

# International Pandemic Lawmaking: Conceptual and Practical Issues

November 2021

Edited by Alicia Ely Yamin, Joelle Grogan and Pedro Villarreal



THE PETRIE-FLOM CENTER  
FOR HEALTH LAW POLICY, BIOTECHNOLOGY,  
AND BIOETHICS AT HARVARD LAW SCHOOL



MAX PLANCK INSTITUTE  
FOR COMPARATIVE PUBLIC LAW  
AND INTERNATIONAL LAW



Middlesex  
University  
London

Verfassungsblog  
ON MATTERS CONSTITUTIONAL



BILL OF HEALTH  
EXAMINING THE INTERSECTION OF HEALTH  
LAW, BIOTECHNOLOGY, AND BIOETHICS

## About

Between 20 September and 4 November 2021, the [Petrie-Flom Center for Health Law Policy, Biotechnology, and Bioethics at Harvard Law School](#), [Middlesex University London](#), and the [Max Planck Institute of Comparative Public Law and International Law](#) launched a digital symposium hosted by [Bill of Health](#) and the [Verfassungsblog](#) on International Pandemic Lawmaking. The Symposium was convened by Alicia Ely Yamin (Petrie Flom Center), Joelle Grogan (Middlesex University London) and Pedro Villarreal (Max Planck Institute). It brought together experts from across the world in the fields of law, public health, bioethics, political science, and economics. Over the course of the three editorials and 26 commentaries, now published in this collection, key points of contention and debate in the consideration of any future pandemic instrument, as well as wider issues related to the response to global health crises and global health justice are examined.

The Symposium featured three webinars on emerging themes of the Symposium, which are available for viewing here:

[“Beyond the State – Global Health Governance”](#) (22 September 2021)

Chair: Joelle Grogan; Speakers: Gian Luca Burci, Sakiko Fukuda-Parr, Aeyal Gross, and Tsung-Ling Lee

[“Addressing Scientific Innovation through Pandemic Lawmaking”](#) (19 October 2021)

Chair: Pedro Villarreal; Speakers: Ellen ‘t Hoen, Ciara Staunton, Paul Ogendi and Cassandra Emmons

[“Can a ‘Pandemic Treaty’ Promote Global Health Justice?”](#) (4 November 2021)

Chair: Alicia Ely Yamin; Speakers: Sebastián Guidi, Judith Bueno de Mesquita, Luciano Bottini Filho, Manjari Mahajan, Rosemarie Garland-Thomson, Mike Podmore, and Martín Hevia

*With special thanks to Chloe Reichel, as well as the teams at the Bill of Health Blog and the Verfassungsblog.*

Suggested citation: Alicia Ely Yamin, Joelle Grogan and Pedro Villarreal (eds.), *International Pandemic Lawmaking: Conceptual and Practical Issues Report* (Petrie-Flom Center and Max Planck Institute, November 2021), available at <https://petrieflom.law.harvard.edu/resources/article/international-pandemic-lawmaking>

# Contents

Executive Summary .....	1
Editorials.....	2
1. International Pandemic Lawmaking: Conceptual and Practical Issues – <i>Joelle Grogan</i> .....	2
2. Scientific Innovation in International Pandemic Lawmaking – <i>Pedro Villarreal</i> .....	3
3. Can a Pandemic Law-Making Exercise Promote Global Health Justice? – <i>Alicia Ely Yamin</i> .....	5
Commentaries .....	9
1. Governance Needs for Pandemic Preparedness and Response (PPR): How to Ensure the Science-Policy Interface – <i>Gian Luca Burci</i> .....	9
2. Whose Global Health Security? – <i>Aeyal Gross</i> .....	11
3. Human Rights and Global Responses to the Pandemic in the Age of Hyper-globalization – <i>Sakiko Fukuda-Parr</i> .....	13
4. Moving Beyond a State-Centric Pandemic Preparedness Paradigm: A Call for Action – <i>Tsung-Ling Lee</i> .....	16
5. Killing Locally or Killing Globally: Inequalities in Framing Cooperation through Pandemics – <i>Luciano Buttini Filho</i> .....	18
6. Strengthening International Legal Authorities to Advance Global Health Security – <i>Lawrence O. Gostin</i> .....	20
7. Limiting Human Rights during Pandemics: Recommendations for Closing Reporting Gaps and Increasing International Oversight – <i>Cassandra Emmons</i> .....	22
8. 21st Century Lawmaking in an Interdependent World – <i>Caroline E. Foster</i> .....	24
9. FRAND Terms for Pandemic-essential Intellectual Property Rights – <i>Kaat van Delm</i> .....	26
10. International Pandemic Lawmaking: Some Perspectives from Behavioural Economics – <i>Anne van Aaken and Tomer Broude</i> .....	28
11. Taking Data Sharing Seriously: Public Interest and Solidarity as Principles for an International Pandemic Treaty – <i>Ciara Staunton and Deborah Mascalon</i> .....	30
12. The Pandemic Treaty as a Framework for Global Solidarity: Extraterritorial Human Rights Obligations in Global Health Governance – <i>Benjamin Mason Meier, Judith Bueno de Mesquita, and Sharifah Sekalala</i> .....	32
13. Addressing IP Barriers in the Context of a Pandemic Treaty – <i>Paul Ogendi</i> .....	34
14. The Pandemic Treaty and Intellectual Property Sharing: Making Vaccine Knowledge a Public Good – <i>Ellen 't Hoen</i> .....	36
15. A Shared Responsibility Model – <i>Sharon Bassan</i> .....	38

16. Strengthening Global and National Governance for Gender Equality in Health Emergencies – <i>Anna Coates</i> .....	40
17. The Right to Participation in Global Health Governance: Lessons Learned – <i>Sara (Meg) Davis and Mike Podmore</i> .....	42
18. The Import of the UNCRPD and Disability Justice for Pandemic Preparedness and Response – <i>Joel Michael Reynolds and Rosemarie Garland-Thomson</i> .....	45
19. Towards Member-driven International Pandemic Lawmaking – <i>Ching-Fu Lin and Chuan-Feng Wu</i> .....	47
20. Why We Need a Transformative Right-to-Health Pandemic Treaty Now – <i>Martín Hevia and Ximena Benavides</i> .....	49
21. Pandemics without Borders? Reconsidering Territoriality in Pandemic Preparedness and Response Instruments – <i>Raphael Oidtmann</i> .....	51
22. Decolonizing the Pandemic Treaty Through Vaccine Equity – <i>Tlaleng Mofokeng, Daniel Wainstock, and Renzo Guinto</i> .....	52
23. Who Will Pay for COVID-29? (Or, Who Will Pay to Avert It?) – <i>Sebastián Guidi and Nahuel Maisley</i> .....	55
24. The Covid-19 Pandemic, the Failure of the Binary PHEIC Declaration System, and the Need for Reform – <i>Ilja Richard Pavone</i> .....	57
25. Casualties of Preparedness: Rethinking the Global Health Security Paradigm – <i>Manjari Mahajan</i> .....	59
26. From Cooperation to Solidarity: A Legal Compass for Pandemic Lawmaking – <i>Guillermo E. Estrada Adán</i> .....	61
Authors.....	64

## Executive Summary

In preparation for the Special Session at the World Health Assembly to discuss a potential new international instrument on pandemic preparedness and response, this report gathers the collection of contributions to the international symposium, which individually and collectively examine critical themes and points of contention regarding such a lawmaking exercise. In analyzing the prevailing gap between national and international law in responses to the pandemic, the symposium offered key points to consider in the framing and drafting of a new legal instrument on pandemics.

An essential point echoed throughout the contributions has been the necessity of justifying the creation of a new instrument, and/or the reform of existing instruments and guiding principles, with particular attention to not replicating the inadequacies and failures of past reforms of the International Health Regulations (2005).

A second key point is to recognize and reject the siloing of health issues. What is manifest in the global experience of the COVID-19 pandemic is that, while it is a health crisis, its genesis is likely rooted in the environmental regulation matrix; its disproportionate impact on certain communities reflects and more deeply entrenches divides of socio-economic disparities between North and South and across marginalized and disenfranchised communities; and it deepens wider social, economic and political crises. A focus on health as an isolated technical matter insulates decision-making from democratic scrutiny and accountability, undermining general trust in governance. Likewise, it fails to account for the intersecting ecological, economic, and political drivers, as well as impacts, we have witnessed in COVID-19 and will be present in future pandemics.

Third, in recognizing the shared responsibility for preventing and responding to pandemics, we simultaneously need to understand that those burdens are not equally borne and are shaped by factors beyond the nation-state. While nationalistic responses have been an enormous obstacle to COVID-19 response, the symposium highlights that there are multiple types thereof. The nationalism of closing borders to protect a country's population when a government has no vaccine access and a precarious health system differs in kind and not just in degree from, e.g., the nationalism of vaccine hoarding, and export controls imposed by a number of states and the European Union.

A set of necessary conditions for pandemic lawmaking to be equitable have been laid out by the contributions in this symposium. For example, information-sharing is essential to effective pandemic response: it requires a framework for data governance, equitable access, and international institutionalization of sharing transparent information and technical expertise. Similarly, wide representation and participation from varied constituencies, including persons representing diverse fields of expertise, citizens, and civil society — both within and across countries of differing income and resource levels — should be involved in both the drafting and development of any instrument which seeks to prepare and respond to future pandemics. In these and other points, commentaries underscore that a focus on "crisis" is unhelpful; robustly institutionalized processes and harmonized legal frameworks are required in "normal" times to be effective when societies are placed under extreme stress.

The Editors, November 2021

## 1. International Pandemic Lawmaking: Conceptual and Practical Issues

Joelle Grogan *on behalf of the editors*

September 20, 2021

This symposium, “International Pandemic Lawmaking: Conceptual and Practical Issues,” was convened with two primary aims: to shed light on the inequities and imbalances exposed by global pandemic response, and to advocate recommendations on which principles should guide the framing and drafting of a potential international instrument on pandemic preparedness and response.

However, while good principle can guide good action, to be effective it must be more than good principle; and more substance is needed than good design. Thus, these symposium commentaries published on *Bill of Health* and the *Verfassungsblog*, along with our accompanying editorials, look not only to the *design* of such an instrument, but also its *implementation* and *enforcement*.

The SARS-CoV-2 pandemic has brought global health structures into sharp relief: it exposed the gross inequalities and inequities of health care access, as well as the symbiosis between human rights, health care, politics, economics, and the law. National lockdowns, stay-at-home mandates, business and educational establishment closures, and consequent mass unemployment — primarily of low-skilled and casual workers — have disproportionately and negatively impacted vulnerable and marginalized groups, including [women](#), [children](#), [minorities](#) and [indigenous communities](#). While unprecedented sums for social welfare packages have been disbursed, they have been [ineffective](#) in forestalling escalating rates of poverty and inequality.

The locus of authority for pandemic response has been primarily within national executives,

and often to the exclusion of any international coordination or influence, representing, in effect, a [nationalization of response](#).

The chasm between international law and national law responses to COVID-19 is reflected in the comparative poverty of references to international norms or standards in the actions and decisions taken at the national level. Measures adopted have made scarce reference to the International Health Regulations (2005). The limited observable engagement with international human rights obligations in executive decision-making or national discussions on the legitimacy, proportionality, temporariness, and legality of pandemic responses only provide further evidence of this gap.

While calls for solidarity have echoed in the global context of sharing information and data, there are sharp divides in the willingness to share the fruits of that labor in the intellectual property for diagnostics and vaccines. In May 2021, the Director-General of the World Health Organization highlighted with concern that 75% of all vaccines had been administered in [only ten countries](#), and, to date, [less than 3% of people in low-income states](#) have received at least one dose, compared to almost 60% in high-income states. It is within this context that a [special session of the World Health Assembly](#) is scheduled to take place in November 2021 to discuss a potential international instrument on pandemic preparedness and response.

The Symposium seeks not only to inform the upcoming international discussions on a new legal instrument, but to widen the debates.

Leading scholars and rising voices from around the globe will *inter alia* advocate for: global regulatory standards to recognize mutual interest and prevent transboundary harm; the integration of gender and intersectional equality mechanisms; a framework for data governance; and the international institutionalization of sharing transparent information and technical expertise; as well as means by which isolationist nationalized institutional processes for decision-making in pandemic preparedness and response can be eschewed in favor of a collective and coordinated global effort. The Symposium will showcase a range of perspectives, from enthusiastic embrace of a pandemic treaty, to skepticism surrounding the geopolitics of such a law-making exercise.

In hosting this Symposium, we join with other communities of scholars and advocates engaged in similar debates across regional fora, and from different disciplinary perspectives, and recognize the problem of siloed discussion. Publishing our editorials in English, French, and Spanish on blogs based in the U.S. and Germany, with webinars hosted in the U.K. presenting speakers based around the globe, we hope to recognize and invite wide participation in this essential debate on a collective challenge.

In the opening to this Symposium, we offer some initial thoughts: As evidenced, rhetoric of solidarity and sharing responsibility often only echoes until the bill for health is put on the table. Invocations for the essential importance of human rights must recognize the underlying socio-legal complexities in how they may be realized. The global asymmetries in capacity to respond must be reflected: for legitimacy, collective investment, and sheer quality, a democratized process involving wide representation and participation from varied constituencies, including civil society both within and across countries of differing income and resource levels, must be present.

To be integrated with any serious consequence, a new instrument on pandemic response must engage with the boundaries of national constitutional or other public norms. States must also pay more than lip service to the obligations of international human rights instruments in the limitation and derogation of rights. A first hurdle, however, is to *justify* the need for such a new instrument where it does not replicate the inadequacies, limitations, and incapacities of past and existing instruments.

## 2. Scientific Innovation in International Pandemic Lawmaking

Pedro Villarreal *on behalf of the editors*

*October 18, 2021*

Perhaps there is some Utopia where scientific research could immediately provide us all the accurate data on a novel disease's severity and fatality rate. No doubt some (although not everyone) believe that such an ideal world would include mathematical models that could accurately predict both the disease's pattern, as well as the effectiveness of the array of medical and non-medical tools to confront it. In this imaginary reality, data could tell us exactly to what extent restrictive public health

measures are necessary in a given society to limit the spread of a pathogen, and it would be shared without constraints across the globe. Moreover, in this mythical world, there would be no distance between research and its application, as policymakers would simply need to draw from existing information to "make the right call." Failsafe mechanisms would be in place to avoid the temptation of either altering scientific data, or using it for partisan motives. And, needless to say, in an

ideal world, both research and the products of scientific innovation, including diagnostics, therapeutics and vaccines, would be available to everyone, globally, on the basis of need rather than ability to pay.

No such world is possible because science does not work that way. However, the broken world in which we find ourselves underscores the central imperative of reflecting on how lawmaking can be deployed to advance scientific innovation and equity.

The novel SARS-CoV-2 virus laid bare the limits of “objective” scientific recommendations, which evolved continually and continue to do so. Mathematical models produced by the [Institute for Health Metrics and Evaluation](#) and other similar indicators were wrong more often than they were right. In some countries, science-based recommendations were blatantly manipulated to suit partisan purposes, with deadly consequences. In many others, governments guided by committees of experts, epidemiologists, and infectious disease specialists struggled to take stock of multiple dimensions of the impact of both COVID-19 and the manifold public health measures adopted to face it. Numerous studies have found that both laissez-faire policies underplaying the need for protection and restrictive measures adopted over the last 18 months have exacted a disproportionate toll on persons in situations of vulnerability, from informal workers to persons with disabilities.

On a global level, rather than countries being straightforward with their data, painting a positive picture of the country’s pandemic response often took precedence over collecting and disseminating accurate epidemiological as well as other information. This lack of transparency hindered any attempts at a global system of disease surveillance meant to convey information efficiently and accurately to all countries, which may itself have revealed itself as a thin,

“performative” accountability, as [Mahajan](#) terms it.

Moreover, scientific innovations leading to effective diagnostics, therapeutics, and vaccines against COVID-19 were heavily underwritten with public monies but have been allocated according to a market logic that suits the interests of pharmaceutical companies. Although developed in record time, as pointed out in [this symposium’s Launch Editorial](#), the overwhelming preponderance of vaccine doses have been delivered to wealthy countries, while countries in Sub-Saharan Africa did not meet even the scaled-back aspirations announced by the WHO of 10% coverage by the end of September through the COVAX Facility. There are a variety of views on how to make the most of the relationship between scientific innovation and intellectual property regulation, but the business-as-usual model of patent protection coupled with exclusive control over technological know-how and manufacturing capacity is clearly unsuited for a global pandemic.

If it is safe to say, as Sheila Jasanoff foresaw at the pandemic’s onset, science [“did not come on a white horse with a solution.”](#) At the same time, science denialism has led to catastrophic results in some countries, [such as Brazil](#). Moreover the pandemic has made clear that the world we live in faces a crisis of trust in democratic institutions from which health is no longer exempt. An [“infodemic” around COVID-19 is rampant](#), spread through informal channels, including, but not limited to, social media, as well as through governmental channels. Misinformation and disinformation have maximized distortions of findings and fueled reactionary movements against pandemic responses throughout high-, middle- and low-income countries alike.

Looking forward, more inclusive models for scientific data sharing at the international level clearly can and must be devised. Doing so will require stronger commitments by states, improved multilateral mechanisms, and legal



rules that facilitate the fair allocation of fruits of scientific progress without influence from competing agendas.

We must also scrutinize the parties setting research priorities during (and outside of) global public health emergencies. As highlighted in [recent discussions in \*The Lancet\*](#), conducting cutting-edge biomedical and other types of research can be cost-prohibitive for many low- and middle-income countries. Moreover, [some suggest](#) that the focus on the “emergency” aspect of the pandemic ignores endemic health challenges in much of the world and skews both scientific machinery and legal rules toward prioritizing problems affecting countries from the Global North.

Whether it is catering to the for-profit private sector’s own priorities, or to the temptation of using research as a geopolitical instrument rather than a vehicle for solidarity, numerous actions we have witnessed during COVID-19 warrant deeper scrutiny as the world considers a pandemic law-making exercise.

The contributions in the current symposium address these and other issues related to scientific innovation and the rights to the benefits of scientific progress with nuance, while offering several creative proposals. The second webinar will focus in particular on the hurdles for increasing the availability and accessibility of scientific innovations during a pandemic, and how a pandemic law-making exercise can better tackle [the science-policy interface](#), as Gian Luca Burci discusses in his article.

Whether international law can enable solutions to any of these challenges ultimately depends on the prevailing political will of the governments at the table. Nonetheless, should these leaders disregard the need to revise rules regarding the development, communication, and sharing of scientific innovations in pandemic preparedness and response, they would be doing the world a major disservice.

### 3. Can a Pandemic Law-Making Exercise Promote Global Health Justice?

Alicia Ely Yamin *on behalf of the editors*

*November 4, 2021*

Amid the unfolding ["moral catastrophe"](#) of COVID-19, and across the entries in this symposium, we see a clamor for any pandemic law-making exercise to promote more justice in global health.

However, this universally-embraced imperative masks a wide array of divergent views about the nature and sources of inequalities in global health, and in turn what should be done if we were to think beyond a narrow pragmatism of the moment.

In this final editorial, we attempt to surface some of the critical contestations that underlie any future pandemic treaty or revisions of the International Health Regulations (IHR).

In a democratic state of law, where everyone is in theory an equal member of the polity, there is a broad ethical consensus that health inequalities are unjust if they result from avoidably unfair distributions of socially controllable factors. Of course, as the pandemic has made starkly apparent, there are heated debates about what is *avoidably* unfair and which factors are *or should be*

socially controllable, as well as the normative legitimacy of different forms of social control.

But this doesn't necessarily tell us about international inequalities arising during or prior to the pandemic. Across this symposium, authors implicitly or explicitly address three overlapping, but nonetheless distinct, sources of global health inequalities.

### Sources of Global Health Inequalities

First, in addition to domestic variation (e.g., topography/geography), we have seen plenty of domestic injustices that create inequalities between, as well as within, countries. For example, legislative, regulatory, and implementation gaps that fail to deliver access to health-related goods and services; and political culture or lack of political accountability for rampant leakage, corruption, or wanton indifference to the population's suffering.

Second, international norms, institutional arrangements, and practices drive global health inequalities. For example, a ["One Health"](#) approach aims to address human, animal, and planetary health, and gives rise to transnational solutions. These ["norms, policies, and practices that arise from transnational interaction,"](#) termed ["political determinants of health"](#) by the Lancet-Oslo Commission on Global Governance for Health, include debt and structural adjustment; access to research and data; trade agreements; and anti-democratic global governance.

Finally, both domestic and global factors contributing to inequality are framed by what are often called the chains of history, including multiple expressions of colonialism and coloniality.

### Promoting Global Health Justice

The ways in which scholars in the symposium and beyond understand the nature of global health injustices, and the interactions among these sources of inequalities, are invariably reflected in distinct proposals about how to promote global health justice through a pandemic lawmaking exercise.

Multiple entries argue that justice requires going beyond narrow disease surveillance (the hallmark of the IHR) to enhance legal as well as health system preparedness for future pandemics, with inter-state technical and financial assistance to enhance domestic resources and capacities in lower-income countries.

Some propose embedding extra-territorial obligations into such a treaty as a way to reinforce general legal obligations of ["international assistance and cooperation"](#) and ["international collaboration and assistance."](#) Some go further in asserting the need for a ["Framework Convention on Global Health"](#) (FCGH) that would harness such international assistance not just for addressing health emergencies or global health security, but for universal and equitable health systems that underpin enjoyment of health-related rights in "normal" times.

Other scholars and practitioners across and beyond the symposium understand the nature of the imperative differently, arguing that justice in global public health requires re-making the aid system and unshackling the constraints on low and middle-income countries that underpin the perpetuation of dependency, including [reviving proposals for the right to development](#) and a 21<sup>st</sup> century version of the [New International Economic Order \(NIEO\) endorsed at the Alma-Ata Conference on Primary Care.](#)

Access to medicine advocates, as well as scholars in the symposium and elsewhere, have argued that we must [deconstruct and](#)

[remove structural barriers](#) in the architecture of [intellectual property regulation](#) (e.g., TRIPS) as a starting place for promoting fairness in global health, and effective enjoyment of health rights. Pandemic lawmaking that does not consider the need for creating different incentives for sharing vaccine know-how (recipes), transferring technology, and decentralizing manufacturing will ineluctably reproduce reliance on the fickle and miserly compassion of the economic North, which were exemplified by the failures of COVAX.

Adding to the perpetuation of dependency, the costs of structural prevention would disproportionately burden parts of Sub-Saharan Africa, Asia and Latin America. For example, as Maisley and Guidi write, halting deforestation in the Amazon in order to stop future zoonotic diseases --which are responsible for the preponderance of novel diseases and arguably other climate-related illness --would heavily fall on South America.

Others argue that the paradigm of causation and prevention encoded in a [global health security framework is inherently flawed](#). In this example, for instance, reducing demand for meat is not just a matter of regulating cattle breeding in Brazil, Mercosur countries, or even South America. Rather, it [calls for systemic structural changes](#) of the political determinants of health in our [globalized, financialized and commercialized food system](#), including strengthening effective regulation in wealthy countries where relevant transnational corporations are headquartered, or reining in commodities speculation where doing so could have a substantial impact.

Finally, a number of authors signal that any pandemic lawmaking exercise that fails to address diseases that disproportionately ravage the global South, killing hundreds of thousands of people a year, such as [malaria and tuberculosis](#), smacks of colonialist selectivity regarding what constitutes a *crisis*.

While some scholars view [the reassertion of U.S. leadership in a regime of global health security as an imperative for global justice](#); others see the [extension of U.S. influence as a dystopic deepening of toxic synergies](#) between imperialist control and illiberal national governments in the name of health “security.”

### Reparative Justice and Human Rights

If we take seriously reparative justice for [inequalities grounded in colonialist extraction](#), structural violence, and subordination, the questions regarding how a global health law might contribute become even more complex. But the increasing trend in rhetorical calls for “decolonizing global health” should not obscure, as [Seye Abimbola argues](#), that it is impossible for people with different agendas and positionalities to use those terms and refer to the same thing. Indeed, as [Gonzalo Basile](#) asserts, meaningfully decolonizing theory, politics and practices in global health seems to demand not a universal vision from above, but historically-contextualized approaches that seek to subvert dominant epistemic as well as institutional paradigms.

All normative arguments are inextricably framed by readings of history and, to adopt Nietzsche’s expression, “how things become what they are.” The starting point for all pandemic lawmaking must be the revision of the IHR of 2005. [Meier, Bueno de Mesquita and Sekalala](#) view the IHR as “ensuring the incorporation of human rights” and providing “a legal foundation to align global health law with human rights law, harmonizing treaty interpretation across legal regimes.” Other commentators, far from sharing that narrative, see the global health security paradigm embedded in the IHR as entrenching a particular neoliberal form of colonialist governance in a hyper-globalized world. Rights protections for travelers may be necessary to sustain international traffic and trade, but critics argue that the institutionalized social

order itself is fundamentally incompatible with universal enjoyment of human rights in practice.

Far from the mantra of “human rights-based approach” resolving these and other tensions, the symposium underscores how rights, including the right to health, are sites of profound contestation over conceptions of distributive justice, as well as tools of struggle. An array of human rights scholars and practitioners tackle the question of whether and how human rights principles might be [integrated into global governance without](#)

[being coopted](#). Some suggest possible modes of civil society participation in the design, [as well as governance](#), of a pandemic lawmaking instrument.

As editors, our hope is that far from presenting these fundamental issues regarding the relationship between pandemic lawmaking and global health justice as settled, the symposium will open space for greater debates across disciplinary, ideological, and geographic boundaries.

## 1. Governance Needs for Pandemic Preparedness and Response (PPR) How to Ensure the Science-Policy Interface

Gian Luca Burci

*September 21, 2021*

The COVID-19 pandemic has been characterized by mistrust in science, the manipulation of science for political purposes, the “infodemic” of mis- and disinformation, and a repeated failure to base policy decisions on scientific findings.

The crisis of confidence in scientific analysis is paradoxical and disquieting, particularly in light of increasing international regulation to manage acute or systemic risks and its reliance on science. This so-called “[science-policy interface](#)” (SPI) incorporates scientific expertise into global policy-making and regulation in fields as diverse as climate change, biodiversity, and nuclear safety, but it is arguably less developed in global health and in particular for pandemic preparedness and response (PPR).

As international policymakers consider various [proposals](#) aimed at preventing another pandemic through better and stronger global rules — whether in the form of a WHO “pandemic treaty,” revised International Health Regulations, a UN political declaration, or regulatory framework — the integration of SPI in their design will be of crucial importance for their credibility and effectiveness.

SPI, however, is only one side of the regulatory coin; the other side consists of the normative commitments that must guide national action and international cooperation in implementing measures inspired by scientific consensus.

From this latter perspective, two critical aspects are: 1) [compliance mechanisms](#) to assess national progress and challenges,

identify systemic problems, and build mutual confidence among states; and 2) [an institutional framework](#) to manage compliance oversight, provide a forum for consensus building and technical support, and turn SPI findings into agreed targets and benchmarks.

Examples of SPI that present interesting features for our purposes are: the Intergovernmental Panel on Climate Change ([IPCC](#)), the Intergovernmental Science-Policy Platform on Biodiversity and Ecosystem Services ([IPBES](#)), the IAEA Safety Standards, and WHO’s [standard-setting](#). All of these examples (excepting WHO’s standard-setting) are linked functionally to international treaties.

Some recurring elements in those initiatives should be carefully considered:

1. [Institutional framework](#): IPCC is an inter-agency program (WMO, UNEP, IUCN) with an independent secretariat, IPBES is a self-standing intergovernmental program serviced by UNEP, while the other two are part of the regular programs of IAEA and WHO, respectively. The main consideration here is between institutional integration versus a dedicated framework controlled by participating states. For a “One Health” approach, which targets the interface of human and animal health and environmental protection, the parallel competence of multiple organizations may require mechanisms to compile scientific findings and channel them into an intergovernmental process.

2. Relations between science and policy: One of the challenges of SPI is to balance the integrity of scientific analysis with political acceptability. In the case of IPCC, summaries for policy-makers are adopted line-by-line by the full intergovernmental panel, in dialogue with the authors, while technical summaries are left untouched. In contrast, WHO guidelines and similar standards are mostly elaborated by the secretariat with the support of experts and technical partners, with governments limited to providing comments. Intergovernmental endorsement of scientific findings is seen as more conducive for negotiations, with the notable example of the IPCC, whose periodic assessments have coincided with, and deeply influenced, major international legal developments.
3. Process: IPCC and IPBES use a structured and public process to select large numbers of authors and reviewers and organize their work, with successive draft reports undergoing intergovernmental review. WHO, in contrast, usually appoint experts from existing internal rosters with relatively limited transparency, and the final outcomes are issued by the secretariat. Considerations of legitimacy and accountability should weigh heavily in considering options for the future.
4. Policy-relevant or prescriptive? The examples mentioned above are mostly policy-relevant, where SPI leads to findings or recommendations left to the discretion of states. A possible exception are IAEA's safety standards that constitute benchmarks for compliance with the [Convention on Nuclear Safety](#). A different and preferable approach for a future PPR instrument is policy-prescriptive SPI, where the implementation of treaty obligations is assessed against compliance with the scientific conclusions and guidance generated within the SPI process, subject to technical and financial support and capacity-building.

If we consider pandemics along a continuum starting with the identification of pathogens and ending with the deployment of countermeasures, there are several points where SPI is, conceptually, a critical component of future international regulation.

To illustrate this need with an example, we may consider one such time point: the pre-pandemic identification of pathogens phase and the management and reduction of the risk of spillover of pathogens from animals to humans. In a recent, co-published [Lancet comment](#), I argued that a future pandemic treaty should incorporate "deep prevention" of zoonotic spillover, a legal blind spot between global health law, which focuses on containment of occurring outbreaks, and environmental law, which addresses different risks. This is an area of considerable complexity that is receiving increasing attention given the frequency of outbreaks of zoonotic diseases including (possibly) COVID-19.

Recent research projects, such as [Predict](#) and the [Global Virome Project](#), aim at prospectively identifying and characterizing animal viruses of zoonotic potential. Concurrently, WHO, FAO, OIE and UNEP each have been pursuing a One Health agenda, both under their individual mandates, as well as through an intensifying quadripartite cooperation embodied most recently by the establishment in November 2020 of a [One Health High-Level Expert Panel](#) (OHHLEP).

Still, the confluence of different disciplines and epistemic communities make coordination and coherence challenging. What is missing from these initiatives, moreover, is the regulatory interface, given the absence of dedicated international legal instruments. Scientific findings are at best policy-relevant, offering empirical bases or guidance for discretionary national or local measures.

The challenge for the negotiators of a future pandemic instrument will be to devise an SPI

framework that will simplify and integrate the inherently complex and intersectoral nature of zoonotic risk management through processes

that are at the same time scientifically cogent and politically conscious so as to inspire and guide intergovernmental processes.

## 2. Whose Global Health Security?

Aeyal Gross

*September 22, 2021*

The [current](#) discussion [within the World Health Organization \(WHO\)](#) of a “[pandemic treaty](#)” aims at better solutions to “health emergencies.”

But, if this focus on “emergencies” comes at the expense of chronic and underlying issues, including the overall status of health systems, we risk replicating, with this legal instrument, [the colonial legacy of international health](#) supposedly left behind with the shift to “global health.” This points to the urgent need to rethink what is considered a “crisis” or an “emergency,” as part of the effort to “[decolonize global health](#),” including global health law (GHL).

The so-called “international health” approach to infectious disease began to take shape in the mid-nineteenth century, as [David Fidler shows](#). The driving motivation behind this approach was to protect Europe and North America from “Asiatic diseases” spreading from Asia and the Middle East. This regime was streamlined and universalized with the establishment of the WHO and its 1951 international sanitary regulations (renamed as International Health Regulations [IHR] in 1969) that replaced the previous treaties and led eventually to the 2005 IHR.

Eventually this regime faltered, as developed countries made significant strides in reducing the threat of infectious disease to their populations and economies following the availability of clean water, sanitation services, and new medical technologies, such as

vaccines. The concern in developed countries shifted to non-communicable diseases.

In the 1980s, however, developed countries once again became concerned with infectious disease, in light of emerging infectious diseases (EID) such as HIV/AIDS, and later SARS and COVID-19, and re-emerging old ones (e.g., tuberculosis and malaria). A new international legal regime suited to these developments was needed, and “global health governance” emerged as the favored strategy. The 2005 IHR revision process embodied the new strategy of global health security and the new approach of global health governance.

This approach is supposed to be “global” and different from obsolete, colonial “international health.” It purports to understand the global nature of disease, rather than center on transmission solely in one direction. But, in practice, it seems to replicate much of the state-focused, [colonially-tainted international health scheme](#). As the COVID-19 pandemic has shown, global health governance often favored unilateralism, nationalism, and populist self-interest over global solidarity. [Vaccine nationalism, vaccine hoarding, and vaccine diplomacy](#), together with other [nationalist and populist reactions](#) to COVID-19, can attest to this.

[Sekalala and Harrington](#) point to the speedy nature of security-led responses, which are subject to what they call the “tyranny of the urgent” implying, *inter alia*, the prioritization of rapidly spreading diseases like COVID-19

over endemic conditions like malaria, which impose a much greater burden on the population's health but are less likely to travel. These approaches end up favoring the nations of the global north, reproducing domination patterns typical of European colonialism.

The risks of the “tyranny of the urgent” became apparent during the COVID-19 pandemic when [concerns were raised](#) about the [potentially disruptive](#) effects of COVID-19 control measures on efforts to combat [AIDS, malaria, and tuberculosis](#). Research shows, for example, that [the provision of TB health services \(diagnosis, care, and prevention\) was severely disrupted](#) by COVID-19 mitigation measures, partly due to restrictions on freedom of movement and the re-allocation of resources, [and, more generally, that COVID-19 has caused significant setbacks in the fights against HIV, TB, and malaria. Additionally, funding for non-communicable diseases \(NCDs\) as a share of foreign aid declined during COVID-19.](#)

Whose security, then, is included in the “Global Health Security” paradigm? The COVID-19 pandemic has illustrated how “Global Health Security” is triggered when new diseases reach, or threaten to reach, the global north. These new threats are viewed as “urgent,” unlike endemic diseases, such as TB or malaria, which nevertheless critically threaten the global south.

The current focus on duties surrounding new and emerging pandemics draws attention, resources, and efforts to diseases like COVID-19, which are declared part of the “Public Health Emergency of International Concern” (PHEIC) paradigm under the IHR.

Meanwhile, although diseases like TB, malaria, and AIDS each kill hundreds of thousands in Africa every year, they are not “new,” do not travel easily, and are not defined as PHEIC in the IHR, meaning they do not constitute

“extraordinary events” posing a public health risk to *other countries* through their international spread (PHEIC definition, IHR Article 1). NCDs are addressed almost exclusively through non-binding global action plans, strategies, and recommendations. Although [some have described the rise of NCDs as a pandemic or crisis](#), within GHIL they are not viewed as “emergencies.”

In other words, when infectious diseases endemic to the global south are at stake, there are no specific norms and duties in international law other than general obligations that can be derived from the right to health, though [soft law does play a significant role](#) in dealing with diseases that are not part of the PHEIC paradigm.

The focus on “health emergencies” in the IHR seemingly makes GHIL a “discipline of crisis,” to borrow the term [used by Hilary Charlesworth to describe international law](#) in general. COVID-19 has often been described as a crisis and, as Charlesworth shows, the obsession of international law with crises leads us to concentrate on single events or series of events, often missing the larger picture. This promotes a narrow agenda for international law, and creates silence on issues outside the lens of crises. Charlesworth suggests instead that international law should refocus on the structural justice issues underpinning everyday life, a significant lesson for GHIL given the concentration on crisis — and especially on events defined as PHEIC under the IHR, such as COVID-19 — in a way that raises the question not only of the focus on “crisis,” but also on the biases affecting the decision as to what *is* a crisis, especially given the paucity of norms within GHIL touching on endemic and non-communicable diseases.

While the content of a prospective pandemic treaty is still to be determined, [it is expected to clarify state obligations to prevent, detect, and respond to pandemic threats and](#)



[strengthen WHO powers” to address novel outbreaks with pandemic potential.](#) The suggestions to [focus on prevention and adopt a “One Health” approach](#) within a pandemic treaty, and to include principles of equity and [human rights](#) are welcome.

However, the focus on novel outbreaks and PHEIC-like situations within a pandemic treaty ignores the need for expanded concern with

background issues, NCDs, and endemic diseases, and remains within the restricted and biased “crisis” framework. The proposed pandemic treaty may replicate this bias, unless it includes a complete paradigm shift of what is considered a pandemic of international concern.

### 3. Human Rights and Global Responses to the Pandemic in the Age of Hyper-globalization

Sakiko Fukuda-Parr

*September 23, 2021*

In 1999, the [Human Development Report](#) called for stronger international arrangements to govern people in a globalized world, stating: “the present era of globalization, driven by competitive global markets, is outpacing the governance of markets and the repercussions on people.... An essential aspect of global governance is responsibility to people – to equity, to justice, and to enlarging the choices of all.” As the 21<sup>st</sup> century sped into an era of hyper-globalization, new global institutions are urgently needed to protect the public interest. The architecture of global health emergencies is a case in point. Its core agreement, the [International Health Regulations \(2005\)](#) (IHR) remains state centric, catering to national interests, bound to colonial epistemic frameworks, and silent on market power that can trample on human rights. The age of hyper-globalization requires global institutions that enable global – collective – responses to contain pandemics worldwide, that build on international solidarity and human rights norms, and structures that break free from North-South hierarchies of power and knowledge.

#### **From surveillance to global response**

Although the ultimate purpose of the IHR is to protect people from health threats, its objective is not to manage epidemics domestically but to prevent their spread beyond national borders. As [Ramakrishnan Gopakumar](#) points out, the IHR is a framework in which the legal obligation “is effectively reduced to inform WHO on the outbreaks. It is an apparatus to maintain the surveillance system to fulfill the above obligation.” Yet the risk we face in this era of hyper-globalization – with intense flows of people and goods, globally integrated and interdependent economies and lives, and high risks of zoonosis – is another COVID-19, a deadly novel virus that has defied the capacity of the most equipped nations to contain, let alone prevent its outbreak.

The experience has demonstrated the interdependence of countries in containing the pandemic in which ‘no one is safe until everyone is safe’; lack of capacity in one country to contain the contagion poses a threat to people elsewhere in the world of open travel. Though the 2005 revision of the IHR introduced the obligation to develop ‘core public health capacities’, these capacities focus on the prevention of cross-border spread rather than on implementing domestic

containment measures such as case identification/tracing/quarantine, non-pharmaceutical interventions such as social distancing and hygiene, public communication and building trust, treatment, or mass vaccination. It is therefore not surprising that many countries that had high public health capacities prioritized in the IHR have experienced widespread deaths from COVID-19. Countries such as the US and UK that rated high scores in Joint External Evaluation (JEE) reports for IHR implementation have some of the highest mortality rates from COVID-19, while countries with low JEE scores have had very low rates; overall, the [Independent Panel for Pandemic Preparedness and Response](#) concludes JEE scores have shown no predictive value for vulnerability to COVID-19 pandemic deaths. Similar conclusions are drawn for the scores from the State Party Annual Reports, and from the widely referenced [Global Health Security Index](#).

Faced with COVID-19, there has been little disagreement that a global response is needed to contain pandemics. As 25 world leaders stated in their call for a [new pandemic treaty](#): “No single government or multilateral agency can address this threat alone”. The past two years have demonstrated the critical role of global cooperation, not only in information sharing, but in the provision of public goods, notably vaccines. The failure of international institutions to mobilize the full potential of global technologies for the ‘people’s vaccine’, the supply shortage to meet global need, and the inequitable distribution is not only a moral failure but a public health policy error that is prolonging the pandemic.

### **From international cooperation to human rights obligations**

The 2005 revision of the IHR included specific norms for international cooperation, among them Article 44 that refers [primarily to public health capacity](#). But this takes a minimalist approach, limited to collaboration and assistance amongst states ‘to the extent

possible’ in building public health capacities in the form of activities such as mobilization of financial assistance and technical cooperation. It is premised on the idea that a lack of technical and financial capacity in the Global South is a risk for the Global North. It is a state-centric approach to cooperation rather than one based on the need for global solidarity in an inter-dependent world. This minimalist approach to international cooperation is entirely inadequate to develop global public health responses – such as the development of vaccines, diagnostics, treatments – as global public goods. It is also inconsistent with the conception of state responsibility in international human rights law.

The [UN Committee on Economic, Social and Cultural Rights](#) has emphasized the global responsibility of states, noting that ‘states have a duty of international cooperation and assistance to ensure universal equitable access to vaccines wherever needed’ (para 9). Moreover, states have an extraterritorial obligation, for example that ‘corporations domiciled in their territory..... do not violate these rights abroad’ (para 8). These global obligations stem from the Right to Health, but also particularly from the Right to Development (RtD). As asserted in the 1986 [Declaration on the Right to Development](#), ‘States have the primary responsibility for the creation of national and *international* conditions favourable to the realization of the right to development’ (Article 3), and goes on to spell out the ‘duty to take steps, individually and collectively’ for that purpose (Article 4).

This neglected and controversial Declaration lays the groundwork for addressing gaps in global governance as an obstacle to full enjoyment of human rights in the age of globalization. The RtD Declaration takes forward the idea laid out in article 28 of the [Universal Declaration of Human Rights](#) that states “Everyone is entitled to a social and international order in which the rights and freedoms set forth in this Declaration can be fully realized”. The Declaration introduces

[important innovations](#) in departing from the concept of human rights as a protection of individuals against abuse by their own states, and recognizing that actions of states impinge on people outside their borders, and state ability to fulfill human rights are limited by international structural arrangements. It articulates a '[universal entitlement to a human rights-based international order](#)' (100).

In the context of the global governance of health emergencies, the RtD Declaration articulates why states must address the international structural arrangements such as intellectual property agreements that impinge on universal access to vaccines. In contrast to the minimalist scope of international cooperation in the IHR, the RtD requires states to act proactively, stating "States have the duty to co-operate with each other in ensuring development and eliminating obstacles to development... and to promote a new international economic order based on sovereign equality, interdependence, mutual interest and cooperation among all states' (Article 3.3).

### **Challenging hierarchies of power and knowledge**

The IHR reflects the political economy and geography of global health emergencies that is preoccupied with outbreaks of infectious diseases coming from the Global South that threaten the health of people in the Global North. The assumption was that the Global North would have the technological and financial capacity to respond to an alert. Yet the geography of COVID-19 [has challenged these underlying assumptions](#) as the outbreak in early 2020 spread rapidly and globally, but with epicenters concentrated in Europe and North America. Ironically, low and middle income countries of Sub-Saharan Africa and

Asia responded more effectively to containing the contagion through 2020, using conventional low-tech public health strategies. Prior to the advent of the game changing vaccines and variants, these countries kept mortality rates far below world average levels. Yet there is little interest in the international community in learning from these experiences and public health methods and strategies that were used while global knowledge on pandemic response continues to be dominated by public health theories and practices of the Global North.

Since the 1999 Human Development Report called for governance of markets and its repercussions on people, the pace of globalization accelerated, and the power of private actors in shaping global health structures in their self-interest has increased. Despite public exhortations about vaccines as global public goods, governments of the Global North have worked to preserve vaccines as private property. While governments financed much of research and development, pharmaceutical companies retain the intellectual property and now control supply and distribution. Governments do little to support transfer of technology to scale up worldwide manufacture, and almost all resist the proposal supported by over 100 countries for a temporary waiver of the TRIPS agreement provisions on intellectual property for pandemic related technologies.

Setting out new norms and arrangements for the provision of global public goods for pandemic preparedness and response should be a centrepiece of a new legal instrument that is capable of challenging market power, and builds on human rights principles in synch with the age of hyper-globalization

## 4. Moving Beyond a State-Centric Pandemic Preparedness Paradigm:

### A Call for Action

Tsung-Ling Lee

*September 27, 2021*

Despite the World Health Organization's (WHO) recent efforts to broaden participation, the international infectious disease control regime remains state-centric.

As such, the state-centric infectious disease regime violates the fundamental principle of how contagious diseases spread within and across countries — the virus recognizes no national borders, nor does the virus discriminate. The longstanding global health mantra — no country is safe until all countries are safe; no one is safe until everyone is safe — should guide global pandemic preparedness.

Under [the WHO's 2005 International Health Regulations](#) (IHR), State Parties are primarily responsible for strengthening their respective public health core capabilities.

Article 54 of the IHR stipulates the annual reporting obligation: member countries are required to report their IHR implementation progress at the annual World Health Assembly (WHA).

Voluntary commitments include Joint External Evaluations (JEE), After Action Review, and Simulation Exercises, which together form the [IHR Monitoring and Evaluation Framework](#), introduced by the WHO to ensure accountability and transparency in 2015.

In particular, [the JEE is a voluntary collaborative process](#) which seeks to provide independent and external expert review of member countries' core capacities in 19 technical areas, initiated at the request of the member state. The JEE process plays an essential role in identifying public health strengths, weaknesses, best practices and challenges in countries' IHR core capacities.

Yet, neither the JEE nor the annual IHR reporting processes are open to the relevant stakeholders.

The JEE process remains a technical exercise between the WHO and requested member states. Civil societies, academic institutions, private sectors are rarely involved in the evaluation process. As [the JEE assessment often informs national pandemic action plans](#), accounting for local capacities and inputs from diverse viewpoints can enhance the quality of policymaking.

Likewise, there is no shadow reporting of State Parties' IHR implementation during the WHA.

Rethinking the public health monitoring framework from a good governance perspective is integral to mitigate the scale and magnitude of social and economic disruptions that pandemics can cause. As we have seen, the pandemic's rippling impacts go far beyond public health, penetrating economic and social spheres. Sustained dialogues on pandemic preparedness, including a broad array of actors, can cement shared interests and responsibilities.

The gaps revealed by the COVID-19 pandemic in terms of preparedness and real-world responses should guide institutional arrangement reforms at national and international levels.

The Independent Panel for Pandemic Preparedness and Response points out that the world was unprepared for the COVID-19 pandemic: the existing preparedness measures "[failed to account sufficiently for the impact on responses of political leadership](#),

[trust in government institutions and country ability to mount fast and adaptable responses.”](#)

This remark offers a starting point for reorienting our thinking towards pandemic preparedness planning. Successful pandemic responses require the public’s buy-in. Public inputs in preparedness planning can help increase that buy-in. Evaluating pandemic preparedness should involve collaborative multi-sectoral efforts at various levels of governance.

[Experience from the 2014 Ebola outbreak demonstrates that successful infectious outbreak control response necessitates engagement with non-state actors, such as faith-based organizations.](#) Likewise, as the COVID-19 pandemic shows, community health workers are most familiar with local contexts and challenges, and should be part of pandemic preparedness planning. Diversifying viewpoints can engender better quality policymaking and more accurately reflect the needs and demands in local, regional, and global contexts.

The COVID-19 pandemic has shown that to enhance societies’ capacities to respond to uncertainties and risks, and to sustain changes in behavioral and social norms, [building trust](#) is paramount. Establishing prior channels of cooperation before the eruption of a pandemic can yield social dividends during global health crises. Regular meetings, exchanges, and reporting on IHR implementation progress among stakeholders can cement shared responsibilities and interests in a more equitable world by creating multiple public spaces for solidarity.

Thus, the state-centric pandemic preparedness regime is deeply problematic for two reasons.

First, the regime has partly reinforced nationalistic mindsets to the world’s detriment. For instance, during the COVID-19 pandemic, countries first competed for [essential medical supplies](#), then for [vaccines](#).

Second, the state-centric regime tends to neglect the health inequalities *within* countries when evaluating preparedness. [Rising disparities in impacts of the pandemic](#) on communities reveals structural injustice pertaining to race, gender and socio-economic status within countries. For instance, [child marriage may be on the rise in India, as the pandemic has caused disruption to schooling](#). In Asia and the Pacific region, [young adults will bear higher long-term economic and social costs because of disruption in employment](#). Elsewhere, [minorities, migrant workers, refugees](#) also bear disproportionate impacts from the pandemic.

It is imperative that we engage and empower individuals to ensure governments worldwide are held accountable for strengthening their respective public health core capacities.

Likewise, it is also essential to create institutionalized processes at the national and international levels to enable currently unrepresented and unheard voices to participate in decision-making processes that affect them.

[Pandemic preparedness is a global public good](#), where everyone benefits when the world is better prepared. Until individuals around the world recognize global health vulnerabilities elsewhere as their own, global pandemic response and preparedness is likely to continue as fragmented, nationalistic, and fractured.

## 5. Killing Locally or Killing Globally

### Inequalities in Framing Cooperation through Pandemics

Luciano Bottini Filho

*September 28, 2021*

Covid-19 made ‘pandemic’ [a buzzword](#). The world expressed anxiety on the eve of a pandemic declaration from the WHO, a decision monitored as closely as the white smoke for a newly elected pope. Yet, ‘pandemic’ has no legal value in international law by contrast with a declaration of [public health emergency of international concern \(PHEIC\)](#). It is no accident that the 12<sup>th</sup> Commission of the Institute of International Law issued a report on [Epidemics and International Law](#), which bluntly avoided the term pandemic.

Despite this, for the general public, the role of a PHEIC determination remains unknown. Given the inconsistency in declaring PHEIC (only 6 events between 2007 and 2020), many epidemics of considerable proportion [were ignored by the international community](#). Yet the mismatch in the general public consciousness regarding the legal implications triggered by a WHO declaration of a PHEIC is not as problematic as the way lawyers and public health practitioners reinforce the centrality of a pandemic, a concept that still [requires a more solid definition](#).

As an international instrument potentially moves forward to galvanize ‘pandemics’ as a legally defined term – and part of global health governance – we must understand the implication that this word has in relation to disparities between developing countries’ problems and the interests of their richer counterparts. After all, any pandemic would have originated from one or more national epidemics, but it would require a globally recognized procedure to trigger stronger international obligations. As opposed

to pandemics, though, epidemics have persisted for decades and raged in low- and low-middle income settings from Zika to Ebola, demanding support from international actors.

Firstly, this classification is undesirable by producing an artificial differentiation between diseases of similar urgency and lethality, while pandemics preparedness is at the center of international law. Should tuberculosis, which killed [around 1.5 million people](#) in 2019, [be less of a priority](#) than COVID-19? Sometimes called merely a global epidemic, tuberculosis bears many similarities with COVID-19. Both are airborne diseases very skillful in disseminating among vulnerable groups, including those in overcrowded spaces, [such as prisoners in Brazil](#). However, tuberculosis is widespread for decades and has been regarded as endemic to some countries or simply an epidemic, [as described by the WHO and the SDGs target to end the disease by 2030](#).

Thus, the pandemic status is also a political exercise and a way to phrase a crisis according to political interests. As long as some diseases do not reach a pandemic level, they would not elicit the immediate financial help and international cooperation, which has at least been promised (if not delivered) during COVID. By defining the term ‘pandemic’ and enshrining it in international law, with a more powerful procedure than currently exists for declarations of PHEICs, international law can cement the higher status of a pandemic in the global health governance, theoretically forcing member States to collaborate with their resources against pandemics. In practice, COVID-19 [has shown some de-prioritization effect of a pandemic](#) among donors, which

switched priorities about long-term health needs to focus on containing the virus.

As a consequence, pandemic control in international law may have a neo-colonialist impact, such as in [intellectual property law](#), by using the Global South to enforce rules beneficial to major powers. Ultimately, typifying 'pandemic' as a legal category in international law may install a tiered system in which infectious diseases are tolerable, but pandemics are not. This has been, in practice, a reality. Similar to tuberculosis, other communicable diseases may be solely a regional problem for never attaining pandemic recognition. [The international response to Ebola in 2013-2016](#) is an example of the differential treatment to tropical diseases or geographically circumscribed outbreaks. [Despite the criticism of this approach](#), we are still single-minded about pandemics.

This is problematic for countries ravaged by mosquito-borne diseases, such as Dengue or Yellow Fever. Those are countries that should allocate resources for their endemic diseases but possibly would also need to meet international expectations of air-borne disease control and another set of measures to protect the entire world. Their participation would come as the [global inequalities](#) made health systems broken and populations vulnerable to diseases spread in the poorest places, such as cholera, Chagas disease, and malaria (which also may be the result of internal economic inequalities).

A PHEIC should be ideally declared to any ongoing health system disruption or calamity in a broader sense (e.g. in the event of a shortage of medicines for non-communicable diseases), but if States devote themselves to pandemics only, there must be attention to inequalities in epidemic control. A pandemic-centered system should be balanced through mutually beneficial arrangements for the development of health systems and access to

vaccines and medicines in non-pandemic infectious control among the poorest States. Therefore, the least that can be offered, for less developed countries battling alone against their own infectious diseases, is to stipulate obligations to address past and geographically-limited epidemics with equal consideration.

Giving proportionate support to non-pandemic infectious diseases would involve a plan of eradication of current epidemics that would not benefit from a pandemic-oriented treaty (as such obligation would arise solely for future-declared pandemics). Any threshold for a global emergency must not be territorialized and geographically excludent to address ongoing health crises less threatening to the Global North. If an outbreak cannot be a global scale hazard (such as cholera in [Haiti](#), even though technically as part of the [7<sup>th</sup> pandemic cycle](#) of cholera), there should be an efficient international assistance program to monitor and support regional epidemics.

Further, a mutually beneficial agreement should promote health system development in the Global South beyond border control and pathogen surveillance, so poorer governments may be in a position to devote resources to pandemic control (and not become a [breeding ground](#) of disease variants after a pandemic declaration as happened today). In return for establishing a system of health security for wealthy nations, developing countries should receive investment in their [domestic vaccine production](#) and infrastructure to act upon immunization programs as swift as the leading governments. This would include, in exchange for compliance to pandemic measures, a mechanism to invest in research and develop appropriate interventions to neglected tropical diseases and other epidemics less likely to harm the Global North. Such cooperation must consider broader interrelated policies, including environmental risks. As it happens, more evidence shows that

the [proliferation of tropical diseases and new pathogens have been accelerated by global warming](#) or even through [deforestation](#), a problem with the digital mark of the Global North.

It is important to note that, from a human rights-based approach perspective, rendering obligations to prevent pandemics superior to epidemics would be potentially in conflict with core obligations of the international right to health ([General Comment 14](#), para. 44.b and c). In order to harmonize the right to health as provided by the International Covenant on Economic and Social Cultural Rights (ICESCR),

States must take steps to combat epidemics, as provided in [article 12-c](#), which does not refer to pandemics.

In sum, communicable diseases prevention cannot just be a richer countries' problem, seen through the eyes of the victims of a pandemic. The essence of epidemic control by virtue of the right to health has never been to differentiate the local to the global. The international community must avoid entrenching in international law a system indifferent to right-to-health core obligations, instead of effectively promoting international cooperation for all communicable diseases.

## 6. Strengthening International Legal Authorities to Advance Global Health Security

Lawrence O. Gostin

*September 29, 2021*

The COVID-19 pandemic has exposed marked limitations in the International Health Regulations (IHR) and constrained authorities of the World Health Organization (WHO). With a rising imperative to advance pandemic preparedness and response, [more than twenty heads of government proposed a new pandemic treaty](#). This prospective pandemic treaty offers a pathway to develop innovative international legal obligations, strengthening core capacities, good governance, and compliance mechanisms to prepare for novel outbreaks with pandemic potential.

States have provided WHO with expansive constitutional powers to develop global health law. Pursuant to these powers, the World Health Assembly has codified evolving authorities to coordinate international action to prevent, detect, and respond to pandemic threats. In developing global health law under article 21 of the [WHO Constitution](#), the IHR stand as the leading legal agreement to respond to the globalized threat of infectious

diseases. The current [IHR](#), revised comprehensively in 2005 following the SARS-1 epidemic, has near-universal participation from WHO member states, empowering WHO and governments in detecting and responding to public health emergencies of international concern.

However, the COVID-19 pandemic has revealed deep flaws in pandemic preparedness and response, as the IHR have faced limitations in shaping national responses. Just as important, political controversies have weakened WHO governance and institutional capacities. Despite major IHR reforms in 2005, the national and global response to COVID-19 has seen failures to notify WHO promptly of novel outbreaks, delays in declaring a Public Health Emergency of International Concern (PHEIC), non-compliance with WHO recommendations on outbreak responses, state health measures disproportionate to public health risks, and a lack of global



solidarity and equitable allocation of health resources, especially SARS-Cov-2 vaccines.

Redressing IHR limitations in shaping national and global responses, new treaty structures will be needed to face future pandemic threats, drawing from article 19 of the WHO Constitution to develop a binding international convention and providing a legal foundation for proposals to develop a new treaty through the World Health Assembly. A Framework Convention strategy could enable states to agree on core principles, which could then be operationalized through subsequent protocols.

As states prepare for World Health Assembly debates in November, they will consider “the benefits of developing a WHO convention, agreement, or other international instrument on pandemic preparedness and response with a view towards the establishment of an intergovernmental process to draft and negotiate such convention, agreement, or other international instrument on pandemic preparedness and response.” The [O’Neill Institute for National and Global Health Law at Georgetown University](#) (a WHO Collaborating Center) is partnering with the Foundation of the National Institutes of Health to support WHO’s Director-General and member states in the [pandemic treaty process](#). We will be hosting a series of expert consultations among key stakeholders in North America, Europe, Africa, and Latin America.

In identifying the specific strategies for preventing, detecting, and responding to future pandemics, this prospective global health convention provides a unique opportunity to articulate key state obligations, with strong compliance and accountability mechanisms for:

**One Health.** Prioritizing prevention through land management, deforestation, and the effective regulation of wild animal markets and intense human-animal interchange — under a comprehensive “one health” approach across sectors — the new treaty could reduce the

likelihood of naturally-occurring zoonotic spillovers and other novel threats to health security.

**Good Governance.** It is crucial that the new treaty stresses an evidence-based and rights-based public health response while proscribing and sanctioning iniquitous government actions, including “authoritarian power grabs,” continuing monopolies in medical innovations, failure to resource health systems, heightened levels of pandemic-related human rights violations, and an institutional neglect of low-income and marginalized communities.

**International Monitoring.** In promoting outbreak prevention, detection, and response, strengthened global institutions must overcome obstacles of national sovereignty to monitor disease threats. International institutions like WHO must have authority to verify state reports, publish crucial outbreak data without state confirmation, investigate novel pathogens independently, and institute remedial actions.

Given the massive gaps in the COVID-19 response and the cavernous gaps in access to vaccines and other resources between richer and poorer countries, bold new legal obligations and governance appear not simply justified but a global imperative. It may appear that negotiating norms and compliance measures as varied as One Health through to international monitoring will be arduous — and it will be. Yet, the health crisis the world has faced is unprecedented and so too must be the solutions. If the world cannot come together for bold reforms now, it may never be able to effectively prevent and respond to future pandemic threats. The time is now.

The pandemic treaty can achieve these goals by providing WHO with the legal mandate, sufficient funding, and political legitimacy to become the governing institution necessary to meet this historic moment. COVID-19 is an unprecedented crisis that offers a unique opportunity to reform WHO to effectively

coordinate pandemic preparedness and response across member states, partner with other international organizations, and ensure international assistance and cooperation – establishing governing authorities to overcome the limitations of the COVID-19 response and advance global health security and equity.

WHO Director-General Tedros has boldly stated that [“the world cannot afford to wait](#)

[until the pandemic is over to start planning for the next one.”](#) An innovative pandemic treaty could become a transformative model of global solidarity in the face of common threats, but it will require states to overcome nationalist forces to meet this global moment, with leaders embracing diplomacy across nations to prepare legal authorities for new challenges.

## 7. Limiting Human Rights during Pandemics

### Recommendations for Closing Reporting Gaps and Increasing International Oversight

Cassandra Emmons

*September 30, 2021*

Sovereign governments have the prerogative to declare states of emergency when sudden, unanticipated events threaten the lives of the nation and its people. In so doing, government decrees sometimes must contradict other international human rights commitments, balancing the individual versus the collective. Established derogation procedures are supposed to ensure such restrictions are proportionate, non-discriminatory, and last only as long as necessary (for an overview, see [Emmons 2020](#)). COVID-19 has proven that public health emergencies are not equally recognized in either international law or national constitutions; some international treaties permit “limiting” rights in the name of public health rather than requiring derogation, and nationally some governments authorize emergency measures in practice without ever doing so in name. These parallel processes and conceptual gaps create space for governments to restrict individuals’ rights with little to no international accountability during pandemics.

In this piece, I recommend a new international instrument on pandemic response be explicit about reporting requirements when governments suspend rights during such

emergencies. These suggestions incorporate advice from the American Association for the International Commission of Jurists’ [Syracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights](#) (1985), the International Law Association’s [Queensland Guidelines for Bodies Monitoring Respect for Human Rights during States of Emergency](#) (1990), case law of the European Court of Human Rights (ECtHR), and learned experience from the COVID-19 pandemic.

I

First, public health limitations clauses should be subject to the same procedural safeguards as derogation clauses. The rights to movement, assembly, association, residence, information, and manifesting one’s religion are among the limitable rights in most international human rights conventions. However, such limitations are not subject to clear reporting requirements. The Syracuse Principles place the “burden of justifying a limitation” on the state (para. 12), but do not specify by and to whom or within what expected parameters this should be done, posing a risk that the restrictions could become entrenched or

permanent. To rectify this omission, governments should be required to *notify international treaty organizations and/or other relevant bodies* when any actions taken to combat pandemics impinge upon other recognized individual rights, even when proportionate, necessary, and taken within the scope of a limitations clause.

## II

Second, I recommend establishing specific reporting timelines when governments limit or derogate rights during pandemic responses. Changes can be made at three points in the process.

A refined procedure should, first, clarify expectations for when the initial notice must be filed. International human rights treaties that permit derogation all require “immediate” notification ([European Convention on Human Rights](#), Article 15(3); [American Convention on Human Rights](#), Article 27(3); [International Covenant on Civil and Political Rights](#), Article 4(3)). Communications technology being as advanced as it is today, governments should be able to notify the requisite international bodies in a timely fashion. In practice, however, there is some latitude. The ECtHR has acknowledged that notification can be mired by the nature of the emergency, either because it develops “gradually” or because of unavoidable administrative disruptions. The Queensland Guidelines recommend initial notice be made within one week (A.4). ECtHR case law provides a loose set of parameters. In [Greece vs. UK \(1958\)](#), the then-European Commission for Human Rights opined that a three-month delay in notification “was longer than can fairly be attributed to inevitable causes and that it was therefore longer than is justifiable.” Months-long delays were also criticized in the [„Greek case“ \(1968\)](#). In the interim, the ECtHR found twelve days was a sufficient timeframe for notification in [Lawless v. Ireland \(1961\)](#). It is, thus, reasonable for a new legal instrument on pandemics to ask governments to report their

derogation/limitation *immediately, and no later than two weeks after declaration of an emergency.*

Such an instrument should also request an expected date of expiration for the limitations or derogations and mandate updates if the measures are extended. At present, only the ACHR requires this detail in its initial notification (Article 27(3)). Whether and how quickly emergency decrees expire is a national constitutional issue, so where expiration dates are not mandated, a new international instrument could reasonably require periodic updates justifying continued rights restrictions after a predetermined period of time. American states are already in the habit of such notifications: as of 30 June 2021, 11 of the 15 ACHR parties that have formally derogated from the Convention in response to COVID-19 also [followed up](#) with information about extensions and changes to the initial order; several issued multiple communiques. The new instrument could justifiably *require member states to update human rights treaty organizations on the status of the emergency decrees:*

- (a) at the end of the original expiration,*
- (b) at the time of extension or expansion, or*
- (c) within six months of the decree being active, whichever occurs first.*

Finally with respect to timing, the new instrument should set a definitive time frame for formally rescinding the state of exception when the emergency has passed or come under control (Queensland A.4). The Siracusa Principles recommend the government notify the relevant actors the same day that the emergency is terminated (para. 49), as do several of the treaties themselves. This *immediacy can be reasonably expected.*

## III

My third and last recommendation is to increase communication between relevant international agencies and expand the roles for

international non-governmental actors. First, intergovernmental bodies should increase information sharing about rights restrictions in common member states. Between January 2020 and the end of June 2021, only 64% of countries that reported derogations as part of their COVID-19 response to regional bodies such as the [Council of Europe](#) or [Organization of American States](#) also reported those derogations to the [United Nations](#). Automatic recognition of derogation across institutions would close reporting gaps, and facilitate more effective oversight. Additionally, expanding roles for non-governmental actors could improve international assessments of the legitimacy, proportionality, and necessity of rights limitations (Queensland A.3). Non-governmental human rights monitoring groups

can provide accurate accounts of events on the ground even when a government does not report limitations or derogations. Experts in public health and epidemiology in organizations such as the WHO can also assess the scientific necessity and proportionality of a government's pandemic response measures. Combined, these experts can offer policy analyses grounded in science to inform the rest of the international community. A pandemic instrument should thus recognize the changed landscape of the international community and *enhance roles for and communication between regional and global governmental bodies and especially non-governmental actors.*

## 8. 21st Century Lawmaking in an Interdependent World

Caroline E. Foster

*October 4, 2021*

A new pandemic instrument should explicitly embrace the three emerging [global regulatory standards](#) of due diligence, due regard, and regulatory coherence.

These standards sit at the interface between national and international law to help functionally align the two in ways that will protect and advance shared and competing interests in an interdependent world.

The standards require nations to exercise their regulatory power in certain ways, including demonstrating (i) *due regard* for the international legal rights and interests of others, (ii) *due diligence* in the prevention of harm to other States, and (iii) *regulatory coherence* between governmental measures and their objectives. These international law standards are already implicit in and given effect by the operation of WHO's current International Health Regulations (IHR) of 2005.

As we develop new pandemic instruments, their presence should be made increasingly explicit. Giving a stronger profile to the standards will help generate new political impetus and new legal bases for implementation of world health law, and fit it to 21st century application.

A new pandemic instrument should highlight that nations are required, as a matter of general international law, to exercise due diligence in the prevention of transboundary harm. This will significantly reinforce epidemic outbreak control obligations. Too seldom is it acknowledged that the WHO's IHR presently provide the benchmark for operationalizing this due diligence obligation, as does the Paris Agreement in respect of [climate change](#). Due diligence centrally requires giving effect to core [IHR obligations](#) to (a) develop, strengthen, and maintain national surveillance capacity to detect novel outbreaks and public health response capacity, and (b) to notify and

continue to communicate on potential public health emergencies as they unfold, including identifying support needs, information-sharing, and consultation. Due diligence should be recognized as lying at the political and legal heart of a new pandemic instrument and its implementation in national law.

Due regard should also feature foundationally in a new pandemic instrument. This emerging global regulatory standard requires that nations have due regard in their regulatory and administrative actions for the rights and interests of other nations and their populations. Such a standard is increasingly understood as an important underpinning of [international law on cooperation](#).

The standard's application in the multilateral setting is indicated in the World Court judgment on scientific whaling in [Whaling in the Antarctic \(Australia v Japan: New Zealand intervening\)](#). Japan lost this case partly because it had failed as a party to the International Convention for the Regulation of Whaling (ICRW) to give due regard to the recommendations of the International Whaling Commission (IWC) calling for assessment of the feasibility of non-lethal scientific research methods.

Due regard requires nations explicitly to analyze the competing considerations involved in their exercise of regulatory power, including effects on those beyond their voting populace, and including by considering the recommendations of international organizations. Giving the concept of due regard a central place in a new pandemic instrument will provide a strong political and legal footing to hold nations to account should they consider diverging from the views of international organizations with responsibilities in regard to pandemic prevention and management. Espousal of due regard would complement the exercise of any international emergency powers to adopt binding directives that may be created in light of the COVID-19 pandemic.

Global regulatory standards can be expected to work in synergy with one another. Due regard works especially in tandem with the third global regulatory standard, regulatory coherence. The regulatory coherence standard includes requirements that nations' regulatory measures bear a rational relationship with their objectives, as already seen in administrative law worldwide. Nations must not only commit to specific pandemic preparedness and response aims and targets, they must also design appropriate domestic legal rules and processes to implement them. Regulatory coherence is particularly important, too, in relation to nations' rights to take public health measures "additional" to those recommended by the WHO. Article 43 of the IHR requires that "additional" trade-inhibiting sanitary measures are not unnecessarily restrictive, based on scientific principles and scientific evidence, as well as WHO guidance, and reviewed as relevant. States must notify the WHO within 48 hours and advise the health rationale. Nations may depart from WHO recommendations and take their own, [stricter measures](#), based on national strategies and risk settings, provided they are scientifically supported and characterized by sufficient regulatory coherence. Much of this is paralleled in the 1995 [WTO Agreement on Sanitary and Phytosanitary Measures](#) (the SPS Agreement) and regional trade agreements.

The three global regulatory standards discussed here are inherently pluralistic: national sovereignty remains intact, but is conditioned in new ways that [actively consider others' interests](#), consistent with human dignity in governance. The global regulatory standards soften and contextualize the suggested need for nations to ["share" sovereignty](#) with the [World Health Organization](#). These global regulatory standards are beginning to appear consistently across diverse regulatory spheres, from trade to oceans law. They provide a vital means of reconciling the substance of nations' competing interests, and will help promote assistance to those in need through capacity-

building to reduce compliance problems via early detection, monitoring and advance support. They are premised on science-based action at all global legal levels.

These standards should help provide a starting point for conceptualizing the legal foundations of a potential new WHO convention, agreement, or other international instrument on pandemic preparedness and response in the changing 21st century legal landscape when governments meet at the [special session of the World Health Assembly](#) in November 2021 to consider the benefits of developing such an instrument.

The implications for the design of appropriate compliance and accountability mechanisms should also be considered. International law's increasingly detailed and pervasive governance of nations' regulatory activity in an interdependent world has implications for the design of mechanisms that can best help achieve the implementation of this law, and of the global regulatory standards by which it is characterized. An emphasis on enabling conduct consistent with nations' obligations, as seen in the Paris Agreement on climate change, is key.

## 9. FRAND Terms for Pandemic-essential Intellectual Property Rights

Kaat van Delm

October 5, 2021

Our international norms are arguably ill adapted to emergencies such as pandemics. In this contribution I discuss a potential remedy for one related challenge, namely a cooperation amongst competitors for the accelerated development of vaccines. A way to foster cooperation could be the use of fair, reasonable and non-discriminatory ('FRAND') terms to the licensing of pandemic-essential intellectual property rights (IPR). Specifically, states could make participation in public procurement for vaccines by pharmaceutical companies conditional upon accepting FRAND terms for their IPR relevant for vaccine development. I do not suggest changes to the existing rules for allocation of IPR. Rather, I attempt to explore an acceptable limitation of such rights in case of a pandemic.

Transposing the concept of FRAND terms from standardisation to the licensing of pandemic-essential IPR has potential because of the concept's flexibility. FRAND terms do not require commitment to specific royalties in advance, therefore leaving room for [considering new information](#) such as the monetary value of the IPR concerned or the severity of the health crisis.

I consider the more practical implementation of FRAND terms in a global pandemic context, in line with the European Commission's interpretation stipulated in its [Horizontal Guidelines 2011/C 11/01](#). First, as for standardisation, the successful vaccine tenderers would provide '*an irrevocable commitment in writing to offer to license their essential IPR [...] on fair, reasonable and non-discriminatory terms ('FRAND commitment')*' to the concerned WHO member states. The requirements 'fair' and 'reasonable' encompass the new information referred to higher. The requirement 'non-discriminatory' relates to the equal treatment of competitors, in line with the FRAND terms' goal to prevent discriminatory royalty fees. However, unlike for standardisation, vaccine developers should not be expected to apply FRAND terms vis-à-vis all third parties. Rather, their FRAND commitment should extend to all competitors bound by the same commitment, across the WHO member states. Second, a clear IPR policy should be readily available upon the declaration of a pandemic by the WHO, containing principles fit for the pandemic at stake. Third, a requirement for good faith disclosure of pandemic-essential IPR should be

imposed on successful vaccine tenderers. Depending on the developmental stage of the vaccine concerned, the IPR policy could require an ongoing disclosure of relevant IPR, or be limited to disclosure upon committing to the policy.

The proposed regulatory framework consists of three levels. First, the framework falls within the scope of the WTO's [TRIPS agreement](#). Imposing FRAND terms as licensing conditions for a patent concerns a limitation of the rights conferred by said patent. However, as the aim is to foster cooperation regarding research on vaccine development, the framework could benefit from the flexibility included in [Art. 30 TRIPS](#), via a research exception. FRAND terms are inherently well-placed to comply with Art. 30 TRIPS, as reasonableness is a common requirement. The second relevant regulatory level is the national level, concerning member states of both the WTO and WHO. Member states which have transposed the research exception of Art. 30 TRIPS in national law could require vaccine developers to apply FRAND terms to the licensing of pandemic-essential IPR. Such requirement could be imposed via early stage public tenders for vaccines. If not accepted, vaccine developers would be excluded from public procurement, and they would not receive access to potentially relevant IPR from competitors under FRAND terms for research purposes. As finding political consensus for the compulsory introduction of this system is unlikely, WHO member states would participate on a voluntary basis. Also, the prioritisation by member states of vaccines developed on the basis of FRAND terms can only be upheld in so far as it would not jeopardise public health. To ensure a uniform approach by the states, the WHO acts as a third regulatory level. Together with the declaration of a pandemic by the WHO, an IPR policy containing the key aspects of the licensing (FRAND) terms is issued, tailored to a specific pandemic. Such procedure could be formalised by the WHO in an international pandemic treaty or other legal instrument. The new IPR policy would remain

generic, only harmonising what is strictly required to incentivise finding new vaccines against the disease causing a pandemic.

The described framework should remain subject to conditions safeguarding fair competition and compliance with the agreed terms. National courts and competition authorities of WHO member states would perform supervision and enforcement thereof. First, as competition law is not harmonised internationally, supervision will be performed in line with national (or supranational) legislation. Independently of the supervision framework chosen, corporations should in any case *'document all exchanges, and agreements between them and make them available [...] on request'* (EU [Temporary Antitrust Framework concerning COVID-19](#)) in order to facilitate supervision. Second, it is difficult for courts and competition authorities to assess whether FRAND commitments have been honoured, as *'cost-based methods are not well adapted to this context because of the difficulty in assessing the costs attributable to the development of a particular patent'* (Horizontal Guidelines), a statement which can be extended to other IPR. *Ex ante* disclosure of the most restrictive licensing terms to the supervisory authority may constitute a solution. Upon conclusion of the public tender, vaccine developers communicate their most restrictive licensing terms for pandemic-essential IPR, including an estimate of royalties. This could serve as a reference framework for both supervision and enforcement. How the exchange of such information amongst states would take place, is subject to further discussion.

In conclusion, FRAND terms constitute an adaptable framework for vaccine development. Several questions must be addressed to find a good balance: what exactly constitutes 'pandemic-essential IPR'? Up until which phase of vaccine development is it appropriate to share IPR? To what extent is it possible to assess IPR value while vaccine development is still ongoing? Despite these outstanding

questions, FRAND terms for vaccine development could be framed as a flexibility stemming from art. 30 TRIPS, and the drafting of an IPR policy by the WHO is a flexible medium to boost the search for a solution to a

pandemic. It constitutes an interesting baseline for balancing public health concerns and rewarding pharmaceutical R&D.

## 10. International Pandemic Lawmaking: Some Perspectives from Behavioural Economics

Anne van Aaken and Tomer Broude

*October 7, 2021*

In this brief essay, we wish to highlight some insights from behavioural economics that can contribute to a successful process of international pandemic lawmaking. Our interest here is not to engage with individual or collective psychological reactions to pandemics or other large-scale risks, or with substantive policy made in their wake. Several such behavioural issues and dimensions have been dealt with elsewhere, not without (ongoing) spirited debate. For example, [the utility of simple reminders to get vaccinated](#) as individual ‘[nudges](#)’, contrasting with [enforced vaccination](#) is a continuing issue. Indeed, the WHO is addressing such approaches through the Technical Advisory Group on Behavioural Insights and Sciences for Health, in accordance with general [UN behavioural science policy](#). Similarly, elite decision-makers’ [tendencies towards procrastination and omission bias](#) in the face of high degrees of uncertainty, on both national and international levels have arguably negatively impacted large-scale policies with respect to Covid-19. Understanding these and other behavioural dynamics may be crucial in determining the substantive content of a cooperative pandemic regime. Here, however, while building on related frameworks of analysis from the field of behavioral economics, as [applied to international law](#) (including [nudge theory](#)), our focus is on the process and design of pandemic international law-making.

Our framework of analysis recognizes that international lawmaking processes, including treaty negotiation, or formulation of ‘[soft law](#)’ (such as unenforceable decisions and resolutions of international organizations), all involve strategic interactions between actors – states, international governmental/non-governmental organizations and individuals (negotiators, elite decision-makers and subjects). These actors are traditionally assumed to be rationally pursuing self-interest and utility-maximization on domestic and international planes, often within game-theoretical frameworks (e.g., [here](#)). However, this standard rational choice model is cast in doubt by experimental and empirical research in behavioural economics, which demonstrates that the rationality of actors does not necessarily conform to assumptions and expectations. Decision-makers (and at times also corporate actors, such as states) possess forms of bounded rationality (as well as bounded willpower and bounded self-interest), with various psychological biases and heuristics that may determine their ultimate conduct, not least with respect to [public goods](#). Thus, as a central issue, when faced with risk and uncertainty, actors weigh differently losses and gains of an objectively equal quantum, often more concerned with preventing loss than creating gains (‘[Prospect Theory](#)’). Accordingly, framing similar regulatory measures or legal guidelines as either gains or losses can influence their



effectiveness (see, e.g., in an environmental context [here](#)).

With respect to international pandemic law-making, we generally embrace [a recent key analysis](#) of the diminished effectiveness of the World Health Organization (WHO) and the International Health Regulations (IHR) throughout the Covid-19 pandemic, according to which the pandemic raised problems of political cooperation rather than expert coordination, to which the current international legal framework is ill-suited. Indeed, this analysis (at p. 597) also suggests the possibility that “the assumption about rationality is misguided”. Combatting pandemics is a collective action problem with well-known incentive deficits. Although arguably it would have been (globally) welfare-maximizing to distribute vaccines equally in all countries in order to prevent variants making vaccines less effective, not even under the veil of ignorance at the beginning of the pandemic of which countries would be hit hardest could states agree on a legal framework to combat the pandemic. This in itself comports with behavioral writing on [‘pro-sociality’ of states](#), which is very difficult to separate from national self-interest, and when the stakes are as high as during a pandemic, conduct will tend towards the latter. Having said that, while one possible conclusion is that future international pandemic law needs stricter rules and enforcement mechanisms (which indeed might be the case), we offer some complementary suggestions.

First, international soft law can be surprisingly useful and effective, despite the absence of enforcement mechanisms. This can be attributed to both traditional rational choice explanations and to cognitive effects, such as status quo bias associated with ‘default rules’, the difficulty to discount soft rules as information, and anchoring effects associated with legal standards (see [here](#)). We thus contend that non-binding arrangements with explicit rules should be considered, alongside to or as alternatives to ‘hard’ law, which might

be more politically feasible than, e.g., an effective pandemic convention. The WHO and its members have, for example, used soft law successfully in the WHO [guidelines on packaging and labelling of tobacco products](#) (e.g., when the WTO Appellate Body [upheld a dispute settlement Panel’s use of non-binding provisions](#) of the Guidelines as evidence of emerging tobacco control practices on plain packaging). In the context of pandemics, such an approach could be perhaps replicated through guidelines on incentives and ‘nudges’ to vaccination, and the participation of non-vaccinated in public life.

Second, either through hard or soft law, there is a strong case to be made in favor of designing positive [‘rewarding’ mechanisms](#) to encourage cooperation rather (or as complements) to negative sanctioning against non-compliance. For example, insofar as expedient sharing of information regarding disease outbreaks is a major goal of international pandemic law-making, rewarding source states who provide such timely and accurate information of outbreaks and causes may be more effective than the weak threat of symbolic punishment, especially because it eliminates problems of access and verification. Such conditional rewarding for capable and cooperative states— for example, minimum assurances of international assistance and access to medical supplies and vaccinations, through institutionalized initiatives like COVAX— could also address gaps that have clearly emerged during Covid-19 between ‘developed’ and ‘developing’ countries.

Third, attention should be paid to the ‘ground rules’ for negotiation of particular disciplines, such as opt-ins\opt-outs (such as with respect to dispute resolution) – research demonstrates that [states will opt-in significantly less frequently than opting-out](#); yet this may influence the willingness to commit (reflecting on our previous points). Similarly, [positive\negative listing](#), where relevant – e.g. with respect to mechanisms for

the adoption of internationally recognized travel advisories may affect negotiations.

Fourth, again, whether as hard or soft law, the status of international pandemic regulations and decisions should take into account their position as [‘floor or ceiling’](#) – either or both. Minimum standards run the risk of being considered as ‘anchors’ to which no further effort is required (perhaps weakening states’ motivation to take ‘additional measures’ as per Article 43 of the WHO [International Health Regulations](#)). Overly stringent regulation (certain types of lockdowns and restrictions on international travel or excessive vaccination

conduct) can create negative externalities. For example, national vaccination programs can come at the expense of global health – thus the application of ‘ceiling’ regulations may be considered.

There are certainly more fine-grained aspects of behavioural economics that can be very pertinent to both design and content issues of international pandemic law-making. We hope that negotiators will adopt such approaches in overcoming obstacles to agreement and promoting such agreement’s effectiveness.

## 11. Taking Data Sharing Seriously

### Public Interest and Solidarity as Principles for an International Pandemic Treaty

Ciara Staunton and Deborah Mascalonzi

*October 13, 2021*

COVID-19 demonstrated the interconnectedness of the world and that our collective protection and well-being is contingent on our individual response. The importance of solidarity and acting in the public interest became key messages in public health, as too were these principles justified as the basis for data-sharing across borders. Accessing this data was critical and its timely access to this data was essential in research for the much-needed new vaccines.

Solidarity can be understood as the [commitment to carry costs to assist others](#). In the same way that we were told to keep away from loved ones (the cost) to stop the spread of the virus (to assist others), [individuals](#) were encouraged to share their data with researchers and in turn [researchers](#) were encouraged to share their data with other researchers (the cost) to develop vaccines (to assist) for the global collective benefit (others). The response was remarkable. Data sharing became the default (the cost), vaccines were rapidly developed (to assist), but herein the

solidarity pathway stopped. Access was (and still is) largely driven by national and private interests rather than the global collective benefit.

It is clear from this pandemic that the principles of solidarity and the public interest can help drive the data sharing needed for the quick development of vaccines. Data sharing and data access has thus unsurprisingly been called to be included as part of an [international pandemic treaty](#). However, there is not universal support for data-sharing even in a pandemic, in part due to the issue of benefit. In principle, solidarity and the public interest are principles that should guide a pandemic response, but we have seen with COVID-19 that unless these principles are embedded into legally enforceable conditions that clearly dictate benefit, they are not the basis on which to share data. Data sharing in this pandemic has created an imbalance between the values that underpinned data sharing and the values that drove benefit. This is unethical, inequitable, but also creates an environment

in which [variants can more readily emerge](#), potentially wasting the global effort to date. A threat such as this pandemic can only be solved as a global response.

Data sharing and global health in a pandemic must be seen as a common that should be regulated and protected. Only a legally enforceable framework can ensure that solidarity is matched with reciprocity that is in the global public interest.

So where to begin?

There is a plethora of [regulations](#), [legislative frameworks](#), consortium policies, and other [data governance frameworks](#) already in existence that identify key principles to govern data sharing. However, they were not developed for when there is need for immediate and collective *global* benefit. Furthermore, these rules and policies have largely been driven by high income countries (HICs) that serve a neoliberal agenda where access to healthcare is generally provided. This approach to data sharing fails to consider the [reluctance of many researchers](#) to unrestricted data sharing that has been criticized as displaying a [neo-colonial mentality](#). There is a double standard in the [commodification of data](#): there is the expectation that data will be freely given, but that researchers from HICs who have the technology (technology that is often non-existent in resource limited settings) to process the data are the ones to receive property rights on the resulting outputs. A first step in developing legally enforceable rules is the decolonization of the conversation on data sharing, that is not based on unrestricted open access to data whereby data producers relinquish all rights to the data. The interests that data sharing currently serves must be recognized and the barriers to equitable data sharing unpacked. It is only then that rules and principles that embed solidarity and the public interest into data sharing practices during a pandemic can emerge.

The next step is identifying the *process* for developing these rules.

The World Health Organisation (WHO) is the international agency with the responsibility for public health. It already convenes Member States each year at the World Health Assembly to decide, amongst other, key policies. It has developed a [Global Strategy on Digital Health](#), recently established the [WHO Science Council](#) and has proved itself capable of issuing recommendations on challenging and controversial topics such as [human genome editing](#). The WHO therefore already has the systems in place to facilitate the discussion on data sharing rules and could be the appropriate forum in which to develop a framework.

Data sharing rules without accountability mechanisms are pointless, so a third key step in this process is the identification of a body responsible for enforcement of these rules.

Although the WHO may be the moral voice of reason, it may not be the appropriate body. Throughout COVID-19 the WHO's calls for equity and global solidarity in the distribution of vaccines were ignored. We agree with the [Independent Panel](#) that the governance of the WHO must be strengthened, but the process will take time and the necessary political will may be lacking. Individual states, however, have the legal power to ensure compliance, but they have proven themselves in COVID-19 to lack the moral conscience to think beyond national interests.

Therefore, there is a need to consider an appropriate body that emerges from this conversation on an agreed set of rules on international data sharing. It will need to be a partnership that is free from pre-existing rules on data sharing for global health, has equal geographical participation that involves individual countries, but also scientific organisations and funders of science. The Access to Covid-19 Accelerator (ACT-A) is a model that could be adopted. It is premised on

equitable access to COVID-19 tests, treatments and vaccines, and [its data governance framework](#) requires the [equitable access to data](#). What it currently lacks is the power to hold those involved with data sharing

to account. Any new partnership must have this power to ensure that the solidarity pathway is followed from data collection to data sharing, and ultimately access to benefits from data sharing.

## 12. The Pandemic Treaty as a Framework for Global Solidarity: Extraterritorial Human Rights Obligations in Global Health Governance

Benjamin Mason Meier, Judith Bueno de Mesquita, and Sharifah Sekalala

*October 13, 2021*

Rising nationalism has presented obstacles to global solidarity in the COVID-19 pandemic response, undermining the realization of the right to health throughout the world.

These nationalist challenges raise an imperative to understand the evolving role of human rights in global health governance as a foundation to advance extraterritorial human rights obligations under global health law.

This contribution examines these extraterritorial obligations of assistance and cooperation, proposing human rights obligations to support global solidarity through the prospective pandemic treaty.

### Limitations of Global Solidarity in the COVID-19 Response

Global governance is central to the advancement of human rights in global health.

Although the World Health Organization (WHO) long neglected human rights in global health governance, WHO has increasingly assumed obligations to implement human rights under a United Nations (UN) mandate to mainstream [human rights throughout global governance](#), including in the global response to infectious disease.

WHO secured the incorporation of human rights in the 2005 revision of the [International Health Regulations](#) (IHR), with States

recognizing that “implementation of these Regulations shall be with full respect for the dignity, human rights and fundamental freedoms of persons.” These efforts provided a legal foundation to [align global health law with human rights law](#), harmonizing treaty interpretation across legal regimes.

Drawing from these human rights foundations of infectious disease governance, the UN immediately saw [COVID-19 as a human rights crisis](#). A range of UN institutions released [human rights guidance on COVID-19](#), providing necessary frameworks for pandemic responses across States and international organizations. This human rights guidance embraced not only domestic obligations, but also [extraterritorial obligations](#), framing international cooperation in the COVID-19 response, coordination in sharing health resources, and collaboration to reduce economic and social impacts.

However, these extraterritorial human rights obligations have not been implemented in global health governance, with WHO instead pleading for “global solidarity” as a moral responsibility, charitable imperative, and means to collective self-interest. While facing nationalist opposition to WHO guidance and global inequalities in vaccine distribution, WHO has repeatedly implored that “[health is a human right](#),” but has stopped short of invoking extraterritorial obligations of international assistance and cooperation.

Through the implementation of human rights, WHO has an opportunity to advance extraterritorial obligations under the right to health as an international legal basis for global solidarity.

### **Evolving Extraterritorial Obligations Under Human Rights Law**

Extraterritorial human rights obligations speak to State acts or omissions that affect [human rights beyond their territory](#), providing a human rights framework to structure international assistance and cooperation. Positing legal obligations beyond national borders — conceptualizing international assistance not as a voluntary, charitable gesture, but rather as a binding form of reparative and distributive justice to rectify past and ongoing structural harms — States have [codified extraterritorial obligations under international human rights law](#).

These extraterritorial obligations complement States' domestic obligations, recognizing that the enjoyment of human rights in a globalizing world is often determined by actors beyond the territory of a State, including other States, international organizations, and multinational corporations.

As a framework for global governance, extraterritorial obligations include obligations of a global character – to take action jointly through international organizations. The 1948 [Universal Declaration of Human Rights](#) first acknowledged a human rights imperative for international cooperation, declaring that “everyone is entitled to a social and international order in which the rights and freedoms set forth in this Declaration can be fully realized.” States codified this obligation under the 1966 [International Covenant on Economic, Social, and Cultural Rights](#), requiring every State “to take steps individually and through international assistance and cooperation, especially economic and technical, to the maximum of its available resources...”

Through this grounding in international law, extraterritorial obligations provide a binding framework for [global health governance to progressively realize the right to health](#).

Yet, while these health-related extraterritorial obligations have evolved under human rights law, they have found limited application under global health law. States have developed only broad declaratory language on [international assistance and cooperation](#) in the World Health Assembly. Leaving States without clear guidance, the IHR obligate States to “[undertake to collaborate with each other](#),” but the [relationship between these IHR obligations and human rights obligations remains unclear](#).

As a result, the meaning of collaboration has been left to State interpretation. Without oversight procedures to review State compliance with global health law, WHO has limited authority to clarify these obligations and hold States to account.

### **Codifying Extraterritorial Human Rights Obligations in Global Health Governance through a Pandemic Treaty**

The codification of extraterritorial obligations through a pandemic treaty would provide a pathway to strengthen international cooperation to realize the right to health in global health governance.

Even as high-income States in the Global North have [challenged the framing of international cooperation as a legal obligation](#), States in the Global South have emphasized the centrality of such obligations to the universal realization of human rights. These extraterritorial obligations would allow States in the Global South to enter global health negotiations not merely with a plea for charity, but with a [right to assistance and cooperation through global health governance](#).

Mainstreaming extraterritorial obligations in the pandemic treaty would provide

international commitments under global health law and facilitate, through proposed [institutional oversight mechanisms](#), accountability for global solidarity.

The right to health can provide the normative basis for negotiations on the pandemic treaty. Clarifying extraterritorial obligations under the right to health, the [UN Committee on Economic, Social and Cultural Rights](#) (CESCR) reiterated in 2000 that “it is particularly incumbent on States parties and other actors in a position to assist, to provide ‘international assistance and cooperation, especially economic and technical’” to support States in realizing the right to health. In the context of the COVID-19 pandemic, the CESCR and [UN Special Rapporteur on the right to health](#) have repeatedly recognized that global governance is necessary to realize the right to health, clarifying extraterritorial obligations to cooperate with WHO.

These obligations require that States implement the right to health through their engagement with WHO, implementing extraterritorial obligations through global health governance.

The pandemic treaty provides a path to advance human rights in global health law by strengthening extraterritorial obligations. A new pandemic treaty can recognize extraterritorial obligations under the right to health by:

- prioritizing support for low-income States in the Global South;
- cooperating through WHO in coordinating pandemic responses;
- regulating pharmaceutical companies to secure equitable vaccine access; and
- facilitating accountability through complementary monitoring and review mechanisms under WHO and the UN human rights system.

In overcoming nationalist challenges to global health governance, the pandemic treaty can structure global solidarity through extraterritorial obligations, aligning global health law and human rights law in meeting the challenges ahead.

### 13. Addressing IP Barriers in the Context of a Pandemic Treaty

Paul Ogendi

*October 14, 2021*

Tackling the question of how to address the needs for sharing scientific research, pooling technology, and know-how in diagnostics, therapeutics, and potential vaccines in future epidemics is fundamental to any pandemic treaty discussion. Moreover, we also need to consider how such a treaty might address potential conflicts with the Trade Related Intellectual Property Rights (TRIPS) agreement.

First of all, market-based solutions do not work in the context of global pandemics as has been demonstrated in the COVID-19 pandemic that

is currently ravaging the world. Market-based solutions demand putting too much ‘faith’ in the private sector, both in terms of capacity (supply chains, etc) and in terms of equity. By relying on the private sector in the context of COVID-19, many countries are struggling to secure adequate personal protective equipment, testing kits, and more importantly life-saving vaccines.

Despite the World Health Organization (WHO) granting emergency use listing of various vaccines, almost all of the vaccination has

happened mainly in developed nations. Developing countries continue to be marginalized and even the much acclaimed COVAX facility, which originally targeted vaccinations for at least 20% of the population of low and low-middle income countries by the end of 2021 has run into major challenges (WHO, 8 April 2021). Initially relying on supplies from India, the COVAX programme has failed to meet its targets as a result of the Delta variant overrunning India's 'broken' health care system (Vox, 19 August 2021). Curiously, the Serum Institute of India had prior contractual obligations to ship "1 billion doses for low and middle-income countries" but failed to achieve high vaccination in India (Quartz, 26 April 2021). The result is that, as of August 6 in Africa, 'less than 2% of the continent's population is fully vaccinated' (BBC, 6 August 2021).

As a result of these failures in global institutions, other strategies had to be quickly put in place. For example, the African Union (AU)/African Vaccine Acquisition Trust (AVAT), COVAX, and United States Government collaboration which targets to vaccinate at least 60% of the African population (GAVI, 16 July 2021). Even this proposal may run into serious problems if the virus continues to mutate as it has done in the past.

Due to the failures described above, a radical paradigm shift is needed from a market-based paradigm to one that encourages more scientific collaboration transcending national, regional and global levels. All available knowledge and technologies should be made accessible so that all countries can learn from each other on how best to fight the pandemic. The current paradigm is not only inequitable but inefficient and therefore irrational since it prevents such an approach.

The new paradigm necessitates that the norms underpinning the market-based system should be suspended in the short term to last from the time a pandemic is declared up to the time some sort of normalcy is restored. The IP

system is the main target here and specifically the removal of TRIPS Agreement barriers. This is the reasoning underpinning the request by India and South Africa in October 2021 for a temporary waiver of certain provisions of the TRIPs Agreement for three (3) years at the TRIPs Council (WTO, 25 May 2021). The counter-argument by the EU –the principal bloc opposing any waiver at all–calls for limiting export restrictions, supporting the expansion of vaccine production, and facilitating the use of current compulsory licensing provisions in the TRIPS Agreement.' But in the midst of a global pandemic, this tinkering with the current market-based paradigm is unlikely to address any of the inefficiency failures above (WTO, 20 July 2021).

Using the 14 November 2001 Doha Declaration on Public Health and TRIPS Agreement, countries at WTO have already accepted that the TRIPS Agreement "does not and should not prevent members from taking measures to protect public health" (WTO, 20 November 2001). The same sort of language should be given a force of law through an international pandemic treaty so that any future conflict involving the TRIPS Agreement is avoided.

The next problem to be addressed in a pandemic treaty is the prevention of economic and political sanctions that may be imposed by some countries in retaliation in order to protect their IP. A good example is the US Special 301 list, which according to *Medecins Sans Frontieres (MSF)* "violates the integrity and legitimacy of the system of legal rights and flexibilities created by the TRIPS Agreement" (MSF, 30 April 2019).

Thus, the international instrument should envisage specific provisions that legally authorize countries to suspend IP rights in the context of global pandemics. An incentive system should therefore be encouraged through the creation of a Pandemic Fund. Countries or individuals that have contributed

significantly to generation of knowledge and technologies should be fairly compensated from this fund by way of an application (KEI Europe, 24 February 2021). However, the release of the knowledge publicly should not be dependent on compensation.

Such a clear pandemic treaty provision may assist countries to resolve the current conundrum whether or not a solution is found at the WTO. In any event, the WTO should not have so much power to determine the fate of populations in the midst of global health pandemics. The WTO is a forum to support a regime of free trade and it is absurd to expect it to work towards protecting global health. The appropriate forum to guide decision-making on IP rights in a pandemic would be the WHO. There is a limit to what trade regulation can achieve in safeguarding public health.

In conclusion, my proposed provisions for any future treaty have three limbs. The first limb

should reaffirm the rights of every country to take action in the context of global pandemics to protect their public health systems and save lives akin to what the Doha Declaration advocates for. It would therefore be prudent to entrench the Doha Declaration in the pandemic treaty to give it a force of law. The second limb should aim at preventing economic and political sanctions especially from developed countries, which have been the net exporters of technological know-how, by creating a Pandemic Fund. This is necessary because political and economic sanctions have a deterrent effect. The third limb should have a strong emphasis on technology cooperation/transfer/pooling/sharing so that available knowledge about a particular pandemic is freely accessible to all and cooperation is fostered. This will necessitate the creation of a Pandemic Knowledge Pool and Scientific Fora across the world.

## 14. The Pandemic Treaty and Intellectual Property Sharing:

### Making Vaccine Knowledge a Public Good

Ellen 't Hoen

*October 15, 2021*

The COVID-19 pandemic has laid bare the lack of regulation for the sharing of intellectual property (IP) and technology needed for an effective and equitable response to the crisis.

The Pandemic Treaty (or other legal instrument) scheduled for discussion at the World Health Assembly in the fall of 2021 should focus on establishing the norm that the IP and knowledge needed to develop and produce essential pandemic health technologies become global public goods. It should also ensure predictable and sufficient financing for the development of such public goods.

During the COVID-19 pandemic, the world of science delivered knowledge needed to produce safe and effective vaccines within an unprecedented short time frame, thanks to substantial funding from the U.S., U.K., and German governments in particular.

While scientists globally engaged in collaboration and contributed transparently to the knowledge needed to produce COVID-19 vaccines, there was no mechanism in place to ensure that the resulting manufacturing technologies would be globally accessible.

Once that knowledge was transferred to the private sector, these private pharmaceutical



companies became the holders of the knowledge, related intellectual property, and regulatory dossiers that are needed to bring the products to market. This happened even though COVID-19 vaccine development benefitted from vast amounts of public financing. This financing was not conditioned on the sharing of intellectual property and know-how.

The companies that now hold that manufacturing knowledge refuse to share it outside their trusted circle of contract manufacturers. Together with the [hoarding of vaccines by high-income countries](#), this has led to grave global inequities in access to COVID-19 vaccines. For example, only enough vaccine has been distributed in Africa to give 2% of the population [a single dose](#), as compared to 70% of adults in Europe being [fully vaccinated with both doses](#). Dr. Tedros, head of the World Health Organization (WHO), has [called](#) the inequity in access to COVID-19 vaccines, where wealthy nations reach high levels of vaccinations and poor countries close to none, “vaccine apartheid” and has warned that this inequity is [undermining the global recovery](#).

In the early days of the pandemic, the European Union that funded vaccine research committed to ensuring those vaccines would be global public goods. The President of the European Commission (EC), Ursula von der Leyen, [publicly stated](#) on 24 April 2020 at a joint press briefing with the WHO to announce a global fundraising initiative, that COVID-19 vaccines would be “our universal, common good.” Further, the promotion of COVID-19 vaccines as a global public good was determined a “negotiating directive” and was included in [the agreement between the Commission and the EU Member States](#) that established the Commission’s mandate to enter into advanced purchase agreements (APAs) with pharmaceutical companies for COVID-19 vaccines on behalf of the member states.

However, the commitment to develop and promote COVID-19 vaccines as global public goods remained aspirational. [The final APAs with the companies appear not contain any provisions that would have encouraged the sharing of IP or manufacturing know-how, nor provisions to promote](#) access for low- and middle-income countries to these vaccines in sufficient quantity and at low prices.

Fairly early on in the pandemic, a number of initiatives were taken aimed at voluntary sharing of intellectual property, including know-how and transfer of technology. In May 2020, [the WHO established the COVID-19 Technology Access Pool \(C-TAP\)](#). C-TAP was set up to offer a platform for developers of COVID-19 therapeutics, diagnostics, vaccines, and other health products to share their IP, knowledge, and data with quality-assured manufacturers through public health-driven voluntary, non-exclusive, and transparent licenses. In June 2021 the [WHO announced plans for mRNA technology transfer hubs in Africa](#) modelled after the [influenza vaccines technology transfer hubs](#) the WHO had launched in 2007. The Medicines Patent Pool expanded its mandate to be able to work on COVID-19 and is working with C-TAP and the mRNA hubs. Multinational pharmaceutical companies have declined collaboration with C-TAP and with the WHO mRNA hubs on COVID-19 vaccines. Recently the German drug developer [BioNTech has announced collaboration with WHO](#) on supporting mRNA vaccine manufacturing capacity in Rwanda and Senegal, but these efforts [do not include COVID-19 vaccine technology](#).

So far, none of these initiatives have resulted in licensing of intellectual property and technology transfer agreements that would enable expanded vaccine production.

Separate from the voluntary IP and know-how sharing initiatives, on 2nd October 2020, South Africa and India proposed [a waiver of certain obligations under the TRIPS Agreement for the duration of the pandemic](#) at the World Trade

Organization (WTO). The proposal for the COVID pandemic TRIPS waiver was [co-sponsored by over 60 delegations](#). The initiative would focus on [encouraging technology transfer and building of manufacturing capacity](#) globally by allowing any company with existing or potential manufacturing know-how to produce COVID-19 related technologies without concerns about possible IP infringement and related legal consequences. According to a not-yet-published status report by the Chair of the TRIPS Council of 20 July 2021 (JOB/IP/47/Rev.1), despite various formal and informal meetings of the WTO TRIPS Council on the subject, no progress on the TRIPS waiver proposal could be reported.

The COVID-19 pandemic demonstrates that it is difficult to regulate the open [sharing of IP/know-how and technology](#) while a global health emergency is unfolding. It would therefore be desirable to have a global legal framework in place that provides for the sharing of such technology and manufacturing know-how, which is triggered by the occurrence of a pandemic. The World Health Assembly special session this November presents an opportunity to start the process to create such a legal framework.

This framework should oblige States Parties to:

- Incentivize the voluntary sharing of IP / know-how (e.g., via buy-outs);

- Compel the mandatory sharing of IP / know-how (e.g., via funding conditionalities);
- Support (including financing) global pandemic IP / know-how sharing, including regulatory data and technology transfer platforms analogous to C-TAP and the MPP;
- Support, including financing, the development and scale-up of production capacity to ensure sufficiency in all regions of the world;
- Support the adequate supply of necessary inputs (e.g., raw materials) for that production;
- Ensure an optimal distribution of pandemic health technologies for public health needs in all regions of the world; and

Support, including financing, the development of new pandemic health technologies, under the condition that the IP/know-how developed with public funding is shared openly.

The practical implementation of this framework will likely require the involvement of a range of actors and agencies beyond the WHO, including the WTO and international financing mechanisms. Nevertheless, a multilateral recognition of the need to ensure the sharing of pandemic health technologies and the IP associated with it could prevent a situation in which the inequitable access to lifesaving technologies is a serious impediment to addressing pandemics.

## 15. A Shared Responsibility Model

Sharon Bassan

*October 19, 2021*

Piecemeal and fragmented policymaking during Covid-19 underscored the need for an [equity-focused global health agenda](#). Several international health law mechanisms, such as [The International Health Regulations](#) (IHR) and

[“soft law” frameworks](#), try to bring together relevant stakeholders to the table, help ensure international sharing of medical information, and facilitate equitable distribution of the benefits of research in developing vaccines

and therapeutics. Nevertheless, their application during COVID-19 did not result in an effective global governance. Most responses were [nationally-focused](#), lacked global commitment and solidarity, failed to notify the WHO of novel outbreaks, and were non-compliant with its professional recommendations.

Many agree that the solution should be multileveled and structural—a result of the connection and cooperation between participants. The prism of the “[shared responsibility model](#)” provides an interesting opportunity to consider potential [global health governance models](#) for emergency actions. My refined version of the model is based on [Iris Young](#) and [Christian Barry](#)’s suggested models, and includes two pairs of parameters, engaging and assigning. Engaging parameters locate the involved actors, and explain why they are assigned responsibilities. Assigning parameters address the type of duties each actor bears, and the site where they are expected to take action.

“Engaging parameters”, *accountability* and *benefit*, redirect attention from those who experience injustice to those who contribute to or enjoy from the status quo. The *accountability* parameter looks who is accountable for an area where correction and prevention of ongoing structural injustice is required, rather than looking for actors who have contributed to bringing unjust situations about within their actions with the purpose to blame for mal-intent. Such actors could, for example, be those who advance the public’s health in national and international contexts, rather than who has contributed to the breakout of COVID-19. The *benefit* parameter is based on the unjust gain, or relative privilege, contributors may get from the situation. Privileged actors have more power in the structure and are usually those who will have the capacity to change the structure in their favor. It is debatable if anyone gains from a pandemic, but some actors are more privileged than others, have better access to

vaccines, medical equipment or relevant information, thus should play the substantial role.

The engaging parameters enable allocating responsibilities between different kinds of actors, with asymmetric powers, beyond governments. While the engagement of the [UN](#), [WHO](#), or governments is obvious, the accountability parameter may also engage other stakeholders to sit at the table. For example, domestically, [representatives from the education systems](#) responsible for student’s health, employers’ representative responsible for worker’s health, or individuals whose [accountabilities](#) (to social distance, wear a mask, or get vaccinated) are required overcome the pandemic.

Globally, the benefit parameter should include privileged as well as less privileged countries to include a diverse perspective to needs and the feasibility of solutions in different contexts. The model could be adopted in different contexts, emergency or others, for different goals. Since it is forward-looking, it could focus on healing and minimizing general global health inequalities, beyond the pandemic, or on exacerbated inequalities due to the pandemic. However realistically, emergency goals provide more incentives to collaborate. Issues that are not unique to the pandemic may be addressed in a separate process. Inability of governments to address the pandemic in their border will not only result in greater health impact to their citizens, but will also inevitably affect other countries, capable or not. Since the pandemic does not recognize national borders, the commitment of governments should extend beyond national interests. [Affluent countries may be assigned duties](#) towards less capable countries, for example to help them negotiate with pharmaceuticals to get vaccines before providing a third boost for their own citizens. Similarly, during pandemic, pharmaceuticals companies who may benefit if their product is used all over the world should be engaged due to their benefit from their product, for which

they are accountable and show how they can reduce the spread of COVID-19. In a non-emergency situation they may have a different goal-specific duty, such as to contribute their share to a more extensive international assistance framework, especially where joint action is necessary. NGOs or human rights organizations could represent individuals' interests and strive to increase access to medical resources and minimize health inequalities in specific regions in accordance with specific needs.

"Assigning parameters," *connectedness* and *capacity*, address the content and the scope of the expected action, according to positions and authorities actors have within the specific context. The *connectedness* parameter looks into inter-relations between actors and the commitment they imply towards fellow actors. Connectedness does not mean how each actor is connected to the injustice (the connection to injustice is a preliminary engagement criterion rather than a parameter for assigning responsibilities). Rather, since each actor is differently positioned, not all stakeholders are connected to the goal of alleviating the burden of COVID-19, or reacting to public health crises in the same way. Responsibilities are different in nature and scope, according to the roles, the different values their positions entail, and specific interaction they may have with others. This implies different areas where action should be taken, even by the same actor. For example, based on their relationship, governments may have certain duties to their citizens, for example to allocate and provide vaccines. Governments may have different

sort, albeit parallel, of duties to fellow governments with reduced capacities, for example humanitarian or political commitments. The *capacity* parameter requires all participants to take independent responsibility within their authority in accordance with each actor's level of powers and influence. This effective and practical parameter transfers many responsibilities to stronger, more capable actors who are better institutionally and materially situated in practices they are involved in. The duties assigned through the model are within the authorities those actors normally have, which may hold the potential to improve compliance, despite lack of governance which raises enforcement concerns regarding unmet duties.

Different goals will most likely engage different scope of actors and the bearers of duties may change according to specific contexts, for example, national and international. In a domestic policy-making, the grand majority of the responsibility lies with the state and its institutions. For example, national [healthcare providers](#) and [public health professionals](#) should be heard at the policy-making level in order to clarify the [feasibility of different interventions](#). In the international sphere, some of the same responsibilities might be shared with international organizations (e.g. WHO) or with other global actors. The international role of states will obviously be different from their role within their sovereignty.

## 16. Strengthening Global and National Governance for Gender Equality in Health Emergencies

Anna Coates

October 20, 2021

An international instrument on pandemic preparedness and response opens a much-

needed space to highlight the centrality of gender inequality considerations in health emergency responses.

With an eye to inclusive governance, investment in gender expertise, and strengthening existing normative mechanisms and architecture for gender equality at global and national levels, a new intergovernmental instrument offers an opportunity for future health emergency preparedness and responses to meaningfully contribute to gender equality.

The COVID-19 pandemic has laid bare the urgency of addressing gender inequalities, including violence against women and girls; access to health care, including sexual and reproductive health care; and economic inequality.

The recent resolution on “[Strengthening WHO preparedness for and response to health emergencies](#)” covers the range of public health issues involved in pandemic responses and includes general references to “gender responsive” interventions. However, the lack of specificity does not represent the full dimensions of pandemic impacts on gender equality, and therefore may limit meaningful action.

Threats to the provision of, and access to, sexual and reproductive health services (including contraception and safe abortion), and thus to women’s sexual and reproductive rights, due to overstretched health services, are indicated in the resolution. The “[shadow pandemic](#)” of increased violence against women and girls is referenced.

However, other key gender equality issues remain invisible, such as the increased unpaid care burden on women in the context of school shutdowns and work from home, and how the economic fallout is damaging precious gains in women’s economic empowerment. Women already faced a gender pay gap, and were over-represented in informal employment, leaving them potentially uncovered within emergency social protection schemes. The gendered digital divide further limits women’s ability to take advantage of

innovative economic opportunities generated by containment measures (See: UN Women’s related [policy brief](#)).

Women are not explicitly mentioned in the well-deserved recognition of frontline health care workers, despite being the majority (for example, according to the Pan American Health Organization ([PAHO](#)), women represented 72% of the over 6,000 health workers in the Americas who had died from COVID-19 by January 2021).

Predecessor frameworks have been stronger in their consideration of gender implications. The [UN Framework for the Immediate Socio-economic Response to COVID-19](#) stresses the necessity of a “strong gender equality imperative” across all axes.

However, even so, normative frameworks such as the [Beijing Declaration and Platform for Action](#) (BPfA) can be sidelined in the context of emergency responses, despite their relevance. Within the twelve BPfA critical areas, three priorities merit especial note as the backbone of all efforts towards gender equality in the COVID response and hence should be explicitly included within any future related instrument: disaggregated data; institutional mechanisms; and women in power and decision making.

Disaggregated data to assess the extent of the gendered dimensions of the COVID-19 pandemic are limited. The [WHO](#) has elsewhere called on Member States to urgently “collect, report and analyze data on confirmed COVID-19 cases and deaths disaggregated by sex and age, at a minimum.” However, existing knowledge already opens windows to significant concerns. As the resolution notes, the consequences of COVID-19, “including increasing gender and other inequalities, have further outlined the need for multilateral cooperation.” This requires strong coordination of gender expertise from multiple domains. The [UN System’s “Minimum Requirements Checklist for Integrating Gender Equality in the Implementation of the UN](#)

[Framework for the Socioeconomic Response to Covid-19](#)” outlines practical considerations for gender-sensitive COVID-19 responses and was made possible by strategically pooling existing gender expertise across the UN system. To ensure its full implementation, global governance for pandemic responses should explicitly strengthen existing UN architecture for gender equality, investing in capacity, expertise, and senior leadership across all entities, including within the WHO as part of its leadership role in “global coordination and cooperation.”

Similarly, any instrument on pandemic preparedness and response needs to fully engage with existing normative mechanisms for gender equality. At global level, the Commission on the Status of Women (CSW) facilitates a unified voice to state and amplify shared priorities and commitments amongst national machineries for the advancement of women / gender equality. National gender equality mechanisms require strengthening for adequate representation and coordination of gender concerns in national pandemic response governance. As [noted elsewhere](#) more generally, attention to Committee on the Elimination of Discrimination against Women (CEDAW) country recommendations would help identify strategic priorities to be addressed in specific settings in the context of health emergencies.

The needs and interests of women and girls — half the population affected by pandemics — need their own voices in the task forces, working groups, and political and scientific committees that form the backbone of response governance at global and national levels. Equal participation, leadership, experiences, perspectives, and world views of women in all their diversity should be made explicit in any instrument for inclusive and effective COVID-19 responses that reflect the uneven consequences of gender inequalities among women according to ethnicity, migratory status, (dis)ability, sexuality, and gender identity, and other social axes. The WHO [resolution](#) outlines civil society’s role in supporting implementation of “multisectoral national action plans.” Also being explicit about their accountability role and the representation of diverse women’s voices would pivot this role to one geared towards motivating transformative action.

COVID-19 responses risk exacerbating gender inequalities. But this juncture also presents an opportunity to advance the rights of women, girls, and those of diverse gender identities. An international instrument on pandemic preparedness and response should seize this foothold and advance gender equality through inclusive global and national governance.

## 17. The Right to Participation in Global Health Governance

### Lessons Learned

Sara (Meg) Davis and Mike Podmore

*October 21, 2021*

What should the role of those most affected by pandemics be in future pandemic governance and co-ordination mechanisms?

Drawing on human rights standards and principles, and on existing structures in the HIV,

TB and malaria sectors, we argue that the human right to participation should extend to permanent seats and votes for civil society and

affected communities on governance boards.<sup>1</sup> Our argument is informed by an [analysis by STOPAIDS, Aidsfonds, CSSN and Frontline AIDS](#), by consultations led by STOPAIDS, and by the examples of the Global Fund to Fight AIDS, TB and Malaria (“the Global Fund”), Unitaid, and the Access to Covid Technologies-Accelerator (ACT-A).

The right to participation is now widely accepted in development cooperation. Under international human rights law, this right is grounded in the rights to information, freedom of expression, peaceful assembly and association, and freedom of political and other opinion established in the [International Covenant on Civil and Political Rights](#). The right to participation is articulated in other human rights treaties that are binding on states, including the [Convention on the Elimination of Discrimination Against Women](#), [Convention on the Rights of Persons with Disabilities](#), and the [International Convention on the Rights of All Migrant Workers and Members of their Families](#).

The content of this right has been elaborated by [human rights treaty bodies and special procedures](#), as well as in other statements of soft law: the [Declaration on the Right to Development](#), the [Declaration on the Rights of Indigenous Peoples](#), and the [Guideline for States on the Effective Implementation of the Right to Participate in Public Affairs](#). UN member states further [committed to upholding participation rights](#) through the Sustainable Development Cooperation Framework. Global community networks successfully pushed UNAIDS to institutionalize the [Greater Involvement of People Living with HIV/AIDS \(GIPA\) principle](#). Member states endorsed the GIPA principle again in the 2021 [UN Political Declaration on HIV and AIDS](#).

In practice, interpretations of the right to participation vary. Certainly, it includes a right

to be consulted throughout decision-making processes. Consultation is widely recognized in development cooperation, with good examples in health. For example, the [Global Commission on HIV and the Law](#) held regional dialogues with lawmakers, policymakers and communities to interrogate the relationship between law, human rights and HIV. This resulted in new analyses, tools, and national reforms, work that continues today.

Considering the unprecedented suffering caused by COVID-19, any future pandemic lawmaking should be informed by public consultations that prioritize hearing the experiences of people most affected by the crisis, and that facilitate their identifying the redress and reforms they want. Such a process will be critical to rebuilding trust in public institutions.

However, consultation, whether to inform the drafting of a legal instrument, or in the establishment and governance of any mechanism that instrument may establish, is likely to have a minimal effect unless it is backed up with permanent governance seats and votes for these communities.

The failures of the ACT-A are a case in point. The ACT-A’s poorly-designed structure favors the priorities of the Global North, [lacks meaningful representation from the Global South](#), and marginalizes civil society and communities affected by Covid-19. In our experience, it took a fight to get civil society and communities representation into all the pillars of the ACT-A. Once included, they joined ACT-A working groups, but had little opportunity to input meaningfully, with real decision-making happening behind closed doors among powerful agencies. In a context of global vaccine inequity, civil society inclusion in the ACT-A has given legitimacy to

---

<sup>1</sup> We use both “communities”, to describe those most affected by a disease, and “civil society”, which may include organizations led by those not directly affected.

decisions, even though their input has either not been sought or been ignored.

The Global Fund has also struggled to fulfill the right to participation. Many implementing states that receive Global Fund financing still fail to include key populations (sex workers, LGBTIQ+ people, people who use drugs) in national governance and programming. One [2016 community-led survey](#) of African key populations shared allegations of tokenistic consultation, and of threats of retaliation by powerful national actors.

However, there is a strong organizational commitment to meaningful participation at both Unitaid and the Global Fund Secretariats; permanent seats and votes were established early on for community and civil society on their governance boards. Similarly, UNAIDS was the first UN programme with formal civil society representation on its governing body. While many challenges still remain, these structures have made community input more difficult to ignore.

This is in part through design. Representatives on these boards benefit from a steady flow of input from national and global networks of key populations, transnational networks of women's groups, trade unions, faith-based organizations, and many others in every region. The structure of voting on the Global Fund board, and the requirement to include civil society and community on powerful standing committees, creates multiple openings for internal debate that leverage underlying input. Important attention has also been paid to governance culture, explicitly recognizing power imbalances and building relationships of trust among diverse board members.

Each civil society and community delegation tries to ensure gender balance, have representation from all geographic regions, as well as to ensure technical expertise on each of the three diseases and cross-cutting topics such as intellectual property, medicine, health systems, epidemiology, programming, etc.

Delegations that fail to be inclusive face criticism by their constituencies, or by peers on the board.

This representation and consultation structure (supported by funding from the Secretariats) enables civil society and community delegations on the board to escalate concerns from national and community levels and to push the board and Secretariat for solutions, a "[boomerang effect](#)" in which advocates who are blocked locally can directly access global mechanisms. As a result of the work of these delegations in partnership with their constituencies: millions more in funding has gone to address human rights and gender inequality, human rights and gender equality has been institutionalized in the Fund's strategy and technical guidance, and key populations representation is now an eligibility requirement for the over 100 national CCMs that manage millions in HIV, TB and malaria financing.

We argue that the right to participation as institutionalized in the HIV, TB and malaria responses should not be limited to these sectors but apply equally to all. The development of any future treaty, and design and operation of any resulting new global health mechanism, should include such formalized roles.

It is critical that these representatives are selected through a legitimate, open and transparent process that is led by civil society themselves, as is normally done for the Global Fund and Unitaid, and as was also done in the case of the ACT-A Civil Society and Representatives Platform. Once the mechanism is established, financial support from the host institution should enable civil society and community delegations to convene and consult with those they represent; fulfilling the right to participation should not leave rights-holders with a financial deficit.

The increasing reduction in civic space, including sweeping attacks on civil society,



coupled with the criminalization of and widespread discrimination against particular groups in many countries, means that many consultation processes fail to capture all voices, and that rich local experience fails to shape global health decision-making. It is more

important than ever to ensure that the most marginalised have a voice and a vote in their own future.

## 18. The Import of the UNCRPD and Disability Justice for Pandemic Preparedness and Response

Joel Michael Reynolds and Rosemarie Garland-Thomson

October 25, 2021

During the COVID-19 crisis, many nation-states [did not consult](#) or [substantively take into consideration](#) treaties protecting the rights of people with disabilities when developing their pandemic responses.

For example, the United Nations' 2008 [Convention on the Rights of Persons with Disabilities](#) (UNCRPD) is an international [human rights treaty](#) intended to protect the rights and dignity of all [persons with disabilities](#). It articulates principles of non-discrimination (see especially [Articles](#) 2, 3, and 5) and broader obligations upon specific parties, such as states parties, which are obligated to protect the rights and freedoms of people with disabilities (see [Article](#) 4, et al.).

The failures to uphold these principles and obligations during the COVID-19 pandemic were met with a swift response. The Office of the United Nations High Commissioner for Human Rights (OHCHR) produced [guidelines](#) on COVID-19 and the rights of persons with disabilities in April of 2020, as well as a [policy brief](#) in May of that year.

This commentary outlines three of the more important considerations for international pandemic lawmaking — both for specific instruments and wider deliberation — with respect to people with disabilities in general and the United Nations' 2008 [Convention on](#)

[the Rights of Persons with Disabilities](#) (UNCRPD) in particular.

### Three Core Takeaways from the UNCRPD for Pandemic Preparedness and Response

1. *Triage or other sorts of critical care policies that specify differential treatment on the basis of disability alone are in conflict with the UNCRPD.*

[Article 4.1.E](#) states that states parties should “take all appropriate measures to eliminate discrimination on the basis of disability by any person, organization or private enterprise” (see also [5.2](#) and [11](#)).

Policies *could* be developed that allow differential treatment options depending upon *specific medical information*. For example, if there is one ventilator left and two patients are indicated for ventilator use, specific information about the likelihood of response to intubation could, arguably, be used to determine which patient gets it.

Contrast this particularized approach to one that instead stipulates “those with pre-existing respiratory impairments should be de-prioritized during crisis standards of care.” On our interpretation of the UNCRPD, the latter is unjust and discriminatory while the former is, at least arguably, just.

Further, judgments based upon long-term predictions are not appropriate. This is in line with the [OHCHR's guidance on the subject matter](#), which advises against “triage guidelines for allocation of scarce resources with exclusion criteria based on certain types of impairment, having high support needs for daily living, ‘frailty’, chances of ‘therapeutic success’, as well as assumptions on ‘life-years’ left should they survive.

[Solomon et al.](#) expand on this, arguing that “the ability to predict long-term survival is poor and therefore susceptible to bias. Furthermore, many disadvantaged populations have reduced life expectancy, and triage protocols should not exacerbate health inequities.” Given the evidence suggesting that [quality-of-life metrics are biased](#) and negatively impact [equity of care](#) for disabled people, they agree that “scoring systems using quality-adjusted or disability-adjusted life-years should not be used.” They do suggest, however, that “*near-term survivability...can be assessed independently from disability,*” where “near-term” picks out 12 months or less from discharge.

2. *In the spirit of [Article 4.1.H](#), official information concerning the pandemic must be made as accessible as possible.*

This means including closed captioning as well as sign-language interpreters for all pandemic-related communications; it also means ensuring the availability of high-speed internet to all people as well as accessibly designed web interfaces (usable for those with screen readers, etc.) There are many [resources available](#) to help various bodies increase the accessibility of their communication strategies.

3. *People with disabilities should be included in the development and review of pandemic preparedness and response at all levels and with respect to all relevant institutions.*

[Article 29.B](#) specifies that state parties shall “promote actively an environment in which

persons with disabilities can effectively and fully participate in the conduct of public affairs, without discrimination and on an equal basis with others, and encourage their participation in public affairs.” This includes any potential negotiations of new legal instruments relating to pandemics.

For more detailed analyses and suggestions, including those that take into account broader economic concerns, we recommend the following pieces:

- United Nations, “[Policy Brief: A Disability-Inclusive Response to COVID-19](#)”
- United Nations OHCHR, “[Covid-19 and the Rights of Persons with Disabilities: Guidance](#)”
- Banks et al., “[Disability-Inclusive Responses to COVID-19: Lessons from Research on Social Protection in Low- and Middle-Income Countries](#)”
- Guidry-Grimes et al., “[Disability Rights as a Necessary Framework for Crisis Standards of Care and the Future of Health Care](#)”
- Solomon et al., “[Covid-19 Crisis Triage—Optimizing Health Outcomes and Disability Rights](#)”

### From Civil Rights to Human Rights

It is worth noting that while the United States of America signed the UNCRPD in [July 2009](#) during the presidency of Barack Obama, it has not been ratified by the United States Senate. The [Leadership Conference on Civil and Human Rights](#) notes, “After four years [2016-2020] of an administration that [has attacked disability rights](#) through its policies and appointees...the United States must make its position on disability rights clear. Ratifying CRPD represents an opportunity to take bipartisan action and unite with the rest of the world in advancing the civil and human rights of people with disabilities everywhere...*Disability rights are civil and human rights.* Now, more than a decade after

the United States signed the treaty, it's time to finally make a global commitment to protecting disability rights by ratifying it.”

While civil rights/anti-discrimination laws like the [Americans with Disabilities Act](#) in the U.S. or the [Disability Discrimination Act](#) in the U.K. are certainly steps in the right direction, they are [insufficient](#) to forward disability justice and to enforce human rights that are inviolable

regardless of ability status. National responses are limited. We encourage the development, implementation, and enforcement of international laws designed to uphold disability rights and realize disability justice across borders. Whether during times of crisis or times of calm, defending disability rights is essential to all human rights efforts at local, national, and international levels.

## 19. Towards Member-driven International Pandemic Lawmaking

Ching-Fu Lin and Chuan-Feng Wu

*October 26, 2021*

The COVID-19 pandemic has blatantly exposed the flaws of the World Health Organization (WHO) and its International Health Regulations (IHR) in addressing cross-border communicable diseases. Commentators have examined the IHR's decades of struggle in fulfilling its objectives to control cross-border pandemics such as COVID-19, pointing out problems over the level of obligation, precision of language, delegation of power, settlement of dispute, and lack of enforcement power, among others. What has been overlooked, however, is the crucial question of whether the institutional design of the IHR enables the WHO and its Member States to deliver good global pandemic governance.

We argue that the IHR is ill-designed: its rules and mechanisms are disproportionately tied to the Director General's (DG) exercise of power, rendering insufficient member access to and participation in core decision-making and greater tendency of regulatory capture. For example, the IHR [failed](#) to facilitate the timely declaration of a Public Health Emergency of International Concern (PHEIC) due to the DG's and the Emergency Committee's misinterpretation and misapplication of rules allegedly driven by political considerations. On 23 January 2020, even when COVID-19 cases had already been found outside of China, thereby indicating the risk of cross-border

transmission (IHR Article 12(4)(e)), the second meeting of the Emergency Committee [decided to confine](#) the definition of “international spread” to “having *actual local spread* of COVID-19 in a country beyond China,” instead of “having the *potential* for, or a *risk* of, cross-border transmission,” and refused to declare a PHEIC. The WHO is also criticized for abusing its bureaucratic influences to [further the agendas of individual Member States](#) like China, letting [politics override science](#).

Clearly, an institutional design overhaul is sorely needed for the future of international pandemic lawmaking. To make headway on this goal, we argue that the new treaty should embrace a member-driven rather than a DG-oriented governance model, to be supported by mechanisms that ensure civil society inclusiveness and public reason. A framework convention could be a promising first step in this direction.

The WHO Constitution empowers the WHO to adopt two legal instruments to achieve global health: Article 21 “Regulations” and Article 19 “Conventions” — both are technically “treaties” but demonstrate different strengths and weaknesses. A framework convention can better address pandemic control challenges because its institutional design generally allows for regular review, deliberation on

emerging issues, and progressive/adaptive lawmaking, thereby creating more room for Member State access, deliberation, and decision-making. This is particularly desirable in the rapidly changing and unpredictable context of pandemic control.

Compared to a full-fledged convention, which includes comprehensive and deep commitments and incurs cumbersome negotiations, a framework convention [draws political momentum more easily](#), as it focuses on core principles, priorities, and targets for pandemic control, presenting a model that [puts aside political disagreement](#) over specifics. The framework convention constructs a forum for Member States (usually a Conference of the Parties) to deliberate, because basic principles, rights, and obligations set out in the framework convention need further clarification and elaboration through guidelines or protocols negotiated and adopted by State Parties. This normative structure [ensures](#) a member-driven process with direct engagement, consensus building, and regular exchange of views and information. In the issue area of global pandemic control, it is imperative to enable full stakeholder participation and facilitate a continuing process of treaty evolution that encourages adaptive and innovative solutions in response to dynamic and complex risks patterns and scenarios.

While the WHO is formed by its Member States, it does not automatically entail member-driven governance. Rather, it has been dominated by its bureaucratic bodies and technocratic traditions. While the WHO has previously deferred to [national governments' agendas](#) when formulating pandemic control actions, these practices by no means demonstrate member-driven international pandemic lawmaking because such deference is usually paid to the sovereignty of one individual Member State rather than based on the collective will or consensus. By contrast, a framework convention systematically solicits a wider scope of interests, views, expertise, and

agendas from State Parties (and beyond), especially when they convene to negotiate upon and shape the forms and substances of detail-oriented, readily operational implementation guidelines and protocols.

A member-driven rather than DG-oriented governance model embedded in the framework convention can also alleviate legitimacy and accountability deficits and enhances transparency. For example, the emergency power plays an important role in global pandemic control, and the WHO's technical expertise is usually a source of legitimacy and a basis of (technocratic) authority therein. However, controversies and frictions have remained regarding the question whether technocratic authority should prevail merely in the context of scientific debate, or should stretch more broadly to justify political decisions. In light of the politically salient nature of pandemic emergencies, the [tension](#) between scientific and legal/political values cannot be overemphasized, and technical expertise should not stand as the sole justification for the WHO's decisions. A member-driven international pandemic lawmaking under the framework convention model, such as the Framework Convention on Tobacco Control, supplemented by [proper mechanisms](#) to ensure civil society inclusiveness and public reason, presents a potential balance between technocratic and democratic decision-making and better safeguards transparency, legitimacy, and accountability.

We envisage the future of international pandemic lawmaking to premise not on mere bureaucratic influences of an international organization, but on a shared arena of stakeholder access, deliberation, and decision-making. A member-driven international pandemic lawmaking in general, and a framework convention approach in particular, promise this vision of global pandemic governance.

*The authors would like to thank Prof. Chien-Huei Wu for offering his insights in the process of writing this piece.*

## 20. Why We Need a Transformative Right-to-Health Pandemic Treaty Now

Martín Hevia and Ximena Benavides

*October 27, 2021*

Acknowledging [what went wrong](#) during the COVID-19 pandemic is crucial to any pandemic lawmaking efforts. Chief among these concerns should be the centrality of human rights to global health security.

Health systems that [lack universality and inclusivity](#) will always fall short on disease surveillance, detection, and response during health emergencies, at the risk of not reaching all populations. The risk of exclusion exceeds national borders. Regional and global health governance favor the ‘competition of a few’ over (formal) solidarity, which explains why some of the small number of international collaborative initiatives aiming to reach the poorest countries during the pandemic are [falling short](#).

Nonetheless, human rights remain at the periphery of the global health security conversation and the pandemic treaty debate.

Following the call of dozens of world leaders for [a new treaty or another legally binding instrument to strengthen pandemic preparedness and response](#), the World Health Assembly will [convene a special session in November 2021](#) to consider a new binding agreement that could address key failings in the COVID-19 response, including the insufficient international cooperation to implement the [International Health Regulations’ \(2005\)](#) public health capacities. Such an initiative should also serve as the long-awaited international policy-making window

to address our health systems’ deep structural problems.

How can a pandemic treaty positively transform our health systems? In this contribution, we outline four core strategies.

1. First and foremost, we ought to relocate the right to the highest attainable standard of health to the center of the post-COVID-19 global health architecture.

Even before the current pandemic, a group of civil society organizations, global health leaders, and academics advocated for [a Framework Convention on Global Health \(FCGH\)](#) that can strengthen our health systems *and* address the day-to-day [indignities and inequities](#) that national and global health systems exhibit. In fact, in 2016, Ban Ki-Moon, then UN General Secretary, called for action by “encourag[ing] the international community to consider and recognize the value of a comprehensive framework convention on global health.”

We must advance the right-to-health principles of [equitable access, accountability, and participation](#) through global and national [programs of action](#) with health equity incentives and action-oriented roadmaps that factor in the SDH. The goal is to fortify public trust that can ensure broad compliance with public-health measures, for example, to reduce vaccination hesitancy. This can be achieved, for instance, by including the appropriate mechanisms for the community to

set priorities and participate in decision-making processes for public health policies. In turn, accountability would establish the duty of disclosure of contracts, budgets, and criteria for the allocation of health resources.

2. A pandemic instrument should contribute to health, financial, and human capacity through a national and international funding framework that can ensure sufficient and efficient spending and strategies to overcome implementation shortcomings.

3. Following the example of international, legally binding treaties such as the Paris Agreement, a pandemic instrument should set coordinated, concrete commitments, and impact assessments to help countries improve their health systems and adjust national policies that affect the health of their own populations and beyond borders, particularly of those most vulnerable and marginalized.

4. Lastly, this instrument should promote the right to health in the private sector by establishing standards that ensure that companies do not undermine the right to health nationally or abroad; that is, to enforce the [UN Guiding Principles](#) on Business and Human Rights with respect to the right to health.

Why do we need a treaty or another binding legal instrument to channel such transformations? To be clear, an international legally binding instrument is not indispensable in order for health stakeholders to collaborate and prepare for future pandemics. Nations can cooperate with each other and make key joint decisions as they have in the past to overcome global crises.

However, this has clearly not been the way most countries have conducted themselves

with respect to procurement of [vaccines](#), medical protective equipment, and [COVID-19 tests](#), as well as with respect to sharing intellectual property on [vaccine technology](#).

As the pandemic continues to reshape the politics and economies of many countries and challenges multilateralism, a more critical approach to health governance and speedy, scaled response from *all* political leaders is needed. In this context, it is clear an international lawmaking effort is justified.

Further, at a time when nationalist populism threatens global cooperation, international lawmaking efforts promise to reinforce the World Health Organization's independent monitoring power and unify a broader and actively involved supportive constituency — including experienced organizations and advocacy groups who are trusted and have a track record of success in promoting health worldwide. A recent good precedent is the Framework Convention on Tobacco Control, where the WHO exercised its constitutional treaty-making power by consensus.

We are witnessing an extraordinary moment in history that urges leaders, international health organizations, global health advocates, the private sector, and the civil society to have a truthful conversation on how to transform our health systems through a health justice framework. The special session of the WHA is an opportunity to empower and engage with a larger constituency to lead deep reforms in global health governance. By agreeing on a set of standards on the right to health, we can initiate the process of transforming the nature of our health systems while reinvigorating global health security, institutions, and governance.

## 21. Pandemics without Borders?

### Reconsidering Territoriality in Pandemic Preparedness and Response Instruments

Raphael Oidtmann

October 28, 2021

The COVID-19 pandemic has (yet again) disclosed that, in contemporary international law, the notion of borders resembles a distinct emanation of legal fiction, i.e. 'something assumed in law to be fact irrespective of the truth or accuracy of that assumption'. This characterization of international borders holds particularly true with a view towards managing, containing, and countering the spread of highly contagious pathogens: especially in the context of responding to the global COVID-19 pandemic, it has hence become apparent that the traditional conception of borders as physical frontiers has been rendered somewhat moot. On the contrary, the pandemic experience has proven that a more flexible, fluid, and functional understanding of (international) borders might be warranted, also with a view towards (re-)conceptualizing international health law.

The insinuated conceptual realignment of borders in international (health) law hence requires scholars and practitioners to relinquish the hitherto applied focus on territoriality. The classical reading has thus perceived borders primarily in physical terms, i.e. construed as rather static lines of division between delimitable entities with defined points of entry, such as harbours or airports, where selected border measures might be implemented. This reductionist sympathy of borders as stable physical frontiers, however, neglects their multi-dimensional and complex character, various instances in which borders have proven rather porous and fragile, as well as the multiple ways in which borders 'are not necessarily where they are meant to be according to the conventional inside/outside model' ([Vaughan-Williams 2008: 63](#)). While we ought to take note of certain *sui generis* cases in which geographically determined borders

are (still) synonymous with contemporarily applicable borders (such as, *inter alia*, in the case of Australia), it is thus about time to thoroughly re-examine and, contingently, re-conceptualize the notion of international borders for the purposes of pandemic preparedness and response.

When the Special Session of the [World Health Assembly](#) will gather in November 2021 to 'consider developing a WHO convention, agreement or other international instrument on pandemic preparedness and response', it therefore might wish to re-examine the manifold effects that have been caused by the imposition of border measures, also during the COVID-19 pandemic, and to ponder contingent avenues to improve the international community's responsiveness towards future pandemic outbreaks. In deliberating a future international treaty or other instrument, this contribution posits, the World Health Assembly should thus refrain from further designating border action as 'additional health measures' in the meaning of Article 43(1) of the [2005 International Health Regulations](#), thereby opening a contingent strategic space, which might be unilaterally embellished by single States. Rather, it is suggested here that any future international treaty or instrument should re-emphasise a return to the original 2005 IHR framework's overall alignment, which put particular emphasis on international cooperation in fighting globally spreading diseases, including by engaging (and complying) with the quasi-compulsory reporting mechanism under Article 6 2005 IHR. Rather than allowing for States to impose unilateral measures, including such unfolding their effects immediately at the border. While it is hence acknowledged that single States that have imposed different kinds of border

measures, it remains unclear whether and to what extent positive developments, e.g. a decrease of infections or mortality rates, might be directly attributable to the imposition of border measures. Beyond that, this insinuated re-orientation would constitute an important step towards mitigating one of the most far-reaching conceptual flaws inherent in the 2005 IHR, namely that – despite the WHO’s overall preference for enhanced multilateralism – it maintained a discreet, yet formative ‘Westphalian’ ([Fidler 2003: 485](#)) element, allowing States to impose unilateral border measures, including border closures, under the heading of Article 43 2005 IHR in conjunction with Article 3(4) 2005 IHR, the latter highlighting States’ ‘sovereign right[s] to legislate and to implement legislation in pursuance of their health policies’.

Why is that necessary, one could ask? Well, if COVID-19 has taught us one thing, it is that pathogens do not heed to human-imposed borders, neither domestically nor internationally. This fact protrudes even more in an ever more globalized world with intercontinental flights, open-border regional economic areas, and overall increased human mobility and interaction. Notwithstanding that selected sanitary measures implemented at defined points of entry – for example, compulsory testing regimes at airports or imposed quarantine measures – have crystallized as useful early-warning instruments aiding in managing disease outbreaks, our previous (legal) understanding

of international borders has proven to be rather obstructive: the observed renaissance of States imposing unilateral border measures as a means to counter the spread of COVID-19, including the closure of borders, has caused wide-spread and detrimental ramifications, *inter alia* for international trade and commerce, for the maintenance of international supply chains, as well as for human mobility (including medical professionals) – not to mention profound human rights-related challenges, including with a view to refugees being denied entry at the border. While acknowledging certain isolated successes in limiting the spread of *inter alia* COVID-19, any future international treaty or instrument on pandemic preparedness and response should thus refrain from further perpetuating an understanding of international borders that is primarily based on considerations of territoriality – rather, it should ensure that borders are no longer a constitutive element determining the international community’s effort of fighting the spread of dangerous diseases.

*This contribution is based on a chapter drafted for the 2020 edition of the Centre for Studies and Research at The Hague Academy of International Law on the topic of ‘[Epidemics and International Law](#)’, forthcoming with Brill Publishers.*

## 22. Decolonizing the Pandemic Treaty Through Vaccine Equity

Tlaleng Mofokeng, Daniel Wainstock, and Renzo Guinto

*October 29, 2021*

In recent years, there have been growing calls to “[decolonize](#)” the field of global health. Global health traces its roots back to [colonial medicine](#) when old empires sought to address

tropical diseases which, if not controlled, could be brought by colonizers back home.

Today, many countries in the Global South may have already been liberated from their



colonizers, but the colonial behavior of global health continues to manifest in policies, funding, research, and operations.

Unlike the tropical diseases of the past, SARS-CoV-2 has affected rich and poor countries alike, but the tools for [putting this pandemic under control](#) — most notably vaccines — remain unevenly distributed across the world. As of [October 27, 2021](#), 63.5% of individuals in high-income countries have been vaccinated with at least one shot of the COVID-19 vaccine. Meanwhile, in low-income countries, only 4.8% of the population has been vaccinated with at least one dose.

To make sure that COVID-19 is the last pandemic of its kind, the international community is considering the creation of [a new pandemic treaty](#). The goal of such a legal instrument is to enhance the world's capacity to predict, prevent, detect, assess, and respond to future disease outbreaks.

This treaty cannot become another agent of the perpetuation of global health's coloniality. One of the ways to "decolonize" the treaty is to ensure that vaccine equity is at its very core.

There is still an opportunity to achieve vaccine equity for this current crisis, but cementing it in a pandemic treaty will ensure that this goal remains should another pandemic emerge in the future.

### **Promoting vaccine equity between and within countries**

Vaccine inequity is occurring between and within countries during the COVID-19 pandemic. A future pandemic treaty must ensure this does not happen again.

In order to ensure vaccine equity globally, actions must be taken through international cooperation and assistance. A [statement](#) of the UN Committee on Economic, Social, and Cultural Rights emphasizes this imperative. International cooperation with respect to

vaccines is vital because many low- and middle-income countries (LMICs) do not have the financial resources to guarantee the vaccination of their population. According to the United Nations Development Program ([UNDP](#)), low-income countries have to increase their health care spending by around 56% to afford to immunize 70% of their citizens.

To ensure that vaccine equity exists not only between countries, but also within them, it is crucial to uphold the principle of non-discrimination. As [noted](#) by the UN Special Rapporteurs on the human rights of migrants and on the right to health:

*"In times of crisis, the focus should be given to international solidarity, equality, and inclusiveness. We call on world leaders to refrain from discriminatory discourses that may lead to the exclusion of certain groups (...). The prioritization of vaccines within countries should include all those who qualify under a priority group, regardless of who they are."*

### **Reforming intellectual property rights**

The [TRIPS Agreement](#), which establishes global intellectual property standards, has caused an [adverse impact](#) on the availability of vaccines. Therefore, the UN Committee on Economic, Social, and Cultural Rights [argues](#) that States should use, when necessary, all the flexibilities of the Agreement to ensure universal access to vaccination.

The [Doha Declaration](#), enacted in 2001, attempts to address global inequities stemming from intellectual property protections by allowing countries to grant compulsory licenses for the production of pharmaceuticals for international exports. However, the Doha Declaration has not been capable of ensuring vaccine equity during the current pandemic. Accordingly, the delegations of India and South Africa, co-sponsored by many developing countries, submitted to the WTO TRIPS Council [a](#)

[proposal](#) for a temporary TRIPS waiver in response to COVID-19. The World Trade Organization (WTO) members should endorse the waiver proposal, which will expand licensing agreements and facilitate technology transfer.

Another vital measure to promote vaccine equity is building vaccine manufacturing capacity in the Global South, as argued by [The Independent Panel](#). The African continent, for instance, has [less than 1%](#) of the world's vaccine manufacturing capabilities. To address this issue, the World Health Organization (WHO) created the [COVID-19 Technology Access Pool \(C-TAP\)](#), a platform for developers of COVID-19 vaccines and other health products; which enable them to voluntarily share their scientific knowledge, know-how, and intellectual property rights with manufacturers, especially from LMICs.

Though the “[paragraph 6 decision](#)” regarding the Doha Declaration already addressed the issue of manufacturing capacity in 2003, it has [not effectively](#) solved the problem. In light of this, the [UN High-Level Panel on Access to Medicines](#) recommended that WTO Members should revise the decision to find a solution that enables expedient exports of pharmaceutical products produced under compulsory licenses. The pandemic treaty can incorporate this revision to allow accelerated vaccine production and distribution in the case of future pandemics.

### Reshaping the COVAX Facility

The [COVAX Facility](#) was created to avoid vaccine monopoly by wealthy countries, as what [happened during the swine flu pandemic](#). Still, during the COVID-19 pandemic, the consortium has faced the drastic consequences of “[vaccine nationalism](#).” For example, the [U.K.](#), [U.S.](#), and [Israel](#) have

decided to roll out booster shots in times of vaccine scarcity, when doses are much needed by COVAX for developing countries. Moreover, the lack of inclusive governance, little financial support, poor transparency, and supply constraints have [impaired COVAX's capacity](#) to promote global vaccine equity.

Therefore, the COVAX Facility should increase [transparency](#) by publishing contracts and procurement prices. Moreover, stakeholders must monitor commitments by suppliers to reducing profit through third-party audits, the results of which must be publicly shared. Accountability mechanisms are also imperative to ensure the facility's effective functioning.

Given COVAX's supply shortages, the WHO should consider [supporting other actors](#) as well, such as the [African Union Vaccine Acquisition Task Team \(AVATT\)](#) — an initiative that aims to provide access to COVID-19 vaccines for Africa. These reform measures for reshaping COVAX must be taken into account by a pandemic treaty to ensure a sustainable global supply of vaccines during future pandemics.

### Decolonizing starts with vaccines

There surely are many other aspects of the pandemic response that will need to be reformed and “decolonized” — for instance, pandemic policy and guideline development, knowledge and information sharing, and global health financing flows. But putting vaccine equity at the center of a pandemic treaty will already be a huge step towards global health's decolonization.

*The authors are grateful to Catarina Vallada, Mariana Torquato, Julie Huffaker, and Bianca Carvalho for their thoughtful research assistance in developing this article.*

## 23. Who Will Pay for COVID-29? (Or, Who Will Pay to Avert It?)

Sebastián Guidi and Nahuel Maisley

November 1, 2021

Pandemics have very real costs. When they hit, these costs are obvious and dramatic — people fall ill and die, businesses go bankrupt, children are kicked out of school. When they don't, it's very likely because we have already taken extremely costly measures to prevent them.

These costs are inevitably distributed — [through act or omission](#) — by international law. As the international community [discusses a new pandemic treaty](#), complementary to the [International Health Regulations](#), it bears emphasizing that any global framework that does not reckon with cost will fall short of an acceptable solution.

Take COVID-19 as an example. Latin America is (as of this writing) arguably the region hit hardest by the pandemic along nearly every dimension. The region's GDP [fell](#) in 2020 by 3% more than the world average (reaching a staggering 7%), and as of May 2021, it had suffered more deaths per capita than any other region in the world ([three of ten](#) people killed by COVID died in Latin America). Over 22 million people [fell](#) into poverty. Latin America is also the region with the longest school closures: while the region houses only six percent of the world population, it is home to 60% of those kids who [lost](#) an entire school year in the world.

Additionally, and perhaps paradoxically, if a new global framework takes the prevention of pandemics seriously, the region most harshly hit by COVID-19 could also be the one most harshly hit by the prevention of future diseases. Being home to the largest rainforest in the world and to the highest cattle-per capita rate, the costs of halting deforestation and reducing meat consumption ([arguably](#) the most effective measures to prevent future zoonotic diseases from emerging) would

disproportionately burden Latin America as well.

A key policy question, then, is who should pay the price of pandemics — and, ideally, of their prevention. *Prima facie*, international law allows for three different strands of argument in response to this conundrum.

The first is based on [solidarity](#). Under [articles 55 and 56 of the UN Charter](#), states are under an obligation to “to take joint and separate action” to find solutions to “international economic, social, health, and related problems” in a way that promotes the highest “standards of living, full employment, and conditions of economic and social progress and development,” [bearing in mind “the equal rights of men and women and of nations large and small.”](#)

International leaders rehearsed this argument in relation to COVID-19: many in international forums insisted on a [“cooperative, global and human rights-based approach to the crisis”](#) based on [“unity and solidarity.”](#) Reality would quickly [frustrate](#) these high hopes: e.g., while developed countries have largely surpassed the amount of vaccines they need, poor countries are still struggling to protect even their most vulnerable.

The second answer is based on blame. Under international law, [states have a broad obligation not to harm each other](#) — and a pandemic is certainly harmful to states and their citizens. If some state were actually found to have impermissibly caused the pandemic, it could be held accountable and be called to compensate for the harm. This, at least, was the reasoning of nationalists worldwide, led by Donald Trump, who in March 2020 announced they would sue China for [“unleash\[ing\] this plague onto the world.”](#) As we show [elsewhere](#),

even if this kind of attribution is motivated by nativist sentiment or by the search for a scapegoat, it can also be reconstructed to entail deep distributive judgements. In any event, in the case of COVID-19, this strategy was quickly abandoned in the face of [insurmountable jurisdictional hurdles](#).

The third path is ultimately based on brute luck. Since [“restrictions upon the independence of states cannot \[...\] be presumed,”](#) absent specific commitment, states have no legal responsibility for the fates of those beyond their borders. No matter their capacity to pay or how severe the impacts of a pandemic are, each state only has [the responsibility to protect its own nationals](#). The costs of a pandemic, therefore, lie mostly where they fall.

In the case of COVID-19, the response of the international community was paradoxical. Whereas most social and political actors discursively — and, one can think, sincerely — embraced either the first or the second option, reality disappointingly left us with the third. In fact, whereas the principles of international law allowed for alternative solutions, down-to-earth regulations and institutional inertia did not permit the kind of ambitious redistribution necessary to allow for a more thoughtful allocation of costs—even if [global leaders themselves committed to doing so](#).

One could have expected to find an explicit solution to this challenge, one which allocated costs fairly, in the most important international law instrument dealing with pandemics: the [International Health Regulations](#). However, the IHR stop short from arbitrating between these substantive choices; instead, they [only establish procedural obligations](#) (with marginal distributive impact). The focus on procedure is understandable. As [explained by Martti Koskenniemi](#) in a different context, states sometimes resort to these solutions because “[a]greement on substantive law requires more of a consensus about political value than agreeing upon procedure. Procedural solutions, combined

with generally formulated calls for equitable balancing, do not prejudice any State’s substantive policy.”

From [what we know](#), the new pandemic treaty will likely replicate this procedural focus. Just as the IHR, it may include (enhanced) obligations of early detection, notification, [information sharing, and broad cooperation](#).

This, however, would ultimately leave open the [substantive questions necessitated by a deliberate allocation](#) of the costs of pandemics. Who should halt deforestation in their territory (and who, if anyone, is going to compensate for the loss of economic development)? Who should shift their food consumption patterns to allow for safer methods of meat production? Should richer states fund and distribute vaccines and medication—even as their own populations are not fully covered yet? And, if none of this works, should the economic and social losses of pandemics be mitigated by those who were most spared?

These questions of pandemics’ cost allocation are inevitable, but they are also fairly intractable. Very likely, any pandemic treaty will not settle, even minimally, these complex substantive matters.

But if states really want to meaningfully address the key issues that will invariably arise regarding future pandemics, cost-allocation questions must be tackled, candidly and rigorously. Not being able to fully agree at this point in time is different from being unable to do anything.

First and foremost, states could explicitly reject the current default according to which costs lie where they fall, which [is manifestly unjust](#). Second, they could sketch the broad normative criteria that should guide their distribution in the future. And third, they could create the appropriate institutional mechanisms — with [civil society participation, transparency,](#) and the [adequate](#)

[representation of all voices](#) — to enable and foster ongoing global democratic dialogues on these substantive questions, and secure responses that are reflective of the views and interests of people around the world.

These conversations will be difficult, but their alternative is worse. If we don't have them, the response to an eventual COVID-29 might be more orderly and well-mannered, but, at a fundamental level, will be equally unjust.

*This blog entry builds upon the article we recently published “Who Should Pay for COVID-19? The Inescapable Normativity of International Law.” (96 NYU Law Review). In this piece, we argue that the widespread discussion about suing China for the COVID-19 pandemic reflects an uneasiness about the way in which the costs of the pandemic were distributed by international law. Addressing this discomfort inevitably leads to a complex normative discussion on the distribution of the costs of the pandemic.*

## 24. The Covid-19 Pandemic, the Failure of the Binary PHEIC Declaration System, and the Need for Reform

Ilja Richard Pavone

November 2, 2021

The COVID-19 pandemic has raised unprecedented challenges for the global health framework and its long-term consequences are not yet in full sight. The legal and institutional regime aimed at preventing and controlling the spread of infectious diseases, grounded on the International Health Regulations (IHR) [was heavily criticized](#).

The alarm mechanism based on the declaration of Public Health Emergency of International Concern (PHEIC), in particular, has been [severely tested](#). A PHEIC is an extraordinary event that constitutes a potential public health risk through the international spread of a disease outbreak. The WHO Director-General bases his decision to ‘ring the bell’ upon the technical advice of an Emergency Committee (EC) carrying out “an assessment of the risk to human health, of the risk of international spread, and of the risk of interference with international traffic”.

A PHEIC, then, is declared only when an event is already sufficiently acute and has started to spread internationally. It is not an early warning, but a formal alert, and in the case of

COVID-19 it was issued with extreme delay only [on 30 January 2020](#), (one month after notification of early cases by the Chinese government), after Beijing had already adopted quarantine measures around the city of Wuhan, and draconian measures to curb the spread of the disease in the country had been announced.

It is not yet clear why the EC, which was summoned on 22 and 23 January 2020, decided that it was [‘too early to declare a PHEIC’](#). It has been arguably a problem of political pressure by the Chinese delegate, as well as of incapacity of the EC’s members. More probably, due to the lack of precise information by the Chinese government on the real extent of the disease outbreak, they opted for a conservative approach, well aware of the economic and political consequences of a PHEIC declaration for the concerned State. In general terms, one of the problems lies in the [rigid binary nature of a PHEIC](#) – that is declared or not – and does not envisage intermediate levels of alert.

In the Declaration of 30 January 2020, the DG showed awareness about this problem, hoping

that the “WHO should continue to explore the advisability of creating an intermediate level of alert between the binary possibilities of PHEIC or no PHEIC, in a way that does *not require reopening negotiations* on the text of the IHR (2005).” He recommended developing a New Alert and Response Notice (WARN) system that should provide adequate information to the WHO Member States of the actions required to tackle an event that has not yet reached the threshold of a PHEIC, but may nonetheless require a coordinated response. It should take the form of a notice containing a WHO risk assessment to be shared amongst the Member States, and it should detail the specific public health actions that are recommended to prevent cross-border transmission. Given that the WHO has provided recommendations even [when it has not declared PHEIC](#), the legal added value of this WARN system is not however clear

The need of a reform was then reiterated in a [WHO’s Interim Report](#), which proposed an intermediate level of alert, a sort of ‘yellow light’ as an initial warning signal (Para. 32).

This kind of proposal is not a novelty, since it was already recommended in a previous document on the [response to the Ebola outbreak](#) in Western Africa (although it was never endorsed by the WHO Member States). The Panel recommended “the possibility of an intermediate level that would alert and engage the wider international community at an earlier stage in a health crisis. This could facilitate preparedness, preventive action, and dedication of resources, which could avert an escalation of the situation”.

This kind of reform, that could be labelled as a [‘traffic light mechanism’](#), or [‘tiered alert system’](#), to be really functional should bypass the [risk based approach](#) upon which the assessment of the DG is conducted. It would imply to overtake the classic [reluctance of the WHO and the EC to impose travel and trade restrictions](#) before a risk assessment is carried

out, since they are usually considered as ineffective and counterproductive.

Even though the various proposals envisioned different tiers –ranging from only a yellow light before a PHEIC to a [flowchart with 5 levels of alarm](#) – they all have the goal of encouraging early reporting of and response to, potentially serious disease outbreaks.

Despite the wide range of possibilities, the first problem is, however, how to concretize a potential reform. The easiest solution could imply the negotiation and adoption of an additional protocol amending the IHRs or at least Annex II, and introducing a more nuanced alarm mechanism.

Otherwise, a technical note could provide a specific flowchart to both the EC and the DG, based on a multi-tiered declaration approach; in few words, the DG could be able to recommend specific measures to its Member States even before the formal declaration of a PHEIC.

The necessity to replace the all-or-nothing nature of PHEIC declarations is not a novelty in the academic debate, but in light of the worldwide diffusion of the COVID-19 pandemic it became crucial. Such reform could relaunch the IHR and beef up the role of the WHO in managing future pandemics, but the normative power of a PHEIC declaration should not be overestimated, which is not a binding act but rather an instrument of governance through information. Indeed, States do not wait for the ‘red light’ of the WHO to react to a potential epidemic or pandemic, but in view of their own source of information can decide to react earlier if they want. This was witnessed in the early stages of COVID-19, when Vietnam and Taiwan decided to adopt stringent measures well before the end of January.

In conclusion, as underlined by [some scholars](#), a reform of the PHEIC’s mechanism would not solve the core issues of the alert and response

system behind the IHRs, that do have mainly a political dimension. Indeed, States are reluctant to act in good faith and to share information in case of a disease outbreak, tend not to comply with the DG's temporary

recommendations, and have not developed adequate core capacities to respond to disease outbreaks.

## 25. Casualties of Preparedness: Rethinking the Global Health Security Paradigm

Manjari Mahajan

*November 3, 2021*

The calls for a new pandemic treaty, like the genesis of the [International Health Regulations](#) (IHR), have been anchored within a paradigm of “global health security.” Before undertaking new projects of international lawmaking, it behooves us to examine this dominant paradigm and assess whether it actually leads to the goal of pandemic preparedness across countries. At stake are the future contours of a global normative, legal and infrastructural machinery and whether its animating logics are historically informed, evidence-driven, and geographically equitable.

The prevailing global health security paradigm was institutionalized in international law through the IHR, a policy centerpiece that was most recently revised in 2005 in response to a series of new infectious diseases including [AIDS, SARS, and Ebola](#). At its foundation, the schema identifies the problem at hand as outbreaks of emerging infectious diseases, which become global security threats as they travel across borders. The focus is very much on *new* and re-emerging infectious diseases, and not ongoing health-related problems in a population. Moreover, this framework is animated by a special anxiety about contagion from poorer, purportedly primordial and volatile countries in the global South to the North.

The emphases on new infections and preventing their travel from the South to the North have resulted in a politics of control and enforcement that carry with it particular normative and infrastructural demands.

First, it has required that member states invest in building surveillance and reporting systems that allow for rapid reporting of infectious outbreaks to a global machinery. The global health security paradigm has not focused on building national capacities to address existing diseases or overall public health in a population. However, the COVID-19 pandemic has vividly illustrated that making a stark distinction between capacities to address new infectious outbreaks and routine public health is a costly mistake.

Second, the global governance of health security has demanded some ceding of national sovereignty, with member countries required to adhere to a common template of surveillance and reporting systems. States have to put into place a suite of narrow technical and administrative measures for biosafety and biosecurity; a country's pandemic preparedness has been judged based on their having met these [universal benchmarks](#). This has produced a disproportionate burden on poorer countries.

Especially from the point of view of a developing-country government, it might be less effective to use limited resources to add narrow technical capacities to feed a global machinery of surveillance, than to invest in overall scientific infrastructure that is integrated into a national system of research and innovation reflecting local needs. The one-size-fits-all benchmarks set by global managers has disallowed consideration of domestic imperatives and political judgment about resource allocation.

Moreover, one of the striking lessons of COVID-19 has been that countries that have provided relatively sustained and competent responses to the pandemic [have not followed any single template](#). Successful public health action has been enabled by diverse assemblages of institutions, policies, historical legacies, and socioeconomic resources that have been necessarily highly contextual to each country. These heterogenous responses belie the convenient notion that it is possible or necessary to have [neat templates of preparedness](#) that can be applied uniformly across countries.

Third, much emphasis has been put on individual governments reporting to a larger international machinery. Here, a government's accountability is not to its own people or to achieving particular health outcomes or adhering to national laws. Rather it is conceptualized as a government's capability to assure a global apparatus.

Accountability becomes equated to a [performative visibility](#) where a government has to frontstage and show its preparedness capacity in a way that can be easily measured by indices and checklists of the global machinery. The privileging of reporting echoes secular trends within global health, where audits of governments and NGOs to donors anchor definitions and procedures of accountability. Inevitably such a framework creates perverse incentives for organizations to invest in producing information that can be

captured by indicators, often at the cost of more meaningful work.

The limitations of this conceptualization of accountability are vividly illustrated by the fact that before the current pandemic, the United States and the United Kingdom were considered the "most prepared" by multiple [global health security indices](#). Even though both countries tick-marked many of the requisite boxes in the preparedness checklist, they have since had a disastrous track record in managing the pandemic.

Ironically, even as extant accountability measures privilege national reporting to a global machinery, they completely elide any enforceable commitment by the international community to ensure equitable access to technological countermeasures, such as vaccines and medicines. Similarly, this understanding of accountability doesn't include a global commitment to increasing capacity for knowledge and technological development across countries determined by sovereign priorities.

Lessons from history and a commitment to global equity require that our analytical frameworks and ensuing international governance systems move away from the overwhelming focus on centralized reporting and generic templates. Rather they have to include divergent approaches that speak to different countries' historical experiences, social needs, and political imperatives.

Abandoning a universal templated approach to control and enforcement is a significant challenge for global governance of health, which has long relied on modeling countries on generic templates and metrics, and tick marking through common checklists. Nevertheless, COVID-19 has starkly illustrated the urgent need for more sophisticated narratives and frameworks that embrace complex understandings of health and preparedness. This will undoubtedly require more complex and "messy" analyses; yet it is



necessary — the alternative prevailing global health security paradigm is an emperor without clothes.

As the international community debates a new pandemic treaty or another legal instrument, the history of the last several decades of international health, and the more proximate experiences with COVID-19, should force a reckoning of the limitations and unintended consequences of the dominant global health security paradigm. The lessons do not point to the need for an exclusive and overwhelming focus on surveillance and reporting infrastructure, nor stricter enforcement mechanisms managed by global authorities.

Rather, there is a need for a different conceptualization of global health security that is anchored in frameworks that contextualize health in broader historical narratives and political and social determinants. State capacities, social resilience, economic imperatives, and political culture have to be understood not as ancillary sideshows as much as inextricable determinants of preparedness. Accordingly, the governance of global health security must systematically integrate different kinds of expertise and meaningfully represent states around the world. It must go beyond rhetorical gestures to participation toward a substantive consideration of the complex underpinnings of health and its varied national trajectories.

## 26. From Cooperation to Solidarity: A Legal Compass for Pandemic Lawmaking

Guillermo E. Estrada Adán

*November 3, 2021*

This article proposes incorporating solidarity as a legal compass for international norms in a new international pandemic law agreement or reform.

The current model of global health governance espoused by the World Health Organization (WHO), based heavily on cooperation between states, has significant shortcomings. An approach that relies on solidarity, rather than cooperation, would better advance states' responsibilities to ensure the protection and enjoyment of each individual's rights.

*The failure of interstate cooperation*

[Eyal Benvenisti argues that](#), beyond the criticisms against the WHO's belated reaction during the COVID-19 pandemic, the fundamental problem is the structural limitations of an international organization based on scientific cooperation.

The WHO's framework rests upon a high-level model of collaboration that can only be successful if states align their interests. When that common objective is not present, cooperation is simply not possible. In recent months, states have steered the pandemic, including vaccination campaigns, in accordance with their own electoral, political, or economic interests, but never under a collective vision.

Such an approach can be understood because, at least discourse-wise, states act under Westphalian sovereign equality and, therefore, fulfill the same role as equals at the international stage. Upon closer inspection, however, it is actually economic and hegemonic geography that determines important decisions, and not states' equal voices. From declaring a state of emergency to distributing vaccines, questions of global import are decided by economic and political criteria, and not in terms of human rights or

the interests of other populations. During the pandemic, decisions affecting the entire world have not been made with representatives from each nation on equal footing – rather, countries have made choices with their narrow self-interest in mind.

In the best of cases, the enjoyment of rights is a matter that is solved under the traditional notions of borders and nationality: our own nationals within the territorial jurisdiction are always first and foremost. Coordination is only effective if states have the same objectives; otherwise, instead of converging, actions become fragmented.

Against this backdrop, the divide between the Global North and the Global South determined political and legal actions by states when facing the COVID-19 pandemic.

We need a different compass to orient the creation and implementation of potential new international norms. Otherwise, we risk allowing the North-South divide to define present and future pandemic preparedness and response. We need to move from the existing framework to another of greater collective legal responsibility, that is, from a model of international cooperation to one of global solidarity.

#### *Solidarity as a legal tool*

When demanding the fulfilment of legal obligations, solidarity should guide political decision-making.

Solidarity is a term used often in private law, which places all debtors on the same level of responsibility towards the fulfilment of a specific obligation. At the same time, solidarity may refer to collective ethics.

In public international law, save for isolated and weak references, such as the Inter-American Declaration of Principles on Solidarity and Cooperation of 1936, the notion of solidarity has been scarcely used in

comparison to other terms, like cooperation or collaboration. In the United Nations Charter, the word solidarity does not show up at all. In the Charter of the Organization of American States, at least eight references are made between its Preamble and the reference to the region's collective security. Nevertheless, there is no overarching definition, nor does the word take an important place in the development of other principles or obligations. The Constitution of the WHO certainly does not include the term.

Including solidarity in a potential new or reformed legal instrument on pandemics would link the circumstances of the most disenfranchised persons to concrete decision-making. By understanding legal obligations in terms of solidarity, states would be guided toward actions that favor collective over individual benefit.

Thus, when facing actions related to pandemic response – quarantines, isolation, vaccination, and human rights restrictions generally – the decisive argument would have a global, instead of a particular reach. In the context of different values underpinning positions held by states, non-state actors, or even international and supranational organizations, solidarity would be the trumping term. It could lead to restricting rights or distributing medical and public health goods and supplies on the basis of global criteria.

Solidarity would also be anchored to *erga omnes* obligations, or rights owed to all. This legal institution, of recent pedigree, would engender procedural bridges to identify states that, far from striving towards collective benefits, only look at their own. One state could demand from another the fulfilment of such obligations, even when the former is not considered to be an injured party. Human health and its protection may be one such obligation, which has acquired the status of a human right within agreements of both universal and regional scope.

The inclusion of solidarity in the Preamble of, or as a special part within, a new international treaty or other legal instrument concerning pandemics would allow for better protection of the rights of everyone everywhere, instead of the status quo of individual states' interests prevailing. Consequently, this article proposes that the term solidarity should take center stage in any new international agreement or reforms on pandemic preparedness and response.

As a legal term for interpreting and applying law, solidarity is a parameter that goes beyond global health governance. It is, rather, a collective value, applicable as long as there is a trend for equity in international law. The opportunity to revise the existing model of global health governance can allow for placing persons, both of present and of future generations, at the center of legal protection.

## Authors

[Anne van Aaken](#), Alexander von Humboldt Professor for Law and Economics, Legal Theory, Public International and European Law at the University of Hamburg.

[Sharon Bassan](#), legal scholar with expertise in (bio)ethics, health policy, innovation, and information technology law and ethics. She is currently the Jaharis Faculty Fellow in Health Law and Intellectual Property at the DePaul University College of Law.

[Ximena Benavides](#), Yale Institute for Global Health (YIGH) Fellow, Yale Fox International Fellow, and a member of the Executive Committee of the Framework Convention on Global Health Alliance.

[Tomer Broude](#), Bessie & Michael Greenblatt, Q.C., Chair in Public and International Law at the Faculty of Law and Department of International Relations at the Hebrew University of Jerusalem.

[Gian Luca Burci](#), Adjunct Professor of international law at the Graduate Institute of International and Development Studies and academic adviser of the Global Health Centre of the Graduate Institute.

[Luciano Bottini Filho](#), Lecturer at Sheffield Hallam University and Ph.D. Candidate at the Centre for Health, Law and Society, University of Bristol.

[Judith Bueno de Mesquita](#), Lecturer and Co-Deputy Director of the Human Rights Centre in the School of Law and Human Rights Centre at the University of Essex.

[Anna Coates](#), Chief, Office for Equity, Gender, and Cultural Diversity, Pan American Health Organization (PAHO/WHO). The author holds sole responsibility for the views expressed in this commentary, which may not necessarily reflect the opinion or policy of PAHO.

[Sara \(Meg\) Davis](#), Senior Researcher, Digital Health and Rights Project at the Global Health Centre, Graduate Institute of International and Development Studies, Geneva.

[Alicia Ely Yamin](#), Senior Fellow on Global Health and Rights at the Petrie-Flom Center for Health Law Policy, Biotechnology and Bioethics at Harvard Law School and Senior Advisor on Human Rights and Health Policy at Partners In Health.

[Cassandra Emmons](#), postdoctoral fellow with the Weatherhead Center for International Affairs' Research Cluster on Regions in a Multipolar World at Harvard University.

[Guillermo Estrada Adán](#), Professor of International Law at the Universidad Nacional Autónoma de México (UNAM), a Research Fellow at its Institute of Legal Research, and Professor of Constitutional and International Law at El Colegio de México.

[Caroline E. Foster](#), Associate Professor at the University of Auckland.

[Sakiko Fukuda-Parr](#), Professor of International Affairs at The New School.

[Sebastián Guidi](#), JSD candidate (Yale).

[Joelle Grogan](#), Senior Lecturer at Middlesex University London, and Research Fellow at the CEU Democracy Institute Budapest.

[Martín Hevia](#) is the Dean of the Universidad Torcuato di Tella Law School, President of the Ibero-American Association of Law Schools, and Past-Founding Chair of the Framework Convention on Global Health Alliance.

[Ellen 't Hoen](#), lawyer and an independent consultant in medicines policy and law.

Courtenay Howe, Coordinator for the ACT-A Civil Society & Community Representatives Platform and Senior Advocacy Advisor at STOPAIDS, and previously the NGO Delegation Liaison Officer (Unitaid Board).

[Rosemarie Garland-Thomson](#), Professor Emerita of English and Bioethics at Emory University and Senior Advisor and Fellow at The Hastings Center.

Lawrence O. Gostin, O'Neill Professor of Global Health Law and Director of the O'Neill Institute for National and Global Health Law at Georgetown University. He directs the WHO Collaborating Center on National and Global Health Law.

[Aeyal Gross](#), Professor of International and Constitutional Law at Tel-Aviv University's Faculty of Law. He is also Visiting Professor of Law at SOAS, University of London.

Renzo Guinto, Associate Professor of the Practice of Global Public Health and Inaugural Director of the Planetary and Global Health Program of the St. Luke's Medical Center College of Medicine in the Philippines and Chief Planetary Health Scientist of the Sunway Centre for Planetary Health in Malaysia.

[Tsung-Ling Lee](#), an Assistant Professor of Law at Taipei Medical University.

[Ching-Fu Lin](#), Associate Professor of Law, National Tsing Hua University, Taiwan.

[Nahuel Maisley](#), Professor of International Law (University of Buenos Aires/NYU).

[Manjari Mahajan](#), Associate Professor in the Julien J. Studley Graduate Programs in International Affairs and the Starr Professor and Co-Director of the India China Institute at The New School.

[Deborah Mascalzoni](#), ELSI research group leader at the Institute for Biomedicine, Eurac Research in Italy, senior Researcher at Uppsala University, Centre for Research Ethics and Bioethics and academic affiliated at Helex OXFORD.

[Benjamin Mason Meier](#), Professor of Global Health Policy at UNC-Chapel Hill.

Tlaleng Mofokeng, United Nations Special Rapporteur on the Right to Health.

[Paul Ogendj](#), Lecturer at University of Nairobi, Faculty of Law, and Advocate of the High Court of Kenya.

[Raphael Oidtmann](#), PhD Candidate at Goethe University Frankfurt and Adjunct Lecturer at Mannheim Law School.

[Ilja Richard Pavone](#), Professor of European Law and Biotechnologies, Catholic University of the Sacred Heart, Rome, and Researcher of International Law, National Research Council of Italy (CNR), Rome.

[Mike Podmore](#), Director of STOPAIDS, a member of the Developed Country NGO Delegation to the Board of the Global Fund to Fight AIDS, TB and Malaria, co-facilitator (with Global Fund Advocates Network and WACI Health) of the Access to Covid Technologies-Accelerator (ACT-A) Civil Society & Community Representatives Platform, and co-focal point for Covax civil society representatives.

[Joel Michael Reynolds](#), Assistant Professor of Philosophy and Disability Studies at Georgetown University, Senior Advisor at The Hastings Center, and Senior Research Scholar at The Kennedy Institute of Ethics.

[Sharifah Sekalala](#), Reader/Associate Professor in Global Health Law at the University of Warwick.

[Ciara Staunton](#), Senior Researcher at the Institute for Biomedicine, Eurac Research and an Honorary Research Associate, Faculty of Medicine and Health Sciences, University of Cape Town.

[Kaat Van Delm](#), PhD researcher at KU Leuven (Leuven Institute for Healthcare Policy (LIHP)) working on a doctoral thesis on big data and health law.

[Pedro Villarreal](#), Senior Research Fellow at the Max Planck Institute for Comparative Public Law and International Law in Heidelberg.

Daniel Wainstock, law student at Pontifical Catholic University of Rio de Janeiro (PUC-Rio) and Research Assistant to the United Nations Special Rapporteur on the Right to Health.

[Chuan-Feng Wu](#), Associate Research Professor, Institutum Iurisprudentiae, Academia Sinica, Taiwan.