
Moving Towards Global Solidarity for Global Health through Multilateral Governance in the Covid-19 Response

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I. Introduction

The rapid spread of, and devastation caused by, Covid-19 worldwide reflects not only its viral properties, but the dichotomy between a globalised world profoundly connected by trade and travel and the absence of global solidarity and coordination in the response to the pandemic. Challenging a rising disengagement from multilateral governance, the UN Secretary General, the World Health Organisation (WHO), and the UN Committee on Economic, Social and Cultural Rights (CESCR) have all called for global solidarity and international assistance and cooperation to be at the heart of the Covid-19 response.¹ In this paper, we explore what this means for global health, giving particular attention to two core components of global health law that provide legally binding obligations regarding Covid-19: the commitments to global governance under the International Health Regulations (IHR) and obligations of international assistance and cooperation towards the realisation of economic, social and cultural rights, including the right to health, under the International Covenant on Economic, Social and Cultural Rights (ICESCR). Situating the global pandemic response in the context of the contemporaneous decline of multilateralism, our article takes a critical look at the international institutions and frameworks and their role during pandemic responses, and the imperative of a more cosmopolitan approach to global governance, embracing solidarity and international cooperation in a way that serves low-income countries and rights holders everywhere.

II. The Rise and Fall of Multilateralism in Global Health

Institutions of global health and human rights have brought the world together in unprecedented cooperation since the end of World War II. The rise of multilateralism in global health reflects the broader cosmopolitan worldview that gave birth to global governance in the aftermath of World War II, embedding global solidarity and cooperation within an increasingly interconnected world. Beginning in the nineteenth century, the spread of infectious disease began to unify states in shared vulnerability, with international cooperation recognised as necessary to prevent disease transmission through regulatory coordination, with early efforts to control specific infectious disease outbreaks evolving to become a standing international public health bureaucracy through WHO.² The WHO Constitution (1946), proclaiming for the first time a human right to ‘the enjoyment of the highest attainable standard of health,’ encompassed the normative aspirations of WHO’s mandate for international health governance to realise the right to health, developing ‘the broadest and most liberal concept of international responsibility for health ever officially promulgated.’³ Despite increasing multilateral integration in the decades that followed, the

¹ Committee on Economic, Social and Cultural Rights (CESCR), ‘Statement on the Coronavirus Disease (COVID-19) Pandemic and Economic, Social and Cultural rights’, UN Doc. E/C.12/2020/1, 9 April 2020; World Health Organisation, *Addressing Human rights as Key to the COVID-19 Response*, 21 April 2020, <https://www.who.int/publications-detail/addressing-human-rights-as-key-to-the-COVID-19-response>.

² David P. Fidler, *International Law and Infectious Diseases* (New York: Oxford University Press, 1999).

³ Charles E. Allen, ‘World Health and World Politics,’ (1950) 27(4) *International Organization* 27-43.

global vision for the WHO has been undermined by the rising reluctance of States to adequately support global health governance, a reluctance driven by the resurrection of nationalism.

In a direct attack on the shared goals of a globalising world, nationalism has spurred isolationism and has sought to retrench nations inwards. Right-wing populists have directly challenged multilateral institutions, including those in the area of global health and human rights. Some nations have retrenched and withdrawn from multilateral partnerships and international organisations. For example, nationalist governments have withdrawn from the Rome Statute of the International Criminal Court in recent years,⁴ and the USA government, seeing health and human rights as oppositional to traditional nationalist values, has slashed funding to the United Nations Population Fund and other institutions of global governance.⁵ These right-wing nationalist governments have further attacked human rights, undermining the global work of the UN Office of the High Commissioner for Human Rights (OHCHR) whilst turning increasingly autocratic through attacks on minority populations, independent media outlets, and civil society organizations.⁶ Such counter-cosmopolitan retrenchment is leading to a rejection in some quarters of global governance and human rights as a basis for global health, threatening progress that has been made, jeopardising the health and human rights of vulnerable populations worldwide and raising obstacles to future institutional progress.⁷ This new global order, detached from the science of public health and the obligations of human rights, is the context into which Covid-19 emerged. The response to the pandemic is illustrative of the nationalist tenor, undermining global health and human rights through a rejection of multilateralism.

III. The Emergence of Covid-19 into a Nationalist World

The rapidity and scale of transmission of Covid-19 is testimony to the enduring nature of our shared global vulnerability in an increasingly interconnected and globalised world. However, many State responses have shunned transboundary cooperation. While still in the early stages of this devastating pandemic, such actions not only exert negative repercussions on global public health and well-being; in impeding (and at times undermining) multilateralism, they also risk rebounding on nations by inhibiting coordinated strategies to address a virus that has no respect for national borders. For example, in responding to this emergency, States have adopted widespread unilateral travel restrictions in an attempt to interrupt transmission. Amounting to a violation of the IHR, the WHO has cautioned that they also have a perverse public health effect by diverting action away from health system and surveillance preparation. Undercutting the foundations of a human rights-based world, these nationalist actions have broader consequences on health and livelihoods worldwide by undercutting a collective response through compromising the global movement of essential medical supplies and personnel to fight the pandemic, as well as undermining humanitarian assistance more broadly and causing economic disruptions.⁸ With an unmet burden of need for medical equipment, as well as protective

⁴ Jina Moore, 'Burundi Quits International Criminal Court,' *The New York Times*, 27 October 2017.

⁵ 'U.S. withdraws funding for U.N. Population Fund,' *Reuters*, 3 April 2017, <https://www.reuters.com/article/us-usa-un-populationfund-idUSKBN17600T>.

⁶ Alison Brysk, *The Future of Human Rights* (Cambridge: Polity Press, 2019).

⁷ Lawrence O. Gostin, Andrés Constantin, and Benjamin Mason Meier, 'Global Health and Human Rights in the Age of Populism,' in Lawrence O. Gostin and Benjamin Mason Meier (eds) *Foundations of Global Health and Human Rights* (New York: Oxford University Press, 2020) 439-458.

⁸ Sharmilla Devi, 'Travel Restrictions Hampering COVID-19 Response,' (2020) 395 *The Lancet* 1331.

clothing for frontline staff, and with spiralling costs, countries have turned to an agenda of self-reliance and protectionist curbs on exports. Even as states recognize that the pandemic will not come to an end without an effective and universally-shared vaccine, some states have continued to take nationalist approaches to vaccine development and distribution.⁹ Such approaches create particular anxieties in terms of the equitable distribution of a future vaccine, leading to calls for a “People’s Vaccine” that would be available to all.¹⁰

At the same time, multilateralism has been undermined by the failure of some States, particularly the most powerful, to engage with those institutions best-placed to mount a multilateral and coordinated response. The Government of China received widespread condemnation for suppressing information about Covid-19 in the weeks after its emergence, where Chinese efforts to conceal a disease outbreak from WHO (to limit domestic economic damage) harmed the ability of the world to prepare for a pandemic under the International Health Regulations.¹¹ The US Government’s unprecedented and unjustified withdrawal of funding from the WHO,¹² driven by domestic political considerations, is denying the organisation vital resources when they are most needed to coordinate a global response, as well as to maintain its other vital programmes across the world. This US action has emboldened other countries to neglect global solidarity in the face of the pandemic, with Brazil now also threatening to withhold funding from WHO,¹³ as the European Union (EU) and UK squabble over the British financial contribution to the EU’s coronavirus emergency fund.¹⁴ Such financial wrangling is undermining cooperative health efforts: as the pandemic took hold, the EU mounted an initially weak public health response as its member states, overwhelmed by the quickly escalating crisis, focused on domestic responses.¹⁵ Perhaps most disturbingly, the US has continued to block the passage of a Security Council resolution calling for a global ceasefire to support delivery of aid in the context of Covid-19 to conflict regions which are particularly vulnerable.¹⁶

With nationalist responses predominating, their practical ramifications for the well-being not only of those beyond States’ own borders, but those within them too, presents a paradox in that they have undermined not only global health governance, but also national self-interest – linking national security with global solidarity. These linkages are a stark reminder of the original goals, and continued relevance, of global health law as a foundation of multilateral governance in the Covid-19 response.

⁹ Michael Peel, Leila Abboud, and Hannah Kuchler, ‘EU to Spend Billions to Secure Coronavirus Vaccine,’ *Financial Times*, 12 June 2020.

¹⁰ The People’s Vaccine: Available to All, in all Countries, Free of Charge, Open Letter. See UNAIDS, ‘Uniting behind a People’s Vaccine against COVID-19’, 14 May 2020, https://www.unaids.org/en/resources/presscentre/featurestories/2020/may/20200514_covid19-vaccine-open-letter.

¹¹ Lawrence O. Gostin, Roojin Habibi, and Benjamin Mason Meier, ‘Has Global Health Law Risen to Meet the COVID-19 Challenge? Revisiting the International Health Regulations to Prepare for Future Threats’, *Journal of Law, Medicine & Ethics* (Forthcoming, 2020).

¹² Madhukar Pai, ‘U.S. Withdrawal from WHO is Sad for Global Health and Bad for America,’ *Forbes*, 3 June 2020.

¹³ Lisandra Paraguassu and Ricardo Brito, ‘Bolsonaro threatens WHO exit as COVID-19 kills “a Brazilian per minute”,’ *Reuters*, 5 June 2020.

¹⁴ Charlie Cooper, ‘UK and EU clash over British share of Covid fund,’ *Politico*, 4 June 2020.

¹⁵ Jacint Jordana and Juan Carlos Triviño-Salazar, ‘Where are the ECDC and EU-Wide Responses in the COVID-19 Pandemic?’ (2020) 395 *The Lancet* 1611.

¹⁶ J. Borger, ‘US blocks Vote on UN’s Bid for Global Ceasefire over Reference to WHO’, *The Guardian*, 8 May 2020.

IV. Global Health Law

As globalisation has presented challenges to national disease prevention and health promotion efforts, global health law, offering the promise of addressing transboundary health challenges and promoting global health with justice,¹⁷ describes evolving multilateral efforts to address:

- New health threats – including non-communicable disease, injuries, mental health, dangerous products, and other globalised health threats,
- New health actors – including transnational corporations, private philanthropists, civil society, and other non-state actors, and
- New health norms – including “soft law” instruments, human rights obligations, global justice, and other normative standards of global health policy.¹⁸

Global health law instruments codify public health obligations across the global health landscape, seeking to realise both global health and human rights within and among nations through a multilateral response. Yet, global health law has been challenged by the Covid-19, with State responses falling short of global health law obligations. The scale and nature of the crisis has led for calls for strengthening and reform of the multilateral laws and institutions of global health.

d) Global Health Governance: The International Health Regulations

Drawing from the long history of international health law, the 1946 WHO Constitution provided WHO with the multilateral authority to propose conventions, regulations, and recommendations on any public health matter – with regulations, once adopted by the World Health Assembly, automatically binding on all WHO member states unless explicitly rejected. With this broad international legal authority to regulate public health, WHO assumed governance over the International Sanitary Regulations (1951); yet, with their revision and consolidation into the International Health Regulations (IHR) in 1969, the scope of these provisions was limited to only three select diseases (cholera, plague, and yellow fever). As the world faced a continuous stream of emerging and re-emerging diseases, the principal international legal instrument for preventing, detecting, and responding to infectious disease outbreaks was increasingly seen as inadequate.¹⁹

The 2005 revision of the IHR sought to codify a contemporary global health governance system under WHO – to prevent, protect against, control, and respond to the international spread of infectious disease through public health measures that avoid unnecessary interference with international traffic and trade.²⁰ States bear an obligation under the IHR to notify the WHO within 24 hours of all detected events within their territory which may constitute a Public Health Emergency of International Concern (PHEIC), which is any extraordinary event which is determined to:

¹⁷ Lawrence O. Gostin & Benjamin Mason Meier, ‘Introducing Global Health Law’ (2019) *Journal of Law, Medicine & Ethics*.

¹⁸ Lawrence O. Gostin, *Global Health Law* (Harvard University Press, 2014).

¹⁹ David P. Fidler, ‘Germs, Governance, and Global Public Health in the Wake of SARS,’ (2004) 113 *J Clin Invest* 799.

²⁰ Lawrence O. Gostin and Ana S. Ayala, ‘Global Health Security in an Era of Explosive Pandemic Potential,’ (2017) 9 *J. Nat’l Sec. L. & Pol’y* 53.

- 1) constitute a public health risk to other states and
- 2) potentially require a coordinated international response.

Based upon information received from both state and non-state sources (e.g., media, civil society, and other states), the WHO Director-General has the authority to determine whether an event constitutes a PHEIC.²¹ This PHEIC declaration has since been employed by WHO six times to control the international spread of infectious disease – most recently in the ongoing global struggle against Covid-19.²²

However, the Covid-19 pandemic has brought into sharp focus the limitations of the IHR in (1) reporting public health risks to WHO; (2) declaring a PHEIC where necessary to the international response; (3) coordinating national responses commensurate with public health risks; and (4) supporting national capacity for infectious disease control.

From the initial outbreak in China, delayed reporting hampered WHO's ability to understand the scope of the threat and coordinate the public health response. Legitimate questions remain as to what Chinese authorities knew, when they learned it, and whether they reported this knowledge to WHO in a "timely, accurate and sufficiently detailed" manner in accordance with the IHR.²³ Since the IHR does not give WHO unilateral authority to investigate events independently, it must continue to rely on states' "request for assistance," leaving WHO with insufficient information to declare a PHEIC without state support.

China notified WHO of this potential threat on 31 December 2019, but even with this notification, the IHR did not facilitate the timely declaration of a PHEIC. With inadequate reporting and a split in expert opinion, WHO Director-General Tedros Adhanom Ghebreyesus convened an Expert Committee on three occasions in late January 2020 to advise on the declaration of a PHEIC.²⁴ A PHEIC was finally declared on 30 January 2020, by which point the coronavirus was well on its way to becoming a pandemic. Global health scholars have often questioned WHO's tentative approach to declaring a PHEIC;²⁵ however, WHO has remained hesitant to exercise its authority to declare a PHEIC, apprehensive of a declaration that could devastate the economies of powerful states, and this reticence has delayed global preparations for a pandemic.

Following the PHEIC declaration, states have responded—in contravention of WHO guidance²⁶—with overwhelming restrictions on international traffic, individual rights, and global commerce. Whereas responses are generally expected to adhere to WHO's temporary recommendations and other IHR parameters, states are permitted to deviate from WHO guidance in only limited circumstances: where the different measures achieve

²¹ International Health Regulations (IHR) (Geneva: World Health Organization, 2005).

²² WHO, Statement on the second meeting of the International Health Regulations (2005) Emergency Committee regarding the outbreak of novel coronavirus (2019-nCoV), 30 January 2020, [https://www.who.int/news-room/detail/30-01-2020-statement-on-the-second-meeting-of-the-international-health-regulations-\(2005\)-emergency-committee-regarding-the-outbreak-of-novel-coronavirus-\(2019-ncov\)](https://www.who.int/news-room/detail/30-01-2020-statement-on-the-second-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-outbreak-of-novel-coronavirus-(2019-ncov)).

²³ Matthew M. Kavanagh, 'Authoritarianism, Outbreaks, and Information Politics,' (2020) 5(3) *The Lancet Public Health*, E135.

²⁴ Mark Eccleston-Turner, 'COVID-19 Symposium: The Declaration of a Public Health Emergency of International Concern in International Law,' *Opinio Juris Blog*, 31 March 2020.

²⁵ Richard Horton, 'The Politics of PHEIC', (2019) 393 *The Lancet* 2470.

²⁶ World Health Organisation, 'Updated WHO advice for international traffic in relation to COVID-19 outbreak', 29 February 2020.

equal or greater health protection than the IHR and WHO's recommendations and where they are based on scientific principles, and are not more invasive to persons nor more restrictive of international traffic than reasonably available alternatives, and implemented with full respect for human rights.²⁷ However, a number of countries rapidly implemented violative health measures—including traveller restrictions, flight suspensions, visa restrictions, and border closures—bringing the world to a standstill.²⁸

Further undermining the IHR through these nationalistic measures, states are actively undercutting global solidarity by sidelining their common and shared responsibility to 'collaborate...to the extent possible' in ensuring that every state achieves minimum core public health capacities to detect and respond to outbreaks.²⁹ Neglecting the IHR duty of international assistance, states have taken advantage of these ambiguities to limit, at their own peril, their field of vision to national frontiers and neglect their international responsibilities. This nationalistic short-sightedness amidst the Covid-19 pandemic is exposing the majority of the world to the threat of staggering humanitarian upheaval, economic instability, and health insecurity.

e) Human Rights Governance: The ICESCR

In addressing a global pandemic, international human rights law is uniquely placed in that it comprises a legally binding set of universally applicable norms to guide an equitable and effective response by States to Covid-19. The central place of human rights for pandemic responses is duly reflected in the IHR, which embed human rights at the heart of its approach to infectious disease prevention, control and treatment. International human rights law supports multilateralism for global health because it provides a shared and legally binding framework for action among States as well as recognising duties for other actors, and because it gives rise to multilateral and global obligations, as well as individual and domestic obligations, for the right to health.

Like global health governance, international human rights governance emerged at the conclusion of World War II, and is equally infused with ambitions of global solidarity and a cosmopolitan outlook. The Charter of the United Nations includes a commitment by member states to take joint and separate action for the protection of human rights and fundamental freedom on the basis of non-discrimination and equality.³⁰ The Universal Declaration on Human Rights, which recognises that 'all individuals are born free and equal in dignity and rights', recognised the right to an 'international order in which the rights and freedoms set forth in this Declaration can be fully realized' and a right *through* international cooperation to economic, social and cultural rights.³¹ Translating this vision into internationally binding obligations on States, the ICESCR (and subsequent international human rights treaties) have given rise to an obligation of international assistance and cooperation on States to realise economic, social and cultural rights, which include the rights to health, to an adequate standard of living and to the enjoyment of the benefits of

²⁷ World Health Organisation, International Health Regulations, (2005) Art. 43, para. 1(b).

²⁸ Roojin Habibi et al., 'Do Not Violate the International Health Regulations During the COVID-19 Outbreak,' (2020) 395 *Lancet* 664.

²⁹ WHO, International Health Regulations, (2005) Art. 44, para. 1(a).

³⁰ United Nations, Charter of the United Nations, 1945, 1 UNTS XVI, articles 55 and 56.

³¹ UN General Assembly, Universal Declaration of Human Rights, 10 December 1948, 217 A (III).

science.³² These rights give rise to obligations on States parties to take steps not only at the domestic level but also through international assistance and cooperation for, amongst other things, the 'prevention, treatment and control of epidemic, endemic, occupational and other diseases' and to assure 'medical service and medical attention in the event of sickness.'³³

Because persistent poverty and global inequity (reinforced by the actions and arrangements of globalised institutions) hinder low-income State governments from fully realising the right to health of their people without foreign resources, international obligations of assistance and cooperation provide a means to call on the international community for cooperation and assistance in realising the right to health. The international community thus becomes a duty-bearer under the right to health, responsible for respecting, protecting, and fulfilling all the economic, social, and cultural rights that underlie health through coordinated, legally accountable responses.³⁴ As clarified by the CESCR, this international assistance and cooperation requires a range of actions from States in the context of Covid-19, including: 'sharing of research, medical equipment and supplies, and best practices in combating the virus; coordinated action to reduce the economic and social impacts of the crisis; and joint endeavours by all States to ensure an effective, equitable economic recovery.'³⁵ It also means that States should refrain from 'imposing limits on the export of medical equipment, that result in obstructing access to vital equipment for the world's poorest victims of the pandemic'³⁶ and refraining from unilateral border measures that 'hinder the flow of necessary and essential goods, particular staple foods and health equipment',³⁷ as well as lifting sanctions that interfere with medical equipment procurement, debt relief and the use of flexibilities under international trade law to allow universal access to diagnostics, medicines and vaccines.³⁸

Whilst not naming all specific international institutions and initiatives, the CESCR Statement is indicative of the variety of global health governance institutions and laws that provide pathways for global cooperation and solidarity, grounded in human rights, to effectively and equitably address Covid-19. The central role of the WHO is recognised in global health governance; yet, looking across the global governance landscape, States should 'use their voting powers in International Financial Institutions to alleviate the financial burden of developing countries in combating the pandemic',³⁹ and promote flexibilities in the World Trade Organisation intellectual property regimes 'to allow universal access to the benefits of scientific advancements relating to Covid-19 such as diagnostics, medicines and vaccines.'⁴⁰

³² International Covenant on Economic, Social and Cultural Rights (ICESCR), G.A. Res. 2200A (XXI) (1966), Art. 2.1.

³³ *Ibid.*, Art. 12.

³⁴ Ashley Fox and Benjamin M. Meier, 'International obligations through collective rights: Moving from foreign health assistance to global health governance,' (2010) 12(1) *Health and Human Rights* 61.

³⁵ Committee on Economic, Social and Cultural Rights (CESCR), 'Statement on the coronavirus diseases (COVID-19) pandemic and economic, social and cultural rights'. UN Doc. E/C.12/2020/1, 17 April 2020, para. 19.

³⁶ *Ibid.*, para. 20.

³⁷ *Ibid.*

³⁸ *Ibid.*, paras. 19-23.

³⁹ *Ibid.*, para. 21.

⁴⁰ *Ibid.* See also Chuang-Feng Wu and Chien-Huei Wu, 'International Trade, Public Health, and Human Rights,' in Lawrence O. Gostin & Benjamin Mason Meier (eds), *Foundations of Global Health & Human Rights* (New York: Oxford University Press, 2020) 351-372.

Further, the UN has established a range of global initiatives that are intended to facilitate global solidarity for health in responses, providing new pathways for multilateral cooperation, most notably: a Strategic Preparedness and Response Plan, led by the WHO;⁴¹ a Global Humanitarian Response Plan, led by the Office for the Coordination of Humanitarian Affairs, particularly focused in the 63 countries facing a humanitarian or refugee crisis;⁴² and the UN Socio-economic Framework, led by the UN Development Program to mitigate the social and economic impact of Covid-19.⁴³ Yet beyond these important, forward looking examples of multilateral governance for global health, as shown by examples highlighted above, including actions to protect and preserve vaccines for domestic populations,⁴⁴ the withholding of scientific knowledge and funds from the WHO,⁴⁵ and travel restrictions,⁴⁶ States responses appear to conflict with their obligations under the ICESCR.

These failures of compliance are indicative of a broader disconnect between the valuable normative framework of international human rights law for more equitable global health responses through international assistance and cooperation, and a range of shortcomings that militate against the realisation of this vision.⁴⁷ The obligation on States of international assistance and cooperation is contested, with high income countries approaching it as a moral, rather than a legally binding obligation.⁴⁸ Further, while exerting binding legal obligations on States, international human rights law does not directly bind other important global health actors, including the private sector and philanthropic organisations, which have important roles to play in the context of Covid-19. The CESCR and other human rights actors support legally binding obligations on international organisations such as the International Financial Institutions, but this position is strongly contested by those organisations.⁴⁹ Further, despite a range of global accountability procedures, State compliance with international human rights law is often weak.⁵⁰ The challenges of Covid-19 for human rights across borders illustrate why scholars have called for a rethinking of international human rights, as well as other global health governance institutions, including the IHR,⁵¹ to render them fit for purpose to effectively address global challenges,

⁴¹ World Health Organisation, 2019 Novel Coronavirus (2019-nCoV): Strategic Preparedness and Response Plan, Draft of 3 February 2020.

⁴² United Nations Office for the Coordination of Humanitarian Affairs, 'Global Humanitarian Response Plan: COVID-19', 28 March 2020.

⁴³ United Nations, 'A UN Framework for the Immediate Socio-Economic Response to COVID-19', April 2020.

⁴⁴ Jon Cohen, 'Unveiling "Warp Speed," the White House's America-first push for a coronavirus vaccine', *Sciencemag*, 12 May 2020.

⁴⁵ Pien Huang, 'Trump and WHO: How Much Does The U.S. Give? What's The Impact Of A Halt In Funding?' *NPR*, 15 April 2020.

⁴⁶ Benjamin Mason Meier, Roojin Habibi and Y. Tony Yang, 'Travel restrictions violate international law', (2020) 367(1485) *Science* 1436.

⁴⁷ See, for example, Elena Pribytkova, 'What Global Human Rights Obligations Do We Have?' (2020) 20(2) *Chicago Journal of International Law* 664.

⁴⁸ UN Commission on Human Rights, 'Report of the Open-Ended Working Group to Consider Options Regarding the Elaboration of an Optional Protocol to the International Covenant on Economic, Social and Cultural Rights on its Second Session', UN Doc. E/CN.4/2005/52, 10 February 2005, para. 76.

⁴⁹ Committee on Economic, Social and Cultural Rights (CESCR), 'Statement on Public Debt, Austerity Measures and the International Covenant on Economic, Social and Cultural Rights', UN Doc. E/C.12/2016/1, 22 July 2016, para. 8.

⁵⁰ See, for example, Valentina Carraro, 'Promoting Compliance with Human Rights: the Performance of the United Nations' Universal Periodic Review and Treaty Bodies,' (2019) 63(4) *International Studies Quarterly* 1079-1093.

⁵¹ Allyn Taylor, Roojin Habibi, Gian Luca Burci et al., 'Solidarity in the Wake of COVID-19: Reimagining the International Health Regulations', *The Lancet*, 19 June 2020.

stakeholders and relationships that determine the enjoyment of economic, social and cultural rights worldwide.⁵²

V. Conclusion

Covid-19 is a global public health crisis that calls for global solidarity and coordinated action, yet many States have responded with nationalist approaches that ignore the need for collective action in facing this common threat. With infectious diseases providing the original impetus for the global cooperation in health, Covid-19 is a reminder of why global solidarity must be preserved and enhanced, including through strengthening global institutions to oversee a robust response. Following this unprecedented pandemic response, global health law will need to be revised to reflect the weaknesses highlighted by the Covid-19 pandemic and the need for global solidarity in facing future threats – bringing together human rights law with global health governance.

Over time, however, we are witnessing some movements towards cooperation and solidarity. With UN-led initiatives being established, countries including the UK and China enhanced contributions to the WHO, whilst € 7.4 billion was raised at an EU-hosted virtual pledging conference to fund the development of Covid-19 vaccines. Further, the African Union and African Centres for Disease Control and Prevention have been praised for collaborative efforts.⁵³ However, much more is needed, particularly more financing, for vaccine development, the global distribution of treatment and diagnostics for Covid-19, and to support both national and global responses to and preparedness for the pandemic.⁵⁴

Multilateral efforts remain a crucial health and human rights imperative, and States must continue to build up their international assistance and cooperation obligations under international human rights law, as well as their obligations under the International Health Regulations. As policymakers increasingly recognise that this pandemic will only truly end with the development of an effective vaccine, human rights obligations—at the intersection of the right to health and the right to benefit from scientific progress—international assistance and cooperation will be crucial in progressively realising universal access to the necessary benefits of this scientific breakthrough, bringing the world together to assure the highest attainable standard of health for all.

⁵² Pribytkova (n. 47).

⁵³ Matthew Kavanagh, Ngozi A. Erongu, Oyewale Tomori et al, 'Access to Lifesaving Medical Resources for African countries: COVID-19 Testing and Response, Ethics, and Politics,' (2020) 395(10238) *The Lancet* 1735-1738.

⁵⁴ Marco Schäferhoff and Gavin Yamey, 'Ending The COVID-19 Pandemic Requires Effective Multilateralism', Health Affairs Blog, 27 May 2020, <https://www.healthaffairs.org/doi/10.1377/hblog20200522.123995/full/>.