.

[55] *See* Closser, *supra* note 14, at 391 (discussing work being done to establish more consistent vaccination practices along the border).

[56] Chang, *supra* note 12, at 6.

[57] *See* Roberts, *supra* note 3, at 518.

[58] Chang, *supra* note 12, at 4.

[59] *See* Chang, *supra* note 12, at 1.

[60] Aatekah Owais et al., *Pakistan's Expanded Programme on Immunization: An Overview in the Context of Polio Eradication and Strategies for Improving Coverage*, 31 VACCINE, 3313, 3316 (2013).

[61] Bhutta, *supra* note 1, at 286.

Pakistan, this requires immunizing 35 million children, six times a year.[62] However, the campaigns are estimated to only have a coverage of 88%, with the majority of the gaps of coverage in the tribal areas of FATA.[63] In the past two years, more than 450 million doses have been administered to Pakistani children.[64] In 2013, immunization rates for Pakistani children were at a meager 54%, compared to over 95% in Bangladesh.[65] However, that figure is likely to be largely overestimated, as the survey did not contain information from FATA.[66]

IV. Analysis

Pakistan's anti-polio initiative has been labeled as a "disaster."[67] Bluntly stated by the Independent Monitoring Board of the Global Polio Eradication Initiative, its October 2014 report described Pakistan's program as continuing to "flounder hopelessly, as its virus flourishes."[68] The report describes the present danger of the virus to Pakistan's neighboring countries, where reports of the virus have been traced back to Pakistan.[69] Strains of Pakistan's virus have also been found as far out as Syria and Iraq in 2013.[70] This paper examines three of the major issues regarding the failure of Pakistan's anti-polio initiatives: security, mismanagement, and misinformation.

A. Security

The Pakistani Taliban has continued a brutal campaign against the vaccination drive, often with deadly consequences. The deadliest incident occurred in December of 2012, where militants killed nine polio health workers, including five female volunteers.[71] In October of 2013, militants destroyed a medical distribution center for polio vaccinations, and in the process killed seven people.[72] In all, since December of 2012, more than 80 polio workers have been killed by the Pakistani Taliban in all parts of Pakistan.[73] As a result of the security situation and large exodus of people from the tribal regions of Pakistan, the epidemic has

62 Roberts, *supra* note 3, at 518.

63 *See* Owais, *supra* note 60, at 3314.

64 Declan Walsh, *Polio Crisis Deepens in Pakistan, With New Cases and Killings*, N. Y. TIMES (Nov. 26, 2014), http://www.nytimes.com/2014/11/27/world/asia/gunmen-in-pakistan-kill-4-members-of-anti-polio-campaign.html?_r=0

65 Bhutta, *supra* note 1, at 287.

66 *Id.*

67 INDEPENDENT MONITORING BOARD OF THE GLOBAL POLIO ERADICATION INITIATIVE, 1, 3 (Oct. 2013), *available at* http://www.polioeradication.org/Portals/0/Document/Aboutus/Governance/IMB/9IMBMeeting/9IMB_Report_EN.pdf [hereinafter INDEPENDENT MONITORING BOARD].

68 *Id.*

69 *Id.*

70 *Id.*

71 Animesh Roul, *The Pakistani Taliban's Campaign Against Polio Vaccination*, 7 CTC SENTINEL, 17, 17 (2014).

72 *Id.*

73 *See* Bhutta, *supra* note 1, at 286.

"spread to other parts of Pakistan that had previously been unexposed to the highly contagious virus."[74]

The Taliban have also been orchestrating an effective propaganda campaign, issuing several fatwas, or religious decrees, against the polio vaccination.[75] Since June 2012, militants have banned all polio health workers from FATA, primarily in retaliation for drone strikes.[76] In 2013, the Pakistan Taliban stated that "If they can convince us that these polio drops are Islamic and the spy agencies are not using it to kill our fighters, we would have no objection."[77] Other fatwas have also expressly declared that female workers are not allowed in Islam, and that the vaccines cannot be trusted because they are imported."[78] Since 2012, fatwas have tied the ban on polio vaccines to the U.S. led drone campaign in the tribal regions of Pakistan, stating that the vaccine campaign will not be allowed until the drone strikes end.[79]

B. Mismanagement

With a multitude of overlapping command structures, "multiple vertically run programs create inefficiencies, silos, and dysfunction."[80] Meddling by political figures in appointing vaccinators, 'ghost programs,' and a lack of accountability provide major hurdles in several programs.[81] According to the Polio Eradication Initiative, there are "micro-level management problems, a lack of transparency, and weak leadership in several key programs."[82] Despite public support given by the federal government, there is a "lack of provincial government commitment to rehab the public health infrastructure, as there is no provincial budgetary allocation."[83] The provincial and district level governments have shown a lack of commitment and a lack of accountability measures.[84]

In addition to the mismanagement at the planning level, the management and oversight of aid workers has also been ineffective. Polio workers in many parts of the country refuse to work and have often gone on strike due to lack of payments

[74] David Stout, *Militants Gun Down Pakistan Health Workers as Polio Crisis Intensifies*, TIME, Nov. 27, 2014, http://time.com/3608578/pakistan-polio-taliban-public-health/.

[75] *See* Roul, *supra* note 71, at 18.

[76] *See* Roberts, *supra* note 3, at 521.

[77] *See* Roul, *supra* note 71, at 18 (explaining that the "us" refers to the Pakistani government, in their duty to adequately convince the Pakistani Taliban that the vaccine is strictly for medicinal purposes in treating polio).

[78] *Id.*

[79] *Id.*

[80] *See* Owais, *supra* note 60, at 3317.

[81] POLIO ERADICATION INITIATIVE, INDEPENDENT EVALUATION OF MAJOR BARRIERS TO INTERRUPTING POLIOVIRUS TRANSMISSION IN PAKISTAN, 1, 5 (2009), *available at* http://www.polioeradication.org/content/general/Polio_Evaluation_PAK.pdf [hereinafter POLIO ERADICATION INITIATIVE].

[82] *Id.*

[83] *Id.* at 25.

[84] *See* Chang, *supra* note 12 at 6.

and inefficient security measures provided to them.[85] Many workers have affirmed the lack of payments, reduction in salaries, and runaway supervisors.[86] Absent aid workers, poor performance, and low morale was observed amongst vaccinators.[87] For aid workers, there is a lack of accountability in monitoring them, weak management structures, and insufficient incentives for polio aid workers.[88]

In addition, there are large discrepancies in salaries between national and local staff, and often local staff, working in dangerous environments, were not eligible for hazard payments.[89] About half of the number of workers envisioned for Pakistan's polio initiative are working, which is indicative of the lack of incentives provided to the aid workers.[90] Aid workers are often "under the threat of kidnappings, beatings, harassment, and even assassinations by militant groups."[91] Pens and ink that are given to aid workers that are used to mark the fingers of children that have been vaccinated are of low quality, and there are inadequate back-up power supplies to keep vaccines properly refrigerated.[92] There are also incomplete employment registration records, which are not computerized.[93] Further, in 2009, only 10% of aid working staff were female, mostly working at fixed station sites and not at the door to door campaign, where a female presence may be more beneficial.[94]

C. Misinformation

Although generally residents are aware of the campaigns, they are unaware about what exactly polio is have a lack of understanding of how vital polio vaccinations are.[95] Religious and political leaders in the tribal areas have publically denounced the vaccinations, describing them as a western conspiracy, aimed to cause infertility with the Muslim population.[96] There is generally widespread misinformation about the vaccines, described as a "western plot to curb birth rates in the Islamic world."[97]

The decision of the United States to use a fake hepatitis-B program in order to gather DNA samples and information to help kill Osama Bin Laden drastically eroded the public trust in the national polio drive, feeding into the prevailing

[85] Zahir Shah Sherazi, *Polio Workers in Khyber Refuse to Vaccinate Children*, DAWN NEWS, (Oct. 20, 2014), http://www.dawn.com/news/1139173.

[86] *See* Khan, *supra* note 13, at 698.

[87] *See* POLIO ERADICATION INITIATIVE, *supra* note 81, at 25.

[88] *See* Owais, *supra* note 60, at 3317.

[89] *See* POLIO ERADICATION INITIATIVE, *supra* note 81, at 25.

[90] *See* Khan, *supra* note 16, at 698.

[91] *See* Chang, *supra* note 12, at 6.

[92] *See* POLIO ERADICATION INITIATIVE, *supra* note 81, at 26.

[93] *See* Owais, *supra* note 60, at 3317.

[94] *See* POLIO ERADICATION INITIATIVE, *supra* note 81, at 26.

[95] *Id.* at 25.

[96] *See* Chang, *supra* note 12, at 6.

[97] *See supra* note 13.

notion that vaccines were a deliberate plot by the Western world against Muslims.[98] Legitimate vaccinators were denied entry after the Bin Laden raid, often accused as being spies.[99]

V. Proposal

This section recommends four broad solutions to combating polio in Pakistan, including engaging with local Islamic leaders to provide access and education of the vaccine, borrowing strategies from India's successful anti-polio campaign, provide greater training and incentives to female vaccinators, and using technology to monitor and track polio-initiatives.

A. Engage with Local Islamic Leaders

Focus must be put on engaging and utilizing local religious leaders and institutions. Although prominent and international Islamic leaders have publically declared polio vaccines as permissible, the response from local leaders has been lukewarm.[100] In 2014, prominent organizations, including the Islamic Development Bank, the Organization of Islamic Cooperation, and the National Islamic Advisory Group of Pakistan issued a fatwa, stating that the polio vaccine is fully permissible under Islamic Sharia.[101] Vocal support from religious authorities was considered vital in ending the boycott in Nigeria, where local religious leaders became heavily involved in the campaign.[102] Before military campaigns by Pakistan in the area, Pakistan actively engaged Taliban shuras and ulemas, who issued fatwas allowing access to aid workers without any barriers.[103] Where access is not available, local Islamic organization can conduct the campaign with proper training.[104]

The government should negotiate for pauses in hostilities that allow for vaccinators to enter FATA.[105] Government leaders in Afghanistan negotiated with Mullah Omar, the former leader of the Afghani Taliban, to provide letters that allowed for vaccinators to access conflict areas in 2009, which proved to be extremely successful.[106] This strategy was also successful in Latin America, where

[98] Donald McNeil Jr., *CIA Vaccine Ruse May Have Harmed the War on Polio*, N. Y. TIMES (Jul. 9, 2012), http://www.nytimes.com/2012/07/10/health/cia-vaccine-ruse-in-pakistan-may-have-harmed-polio-fight.html?pagewanted=all.

[99] *Id.*

[100] *See* Bhutta, *supra* note 1, at 286.

[101] INTERNATIONAL ULAMA CONFERENCE ON POLIO ERADICATION, ISLAMABAD DECLARATION/FATWA, *available at* http://www.endpolio.com.pk/images/reports/English-Declaration.pdf [hereinafter ISLAMABAD FATWA].

[102] *See* Owais, *supra* note 60, at 3318.

[103] *See* POLIO ERADICATION INITIATIVE, *supra* note 81, at 23.

[104] *Id.* at 24.

[105] *Id.* at 27.

[106] *See* Chang, *supra* note 12, at 7.

warring factions agreed to 'days of peace' that allowed polio workers to conduct immunizations during authorized lulls in violence.[107]

There is also increasing evidence that augmenting the demand side of the vaccine can lead to better immunization rates, which can be achieved by the approval of local Muslim leaders.[108] These include providing educational messages, conditional cash payments, and tailoring the message to comply with Islamic principles.[109]

B. Engage with Local Islamic Leaders

Pakistan can turn to its neighbor in learning how to eradicate polio. Over three decades ago, India had over 250,000 registered polio cases.[110] However, by 2005, India was annually immunizing 170 million children twice each year.[111] In 2009, India reported over 700 polio cases, which was more than anywhere in the world – that number was reduced to just one in 2011.[112] Like Pakistan, polio cases were concentrated among children under two years of age, who resided in poor Muslim communities that were devoid of basic medical and sanitary services.[113] India's plan to combat polio included careful and meticulous planning and organization, revolving around careful micro-planning, strengthened accountability measures, a mass social mobilization, and an increase in human resources across all political levels.[114] Micro-plans were seen to be effective because they provided targeted data about each area.[115] Further, India's plan for eradication used effective communication strategies and an increase in the number of vaccinators.[116]

Perhaps India's most effective strategy in eradicating polio, however, was its holistic approach towards healthcare.[117] Community mobilizers, in educating parents about the vaccination program, also demonstrated the importance of "hand-washing, sanitation, exclusive breastfeeding, diarrhea management, and routing immunization.[118] Evidence suggests that India's mass media strategy,

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107 *See* Bhutta, *supra* note 1, at 286.

108 *See* Owais, *supra* note 60, at 3317.

109 *Id.*

110 *See Polio in Pakistan: Paralysis*, *supra* note 20.

111 *See* Obregon, *supra* note 26 (exploring the history of polio in India and Pakistan, the progress made by each country, and the lessons learned in eradication attempts in these countries).

112 Patralekha Chatterjee, *How India Managed to Defeat Polio*, BBC, (Jan. 13, 2014), http://www.bbc.com/news/world-asia-india-25709362.

113 *See* Obregon, *supra* note 26.

114 *See* STRATEGIC PLAN 2013, *supra* note 24, at 4 (examining Strategic Plan to eradicate polio, specifically the plans implemented in India).

115 *See* Chatterjee, *supra* note 112.

116 *See* Khan, *supra* note 16, at 699.

117 *See* Chatterjee, *supra* note 112.

118 *Id.*

which employed the use of famous sport stars and political figures, helped to quell any negative rumors about the vaccination.[119]

In 2010, India virtually became polio-free.[120] Despite its success, India does not plan to stop just yet. In 2014 and 2015, India plans six polio campaigns each year, where over two million workers will help to immunize over 170 million children.[121] This rigorous approach with extensive resources, if applied to Pakistan, would likely help make a dent in the spread of Polio in Pakistan.

C. Incentivize and Train Female Health Workers

Female health workers are also an extremely valuable asset. Where the husband is not present, Muslim homes can be inaccessible to men, and female workers, by gaining trust, can be responsible for "conducting tasks such as micro census, tracking population movements, and working with elders and parents."[122] Previously in Pakistan, the use of female health workers, familiar with the mothers, neighborhoods, and local language, were helpful to gain access to restricted households.[123] In addition, findings from the success of India's program "underlined the need to target women," particularly through "interpersonal communication by trained female health workers."[124] Hiring female workers from the local community in the past has made a noticeable difference.[125]

D. Use Technology to Monitor and Track Progress and Problem Areas

The use of technology can allow planners to target problem areas and keep track of children who have been vaccinated. Rotary International has begun to incorporate technology into its program, by distributing hundreds of cellphones to aid workers to circulate among the communities.[126] Information about missing children and homes that have been visited are uploaded onto a central spreadsheet, and aid workers also track pregnant mothers.[127]

Previously, Pakistan has successfully used technology to help track, monitor, and control another public health outbreak. When there was a dengue outbreak in the country, cell phones were given to workers to "take pictures, enter field activities, and take before and after pictures."[128] With the data that was collected, teams were able to focus on problem areas, and the cell phones provided a mech-

119 *See* Obregon, *supra* note 26.

120 *See* Bhutta, *supra* note 1, at 285.

121 *See* Chatterjee, *supra* note 112.

122 *See* Chang, *supra* note 12, at 9.

123 *Id.* at *9.*

124 *See* Obregon, *supra* note 26.

125 *See* Roberts, *supra* note 3, at 521.

126 Jeffrey Kluger, *The Battle to Eradicate Polio in Pakistan*, TIME, (Jul. 29, 2014), http://time.com/3051398/polio-pakistan-rotary/.

127 *Id.*

128 Beenish Ahmed, *How Smartphones Became Vital Tools Against Dengue in Pakistan*, NPR, (Sept. 16, 2013), http://www.npr.org/blogs/health/2013/09/16/223051694/how-smartphones-became-vital-tool-against-dengue-in-pakistan.

anism to audit and track workers.[129] However, the use of technology would only be effective if properly managed, as "technical innovation cannot overcome gaps in program management and community engagement."[130]

VI. Conclusion

Both Pakistan and the world became painstakingly close in eradicating the polio virus in 2010. With the help of the Global Polio Eradication Initiative, Pakistan saw a drastic decrease in the level of polio cases up through 2008. However, a perfect storm of variables have conspired in making Pakistan the global epicenter of the reemergence of the polio virus. There has already been a spread of the Pakistani variation of the virus to neighboring countries and beyond, and if not controlled quickly, the virus can quickly become uncontainable.

The reemergence of Polio in Pakistan has been attributed to a multitude of core reasons. First, polio initiatives in Pakistan have been ineffectively managed, with lackluster support through all levels of government, insufficient incentives and protection for aid workers, and an overlap of goals and resources. Second, the worsening security situation has effectively made FATA a no-entry zone for aid workers. Third, the rise of misinformation about the vaccine, exacerbated by the exposure of the fake hepatitis-B drive, has decreased the demand-side for the vaccine.

In order to reverse the trend of the increase of polio cases in Pakistan, health officials must engage in a multi-prong approach. First, the initiative should utilize local Islamic community leaders, as their support is essential in both allowing aid workers to enter areas controlled by Islamic militants, and to help stop the spread of misinformation about the vaccine. Second, by following in India's path, and by focusing on a holistic approach by offering a multitude of health services during an anti-polio initiative, aid workers can better communicate the message of the importance of the vaccines. Third, funding must be allocated to improve incentives and training of female health workers, who are in a position to better implement anti-polio initiatives at a grass-roots level.

The reemergence of polio in Pakistan has not gotten out of control yet. However, if steps are not taken quickly, the spread of polio from the tribal regions to urban centers like Karachi, where there are already reports of new outbreaks, can lead to a new global public health crisis.

[129] *Id.*

[130] *See* WORLD HEALTH ORG., *supra* note 24, at 4.

HUMAN RIGHTS IN THE MIDST OF QUARANTINE

Erin Pauley

"Health without liberty is more dangerous to human dignity than liberty without health."[1]

I. Quarantine of the West Point Slum in Monrovia, Liberia

On August 20th, 2014, an entire community consisting of some 80,000 people was cordoned off and barricaded with barbed wire and wooden checkpoints in an extraordinary measure to fight the recent outbreak of the world's most deadly Ebola virus.[2] The decision to quarantine this West Point slum of Monrovia, Liberia was made after a holding center for victims was plundered on August 15th, 2014, a week after Liberia declared a state of emergency.[3] In the ransack, Ebola patients escaped while looters stole infected materials and mattresses from the holding center.[4] In a statement defending the quarantine, President Ellen Johnson Sirleaf said that the ransack had "put the entire community at risk," thus forcing the government to "protect [the community] from themselves."[5] However, sources monitoring the security sector say that the government's decision to quarantine was less about the safety of the citizens of the West Point slum, and

[1] David P. Fidler, *Fighting the Axis of Illness: HIV/AIDS, Human Rights, and U.S. Foreign Policy*, 17 HARV. HUM. RTS. J. 99, 129 (2004).

[2] Clair MacDougall, *Liberian Government's Blunders Pile Up in the Grip of Ebola*, TIME (Sept. 2, 2014) http://time.com/3247089/liberia-west-point-quarantine-monrovia/.

[3] *Id.*

[4] *Id.*

[5] *Id.*

more an attempt to show that the government was in control of the situation.[6] Regardless of the true motive, the slum was barricaded with barbed wire and wooden checkpoints without providing residents "with any information concerning the duration of the quarantine, whether or not food and water would be allowed in, or how severe the consequences would be for attempting to escape."[7]

Adding to the fear and anxiety induced by the restricting elements of the quarantine, emotions quickly turned to fury when the community watched as the Town Commissioner attempted to escape the armed guards with her family.[8] The poverty stricken community panicked, and in the midst of rocks being thrown at police and citizens desperately trying to escape across makeshift checkpoints, several people were killed, including a 15-year-old boy fatally shot by police.[9] The situation in West Point escalated until August 30th, 2014, after ten (10) days of quarantine, when President Sirleaf announced on radio that the quarantine restrictions would be lifted the next morning due to "the overall support and cooperation of the town's people."[10] At 6 a.m. on August 31st, 2014, police and soldiers removed the barbed wire and makeshift wooden checkpoints, marking the end of the quarantine.[11]

Although the quarantine of the West Point slum has not been sanctioned by the international donor community, Dr. Nestor Ndayimirje, the World Health Organization (WHO) representative to Liberia, had warned that quarantining would only work with the community's consent – which was neither gained nor sought in West Point.[12] Furthermore, the African Union Commission Chief Nkosazana Dlamini-Zuma told members at an Ebola crisis meeting, "We must be careful not to introduce measures that may have more social and economic impact than the disease itself."[13] Not only do the cramped living conditions, unavailability of access to running water and poor sanitary conditions of slum communities like West Point put them at high risk of becoming "hot spots" for new Ebola infections,[14] but such extreme quarantine measures of an entire community devastates the pride of the people living within the barricades by stigmatizing their township as an Ebola-infected region.[15] Deadly epidemics raise difficult questions of how "we" as an international community and "we" as each individual nation respond

[6] *Id.*

[7] MacDougall, *supra* note 2. R

[8] *Id.*

[9] *Id.*

[10] James Butty, *Liberia Modifies Ebola Curfew Hours, Lifts Quarantine*, VOICE OF AMERICA (Sept. 9, 2014), http://www.voanews.com/content/liberia-modifies-ebola-curfew-hours-lifts-another-quarantine/2443351.html.

[11] MacDougall, *supra* note 2. R

[12] *Id.*

[13] Butty, *supra* note 9

[14] MacDougall, *supra* note 2.

[15] James Butty, *Liberia's West Point: Life After Ebola Quarantine*, Voice of America, (Sept. 1, 2014), http://www.voanews.com/content/liberias-west-point-ebola-quarantine-lifted/2434374.html.

to fear.[16] How much liberty each person is willing to sacrifice for an "abstract concept of the general welfare of the nation," and who we are willing to designate as experts.[17] In response to the outbreak, President Obama discussed how Ebola necessitates an urgent, strong and coordinated international response:

> Ebola is a horrific disease. It's wiping out entire families. It has turned simple acts of love and comfort and kindness—like holding a sick friend's hand, or embracing a dying child – into potentially fatal acts. If ever there were a public health emergency deserving an urgent, strong and coordinated international response, this is it.[18] - President Obama (September 16th, 2014)

In order to prevent future tragic situations such as the quarantine of the West Point slum in Monrovia, Liberia, there needs to be a strong and collective international initiative enumerating restrictions and protocols in times of infectious disease outbreaks.

II. The Rise of The Ebola Outbreak

Although international media outlets first began to broadcast the devastation and horrors of the Ebola virus in 2014, Ebola outbreaks began to occur in West Africa around 2000 as a result of the handling of primates and carcasses.[19] Ebola virus disease (EVD) is a complex zoonosis that is highly infectious in humans.[20] Humans are exposed to zoonoses through either direct human contact or indirect contact.[21] The first type of epidemiological pattern is through direct human contact with the source of the "zoonotic agent," or through human contact with an animal vector.[22] Usually, as long as the zoonotic agent is not constantly reintroduced, the infection will die out in the human population; however, with more frequent human contact, not only can the zoonotic agent be maintained but eventually it can be transmitted exclusively among humans.[23] The second pattern by which humans are exposed to zoonoses involves indirect contact through "foods, water, environmental contamination," or other methods not relying on direct contact between human and animal hosts.[24] Both types of epidemiological patterns contributed to the first human outbreaks of the Ebola virus; the result of the

[16] Felice Batlan, *Law in the Time of Cholera: Disease, State Power, and Quarantines Past and Future*, 80 Temp. L. Rev. 53, 56 (2007).

[17] *Id*.

[18] U.S. Office of Commc'n, Fact Sheet: U.S. Response to The Ebola Epidemic in West Africa, (Sept. 16, 2014), *available at* 2014 WL 4628793.

[19] Kathleen J. Choi, *A Journey of a Thousand Leagues: From Quarantine to International Health Regulations and Beyond*, 29 U. PA. J. INT'L L. 989, 997 (2008).

[20] David M. Pigott, Mapping the zoonotic niche of Ebola virus disease in Africa, eLife, *available at* http://elifesciences.org/content/3/e04395/abstract-1.

[21] Choi, *supra* note 19 at 991. **R**

[22] *Id.* at 991-92.

[23] *Id.* at 992.

[24] *Id.*

handling of a distinct gorilla, chimpanzee, or carcass, and the outbreaks consisted of multiple simultaneous epidemics caused by different viral strains.[25]

Several of the earliest human and animal Ebola outbreaks occurred between 2000 to 2004 in Gabon and the Republic of the Congo.[26] The marked decline of animal populations during periods of human outbreaks in these areas drew attention to the virus.[27] For example, during a 2001 human Ebola outbreak, a high number of carcasses were found in forested areas, leading researchers to discover that Ebola outbreaks occur abruptly and strike groups of animals locally (as groups living in other areas were barely affected).[28] The researchers concluded that the Ebola virus was a more dangerous type of disease as it followed a pattern of graduating from animal-to-human transmission to human-to-human transmission.[29] Diseases which follow this pattern emerge in settings of high human population density and result from close contact to otherwise wild animals.[30] It is because of this element of the disease that risk of transmission among healthcare workers is heightened by modern health care techniques which involve centrally located hospitals and invasive surgical procedures.[31]

The Ebola hemorrhagic fever ("EHF") is a hemorrhagic illness which causes death in fifty-ninety percent (50-90%) of all diagnosed cases and is transmitted by direct contact with the blood, secretions, organs or other bodily fluids of infected persons.[32] Symptoms of the virus include fever, headache, joint and muscle aches, weakness, diarrhea, vomiting, stomach pain, lack of appetite, and abnormal bleeding, and most commonly appear between eight and ten days after exposure to the virus.[33]

In addition to the absence of an effective treatment for the Ebola virus, the surreptitious characteristics of the virus complicate treatment and endanger health care workers and care-givers.[34] Because the virus' incubation period can be as long as three weeks, a delay in diagnosis not only puts health care workers at risk of exposure, but potentially exposes the entire community to the infection.[35] As a result of the difficulties involved with containing a virus that can remain dormant for up to three (3) weeks (yet contagious as ever), there are many secondary cases of Ebola in health care workers and care-givers that have been

[25] *Id.* at 997.

[26] *Id.*

[27] Choi, *supra* note 19, at 997. R

[28] Choi, *supra* note 18, at 997.

[29] *Id.* at 992.

[30] *Id.*

[31] *Id.*

[32] *Id.* at 996.

[33] U.S. Office of Commc'n, *Questions and Answers on Ebola*, (Aug. 1, 2014), *available at* 2014 WL 3767809; Ctr. For Disease Control & Prevention, *Questions and Answers on Ebola* (Aug. 1, 2014, 9:08 PM ET), http://www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/qa.html (last visited on Sept. 19, 2015).

[34] *See generally* Choi, *supra* note 19. R

[35] *Id.* at 996.

exposed to blood and body fluids of patients who have not yet exhibited symptoms.[36]

In 2014, when Ebola finally became an urgent, international humanitarian concern, major nations declared their strategies to combat the epidemic. The United States' strategy focused on four key goals: "1) controlling the epidemic at its source in West Africa; 2) mitigating second-order impacts, including blunting the economic, social, and political tolls in the region; 3) engaging and coordinating with a broader global audience; and, 4) fortifying global health security infrastructure in the region and beyond."[37] Moreover, the U.S. Africa Command (led by a general from U.S. Army Africa) set up a Joint Force Command headquartered in Monrovia, Liberia to provide regional command and control support to facilitate coordination with U.S. government and international relief efforts.[38]

France's strategy focused on the Ebola outbreak in Guinea, specifically, as the countries' are bound together by their economic and political ties.[39] In an effort to "display friendship, solidarity and hope," France mobilized military personnel to care for and train medical staff in Guinea.[40] Additionally, France brought "essential equipment" to Guinea, committed EUR 100 million, and contributed to the research effort to find "vaccines, tests and any other solution."[41]

Other nations pledged health care workers and millions of dollars in an effort to combat the outbreak.[42] Germany raised EUR 102 million to assist in the fight after President Obama held a conference with the leaders of France, Germany, Italy and the U.K. to discuss a more aggressive response.[43] Additionally, Japan promised forty million dollars and Cuba sent 165 health workers to Sierra Leone as the race to catch up with the virus began in October 2014.[44]

Although the Ebola combatting strategies of these major nations focused on eradicating the epidemic and preventing the deadly virus from spreading to other nations, they failed to enumerate and specify how the disease would be contained locally, much less the logistics of any quarantine.

III. Quarantines of the Past

Quarantine is "when the government or a government entity, a board of health, or police chief, restricts a person to a geographic location due to that individual

[36] Choi, *supra* note 18 at 996.

[37] *See generally* Fact Sheet: U.S. Response to The Ebola Epidemic in West Africa, *supra* note 18. **R**

[38] *Id.*

[39] Embassy of France in Washington, D.C., *France Takes Action to Combat Ebola*, (Sept. 28, 2014), *available at* http://www.ambafrance-us.org/spip.php?article5998.

[40] *Id.*

[41] *Id.*

[42] Andrea Thomas, *Germany Steps Up Ebola Aid Amid Criticism of Slow Response*, The Wall Street Journal (Oct. 16, 2014), *available at*, http://www.wsj.com/articles/germany-steps-up-ebola-aid-amid-criticism-of-slow-response-1413481370.

[43] Thomas, *supra* note 42. **R**

[44] *Id.*

having or being exposed to a contagious disease."[45] The word "quarantine" is derived from the Italian word 'quaranta giomi', which means forty days, and refers to the number of days ships were required to remain in isolation before returning to shore during the Black Plague.[46] Quarantines are used as a means to limit the spread of communicable disease by separating or restricting the movement of exposed persons from unexposed persons.[47] Although individual quarantines are a preferable option, in the West Point slum of Liberia the government chose the *geographic quarantine* by forcefully isolating localities with documented disease transmission from localities still free of infection.[48]

Quarantines can be traced back all the way to biblical times with the isolation of lepers.[49] Quarantine quickly became a form of stigma inflicted on those who were already stigmatized by their predicament, whether that was race, gender, physical ailment, etc.; those who failed to conform to white privileged norms were faced with the greatest adversities.[50] The first, more modern, large-scale quarantines occurred during the 14th century-period of the Black Death, otherwise known as the bubonic plague.[51] As the plague began to spread, "Venice and other southern European coastal trading cities began to impose quarantines on all arriving ships and the travelers coming to land."[52] The preventative and protective use of quarantines (as exampled during the period of the Black Death) was an idea sustained throughout history, and eventually ruled constitutional in the United States in "certain narrow circumstances."[53] Although centuries after the bubonic plague, "the world in which the drafters of the Constitution lived was still one in which almost every family lost a child to illness, communicable disease was the norm, and the livelihood of the entire nation was under threat from unfamiliar diseases of the native peoples."[54] Since "communicable diseases not only threatened individuals, but the state itself, the severity of this" risk was in the forefront of legislators' minds as they passed acts enabling governmental action against dangerous persons and conditions."[55] Although there was hesitation to grant the government the authority to restrict the liberties of its citizens so soon after gaining independence from Britain, "there was a societal consensus that the protection of the nation was more important than the rights of the indi-

[45] Erin M. Page, *Balancing Individual Rights and Public Health Safety During Quarantine: The U.S. and Canada*, 38 Case W. Res. J. Int'l L. 517, 517 (2007).

[46] Batlan, *supra* note 16, at 62-63. R

[47] *Id.* at 113.

[48] *Id.* at 111.

[49] Melanie L. McCall, *Aids Quarantine Law in the International Community: Health and Safety Measures or Human Rights Violations?*, 15 Loy. L.A. Int'l & Comp. L.J. 1001, 1002-03 (1993).

[50] Batlan, *supra* note 16, at 60. R

[51] Adam Klein and Benjamin Wittes, *Preventative Detention in American Theory and Practice*, 2 Harv. Nat'l Sec. J. 85, 176 (2011).

[52] Batlan, *supra* note 16, at 62. R

[53] Christopher Ogolla, *Non-Criminal Habeas Corpus for Quarantine and Isolation Detainees: Serving the Private Right or Violating Public Policy?,* 14 DePaul J. Health Care L. 135, 157-58 (2011).

[54] *Id.* at 153.

[55] Ogolla, *supra* note 46, at 153.

vidual."[56] As a result, "at the turn of the 20th century, individual quarantine orders by state health authorities were an ordinary part of life, but seventy (70) years of vaccines and antibiotics have driven the practice out of the public's memory."[57]

More recent quarantines have highlighted the importance of who belongs to a community (based on their status), who carries the rights of citizenship, and how, even with vaccines and antibiotics, there is still not a cure for human intolerance.[58] Some early epidemics that occurred in the United States and provoked federal quarantines included typhus, cholera, polio and the influenza pandemic.[59] In 1892, the typhus epidemic in New York City prompted the quarantine of thousands of immigrants and city residents, the majority of which were poor Italians and Russian Jews.[60] While the residents were detained in quarantine, the death rate rose dramatically, and this was likely exacerbated by the poor conditions for quarantine itself.[61] The New York City typhus quarantine represented "unchecked municipal power," which resulted in even more deaths and also further stigmatism (media described the quarantined individuals by their immigrant status and their potential to contaminate others).[62]

Even more stigmatizing than the typhus quarantine, the cholera epidemic was blamed on "incorrect home life of poor immigrants."[63] Unlike Typhus, yet similar to Ebola, the topic of cholera was discussed as a part of public conversation.[64] Unfortunately, this public dialogue only worsened the stigmatization as health officials, politicians, physicians and journalists portrayed cholera as a disease of "the uncivilized East that attacked the civilized Christian West through the body of the immigrant."[65] An example of this abhorrent segregation was the "imprisonment" of the upper-class passengers in cabins on Staten Island, while the cabin-class passengers had to remain quarantined on board the ships where infection spread like wildfire.[66] Related racial hostility fueled quarantines even on the other side of the country.[67]

In 1900, the bubonic plague spread throughout Chinatown in San Francisco, California.[68] A federal district judge enjoined a quarantine by the San Francisco Board of Health of that city's Chinatown and in doing so, sealed it off using the

[56] *Id.*

[57] Editorial, *NJ's Ebola Response Should Be Based on Science, Not Fear*, 218 N.J. L. J., No. 5, 2014, at 26.

[58] Batlan, *supra* note 16 at 96. R

[59] *See generally* Batlan, *supra* note 16. R

[60] Batlan, *supra* note 16, at 76. R

[61] *Id.*

[62] *Id.*

[63] Batlan, *supra* note 16, at 76. R

[64] *Id.* at 81.

[65] *Id.* at 80.

[66] *Id.* at 86.

[67] *Id.* at 100.

[68] Batlan, *supra* note 16, at 105. R

same methods as were used in the West Point slum: barbed wire and wooden fence posts.[69] A small businessman who lived inside the quarantine area challenged the Board's action, arguing that it was illegal and enforced only against Chinese residents.[70] The court agreed and held that the quarantine was not medically justified and not a reasonable regulation authorized by the police power.[71] The court further held that while it may be reasonable to quarantine a particular house when an individual inhabitant was ill, it made no scientific sense to quarantine an entire community.[72]

More recently, in 2003, the outbreak of Severe Acute Respiratory Syndrome ("SARS") reminded the world that there is no uniform system in place, nor is there any international plan of action to regulate large scale quarantines.[73] The disease broke the complacency and silence of three decades and made the topic of infectious zoonoses a key headline in public dialogue.[74] The international dialogue resulted in states joining together to design a more effective "surveillance and response system," including the 2005 International Health Regulations ("IHR").[75] Although the need for a uniform system or international plan to regulate large scale quarantines has been more prominent on the world agenda in recent years[76], the difficulty of winning a legal case involving quarantine is so significant, that through the course of the 20th century few cases have been brought.[77] Since there is such an immature and underdeveloped jurisprudence in the area, "cases where courts do prevail remind us of the capacity of the courts to intervene in a public health crisis."[78]

IV. International Organizations and the Governance of Emerging Infectious Diseases

A. Emerging Infection Diseases in the International Community

Emerging Infectious diseases became a prominent public health issue during the 1990s, as was evidenced by the WHO's warning in 1996 that the "world confronted a crisis in the resurgence of infectious diseases."[79] Although morbidity and mortality rates from infectious diseases such as malaria and tuberculosis grew during the 1990s and early 2000s, HIV/AIDS became the usurping disease, "rivaling some of the greatest plagues in history."[80] In the United States, concern

[69] *Id.* at 108.

[70] *Id.* at 107, citing *Jew Ho v. Williamson,* 103 F. 10, 12(N.D. Cal. 1900).

[71] Batlan, *supra* note 16, at 108. R

[72] *Id.*; Ogolla, *supra* note 53, at 157. R

[73] Ogolla, *supra* note 53, at 161. R

[74] Choi, *supra* note 19, at 990. R

[75] *Id*. at 991.

[76] *Id.* at 990.

[77] Batlan, *supra* note 16, at 103. R

[78] *Id.* at 105.

[79] Fidler, *supra* note 1, at 102. R

[80] *Id*.

about infectious disease became a foreign policy and national security topic during the Clinton Administration, and when the Central Intelligence Agency ("CIA") issued an estimate on the danger which infectious diseases posed on national security in 2000, the issuance of the report symbolized the level of "high politics" infectious disease had achieved in international relations.[81]

Although diseases like malaria frequently devastate entire tropical communities in sub-Saharan Africa[82], they rarely become serious enough to trouble the United States' health care infrastructure.[83] When diseases are serious enough to prompt a collaborative plan of action and strategy from the United States, as the Ebola virus did, it typically involves a failure of national or international collective action against deteriorating societal elements of health, often worsened or created by a rapidly mobile and globalized international community.[84] The 2002 Institute of Medicine's "Microbial Threats to Health" listed seven factors that contribute to enabling diseases, such as Ebola, to thrive.[85] They include "human susceptibility to infection, climate and weather, changing ecosystems, poverty and social inequality, war and famine, lack of political will, and intent to harm."[86] With these contributing factors in mind, it is easy to see how the world's worst outbreak of the Ebola virus prospered in a slum of the capital of Liberia.[87]

B. The WHO and the IHR Concerning Quarantine Procedures

The World Health Organization ("WHO") is the international body responsible for leadership during global health crises and sets health standards for member states to follow through the International Health Regulations ("IHR").[88] The WHO was established on April 7th, 1948 when its constitution was adopted at the International Health Conference and signed by 61 state representatives.[89] Today the WHO has over 190 member states and its policies and programs are governed by the World Health Assembly ("WHA"), which is a specialized agency of the United Nations whose mandate is "to act as the directing and coordinating authority on international health work."[90] Therefore, the WHA has the

[81] Fidler, *supra* note 1, at 102. R

[82] World Health Organization, *Malaria*, *available at*, http://www.who.int/mediacentre/factsheets/fs094/en/ (Last visited Sept 16, 2015).

[83] Fidler, *supra* note 1, at 134. R

[84] *Id.* at 136.

[85] *Id.* at 103.

[86] *Id.*

[87] Adam Nossiter, *Lax Quarantine Undercuts Ebola Fight in Africa*, New York Times, (Aug. 4, 2014), http://www.nytimes.com/2014/08/05/world/africa/lax-quarantine-undercuts-ebola-fight-in-africa.html?module=Search&mabReward=relbias%3As%2C%7B%2%E2%80%A6%201/5,%20By%20ADAM%20NOSSITER%20AUG.%204,%202014,%20Accessed%2010-29-14&_r=0.

[88] Gregory P. Campbell, *The Global H1N1 Pandemic, Quarantine Law, and the Due Process Conflict*, 12 San Diego Int'l L.J. 497, 499 (2011); McCall, *supra* note 42, at 1004.

[89] Gregory P. Campbell, *The Global H1N1 Pandemic, Quarantine Law, and the Due Process Conflict*, 12 San Diego Int'l L.J.497, 499 (2011).

[90] Choi, *supra* note 18, at 1004

authority to adopt regulations on quarantine issues, causes of death, nomenclatures of diseases, public health practices, and standards for international diagnostic procedures.[91]

Although the Constitution of the WHO enumerates significant treaty-making powers, with which a treaty adopting an international convention regulating quarantines could be made - to date these powers remain largely unused.[92] This is especially surprising considering that the Constitution provides the WHO with the authority to promote and adopt conventions, regulations, and recommendations that address *any matter within its competence*.[93] Moreover this "competence" is broad, especially considering that the WHO definition of health "is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."[94] This gives the organization ample authority and legal basis on which to develop international quarantine regulations.[95] Furthermore, Article 21 of the WHO Constitution provides a unique treaty-making procedure for the WHA with which to adopt "legally binding regulations concerning sanitary and quarantine requirements and other procedures designed to prevent the international spread of disease."[96] With this authority, it is confounding that the WHO has yet to propose an international agreement pertaining to the restrictions and protocol to be used in geographic quarantines.

A fundamental explanation is the fact that the WHO lacks any mechanism with which to enforce member compliance.[97] For this reason the WHO has only issued a *recommendation* regarding the Ebola virus, saying:

> All hospital personnel should be briefed on the nature of the disease and its routes of transmission. Particular emphasis should be placed on ensuring that invasive procedures such as the placing of intravenous lines and the handling of blood, secretions, catheters and suction devices are carried out under strict barrier nursing conditions. Hospital staff should have individual gowns, gloves, masks and goggles. Non-disposable protective equipment must not be reused unless they have been properly disinfected. Infection may also be spread through contact with the soiled clothing or bed linens from a patient with Ebola. Disinfection is therefore required before handling these items.[98]

Another reason the WHO has been ineffective in leading the fight against Ebola is because it fails to consider the substantive role of human rights in the prevalence of infectious diseases.[99] Although the WHO Constitution's preamble

[91] *Id.* at 1005.

[92] *Id.* at 1004.

[93] *Id.* at 1005.

[94] *Id.*

[95] *Id.*

[96] Choi, *supra* note 18, at 1007.

[97] Campbell, *supra* note 81, at 499.

[98] Choi, *supra* note 18, at 996.

[99] Campbell, *supra* note 81, at 520.

features the right to health ("an economic, social, and cultural right"), it refrains from mentioning civil and political rights.[100] It was not until after the WHO's creation that infectious disease control was viewed as a legitimate reason for restricting the enjoyment of civil and political rights.[101] Because of this, even though basic human rights include the right to be "free from actions that are injurious to the inherent dignity and security of the human being," quarantines (such as the one in West Point) which inherently injure the dignity and security of all those imprisoned, were not recognized as a possible adversary to international human rights prior to the drafting of the WHO Constitution.[102]

In 2005, the WHO promulgated the International Health Regulations ("IHR"), which became the only binding international legal rules for infectious disease control.[103] The IHR requires state parties to adhere to more obligations in order to "develop, strengthen, and maintain core capacities to 1) detect, assess, notify, and report disease events; and 2) respond promptly and effectively to public health risks and public health emergencies of international concern."[104] Where state parties were previously obligated to only report cases of three (3) specific infectious diseases, the revised 2005 IHR requires parties to notify the WHO of *any event* that may develop into a public health emergency of international concern.[105] A "public health emergency of international concern" is defined by the Regulations of the IHR as an event that poses a public health risk to other States through the international spread of disease, and potentially requires a coordinated international response.[106] This new requirement came after the regulations proved irrelevant to the HIV/AIDS outbreak, where state parties were not obligated to report cases of HIV/AIDS because it was not one of the few diseases subject to the IHR.[107]

In adopting the 2005 IHR, the WHO abandoned its prior strict, limited, and general quarantine system for an instrument that determined which level of intervention to use, only after gaging individual infectious disease outbreaks.[108] This new approach allowed the WHO to potentially exert authority in regions where political and cultural strife was affecting the health of its community.[109] Unfortunately, even nine years after the creation of the IHR, no such regulations were considered as the barricades and checkpoints enclosed the citizens of the West Point slum.

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[100] WHO Const. pmbl, *available at*, http://www.who.int/governance/eb/who_constitution_en.pdf.

[101] Fidler, *supra* note 1, at 113.

[102] Lauren Asher, *Confronting Disease in a Global Arena*, 9 CARDOZO J. INT'L & COMP. L. 135, 157-58 (2001).

[103] Fidler, *supra* note 1, at 114.

[104] Choi, *supra* note 18, at 1017.

[105] *Id.* at 1015.

[106] *Id.* at 1016.

[107] Fidler, *supra* note 1, at 114. R

[108] Choi, *supra* note 19, at 1003. R

[109] Choi, *supra* note 19, at 1004. R

V. The Need for a Balance Between Human Rights and Individual Freedoms

To argue that the WHO should have binding and enforceable regulations for infectious disease outbreaks is *not* to say that there should not have been some type of quarantine in the West Point slum. But it *is* to say that quarantines must incorporate some protection of individual rights as well. The community's decision-makers must reach a balance between the extremes of complete protection of public health without any protection of individual rights (i.e., quarantine of the West Point slum), and complete protection of individual rights at the expense of public health.[110] As stated in the opinion of *People v. Robertson*, "among all the objects sought to be secured by governmental laws, none is more important than the preservation of public health."[111] But for every measure taken to protect the public health, it must be moderated against the risk it poses to restrict an individual's rights to personal liberty and due process.[112]

As quarantines and isolation severely restrict the freedom of the individuals for whom they are intended to protect, it becomes even more difficult to balance their need for protection from infectious disease with protection of their freedoms.[113] The most obvious freedoms restricted by quarantines are freedom of movement, right of free association, freedom of assembly and in some cases, freedom of religion.[114] Even more significant, because quarantine is not considered criminal detention, there is no requirement for - nor right to – counsel; therefore, it is especially important to be cognizant of how due process limits are applied.[115] Although it is not improper to restrain an individual's freedom of liberty, privacy or property *per se*, "it is improper to do so unnecessarily, arbitrarily, inequitably, or brutally."[116]

In addition to impinging on the freedoms of individuals, quarantines raise major human rights issues.[117] Rapidly spreading infectious diseases, such as Ebola, terrify not only those quarantined, but also those who believe that a massive epidemic could kill thousands in their own communities as they have witnessed it do in others.[118] As disease and society's response to crisis are never without remnants of the cultures in which they are embedded, this terror often exacerbates the prejudices and discrimination already rooted in the community, priming an already hostile environment for quarantine.[119] A few ways in which quarantines contribute to human rights issues include: discrimination and stigma against

110 Page, *supra* note 45, at 518. R

111 *Id.* (quoting *People v. Robertson*, 134 N.E. 815, 817 (Ill. 1922)).

112 Carrie Lacey, *Abuse of Quarantine Authority the Case for a Federal Approach to Infectious Disease Containment*, J.Legal Med. 24: 199-214, 199 (2003).

113 Choi, *supra* note 19, at 519. R

114 Ogolla, *supra* note 53, at 136. R

115 Ogolla, *supra* note 53, at 136. R

116 Page, *supra* note 45, at 531. R

117 Ogolla, *supra* note 53, at 158. R

118 Batlan, *supra* note 16, at 61. R

119 *Id.*

carriers of the disease, deprivation of liberty by imposing quarantine measures prior to establishing that they pose a significant risk to the community, and failing to maintain the privacy of health information.[120]

A. International Agreements Involving Human Rights

There are several International Agreements involving Human Rights, which also pertain to situations of quarantine and other forms of lawful detention. The Universal Declaration of Human Rights (UDHR) has become the authority in international law regarding the preservation of human rights.[121] Articles 3, 13 and 25 are a few of the most relevant provisions for the analysis of quarantine measures.[122] While Article 3 is more general in granting the right to life, liberty and security of person, Articles 13 and 25 are less ambiguous and recognize "freedom of movement and residence," and grant the right to "a standard of living adequate for the health of oneself and of one's family."[123] Although these enumerated rights should be capable of protecting people from such human rights atrocities as occurred in the West Point slum, in reality they are minimal safeguards against such arbitrary government action.[124]

Other relevant international and regional agreements include the International Covenant on Economic, Social and Cultural Rights (ICESCR), the International Covenant on Civil and Political Rights (ICCPR) and the European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR).[125] The ICESCR is significant to the enforcement of human rights during quarantines with its provision granting a right to work under "just and favorable conditions," as well as the "right to an adequate standard of living, including food, clothing and housing."[126] The ICCPR was also influential, and established the Siracusa Principles, which have become the legal standard for measuring the validity of limitations on human rights.[127] And although not internationally binding, the ECHR has become one of the leading treatises on human rights, providing a forum in the European Court of Human Rights to bring claims against member states for violation of any right protected by the Convention.[128]

Although these international and regional agreements do provide a foundation from which governments can incorporate human rights into quarantine strategies, there are substantial flaws in the agreements which provide opportunity for governments to exploit their power and in doing so, violate human rights. For example, while the Convention of the ECHR guarantees the "right to liberty and

120 Asher, *supra* note 102, at 158. R

121 Campbell, *supra* note 88, at 516. R

122 *Id.*; McCall, *supra* note 49, at 1010. R

123 McCall, *supra* note 49, at 1011. R

124 *Id.* at 1022.

125 McCall, *supra* note 49, at 1012; Asher, *supra* note 102 at 147. R

126 McCall, *supra* note 49, at 1012. R

127 Campbell, *supra* note 88, at 517. R

128 Asher, *supra* note 102, at 146, 147 n.68. R

security of person," it also provides an exception for the "*lawful detention* of persons for the prevention of the spreading of infectious diseases."[129] Since the Convention does not define "lawful detention," the vagueness could allow countries to exercise disproportionate control over personal liberties.[130] Furthermore, the international agreement provisions do not provide an avenue to contest a quarantine order through an independent legal system, do not indicate for how long an individual may be quarantined, and do not enumerate what standard of proof is required to enforce a quarantine.[131] Lastly, a government's order for an involuntary quarantine, such as the quarantine of the West Point slum, directly violates Article 13 of the UDHR's provision granting freedom of movement.[132] Thus, even with the substantial international and regional agreements granting human rights to all peoples, in times of quarantine, the provisions' flaws and loopholes are used to avoid repercussions for violating the most basic, yet essential human rights.

VI. Proposal

A. The Need for Communication and Cooperation between Local, Federal and International Agencies

A key reason quarantines have the ability to quickly become dangerous, ineffective opportunities for human rights violations, is because of the lack of communication and lack of cooperation between local, federal and international agencies.[133] For this reason, much of the criticism of the authority of international institutions is based on either a lack of democratic accountability, or a lack of procedural rigor and transparency.[134] In order to have a unified, legitimate approach to enforcing international guidelines for a restricted and limited quarantine policy, each nation will first have to surrender some of its sovereignty.[135] The presence of an additional layer of international governance, to which the highest national officials must answer regarding all quarantine procedures, would prevent nations and local governments (who may have been allocated the decisions regarding quarantine) from being influenced by the societal and cultural bias and prejudice in the region.[136] Moreover, this additional layer of bureaucracy that the international governance can provide, will ensure that the international officials making the policy decisions regarding quarantine measures are that much farther removed from the citizens of any given nation, and therefore able to analyze each situation without bias or discrimination.[137]

[129] *Id.* at 145.

[130] *Id.* at 146.

[131] Campbell, *supra* note 88, at 514. R

[132] *Id*. at 516.

[133] *See generally Id*.

[134] Choi, *supra* note 19, at 999. R

[135] *Id.* at 990-91.

[136] *Id.* at 1001.

[137] *Id.* at 1002.

Rather than creating a completely new international institution to propose and enforce such quarantine regulations, the IHR should be utilized to implement international human rights into the quarantine provisions, so to prevent such atrocities as occurred in the West Point slum from recurring.[138] A consistent and uniform international approach in quarantine law, implementing individual protections and public safety concerns, could prevent potential abuses of authority by state and community public health officials.[139] The government of each nation needs to be clear about what powers it possesses under a state of emergency, and moreover, consistent in how it utilizes such powers.[140] As stated by Counselor Tiawan Gongloe, Liberia's most prominent human rights lawyer, "[the government] must have an even handed approach to strengthen public trust in the government in order to fight Ebola."[141]

A good example for the IHR of an informative quarantine strategy that is cognizant of the risk to human rights is Canada's national quarantine legislation.[142] For instance, in Canada quarantine law, "an individual cannot be held longer than the length of the incubation period of the suspected disease, but cannot leave without permission of the quarantine officer."[143] Just the fact that a provision restricts the duration of a quarantine, creates a system of checks and balances for the government. However, perhaps the most significant provision of Canada quarantine laws, grants citizens the right to an immediate appeal of his detention decision.[144] The provision elaborates on the appeal process by stating that "a detained individual must immediately be informed of the reason for detention and the right to appeal to the Deputy Minister of Health. . .if the person is to be held more than forty-eight hours, the individual has the right to an attorney and a hearing regarding the detention."[145] If the IHR had implemented and enforced similar provisions prior to the Ebola outbreak, the terror, confusion and uncertainty of the West Point quarantine would likely have been dramatically lessened.

In creating the international quarantine regulations, the IHR should also incorporate the strategy used in the global HIV/AIDS crisis of placing a focus on human rights in the development of a global health governance.[146] In doing so, part of the strategy was to collaborate with non-state actors, such as human rights NGOs, to become involved in public health issues locally, nationally, and internationally.[147] By framing quarantine regulations in the context of human rights

[138] Asher, *supra* note 102, at 150. **R**

[139] *See generally Id.* at 156.

[140] MacDougall, *supra* note 2. **R**

[141] MacDougall, *supra* note 2. **R**

[142] Page, *supra* note 45, at 534-35. **R**

[143] *Id.* at 535.

[144] *Id.*

[145] *Id.*

[146] Fidler, *supra* note 1, at 115. **R**

[147] *Id.*

terminology, the trade-offs between individual liberty and a safer and healthier population will be made knowingly in advance of a public emergency.[148]

Regardless of which international institution provides and enforces international quarantine regulations, it is imperative that there is one and that all nations adhere to the rules and commit to the common cause because of a fundamental fact which is the source for situations such as West Point: all disease is ultimately local when it strikes.[149] It is crucial that nations work together and hold each other accountable as to carrying out international quarantine regulations, and as provided by Article 44 of the 2005 IHR, State Parties are encouraged to collaborate and assist each other in the detection, assessment of, and response to, events.[150] An appropriate example of what happens when there is no uniform system in place during a public health crisis is President Obama's statement on September 16th, 2014:

> Right now, everybody has the best of intentions, but people are not putting in the kinds of resources that are necessary to put a stop to this epidemic. There is still a significant gap between where we are and where we need to be. We know from experience that the response to an outbreak of this magnitude has to be fast and it has to be sustained. It's a marathon, but you have to run it like a sprint. And that's only possible if everybody chips in, if every nation and every organization takes this seriously. Everybody here has to do more.[151]

B. Health in Terms of Social, Economic & Cultural Rights

In addition to establishing international quarantine regulations and procuring the agreement and cooperation of all nations, the IHR needs to be cognizant of individual's social, economic and cultural rights when drafting provisions.[152] Individuals who are isolated or quarantined are not only likely to face stigma, but are often viewed, rightly or wrongly, as dangerous patients.[153] This "dangerous patient perspective" views the quarantined individual as the source of danger, rather than the disease.[154] In order to combat this inherent effect of quarantines, it would be beneficial for the IHR to look to the first Bush Administration's approach the HIV/AIDS pandemic.[155]

The Bush Administration's approach to the HIV/AIDS pandemic took its human rights inspiration from the U.S. constitutional traditions of protecting civil and political rights, rather than from the efforts by international organizations and

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[148] *Id.* at 123.

[149] Choi, *supra* note 19, at 1017-18. **R**

[150] *Id.* at 1019.

[151] President Obama to the International Community: We Must do More to Fight Ebola, (Sept. 25, 2014), available at 2014 WL 4748341.

[152] Choi, *supra* note 19, at 1013. **R**

[153] Ogolla, *supra* note 53, at 142. **R**

[154] *Id.*

[155] Fidler, *supra* note 1, at 122. **R**

NGOs.[156] The approach re-conceptualizes health as "dependent on the achievement of non-negotiable demands of human dignity."[157] By intertwining health and ideology, the Bush Administration used the "top-down" Jeffersonian approach that "health without liberty is more dangerous to human dignity than liberty without health."[158] In order to achieve such liberty, fundamental macro-level reform is necessary to establish a foundation on which "improved health conditions for the people, of the people, and by the people can be built."[159]

Although epidemics and resulting quarantines take place in the realm of science, epidemiology, germs, etc., they are also a cultural phenomena, providing a glance into "issues of state power, individual rights, the role of law, class, gender, race, and a society's anxieties."[160] Disease and society are so interconnected that to attempt to deal with one without the other would be impractical.[161] In order to prevent quarantines such as took place in the West Point slum, it is critical that the IHR analyze the deeper level of societal causes for each individual outbreak, so as to help uproot the pandemic.[162]

VII. Conclusion

The 2014 Ebola Outbreak put the international community on notice of the detrimental flaws in the global health system. The inhumane and poorly organized quarantine of the entire West Point slum in Monrovia, Liberia was just one example of how a lack of an additional governance (one without bias or prejudice) allows a community to make rash decisions that can result in further deaths. Although the international community collaborated and responded to the virus, there was no accountability as to the procedures of a quarantine, and as a result, the community of the West Point slum was put at risk even more so than they already were. In order to prevent a situation like the West Point quarantine from ever happening again, the World Health Assembly needs to utilize its authority to adopt regulations on quarantines and implement them in the International Health Regulations.[163] Once these regulations have been adopted and are enforced, the IHR needs to include human rights provisions along with the procedural measures of quarantines in order to ensure that the citizens are protected from the stigma and discrimination often associated with quarantining. "Society must reach a balance between the extremes of complete protection of public health without any protection of individual rights and total protection of individual rights at the expense of public health."[164]

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156 *Id.*

157 *Id.* at 127.

158 *Id.* at 129.

159 *Id.*

160 Batlan, *supra* note 16, at 68. R

161 Fidler, *supra* note 1, at 114. R

162 *Id.*

163 Choi, *supra* note 19, at 1005. R

164 Page, *supra* note 45, at 518. R