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COVID-19's New Cosmopolitanism? Structural Considerations for the Proposed Pandemic Treaty

ABSTRACT. The current movement to create a global pandemic treaty has the potential to fundamentally reshape the values and structures of global health law. Global health law has generally been organized around norms of security and charity, but the COVID-19 pandemic illustrated the weaknesses of this approach. Now, as the World Health Organization considers deploying its strongest international legal tool, an Article 19 treaty, there is a chance for change. This Note argues that the treaty's drafters should take advantage of the opportunity to shift away from a global health law system based in norms of security and charity, and move instead toward a new, more cosmopolitan view of pandemic preparedness. By combining broad normative analysis with specific technical recommendations, this Note shows how careful treaty construction can drive global health law's transformation into a more equitable and effective system that will leave us better equipped for the next pandemic—whatever and whenever that may be.

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INTRODUCTION

The SARS-CoV-2 particles drifting through Wuhan, entering nursing homes in Spokane, and settling in the lungs of healthcare workers in Milan followed no law. But nearly every other aspect of the COVID-19 pandemic response was shaped by the organizations and legal structures of global health law. International legal obligations guided the transformation of physicians' low whispers of unexplained pneumonia into international alerts, individual illnesses into aggregated disease-spread reports, and nascent scientific theory into a licensed COVID-19 vaccine. Law existed at every juncture of the COVID-19 response — albeit with varying levels of influence, effectiveness, and equity.

Indeed, the COVID-19 pandemic quickly overwhelmed preexisting legal architectures. Legal tools premised on containing disease to a limited geographic area faltered, then failed, growing increasingly divorced from the realities of the global pandemic. The years-long pandemic exhausted reservoirs of goodwill that the world once hoped might suffice for sharing pandemic-fighting resources. And legal safeguards intended to share the burdens and benefits of pandemic response tilted ever more against the interests of Global South¹ countries historically blocked from decision-making power in global health.² Global health legal structures failed to live up to their lofty promises, leaving significant questions about the future of global health law going forward.³

In response to these challenges, academics, advocates, and policymakers have dug into the veritable alphabet soup of legal structures and entities which pepper

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1. This Note uses the monikers of Global North and Global South for their alignment with current dominant terminology in the field of global health but acknowledges that alternative naming conventions such as Global Majority and Global Minority are likely more accurate, although less represented in existing literature. Paul Weller, *The Problems of the White Ethnic Majority' Revisited: A Personal, Theological and Political Review*, 15 *PRAC. THEOLOGY* 23, 31 (2022).
 2. Namely, because at the time of the World Health Organization's (WHO's) founding, more than eighty now-sovereign countries were still occupied under colonialism. *The United Nations and Decolonization*, UNITED NATIONS, <https://www.un.org/dppa/decolonization/en> [<https://perma.cc/G9N3-W9JX>].
 3. The COVID-19 pandemic is by no means over, and cases of COVID-19 will not be eliminated entirely. See *WHO: COVID Cases Drop Everywhere, but Pandemic Not Over*, AP NEWS (Sept. 7, 2022), <https://apnews.com/article/covid-health-pandemics-united-nations-a56980ac42502852ada4f31df4bc9535> [<https://perma.cc/C7ZZ-RVE7>]; Scott Neuman, *Fauci Says COVID-19 Won't Go Away Like Smallpox, but Will More Likely Become Endemic*, NPR (Jan. 18, 2022, 12:19 PM ET), <https://www.npr.org/sections/coronavirus-live-updates/2022/01/18/1073802431/fauci-says-covid-19-wont-go-away-like-smallpox> [<https://perma.cc/W3P2-NJBG>]. However, for clarity, this Note will sometimes utilize terminology of “post-COVID-19” or “following COVID-19” to signal the time period after COVID-19 was identified and sparked response on the global stage in March 2020.

the global health law system – WHO, PEF, IHR, GHSA, TRIPS, CEPI, GAVI⁴ – to reexamine fine print and suggest reforms to existing health governance. The content and scope of these proposals have varied, ranging from relatively modest calls to review existing regulations⁵ to broad critiques of international organizations and uneven distributions of power within global health.⁶ Amid these debates emerged calls for a very specific global health reform: the creation of a new treaty to govern pandemic responses.⁷

The proposal for a new pandemic treaty quickly jumped to the forefront of discussions about what global health governance could, or should, look like in the wake of COVID-19.⁸ In 2021, the WHO began the process of drafting a treaty.⁹ Article 19 of the WHO's constitution grants the WHO the broad legal authority to place binding obligations on countries through its treaty-making

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4. WHO, Pandemic Emergency Financing Facility (PEF), International Health Regulations (IHR), Global Health Security Agenda (GHSA), Trade Related aspects of Intellectual Property Rights (TRIPS), Coalition for Epidemic Preparedness Initiatives (CEPI), Gavi, the Vaccine Alliance (GAVI). This is, of course, a nonexhaustive list of the many international organizations, legal agreements, civil-society organizations, state actors, and individuals which make up the world of global health governance. Indeed, even using the terminology of “system” or “governance” overstates the cohesion of different actors in an international space as notably fragmented as global health. See Neil Spicer, Irene Agyepong, Trygve Ottersen, Albrecht Jahn & Gorik Ooms, *It's Far Too Complicated: Why Fragmentation Persists in Global Health*, 16 GLOB. HEALTH 60 (2020); John Coggon, *Global Health, Law, and Ethics: Fragmented Sovereignty and the Limits of Universal Theory*, in 16 LAW AND GLOBAL HEALTH: CURRENT LEGAL ISSUES 368, 369 (Michael Freeman, Sarah Hawkes & Belinda Bennett eds., 2014) (describing fragmentation in the global health governance system). This Note uses the perhaps more accessible, if less precise, language of global health law “systems” or “governance” for purposes of orienting nonspecialist readers to the field as a whole. Similarly, global health practitioners and scholars will note the use of “global health law” instead of “international law” in certain discussions. See Xinguang Chen et al., *What Is Global Health? Key Concepts and Clarification of Misperceptions*, 5 GLOB. HEALTH RSCH. & POL'Y (2020). This too is a simplification made in support of readability for nonspecialists.
 5. See, e.g., Lawrence O. Gostin, Roojin Habibi & Benjamin Mason Meier, *Has Global Health Law Risen to Meet the COVID-19 Challenge? Revisiting the International Health Regulations to Prepare for Future Threats*, 48 J.L. MED. ETHICS 376 (2020) (identifying critiques of existing regulations); Ching-Fu Lin, *COVID-19 and the Institutional Resilience of the IHR (2005): Time for a Dispute Settlement Redesign?*, 13 CONTEMP. ASIA ARB. J. 269 (2020) (same).
 6. See, e.g., Nicoletta Dentico, *The Breathing Catastrophe: COVID-19 and Global Health Governance*, 64 DEV. 4 (2021).
 7. See, e.g., *Global Leaders Unite in Urgent Call for International Pandemic Treaty*, WHO NEWS (Mar. 30, 2021), <https://www.who.int/news/item/30-03-2021-global-leaders-unite-in-urgent-call-for-international-pandemic-treaty> [<https://perma.cc/8TN2-4K5N>].
 8. *Id.*
 9. *Landmark Decision to Negotiate New Accord on Pandemics 'Cause for Hope,' UN NEWS* (Dec. 1, 2021), <https://news.un.org/en/story/2021/12/1106882> [<https://perma.cc/AND7-DNAP>].

power.¹⁰ To reach this point, however, the treaty must be drafted, negotiated, and accepted through the WHO's procedures and adopted by a two-thirds vote of the World Health Assembly (WHA).¹¹ On this long road, the world has already taken a significant step forward merely by starting the process. Until now, the WHO had only exercised its Article 19 powers once in its history, when it created the Framework Convention on Tobacco Control (FCTC) in 2003.¹² The intervening two decades saw few proposals for another Article 19 process, and none were seriously considered at the international level.¹³ The fact that the WHO has begun an Article 19 process for the pandemic treaty is itself historic.

Currently, the treaty draft negotiations process is in its early stages. Following calls for a pandemic treaty in 2020¹⁴ and a subsequent WHA special session

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10. Constitution of the World Health Organization, art. 19, July 22, 1946, 14 U.N.T.S. 185.
 11. Specifically, states may have obligations at minimum not to impede the treaty's aims — which could kick in even without domestic approval of the international treaty. While outside the scope of this Note, it should be noted that the full impact of a treaty varies per countries' domestic systems of incorporating international obligations into domestic law. For example, under United States law, treaties must be approved by two-thirds of the Senate and then ratified by the President. *Advice & Consent*, U.S. SENATE, https://www.senate.gov/general/Features/Treaties_display.htm [<https://perma.cc/GAX2-7ZC6>]; see also RESTATEMENT (FOURTH) OF FOREIGN RELATIONS LAW §§ 301-02, 304 (AM. L. INST. 2017) (describing the U.S. process, including how some obligations exist even if domestic ratification doesn't ultimately occur).
 12. *WHO Framework Convention on Tobacco Control Overview*, FCTC: WHO FRAMEWORK CONVENTION ON TOBACCO CONTROL, <https://fctc.who.int/who-fctc/overview> [<https://perma.cc/Z3LG-75GL>]. Conceived amid a substantial public shift in opinions on smoking, the Framework Convention on Tobacco Control (FCTC) is now widely regarded as a success story in public health, allowing increased regulation and cooperation around a major health threat. While the FCTC is a landmark moment in global health treaty power, its focus on noncommunicable health threats and specific political considerations (namely, its direct focus on a few major tobacco companies) somewhat limits its applicability to this Note's arguments about structural design choices for the Article 19 pandemic treaty, so it is not central to this Note's argument. WHO Framework Convention on Tobacco Control, adopted May 21, 2003, 2302 U.N.T.S. 166 (entered into force Feb. 27, 2005); see also Heather Wipfli, *The FCTC Turns 10: Lessons From the Fi[r]st Decade*, 26 J. EPIDEMIOLOGY 279, 281 (2016) (describing some successes of the FCTC, including its ability to draw on established research, regulation of a concentrated injury, and importance of NGO "shaming and blaming" in establishing compliance with the treaty).
 13. Some proposals have received significant attention but have not yet prompted serious WHO negotiations. *About*, FCGH ALL. (2019), <https://fcghalliance.org/about> [<https://perma.cc/FP5P-MCE4>] (describing proposals for a framework convention on global health that have not yet received WHO endorsement); see also UN Welcomes 'Most Comprehensive Agreement Ever' on Global Health, UN NEWS (Sept. 23, 2019), <https://news.un.org/en/story/2019/09/1047032> [<https://perma.cc/49GY-N7QF>] (discussing increased momentum for universal health care at the UN).
 14. See *supra* note 7.

in 2021,¹⁵ the WHO created an Intergovernmental Negotiating Body (INB)¹⁶ to kickstart the process of drafting and negotiating a treaty.¹⁷ Feedback from two rounds of public hearings¹⁸ was incorporated into a conceptual zero draft,¹⁹ which was first presented in December 2022²⁰ and most recently updated and considered by the INB in February 2023.²¹ This Note uses the February 2023 treaty draft as a baseline, with the understanding that the language and content of the treaty remain in flux. The INB's current focus is on shaping the treaty for its May 2023 progress report to the seventy-sixth WHA, itself a stop on the road toward the final vote in May 2024 at the seventy-seventh WHA. This current moment of drafting and negotiation is therefore crucial for setting the treaty's subject matter, scope, and structure.²²

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15. *Special Session of World Health Assembly 29 November 2021 - 1 December 2021*, WORLD HEALTH ORG., <https://www.who.int/news-room/events/detail/2021/11/29/default-calendar/second-special-session-of-the-world-health-assembly> [<https://perma.cc/WK7G-GNL3>].
 16. *World Health Assembly Agrees to Launch Process to Develop Historic Global Accord on Pandemic Prevention, Preparedness and Response*, WORLD HEALTH ORG. (Dec. 1, 2021), <https://www.who.int/news/item/01-12-2021-world-health-assembly-agrees-to-launch-process-to-develop-historic-global-accord-on-pandemic-prevention-preparedness-and-response> [<https://perma.cc/RR93-8XNF>]. For a description of the INB's procedure, see *INB Process*, WORLD HEALTH ORG., <https://inb.who.int/home/inb-process> [<https://perma.cc/2SYJ-52MM>].
 17. This Note uses the term "treaty," but it should be acknowledged that the terms "convention" and "agreement" also proliferate in the intergovernmental negotiating body (INB) documentation and literature. *Pandemic Prevention, Preparedness and Response Accord*, WORLD HEALTH ORG. (Nov. 25, 2022), <https://www.who.int/news-room/questions-and-answers/item/pandemic-prevention--preparedness-and-response-accord> [<https://perma.cc/M7H7-NCFZ>]. The terms are functionally synonymous for this Note's discussion of an early-stage treaty.
 18. *Public Hearings*, WORLD HEALTH ORG., <https://inb.who.int/home/public-hearings> [<https://perma.cc/LRS6-XYTQ>].
 19. World Health Organization, *Conceptual Zero Draft for the Consideration of the Intergovernmental Negotiating Body at Its Third Meeting*, U.N. Doc. A/INB/3/3 (Nov. 25, 2022).
 20. *Third Meeting of the Intergovernmental Negotiating Body (INB) for a WHO Instrument on Pandemic Prevention, Preparedness and Response*, WORLD HEALTH ORG., [https://www.who.int/news-room/events/detail/2022/12/05/default-calendar/third-meeting-of-the-intergovernmental-negotiating-body-\(inb\)-for-a-who-instrument-on-pandemic-prevention-preparedness-and-response](https://www.who.int/news-room/events/detail/2022/12/05/default-calendar/third-meeting-of-the-intergovernmental-negotiating-body-(inb)-for-a-who-instrument-on-pandemic-prevention-preparedness-and-response) [<https://perma.cc/E5KX-DB4T>].
 21. World Health Organization, *Zero Draft of the WHO CA+ for the Consideration of the Intergovernmental Negotiating Body at its Fourth Meeting*, U.N. Doc. A/INB/4/3 (Feb. 1, 2023) [hereinafter *Zero Draft*]; *WHO Member States Agree to Develop Zero Draft of Legally Binding Pandemic Accord in Early 2023*, WORLD HEALTH ORG. (Dec. 7, 2022), <https://www.who.int/news/item/07-12-2022-who-member-states-agree-to-develop-zero-draft-of-legally-binding-pandemic-accord-in-early-2023> [<https://perma.cc/4KFN-P4DQ>].
 22. The INB process has also indicated openness to a revision of the International Health Regulations (IHR) under Article 21. *WHO Member States Agree to Develop Zero Draft of Legally Binding Pandemic Accord in Early 2023*, *supra* note 21. However, because the Article 19 process at the

The INB faces a difficult task. The INB must fulfill its mandate of improving upon pre-COVID-19 legal structures and avoid simply replicating an inequitable status quo, but simultaneously it must garner enough support to avoid a total breakdown in support before the 2024 WHA vote.²³ This is a massively complex balancing act. High-income and Global North countries enjoyed disproportionate access to resources (e.g., vaccines)²⁴ and relatively strong economic positions throughout the pandemic, potentially weakening political will for new obligations. Global North actors have also historically resisted attempts at redistributing power in the global health space.²⁵ But without such power-shifting, a pandemic treaty might be yet another legal instrument that lacks both effectiveness and equity.²⁶ The treaty's legal structures will be critical in striking this balance.²⁷

This balancing speaks to existential questions about the goals of international global health law. Yet much of current scholarly attention, especially in the United States, takes place in the weeds, focused on individual aspects of existing

time of writing seemed that it would most likely continue to be the focus of the WHO's attention, this Note focuses on the Article 19 process.

23. At the moment, it is possible and perhaps likely that only a small number of states will sign onto the pandemic instrument, excluding key powers like the United States, China, and Russia.
24. Josh Holder, *Tracking Coronavirus Vaccinations Around the World*, N.Y. TIMES (Jan. 29, 2021), <https://www.nytimes.com/interactive/2021/world/covid-vaccinations-tracker.html> [<https://perma.cc/V2SP-D33D>].
25. See, e.g., Tirana Hassan, *Rich Countries Must Stop Blocking the Covid Vaccine Patent Waiver*, HUM. RTS. WATCH (Dec. 2, 2021, 2:30 PM EST), <https://www.hrw.org/news/2021/12/02/rich-countries-must-stop-blocking-covid-vaccine-patent-waiver> [<https://perma.cc/X7NY-JBCW>] (identifying Global North countries' actions as a barrier to vaccine access); Alexander Kentikelenis & Connor Rochford, *Power Asymmetries in Global Governance for Health: A Conceptual Framework for Analyzing the Political-Economic Determinants of Health Inequities*, 15 GLOBALIZATION & HEALTH art. no. 70 (2019) (discussing how large philanthropic organizations and neoliberal actors do not promote redistributive policies).
26. See, e.g., Carmen C. Gonzalez, *Environmental Justice, Human Rights, and the Global South*, 13 SANTA CLARA J. INT'L L. 151, 153 (2015) (noting ways that environmental human-rights law tends to reinforce international power imbalances).
27. See Precious Matsoso, Co-Chair, Intergovernmental Negotiating Body, Global Pandemic Preparedness and Response: Negotiating the Future, Address at the University of Southern California Institute on Inequalities in Global Health (Feb. 8, 2023) (notes on file with author) (noting the need for legal solutions).

legal instruments²⁸ or the need for attention to a particular subject matter.²⁹ Other projects focus on broader aspects of treaty development³⁰ or more general critiques of global health's inequities.³¹ This Note seeks to fill the gap between the two, linking analysis of necessary normative shifts with specific treaty provisions.

This Note argues that security and charity were the key normative principles underlying pre-COVID-19 global health law, and that this normative system failed in light of COVID-19. Part I begins by applying a four-part normative framework from the public-health-policy literature to the context of global health law, describing the normative underpinnings of global health law's early history and some of its key modern institutions and legal mechanisms. Part II focuses on the COVID-19 response and how the failures of the security- and charity-based global health law system during the COVID-19 response warrant a normative shift toward cosmopolitanism as an alternative normative baseline. Part III links this normative shift to specific decisions about the pandemic treaty's structure and subject matter that could push the treaty toward cosmopolitanism and help global health law move away from the failures of the security- and charity-based status quo.

Before embarking on this effort, a few preliminary notes are in order. First, any call for improvements in international law must balance intense and necessary skepticism of international law's ability to influence the world at all with the hope that it might in fact influence the world for the better. In the pandemic-treaty context, serious debate exists about whether such a treaty can plausibly

28. See, e.g., Sam Halabi & Kumanan Wilson, *The Independence of National Focal Points Under the International Health Regulations (2005)*, 63 HARV. INT'L L.J. 135 (2022) (discussing limitations on the implementation of the International Health Regulations through an empirical study of national focal points).

29. See, e.g., Diane Orentlicher, *Ensuring Access to Accurate Information and Combatting Misinformation About Pandemics*, 36 AM. U. INT'L L. REV. 1067, 1070 (2021) (advocating for a future treaty on pandemics to strengthen efforts at combatting misinformation); Sam F. Halabi & Ana Santos Rutschman, *Viral Sovereignty, Vaccine Diplomacy, and Vaccine Nationalism: The Institutions of Global Vaccine Access*, 36 EMORY INT'L L. REV. 1 (2022) (focusing on global vaccine access); Lindsay A. Wilson, Susan Rogers Van Katwyk, Isaac Weldon & Steven J. Hoffman, *A Global Pandemic Treaty Must Address Antimicrobial Resistance*, 49 J.L. MED. & ETHICS 688 (2021) (focusing on antimicrobial resistance).

30. See, e.g., Lawrence O. Gostin, Benjamin Mason Meier & Barbara Stocking, *Developing an Innovative Pandemic Treaty to Advance Global Health Security*, 49 J.L. MED. & ETHICS 503 (2021) (writing earlier in the treaty's development).

31. See, e.g., Ali Murad Büyüüm, Cordelia Kenney, Andrea Koris, Laura Mkumba & Yadurshini Raveendran, *Decolonising Global Health: If Not Now, When?*, 5 BMJ GLOB. HEALTH art. no. e003394 (2020).

create change³² or only distracts from more transformational improvements to global health governance.³³ This Note takes as given that current treaty drafting efforts will continue, and focuses on which much-needed reforms can occur within that process. This is intended to take nothing away from more fundamental critiques of global health law, and this Note approaches the immediate treaty negotiations with recognition and appreciation of such critiques.

Second, international relations terminology is often deeply contested. The distinctions between “governance” and “law,”³⁴ between different meanings of “cosmopolitanism,”³⁵ and between different conceptions of “rights”³⁶ are the sources of extensive debate. It is outside this Note’s scope to fully explore these debates, but this Note seeks to nuance terminological uses where possible to convey the richness of this literature.

Engaging with global health law’s thorny questions is of critical importance. The ultimate shape of the treaty will have immediate, tangible impacts on how the world deals with the devastating and ongoing COVID-19 pandemic. Three years into the pandemic, almost seven million people overall have died of COVID-19 worldwide,³⁷ and new spikes of cases continue to surge across the world.³⁸ Nor is COVID-19 the only communicable disease demanding action, a

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32. Consider, for example, arguments that power in global health is largely held by the “invisible college” of worldwide health professionals operating outside the formal legal space. DIANE CRANE, *INVISIBLE COLLEGES: DIFFUSION OF KNOWLEDGE IN SCIENTIFIC COMMUNITIES* (1988) (establishing the term).
 33. See, e.g., Unni Karunakara, *Europe Cannot “Treaty” Its Way Out of the Pandemic*, HEALTH POL’Y WATCH (Nov. 30, 2021), <https://healthpolicy-watch.news/europe-treaty-pandemic> [<https://perma.cc/DQ92-KNPL>].
 34. E.g., Francis Fukuyama, *What is Governance?*, 26 GOVERNANCE 347, 347 (2013) (describing “governance” as a broader concept than law).
 35. E.g., David T. Hansen, *Chasing Butterflies Without a Net: Interpreting Cosmopolitanism*, 29 STUD. PHIL. & EDUC. 151, 151 (2009) (describing the wide array of meanings of cosmopolitanism to different people).
 36. E.g., Brigit Toebes, *The Right to Health*, in ECONOMIC, SOCIAL AND CULTURAL RIGHTS: A TEXT-BOOK 169, 169-70 (2001) (describing competing meanings of a “right to health”).
 37. WHO Coronavirus (COVID-19) Dashboard, WORLD HEALTH ORG., <https://covid19.who.int> [<https://perma.cc/6BK8-XXD7>].
 38. Ctrs. for Disease Control & Prevention, *COVID Data Tracker*, U.S. DEP’T HEALTH & HUM. SERVS., <https://covid.cdc.gov/covid-data-tracker> [<https://perma.cc/3SUU-GTVU>]; see also Helen Davidson, *China Claims Covid Wave Has Peaked with Severe Cases, Deaths Falling Fast*, GUARDIAN (Jan. 26, 2023, 11:31 PM EST), <https://www.theguardian.com/world/2023/jan/27/china-claims-covid-wave-has-peaked-with-severe-cases-deaths-falling-fast> [<https://perma.cc/D8UA-ZCWT>] (discussing COVID-19 reports from Chinese health authorities).

reality driven home by recent mpox³⁹ and ebolavirus outbreaks.⁴⁰ Emergencies are ongoing around tuberculosis, HIV/AIDS, and malaria,⁴¹ and an underacknowledged crisis of noncommunicable diseases looms.⁴² The pandemic treaty's design will determine the world's ability to address the ongoing COVID-19 pandemic, other existing crises, and health emergencies yet to come.

I. NORMATIVE FRAMES AND THE PRE-COVID-19 SYSTEM

This Note's contribution is centered on drawing connections between the current and historic norms of global health law and ways that a pandemic treaty might shift these norms through the design of specific provisions. This conversation begins with the formulation of a normative vocabulary for discussing global health law.

First, it is important to note that “global health law” sits at the intersection of two highly normative fields: global health and international law. The prominence of epidemiological statistics and black-letter doctrine in these disciplines belies the powerful normative judgements underlying their practice. Any use of statistics and science relies on answers to basic normative questions. Questions like what, exactly, is health? Is protecting health the domain of the public or private sector, or a combination? Is health the complete elimination of risk, or is there an “acceptable” level of illness in a population? Among who? Who decides? These questions are directly applicable to the realities of pandemics and pandemic decision-making.

International law faces similar normative questions about agenda-setting, decision-making, and relationship building between different actors in the international space.⁴³ Who can bind who under international law? What authorities can shape such obligations, and where do they receive their mandate? Can an “international” law based in historical asymmetries be rehabilitated, or are

39. See generally Clare Wenham & Mark Eccleston-Turner, *Monkeypox as a PHEIC: Implications for Global Health Governance*, 400 LANCET 2169 (2022) (discussing the recent mpox epidemic).

40. *Ebola Disease Caused by Sudan Ebolavirus—Uganda*, WORLD HEALTH ORG. (Dec. 8, 2022), <https://www.who.int/emergencies/disease-outbreak-news/item/2022-DON428> [https://perma.cc/7AWT-FAG8].

41. *WHO Reveals Leading Causes of Death and Disability Worldwide: 2000-2019*, WORLD HEALTH ORG. (Dec. 9, 2020), <https://www.who.int/news/item/09-12-2020-who-reveals-leading-causes-of-death-and-disability-worldwide-2000-2019> [https://perma.cc/J6LU-WVJ7].

42. See *Noncommunicable Diseases*, WORLD HEALTH ORG. (Sept. 16, 2022), <https://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases> [https://perma.cc/TFZ8-Z3Q8].

43. Norms (in the form of customs) are themselves a recognized source of international law, with treaties having the recognized legal purpose of codifying dominant norms into binding international law. See Statute of the International Court of Justice art. 38, ¶ 1.

inequitable histories fatal to the law's legitimacy? Pandemic treaty discussion sits at the center of this critical and complex landscape.

To even begin to navigate pandemic treaty discussions with clarity, we need a normative framework. There are many such frameworks that could apply: broad principles (e.g., "equity"),⁴⁴ political projects (e.g., "neoliberalism"),⁴⁵ movement work (e.g., "decolonization"),⁴⁶ academic theories (e.g., "constructivism"),⁴⁷ rights-based approaches (e.g., "economic, social and cultural rights"),⁴⁸ and more.⁴⁹ However, this Note relies on Raphael Lencucha's discussion of the four "ethical positions" of *security*, *charity*, *isolationism*, and *cosmopolitanism* in global health.⁵⁰ These four positions, individually and in combination, already enjoy relatively widespread use in the global health law literatures and accounts of normative baselines in global health generally.⁵¹ This enables this Note to connect with current prominent literature – including works of authorities such as

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44. See, e.g., Kelly Cullinan, *Entrenching Equity in a Future Pandemic Treaty*, HEALTH POL'Y WATCH (June 10, 2022), <https://healthpolicy-watch.news/entrenching-equity-in-future-pandemic-treaty> [<https://perma.cc/5A83-CMMV>] (discussing equity as a primary normative position).
 45. See, e.g., Rama V. Baru & Malu Mohan, *Globalisation and Neoliberalism as Structural Drivers of Health Inequities*, 16 HEALTH RSCH. POL'Y & SYS. 91 (2018) (describing neoliberalism's political motivations).
 46. See, e.g., Xiaoxiao Kwete, Kun Tang, Lucy Chen, Ran Ren, Qi Chen, Zhenru Wu, Yi Cai & Hao Li, *Decolonizing Global Health: What Should Be the Target of this Movement and Where Does It Lead Us?*, 7 GLOB. HEALTH RSCH. & POL'Y 3 (2022) (describing characterizations of decolonizing global health movements).
 47. See, e.g., Jeremy Shiffman, *Agency, Structure and the Power of Global Health Networks*, 7 INT. J. HEALTH POL'Y MGMT. 879 (2018) (utilizing a constructivist lens).
 48. See, e.g., World Health Organization & Office for the High Commissioner of Human Rights, *The Right to Health: Fact Sheet No. 31*, at 1 (2000) (describing economic, cultural, and social rights as relating to the right to health).
 49. See, e.g., Matiangai Sirleaf, *Responsibility for Epidemics*, 97 TEX. L. REV. 285 (2018) (using need, culpability, and capacity).
 50. Raphael Lencucha, *Cosmopolitanism and Foreign Policy for Health: Ethics for and Beyond the State*, 13 BMC INT'L HEALTH & HUM. RTS. art. no. 29, at 3 (2013). In 2014, Gorick Ooms further expanded on Raphael Lencucha's work by discussing how Lencucha's normative starting points might lead to different forms of global health law and foreign policy. Gorick Ooms, *From International Health to Global Health: How to Foster a Better Dialogue Between Empirical and Normative Disciplines*, 14 BMC INT'L HEALTH HUM. RTS. art. no. 36, at 3 (2014).
 51. See, e.g., Lawrence O. Gostin & Allyn L. Taylor, *Global Health Law: A Definition and Grand Challenges*, 1 PUB. HEALTH ETHICS 53, 56-57 (2008); Clare Wenham, Mark Eccleston-Turner & Maike Voss, *The Risks Associated with a Pandemic Treaty: Between Global Health Security and Cosmopolitanism* (Oct. 10, 2021) (unpublished manuscript) [hereinafter Wenham et al., *Risks*], <https://ssrn.com/abstract=3950227> [<https://perma.cc/HLD2-UX2Y>]. In other formulations, Wenham and colleagues have used the term "globalism" very similarly to "cosmopolitanism," and "statism" very similarly to "security." See Clare Wenham, Mark Eccleston-Turner

Lawrence O. Gostin,⁵² Clare Wenham,⁵³ Ilona Kickbusch,⁵⁴ and Martin McKee.⁵⁵ Contributors to such literature commonly discuss a single one of the four normative starting points, offer dichotomized analysis of dueling norms,⁵⁶ or extend beyond the four normative positions emphasized in this Note to include additional frames. This Note's choice of four primary normative starting positions is therefore in close conversation with current scholars of global health governance, while extending existing work by using the four normative frames as a guide for both past analyses of global health and future projections of an improved global health law space in the novel context of pandemic treaty negotiations. Additionally beneficial is that Lencucha's four-part framework has the capacity to incorporate other major normative discussions which do not use the framework's exact terms.⁵⁷ Finally, the framework's four-part nature makes it manageable and tractable to employ while still preserving nuance between normative positions prevalent in global health discussions.

Before applying this four-part framework, it is necessary to offer a general overview of each of the four framework components and to elucidate how the norm is expressed in the context of infectious disease governance. Table 1 synthesizes this discussion.

& Maïke Voss, *The Futility of the Pandemic Treaty: Caught Between Globalism and Statism*, 98 INT'L AFFS. 837, 838-40 (2022) [hereinafter Wenham et al., *Futility*]; Ilona Kickbusch, *From Charity to Rights: Proposal for Five Action Areas of Global Health*, 58 J. EPIDEMIOLOGY & CMTY. HEALTH 630, 630 (2004) (describing a historical shift of global health away from charity and toward rights-based approaches); David Stuckler & Martin McKee, *Five Metaphors About Global-Health Policy*, 372 LANCET 95, 96 (2008).

52. See Gostin & Taylor, *supra* note 51, at 53 (emphasizing the security dimensions of global health).
53. See, e.g., Wenham et al., *Risks*, *supra* note 51, at 5.
54. See Kickbusch, *supra* note 51, at 630.
55. See Stuckler & McKee, *supra* note 51, at 96.
56. See, e.g., Wenham et al., *Risks*, *supra* note 51, at 4-5 (exploring the dichotomy between security and cosmopolitanism); Stuckler & McKee, *supra* note 51, at 96 (using multiple "metaphors" of global health).
57. For example, Lencucha's norm of "security" can accommodate international relations' discussions of "realism." See Sadia Mariam Malik, Amy Barlow & Benjamin Johnson, *Reconceptualising Health Security in Post-COVID-19 World*, 6 BMJ GLOB. HEALTH art. no. e006520, at 1-2 (2021) (linking realism and security). And this Note argues that equity can, and should, be interpreted as a critical facet of delivering on cosmopolitan norms because cosmopolitanism attends to individual need. See also Lencucha, *supra* note 50, at 6-9 (discussing equity in relation to arguments for cosmopolitanism).

The first ethical frame important for analyzing the global health law landscape is security.⁵⁸ In the global health context, “security” refers to a frequently state-centric approach to global health law that views global health as a means to achieving national or international security objectives, and often implicitly dichotomizes between “us” and “them” in the global health space.⁵⁹ Crafting global health law from the perspective of security norms privileges interventions aimed at infectious diseases with cross-border potential over other possible health threats, such as lack of access to primary care. Legal manifestations of this normative emphasis include international legal obligations that center on containing diseases within national borders.⁶⁰ In this framework, states (the primary unit of analysis) act in response to national-security concerns, such as political and economic stability, access to global trade routes, or national-status goals.⁶¹ In

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58. “Security” as understood here refers to national security. Broader, more colloquial uses of “security” used elsewhere may be compatible with cosmopolitanism or other normative starting points. For example, the term “human security” featured in some parts of global health literature uses the language of “security” but conceptually refers to a focus on individual wellbeing—bringing it closer to the normative baseline of cosmopolitanism. See Lincoln Chen & Vasant Narasimhan, *Human Security and Global Health*, 4 J. HUM. DEV. 181 (2003); Sakiko Fukuda-Parr & Carol Messineo, *Human Security: A Critical Review of the Literature* 2 (Ctr. Rsch. Peace & Dev., Working Paper No. 11, 2012), <https://soc.kuleuven.be/crpd/files/working-papers/wp11.pdf> [<https://perma.cc/B4G9-5CYU>] (describing the origins of human security within national security). Another similar term is David L. Heymann’s “individual health security,” which focuses on individual wellbeing and is associated with Indonesia’s insistence that poor countries be able to share in the benefits of vaccines developed for rich markets. See David L. Heymann et al., *Global Health Security: The Wider Lessons from the West African Ebola Virus Disease Epidemic*, 385 LANCET 1884 (2015). This conception, too, is closely related to the broader category of cosmopolitanism identified by Lencucha.
59. Lencucha, *supra* note 50, at 1.
60. See generally David P. Fidler, *SARS: Political Pathology of the First Post-Westphalian Pathogen*, in *LEARNING FROM SARS: PREPARING FOR THE NEXT DISEASE OUTBREAK* 110 (Stacey Knobler, Adel Mahmoud, Stanley Lemon, Alison Mack, Laura Sivitz & Katherine Oberholtzer eds., 2004) (linking infectious diseases’ “border-hopping” nature with the International Health Regulations).
61. Harley Feldbaum & Joshua Michaud, *Health Diplomacy and the Enduring Relevance of Foreign Policy Interests*, 7 PLOS MED. art. no. e1000226, at 2-3 (2010) (describing global health security as a means used by countries to project power and influence, improve their international image, or support other traditional foreign policy objectives). This form of security is exemplified in the bioterrorism-concerned foreign policy of Global North countries following 9/11. See, e.g., Ali S. Khan, *Public Health Preparedness and Response in the USA Since 9/11: A National Health Security Imperative*, 378 LANCET 953, 953 (2011). Sometimes the military objectives are explicit, such as in the militarization of certain infectious disease responses. See generally Adia Benton, *Whose Security? Militarization and Securitization During West Africa’s Ebola Outbreak*, in *THE POLITICS OF FEAR: MÉDECINS SANS FRONTIÈRES AND THE WEST AFRICAN EBOLA EPIDEMIC* 25 (Michiel Hofman & Sokhieng Au eds., 2017) (describing the militarization of the West African Ebola response).

practice, security is often viewed as the Global North's security against a national-security-threatening "petri dish" of the Global South—a highly problematic perspective that contributes to global health imperialism.⁶²

Charity-based international legal structures, in contrast, are primarily based on voluntariness and reactivity.⁶³ Charity norms center the voluntary distribution of aid and benefits amongst countries, with wealthy countries helping others meet common health goals only insofar as there is domestic political will and resources to do so. Where they exist at all, charity-based legal architectures are usually evidenced by their nonbinding or unenforced nature and expression through both public and private actors.⁶⁴

Cosmopolitan international legal structures, in contrast to both security and charity, *de-emphasize* statist affiliations. Instead, cosmopolitanism is distinct as a normative starting point because it puts the individual at the moral center of law and policy attention.⁶⁵ The ideal of cosmopolitanism views all individuals as "world citizens" rather than focusing on state-level political organizations.⁶⁶ In the health context, operating at the analytical level of the individual and focusing on people's wellbeing noninstrumentally (e.g., not focused on instrumentalist national security ends) creates moral requirements to improve the health of all dependent on need. Functionally, this creates mutual obligations among governments to improve global health goals. Cosmopolitanism therefore necessarily operates on a transnational scale, making international organizations an especially important and frequent site of cosmopolitan norm expression.⁶⁷ In addition, a nonstatist view of responsibility creates impacts for equity where resources and governance attention go toward need regardless of physical location. Attention to individual (vs. state) outcomes, mutual obligations to reach those outcomes in international governance space, and equity therefore represent several key features of cosmopolitanism norms identifiable in analyses of cosmopolitan mechanisms.

This initial framing of cosmopolitanism may sound like an almost idealistic choice amongst our menu of dominant normative starting points. However, it is important to acknowledge that the idealized view of cosmopolitanism has not always translated to practice. The concept of cosmopolitanism has had a fraught

62. See Jacob Levich, *The Gates Foundation, Ebola, and Global Health Imperialism*, 74 *AM. J. ECON. & SOCIO.* 704, 707 (2015).

63. Lencucha, *supra* note 50, at 3; Ooms, *supra* note 50, at 4.

64. For example, bilateral aid programs between states, see Lencucha, *supra* note 50, at 3 (describing aid programs such as disaster response), or philanthropy organizations.

65. *Id.* at 5.

66. James Dwyer, *Global Health and Justice*, 19 *BIOETHICS* 460, 467 (2005).

67. See *id.* at 467-68.

history in international relations, standing at different points for specific interventions for human rights,⁶⁸ imposition of invasive neoliberal economic policies,⁶⁹ and erosion of Global South states' sovereignty,⁷⁰ to offer just a few examples. None of these are the "cosmopolitanism" referred to in this Note. This Note's discussion of cosmopolitanism can be distinguished from past, sometimes harmful forms of cosmopolitanism in that this Note refers to the general concept of cosmopolitanism sketched out in Lencucha's framework rather than any specific application. Further, this Note acknowledges the potential complications of focusing on individual outcomes and transnational governance, such as the tradeoffs in simplicity made when moving from a statist focus (with literal lines around the constituency) to a more open-ended obligation to attend to all people's health. However, this Note's discussion of cosmopolitanism offers concrete touchpoints for legal and policy action that look significantly different from governance stemming from statist security or the hands-off approach of charity.⁷¹ As is further discussed below, the concept of cosmopolitanism is a complex but analytically important one. It should not be read either as an uncritical ideal or a replication of past, harmful policies that bear a slapped-on label of cosmopolitanism.

The final normative perspective highlighted in the four-part framework is isolationism. In contrast to security, charity, and cosmopolitanism, isolationism opposes interconnection of any form in the realm of global health,⁷² especially legally binding international obligations. Isolationist perspectives would reduce the scope of health action to meeting national needs, with no assistance given

68. See generally Willy Moka-Mubelo, *A Cosmopolitan Human Rights Regime*, in RECONCILING LAW AND MORALITY IN HUMAN RIGHTS DISCOURSE: BEYOND THE HABERMASIAN ACCOUNT OF HUMAN RIGHTS 169 (Willy Moka-Mubelo ed., 2017) (using this framing).

69. See generally Nick Stevenson, *Which Cosmopolitanism? Neoliberalism, the Society of the Spectacle and Democratic Citizenship*, J. CULTURAL MATERIALISM 92 (2008) (using this framing).

70. This threat stems from the negative and positive obligations which cosmopolitanism might impose, where positive cosmopolitan obligations require acting to secure another person's rights. Lencucha, *supra* note 50, at 7. Compare Thomas Pogge, *World Poverty and Human Rights*, 19 ETHICS & INT'L AFFS. 1 (2005) (arguing cosmopolitanism imposes negative rights), with Pablo Gilabert, *The Duty to Eradicate Global Poverty: Positive or Negative?*, 7 ETHICAL THEORY & MORAL PRAC. 537 (2005) (arguing cosmopolitanism imposes positive rights).

71. The impact of cosmopolitan norms on approach also explains why this Note focuses on cosmopolitanism as a starting principle rather than other principles such as communitarianism or regionalism which also offer progressive visions of global health. While these approaches have valuable applications in global health law, they both sit outside Lencucha's framework and also rely on country/region/group membership in a manner that arguably do not repudiate statist, security-based norms in global health law as clearly. In light of global health law's particular history, this Note chooses to focus on cosmopolitanism as a primary alternative, while still recognizing the value of other alternative frames.

72. Ooms, *supra* note 50, at 3, 5.

across borders.⁷³ Such a normative perspective manifests in countries' withdrawal from international bodies and rejection of new international obligations, especially where the obligations subject countries to enforcement.

Isolationism might appear to be the odd one out in discussions of international law, considering its fundamentally inward-looking nature. However, it offers important insights on two primary fronts. First, as will be discussed below, isolationism offers starting terminology for understanding how global health law and international obligations came into existence in the first place.⁷⁴ Second, isolationism helps to describe aspects of opposition to the pandemic treaty, often blurring with discussions of "sovereignty," and thus help to define the stakes for a more cosmopolitan instrument.⁷⁵ So while isolationism is not often visible as a normative position *within* a treaty or international instrument, it plays a significant background role both historically and into the present day.

TABLE 1. ADOPTION OF LENCUCHA'S FOUR NORMATIVE STARTING POINTS FOR ANALYSIS OF GLOBAL HEALTH LAW⁷⁶

NORMATIVE POSITION	NORMATIVE ATTITUDE TO GLOBAL HEALTH GOVERNANCE	CORRESPONDING LEGAL FEATURES	GOALS WITHIN INFECTIOUS DISEASE EMERGENCIES
	Countries should help other countries address health issues that are of common concern for	Statist legal structures, resources focused on containing and detecting disease at national borders, global	Contain infectious disease "elsewhere" to avoid cross-border disease spread, enforce state power in
SECURITY			

73. *Id.*

74. See *infra* Section I.A.1.

75. The pandemic treaty does not threaten or constrain states' sovereignty, but the term has served as somewhat of a rallying cry among those who would seem to reject international obligations of any kind – isolationism. Sophia Tulp, *WHO 'Pandemic Treaty' Draft Doesn't Sign over US Sovereignty*, AP NEWS (Feb. 24, 2023), <https://apnews.com/article/fact-check-world-health-organization-pandemic-treaty-212446302001> [<https://perma.cc/5NNN-7LCN>] (refuting such misrepresentations).

76. Adapted from Lencucha and Ooms' typologies. See Lencucha, *supra* note 50, at 3; Ooms *supra* note 50, at 3.

	international stability	health law used to project national power ⁷⁷	international disease response
CHARITY	Countries (and their agents, including in the private sector) can help other countries, if they want, for as long as they want, according to countries own priorities	Bilateral action, legal support contingent on wealthy countries' resources and willingness, ⁷⁸ increased role of private actors through philanthropy ⁷⁹	Support limited international health efforts in alignment with private enterprise
COSMOPOLITANISM	Humanity has a moral responsibility toward humanity, so countries should assist each other to improve health (or people should assist each other, across borders,	Prominence of international organizations, ⁸⁰ shared resources, shared morality, ⁸¹ acceptance of "right to health" framings, more extensive	Maximize all people's health, and share resources to achieve this end

77. See Feldbaum & Michaud, *supra* note 61, at 2-3.

78. See Ooms, *supra* note 50, at 3-4.

79. See, e.g., Jeremy Youde, *Private Actors, Global Health and Learning the Lessons of History*, 32 *MED. CONFLICT & SURVIVAL* 203, 203-08 (2016) (describing the role of private philanthropists in global health).

80. See Ruud Koopmans & Michael Zürn, *Cosmopolitanism and Communitarianism – How Globalization Is Reshaping Politics in the Twenty-First Century*, in *THE STRUGGLE OVER BORDERS: COSMOPOLITANISM AND COMMUNITARIANISM* 1, 3 (Pieter de Wilde, Ruud Koopmans, Wolfgang Merkel, Oliver Strijbis & Michael Zürn eds., 2019).

81. *Id.*

	using countries as instruments)	intercountry obligations	
ISOLATION-ISM	Countries have no responsibility whatsoever to assist other countries in improving health	High deference to country sovereignty, minimal/no intercountry legal obligations	Maintain health only within borders, without engagement in international resource sharing

The remainder of this Part uses Table 1’s normative framework to analyze global health’s historical development, prominent institutions, and specific legal mechanisms relevant to the pandemic governance. As will become clear, the existing global health law landscape is largely characterized by security and charity norms. Understanding this current normative landscape and its origins sets up this Note’s argument that norms which have long prevailed in global health’s history must change with the pandemic treaty.

A. *History of Global Health Law and the WHO*

One way of understanding the history of global health law’s development is by tracing oscillations and tensions of security, charity, cosmopolitanism, and isolationism. This Section weaves together existing literature to argue that global health was primarily founded on security and charity norms.⁸² While the post-WWII emergence of cosmopolitanism led to the formation of stronger organizations such as the WHO, charity and security frames remain dominant into the present day. Understanding the struggle of international organizations to cast off security-charity norms provides crucial context for the subsequent examination of specific pandemic control measures.

1. *Isolationism, Security, and Charity in Early Global Health Law*

For most of history, health concerns, if they were considered at all, were addressed by forms of de facto isolationism—with limited acknowledgment of

82. This overview summarizes the work of critical theorists and global health historians who have outlined in depth the relationships between colonial oppression, international trade, industrialization, and health. Rather than repeat these arguments in full, this Section merely seeks to orient these concepts toward a novel discussion of dominant global health norms, and thus connect this existing work to current pandemic-treaty discussions.

global interconnectedness, let alone coordinated international interventions.⁸³ However, this began to change in the seventeenth and eighteenth centuries as the world entered a period of “Westphalian” state-based international relations, and again in the nineteenth century when expanded trade, military movement, and colonialism increased focus on health governance within this system,⁸⁴ driven by concerns about state security. European countries imposed quarantines to avoid the spread of “Asiatic” diseases that might weaken economic and military productivity.⁸⁵ Early health organizations such as the 1902 Pan American Sanitary Bureau, the 1907 Office International d’Hygiène Publique,⁸⁶ and the Health Organization of the League of Nations formed with the motivation of preventing infectious illnesses from taking hold in European cities.⁸⁷ Countries signed agreements to report on the spread of infectious diseases but, in exchange, sought to minimize public-health policies’ impacts on trade.⁸⁸ Global health as a field arose directly from these concerns about “emergent” infectious diseases, articulated as a threat primarily from the Global South and their potential destabilizing impacts on European cities’ political and economic security. Early global health law efforts operated from a normative position of security

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83. See Obijiofor Aginam, *From Isolationism to Mutual Vulnerability and Back: International Law and Unfair Distribution of Global Disease Burdens*, 95 PROC. ANN. MEETING AM. SOC’Y INT’L L. 58, 58 (2001) (juxtaposing an isolationist view with the post-Westphalian era of international interconnectedness).
84. See generally DAVID P. FIDLER, SARS, GOVERNANCE AND THE GLOBALIZATION OF DISEASE 21-28 (2004) (describing the Westphalian system’s statist and sovereignty-concerned view of international relations, and the challenges that increased state interactions created for health).
85. David P. Fidler, *Caught Between Paradise and Power: Public Health, Pathogenic Threats, and the Axis of Illness*, 35 MCGEORGE L. REV. 45, 54 (2004); *History of Quarantine*, CTRS. FOR DISEASE CONTROL & PREVENTION (July 20, 2020), <https://www.cdc.gov/quarantine/historyquarantine.html> [<https://perma.cc/U7SU-DUE5>]; see also REPORT TO THE INTERNATIONAL SANITARY CONFERENCE OF A COMMISSION FROM THAT BODY, TO WHICH WERE REFERRED THE QUESTIONS RELATIVE TO THE ORIGIN, ENDEMICITY, TRANSMISSIBILITY AND PROPAGATION OF ASIATIC CHOLERA, at iii-iv, 3-12 (Samuel L. Abbot, trans., Boston, Alfred Mudge & Son 1867) (offering a primary account of concerns around “Asiatic” cholera).
86. Madeleine Herren, *International Organizations, 1865-1945*, in THE OXFORD HANDBOOK OF INTERNATIONAL ORGANIZATIONS 91, 96 (Jacob Katz Cogan, Ian Hurd & Ian Johnstone eds., 2016).
87. J. G. Fitzgerald, *The Work of the Health Organisation of the League of Nations*, 24 CANADIAN PUB. HEALTH J. 368, 368 (1933).
88. See Haik Nikogosian, *A Guide to a Pandemic Treaty: Things You Must Know to Help You Make a Decision on a Pandemic Treaty*, GLOB. HEALTH CTR. 16 (2021), <https://repository.graduateinstitute.ch/record/299388> [<https://perma.cc/YF2X-G8T4>] (linking early conventions to the IHR). Early conventions eventually were aggregated into the modern-day global health law of the IHR. See David P. Fidler, *From International Sanitary Conventions to Global Health Security: The New International Health Regulations*, 4 CHINESE J. INT’L L. 325, 332 (2005) (discussing the proliferation of early treaties on infectious-disease control).

that assumed the Global North was under threat from Global South contagion. This law operated to screen and condemn North-bound infectious disease, with little concern for the immense harm that so often flowed in the opposite direction.⁸⁹

Even where this early global health law system did consider some component of mutuality or ethical obligation, it was based on the loose, nonbinding terms of charity – not mutual obligation. Interactions that occurred outside of a threat-containing security framework were pursued exclusively through charity. The late nineteenth and early twentieth century was an era of great capital and colonial wealth in the Global North, and with great wealth came theories of how to spend it.⁹⁰ One racist,⁹¹ Christian nationalist⁹² view was that wealthy (Western) elites had a moral duty to fund public-health work abroad. Another was that voluntary projects could serve as a complement to profit-generating regimes and colonial conquest – both Global North priorities.⁹³ This was strategic global

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89. See João Rangel de Almeida, *Epidemic Opportunities: Panic, Quarantines, and the 1851 International Sanitary Conference*, in *EMPIRES OF PANIC: EPIDEMICS AND COLONIAL ANXIETIES* 58, 62 (Robert Peckham ed., 2015) (describing the panicked reaction of European health leadership and the quarantine measures erected in response); Helen Tilley, *Medicine, Empires, and Ethics in Colonial Africa*, 18 *AMA J. ETHICS* 743, 743 (2016) (describing health harms as part of colonializing processes).
90. See ANDREW CARNEGIE, *THE GOSPEL OF WEALTH* (Carnegie Corp. N.Y. 2017) (1889) (offering steel tycoon Andrew Carnegie's views on philanthropy); see also Matthew Wills, *A Critical Look at Gilded Age Philanthropy*, *JSTOR DAILY* (May 5, 2016), <https://daily.jstor.org/gilded-age-philanthropy> [<https://perma.cc/W4U8-N82S>] (providing a scholarly treatment and critique of these views); Michael Specter, *What Money Can Buy*, *NEW YORKER*, Oct. 24, 2005, at 56, 57-71 (linking capitalism to the health-related philanthropy of the Bill & Melinda Gates Foundation in the modern day).
91. Rudyard Kipling's infamous poem on the White Man's burden and its progeny of international-development projects embodies the racist sentiments of the era regarding international-health obligations as taken on as an act of charity. See Rudyard Kipling, *The White Man's Burden*, *KIPLING SOC'Y* (Oct. 18, 2009) (1899), https://www.kiplingsociety.co.uk/poem/poems_burden.htm [<https://perma.cc/458G-AW5N>] ("Take up the White Man's burden . . . [B]id the sickness cease . . ."); see also Ngozi A. Erondy, Dorothy Peprah & Mis-hal S. Khan, *Can Schools of Global Public Health Dismantle Colonial Legacies?*, 26 *NATURE MED.* 1504, 1504 (2020) (referencing the "white man's burden" concept's centrality to the establishment of the London School of Hygiene & Tropical Medicine, and arguing that global public-health programs continue to embody racist, colonial pasts).
92. See, e.g., Gerard Clarke, *Faith-Based Organizations and International Development: An Overview*, in *DEVELOPMENT, CIVIL SOCIETY AND FAITH-BASED ORGANIZATIONS: BRIDGING THE SACRED AND THE SECULAR* 17, 18-24 (Gerard Clarke & Michael Jennings eds., 2008) (describing the dominance of Christian churches in development projects).
93. For example, such charity-funded projects focused on the elimination of infectious illnesses deemed threatening to capitalist and imperial industry, such as typhus and yellow fever. See Daniel D. Reidpath & Pascale Allotey, *The Problem of 'Trickle-Down Science' from the Global*

health, achieved by the grace of donors, but never a system of mutual or interconnected obligations.

In summary, the pre-WWII era of global health was one that generally moved away from early isolationism and toward systems of international connection. This system was premised on security and charity norms, pursued by Global North governments eager to “protect” national security interests mixed with a smattering of private parties extending charitable resources on a purely voluntary basis.⁹⁴

2. *Competing Norms in the Post-WWII Era*

The global reordering pursued by major powers in the decades after World War II created a moment of cosmopolitan change in global health law, but one which was quickly followed by a resurgence of security framing. The postwar collapse of imperial powers weakened direct military and colonial intervention as world powers sought to limit such conflicts and move toward a new international order premised on a cosmopolitan orientation.⁹⁵ In quick succession, the postwar years saw the creation of the United Nations and its agencies as well as the expansion of human-rights-based legal mechanisms. The laws and declarations created by these bodies were unprecedented in scope, creating international obligations in binding documents such as the UN Charter and the Universal

North to the Global South, 4 BMJ GLOB. HEALTH art. no. e001719, at 1 (2019); Himani Bhakuni & Seye Abimbola, *Epistemic Injustice in Academic Global Health*, 9 LANCET GLOB. HEALTH e1465, e1465–67 (2021). Efforts also included establishing institutions of “tropical medicine” that made up the scientific backbone of the international-health charity movement. See Erondy et al., *supra* note 91.

94. There are many nuances to this broad-strokes account of statist self-interest. For example, public health and medicine during this period served not just as a tool of national governments, but also linked with socioeconomic factors and furthered social-justice movements at the grassroots level—a potential it has continued to fill well into the present day. For U.S. examples, consider how health practitioners and activists have provided reproductive care, mobilized as part of the ACT UP movement, and demanded improved tuberculosis care. See, e.g., Emily Bazelon, *Risking Everything to Offer Abortions Across State Lines*, N.Y. TIMES MAG. (Oct. 4, 2022), <https://www.nytimes.com/2022/10/04/magazine/abortion-interstate-travel-post-roe.html> [<https://perma.cc/6HUM-XFH2>]; *ACT UP Accomplishments & ACT UP Partial Chronology*, ACT UP NY, <https://actupny.com/actions> [<https://perma.cc/GSJ3-TWDV>]; Alfonso A. Narvaez, *The Young Lords Seize X-Ray Unit*, N.Y. TIMES (June 18, 1970), <https://www.nytimes.com/1970/06/18/archives/the-young-lords-seize-xray-unit-take-it-to-area-where-they-say-it.html> [<https://perma.cc/T9SN-YA64>]. However, the growing emphasis on security and charity deserves emphasis for its foundational shaping of later global health law.
95. See *What Is the Purpose or Role of the United Nations?*, DAG HAMMARSKJÖLD LIBR. <https://ask.un.org/faq/176175> [<https://perma.cc/LN48-78SM>] (describing these motivations and citing the UN Charter’s goals of “equal rights” and “fundamental freedoms for all”). The United Nations’ very structure and purpose is proof of a cosmopolitan aim.

Declaration of Human Rights.⁹⁶ In global health specifically, the formation of the WHO as a technical agency and its early involvement in advocating for the right to health via universal healthcare coverage and vaccine campaigns marked an unprecedented postwar moment of cosmopolitanism in global health.⁹⁷ Each of these changes evidences the postwar era's more cosmopolitan leanings compared to what existed prior to the UN system's founding.

However, this top-down cosmopolitan reform had limits. Ongoing colonialism⁹⁸ limited the extent to which this period could be said to be truly cosmopolitan – after all, how can a system claim a global mandate when only a fraction of the world could assent?⁹⁹ Further, this new international governance system maintained direct ties to security- and charity-based structures of the prewar years,¹⁰⁰ and became ensnared in geopolitical power struggles.¹⁰¹ In light of this context, Global South actors and decolonial theorists promoted an alternative, more inclusive form of postcolonial cosmopolitanism. Decolonization movements in Asia and Africa following World War II¹⁰² sparked critical questions

96. See U.N. Charter; Universal Declaration of Human Rights, G.A. Res. 217 (III) A, U.N. Doc. A/RES/217(III) (Dec. 10, 1948).

97. See, e.g., Gilbert Abotisem Abihiro & Manuela De Allegri, *Universal Health Coverage from Multiple Perspectives: A Synthesis of Conceptual Literature and Global Debates*, 15 BMC INT'L HEALTH & HUM. RTS. art. no. 17, at 3 (2015) (discussing cosmopolitanism and noting the Alma Ata Declaration's universal healthcare provision as an illustration of that principle).

98. At the time of the United Nations' founding there was still an entire Trusteeship Council dedicated to imperial, colonial governance. *UN Trusteeship Council Documentation: Trusteeship Council Documents*, DAG HAMMARSKJÖLD LIBR., <https://research.un.org/en/docs/tc/documents> [<https://perma.cc/XFD7-Y4P7>]. Still, there was a marked shift in discussions of international law and health pre- and post-WWII even among imperial states.

99. Only fifty-one countries made up the original UN Member States, as compared with today's membership of 193. See *Preparatory Years: UN Charter History*, UNITED NATIONS, <https://www.un.org/en/about-us/history-of-the-un/preparatory-years> [<https://perma.cc/GP6Z-HV7D>]; *About Us*, UNITED NATIONS, <https://www.un.org/en/about-us> [<https://perma.cc/82MT-Q72C>].

100. For example, the WHO evolved directly from the Eurocentric, security-focused League of Nations Health Organization. See Tilley, *supra* note 89, at 746 (linking the LNHO and WHO).

101. See Mark Harrison, *A Global Perspective: Reframing the History of Health, Medicine, and Disease*, 89 BULL. HIST. MED. 639, 672 (2015) (describing how security perspectives undergirded U.S. and U.S.S.R. vaccination campaigns); Theodore M. Brown, Marcos Cueto & Elizabeth Fee, *The World Health Organization and the Transition from "International" to "Global" Public Health*, 96 AM. J. PUB. HEALTH 62, 65 (2006) (describing the same for smallpox and malaria).

102. *Milestones: 1945-1952*, OFF. HISTORIAN, <https://history.state.gov/milestones/1945-1952/asia-and-africa> [<https://perma.cc/LNU8-Z6G5>].

about how newly established states should engage in the inherited, nonegalitarian international system.¹⁰³ One scholarly approach to this aim, known as the New International Economic Order (NIEO),¹⁰⁴ articulated two interlinked aims of newly independent states: economic engagement in an unequal global economy and investment in domestic priorities, such as health, at home.¹⁰⁵ This attempt to reorient inequitable international hierarchies centered on a form of cosmopolitanism based in postcolonial politics and international justice.¹⁰⁶ Proponents of this alternative cosmopolitanism incorporated an explicit rejection of dependence-creating charity as a baseline for global economic relationships,¹⁰⁷ further sharpening the normative force of cosmopolitanism as borne of mutual international obligations. While NIEO arguments arguably did not find wide international purchase, the contrast between postcolonial cosmopolitanism and the idealistic-but-constrained cosmopolitan vision of the early United Nations system illustrates the tensions visible even within a shared normative frame.

In the final decades of the twentieth century, global health law began to see a resurgence in security and charity norms. This era of neoliberal reforms in the late twentieth century came with harsh restrictions on the kinds of international obligations once envisioned by proponents of cosmopolitan global health. Policies pursued through the World Bank and IMF, particularly structural adjustment loan programs,¹⁰⁸ forced many Global South countries to divest from

103. One important benchmark in this movement was the 1955 Bandung Conference, which launched the Non-Aligned Movement of the “third world” (neither first nor second world, in differentiation from the U.S. and U.S.S.R.’s geopolitical influence) and inspired intellectual movements such as Third World Approaches to International Law (TWAAIL). See Adriano José Timossi, *Revisiting the 1955 Bandung Asian-African Conference and Its Legacy*, S. CTR. (May 15, 2015), <https://www.southcentre.int/question/revisiting-the-1955-bandung-asian-african-conference-and-its-legacy> [<https://perma.cc/LW22-JX5K>]; Michael Fakhri & Kelly Reynolds, *The Bandung Conference*, OXFORD BIBLIOGRAPHIES (Mar. 30, 2017), <https://www.oxfordbibliographies.com/display/document/obo-9780199796953/obo-9780199796953-0150.xml?rskey=3BvBpK&result=1&q=The+Bandung+Conference#firstMatch> [<https://perma.cc/7CS3-9JMY>].

104. ADOM GETACHEW, *WORLDMAKING AFTER EMPIRE: THE RISE AND FALL OF SELF-DETERMINATION 2* (2019). Notice that this framing from New International Economic Order (NIEO) theorists cuts against some common characterizations of decolonization movements as overly statist or incompatible with cosmopolitanism. *Id.* at 14-15. This insight emphasizes that decolonization movements did have substantial elements of cosmopolitanism insofar as NIEO theorizing featured a desire for and focus on international participation, but sought that this participation be equitable.

105. See, e.g., *id.* at 143, 155; *id.* at 171-72 (discussing health).

106. *Id.* at 32, 33.

107. *Id.* at 159.

108. *Id.* at 172.

health infrastructure in order to meet Global-North-imposed economic priorities.¹⁰⁹ Deprivation of domestic public support in turn led to a reliance on international charity and foreign-aid policies instead of the kinds of redistributive funding forms advocated for by NIEO advocates.¹¹⁰ Reliance on such charity-funded nonstate actors from the Global North to fill healthcare-service vacuums further tipped already asymmetrical relationships in health-funding and agenda-setting.

A new expression of security norms arose in the early 2000s from fears of health-based national-security threats. Cold War tensions between the United States and Russia and fears of bioterrorism following the 9/11 attacks put health concerns at the top of “high politics” security agendas.¹¹¹ This further shifted the normative baseline of global health toward security. This new context explicitly securitized global health, with health showing up on agenda items at the UN Security Council and NATO programming, to cite just a few contexts.¹¹² The entrenchment of security framings became even more explicit during the infectious disease crises of SARS (2002-2003) and Ebola (2014-2016), both of which sparked explicitly securitized responses from the international community, including literal military units sent from the United States, China, England, and Cuba to contain the outbreaks.¹¹³

In summary, the modern era of global health governance and global health law reflected broader shifts in international law post-WWII. First, an influx of law and policy fostering global connectedness and responsibility, challenges to extend cosmopolitan reforms further, and then an erosion of (already contested)

109. There are, of course, important complications to this narrative. For example, it is not the case that national governments in the Global South were agentless and only responding to failures at the international level. See Simukai Chigudu, *The Politics of Cholera, Crisis and Citizenship in Urban Zimbabwe: ‘People Were Dying Like Flies,’* 118 AFR. AFFS. 413, 415-17 (2019) (discussing the interlinkages between national political decision-making about allocation of domestic resources and health outcomes in Zimbabwe).

110. See GETACHEW, *supra* note 104, at 158.

111. See Harrison, *supra* note 101, at 672, 674-75.

112. See, e.g., Simon Rushton & Maïke Voss, *The United Nations Security Council and Health Emergencies: Introduction*, 76 AUSTRALIAN J. INT’L AFFS. 1, 1 (describing increased attention to health subjects in the United Nations Security Council); Jim Garamone, *NATO Looks to Ensure Health Crisis Doesn’t Become Security Crisis*, U.S DEP’T DEF. (May 14, 2020), <https://www.defense.gov/News/News-Stories/Article/Article/2187309/nato-looks-to-ensure-health-crisis-doesnt-become-security-crisis> [<https://perma.cc/UV3T-FXYV>] (describing NATO’s attention on COVID-19).

113. See Benton, *supra* note 61, at 29-32 (describing the military response to Ebola). We can contrast this response with potential alternatives such as relying primarily on countries’ professional medical associations or agencies (e.g., Centers for Disease Control and Prevention) to export expertise, a configuration that would more explicitly represent a cosmopolitan rather than security-based approach.

cosmopolitan features as securitized and charitable structures returned. These broad normative patterns are also visible in the specific institutional features of global health's preeminent body: the WHO.

3. *The World Health Organization: The Institution and Legal Powers*

The overall institutional background of the WHO and its associated norms suggest both the potential limitations of a pandemic treaty and the opportunities available for transcending these limitations. As one of the international organizations developed during the post-WWII period of contested normative baselines, the WHO's structure displays a clear cosmopolitan optimism even as it faces practical constraints in delivering on this normative perspective.¹¹⁴ Established in 1948 as the United Nations' specialized health agency, the WHO features a broad constitutional mandate to "promote . . . health"¹¹⁵ for the 194 UN member states which make up its constituency. Practically, the WHO provides expertise to country leadership, offers international guidance on health standards, and collects health data. The WHA, the WHO's governing body, sets the agency's agenda through a one-country, one-vote system, an equitable form of decision-making that reflects the WHO's cosmopolitan ambitions.¹¹⁶ Financial contributions among member countries are similarly democratic, with mandatory contributions rather than an entirely voluntary funding model.¹¹⁷ The WHO's structure provides a cosmopolitan starting point that is relatively unique even within the UN system, and certainly within global health law.

And yet, in practice, the WHO often does not deliver on its cosmopolitan normative promise of its broad institutional mandate. A large and increasing share of countries' contributions to the WHO's budget is voluntary (i.e., chari-

114. See Jennifer Prah Ruger, *Normative Foundations of Global Health Law*, 96 GEO. L.J. 423, 426-27 (2008) (describing the misalignment of the WHO's articulated vision and self-interested realities).

115. Constitution of the World Health Organization, *supra* note 10, pmb1.

116. Compare the World Health Assembly's (WHA) one-country, one-vote voting structure with the authority of the security assembly and the less equitable voting structure in that UN body. See Bjarke Zinck Winther, *A Review of the Academic Debate About United Nations Security Council Reform*, 6 CHINESE J. GLOB. GOVERNANCE 71, 92-94 (2020) (describing the representational challenges with the United Nations Security Council for the Global South).

117. See *The U.S. Government and the World Health Organization*, KFF (May 19, 2022), <https://www.kff.org/coronavirus-covid-19/fact-sheet/the-u-s-government-and-the-world-health-organization> [<https://perma.cc/7XMV-3AAJ>]; *How WHO Is Funded*, WORLD HEALTH ORG., <https://www.who.int/about/funding> [<https://perma.cc/4B4Y-BQAB>]. However, note that funding has become increasingly voluntary. See *infra* note 316.

table), and these contributions are often earmarked for security-focused topics.¹¹⁸ Uneven funding creates diplomatic pressures that weaken the one-country, one-vote governance ideal. For example, because the security-concerned United States and the charitable Gates Foundation are among the largest WHO donors,¹¹⁹ there lies a real risk of stacking the normative deck against other countries' perspectives and preferred normative frames, or at minimum weakening the representative nature of WHA discussions to appease top donors.¹²⁰ This illustrates that while the WHO is cosmopolitan in principle, in practice, it frequently embodies security-charity norms.

These broader institutional observations translate to the WHO's deployment of its specific legal powers. The WHO Constitution sets out several legal tools to further global health priorities, each with differing levels of binding power. First, Articles 23 and 62 of the Constitution give the WHA authority to offer recommendations and monitor compliance with those recommendations, respectively.¹²¹ This ability to set "soft" standards for member-country action through recommendations contributes to customary international law and international legal practice by providing evidence of global consensus (the source of authority for these two statutory forms of international law).¹²² But while countries could face reputational damage for noncompliance, recommendations lack stronger enforceability. Still, WHO recommendations are a tool to develop normative power in global health law¹²³ while avoiding the backlash that arises when an international organization imposes obligations on a country.

118. See *The U.S. Government and the World Health Organization*, *supra* note 117 (describing earmarked funding and focus on specific activities such as emergency response that this Note has shown correlates with national-security priorities).

119. *Our Contributors*, WORLD HEALTH ORG., <https://www.who.int/about/funding/contributors> [<https://perma.cc/8FCG-2F4F>]. Germany is the highest contributor, and the United Kingdom and the European Commission are the fourth and fifth highest contributors. Josephine Moulds, *How Is the World Health Organization Funded?*, WORLD ECON. F. (Apr. 15, 2020), <https://www.weforum.org/agenda/2020/04/who-funds-world-health-organization-un-coronavirus-pandemic-covid-trump> [<https://perma.cc/72MT-B9D2>].

120. An additional potential issue is the prevalence of nonpublic organizations among the WHO's top donors. *Our Contributors*, *supra* note 119. This may raise concerns around transparency and self-interest.

121. Constitution of the World Health Organization, *supra* note 10, arts. 23 & 62.

122. Lawrence O. Gostin, Devi Sridhar & Daniel Hougendobler, *The Normative Authority of the World Health Organization*, 129 PUB. HEALTH 854, 855 (2015).

123. *Id.*

A more powerful form of WHO lawmaking is its Article 21 power to adopt technical regulations.¹²⁴ The WHO can issue regulations binding on its member countries so long as the regulations' topic pertains to a preset menu of subjects deemed within the WHO's remit – sanitation, quarantine, nomenclatures, diagnostic standards, and advertising and labeling of health materials.¹²⁵ These categories reflect early global health law's concern with protecting borders and national security. After the regulations pass a WHA vote, they automatically come into force unless members express reservations in a predefined time window.¹²⁶ Despite the relative power of regulations' opt-out-only treaty structure, their constraint to a few prespecified subject areas that are largely technical and limited to historical ideas of "sanitation" means that regulations are rarely applied outside of health-security contexts.¹²⁷ Even where regulations do exist, country leadership often views them as mere technical guidance rather than as serious obligations to be prioritized.¹²⁸

Finally, Article 19 allows the WHO to create treaties¹²⁹ – its strongest legal power. Article 19 of the WHO Constitution allows a two-thirds majority of the WHA to adopt "conventions or agreements with respect to any matter within the competence of the Organization," after which individual countries then accept and implement the treaty through their own domestic processes.¹³⁰ Article 19 processes differ from regulations in their increased scope of action (any topic

124. The IHR is an example of this form of regulation. These regulations are technically treaties as defined by the Vienna Convention on the Law of Treaties. Jen Kates & Rebecca Katz, *U.S. Participation in International Health Treaties, Commitments, Partnerships, and Other Agreements*, KFF 5 (Sept. 2010), <https://www.kff.org/wp-content/uploads/2013/01/8099.pdf> [<https://perma.cc/8QFW-VECJ>]; WHO: *Health Assembly to Finalize Nature of New Pandemic Instrument*, TWN (Aug. 1, 2022), <https://www.twn.my/title2/health.info/2022/hi220801.htm> [<https://perma.cc/4FZG-2L9Z>].

125. Constitution of the World Health Organization, *supra* note 10, art. 21.

126. Gostin et al., *supra* note 122, at 856. For example, in accepting the authority of the International Health Regulations (a prominent pre-COVID-19 mechanism discussed in detail in Section I.B), the United States submitted a reservation allowing it to waive certain obligations if the United States finds that there are national-security considerations – another explicit example of how security norms interact with WHO governance.

127. See *infra* Section I.B for more detailed discussion of the IHR.

128. Alexandra Phelan & Kilaparti Ramakrishna, *Global Health Law and the Issue of Compliance: What Will Make the Global System Work?*, Panel Discussion at the 116th Meeting of the American Society of International Law (Apr. 7, 2022) (notes on file with author).

129. Specifically, the WHO's Constitution allows the creation of a convention or agreement – terms in international law which, for this Note's purposes, are interchangeable with the more colloquially familiar term "treaty."

130. Constitution of the World Health Organization, *supra* note 10, art. 19.

of WHO competence), their opt-in nature (rather than opt-out), and their domestic implementation requirements.¹³¹ Article 20 strengthens Article-19 treaties by including a requirement that countries domestically implement treaty provisions within eighteen months of the treaty's adoption in the WHA,¹³² with the WHO monitoring country compliance.¹³³ This monitoring authority is unique in international law, where treaties are often left to languish at the domestic level with no oversight.¹³⁴ The pandemic treaty, if accepted by the WHA in 2024, would mark the second use of the WHO's Article-19 power, and could impose a significantly more robust set of international-law obligations than WHO resolutions or regulations.

B. Existing Pandemic-Response Tools

Section I.A presented a broad-strokes view of global health law's normative history and the baseline structure and legal power of its primary institution, the WHO. This Section builds on this discussion to specifically detail legal tools related to pandemic response. Specifically, this Section describes four key legal mechanisms which currently govern pandemic response: (1) the International Health Regulations, (2) the Global Health Security Agenda, (3) the TRIPS Agreement, and (4) the Pandemic Emergency Financing Facility. These are far from the only legal features of the global health law system.¹³⁵ However, the sa-

131. Gostin et al., *supra* note 122, at 856.

132. This is a relatively short timeline in international law.

133. Countries must send reports to the WHO Director-General on domestic progress made and must provide explanations for any suspected barriers for implementing the treaty domestically. As will be discussed further in Section III.B's discussion of compliance challenges, forcing such compliance is a fraught process in international law. However, a requirement for domestic implementation with related monitoring requirements creates a possibility for accountability within public international law that would otherwise be absent.

134. Despite the immense power granted to it by the WHO Constitution, the WHA has exercised its Article-19 powers only once to date – to implement the Framework Convention on Tobacco Control and its subsequent protocols. See *WHO Framework Convention on Tobacco Control Overview*, *supra* note 12. The only other identified recent attempt to create an Article-19 treaty was the 2012 effort to form an alternative model for pharmaceutical research and development, but this was frustrated by opposition from high-income countries. Germán Velásquez & Nirmalya Syam, *A New WHO International Treaty on Pandemic Preparedness and Response: Can It Address the Needs of the Global South?*, S. CTR. 5 (May 2021), <https://www.southcentre.int/wp-content/uploads/2021/05/PB-93-A-New-WHO-International-Treaty-on-Pandemic-Preparedness-and-Response-REV-2.pdf> [<https://perma.cc/EM48-5X7Q>].

135. Keep in mind that the global health-law system is highly fragmented. See *supra* note 4; Anna Rouw, Jennifer Kates, Kate Toole, Anjali Britto & Rebecca Katz, *Assessing the Role of Treaties*,

lience of these mechanisms to the COVID-19 response warrants a particular descriptive and normative accounting of these legal tools, as they help form the backdrop for current pandemic treaty discussions.

TABLE 2. SUMMARY OF LEADING GLOBAL HEALTH LEGAL MECHANISMS RELEVANT TO THE COVID-19 RESPONSE

LEGAL MECHANISM	ORGANIZATIONAL SEAT	HISTORICAL CONTEXT	LEGAL STATUS	SUBJECT MATTER FOCUS	NORMATIVE FEATURES
International Health Regulations (2005)	World Health Organization	Early European infectious disease; HIV/AIDS; SARS	Binding opt-out treaty (Article 21)	Surveillance; notification; travel; trade	Security framing (border focused)
Global Health Security Agenda (2014)	Bilateral (U.S.-led); World Health Organization (through IHR)	Ebola outbreak	Non-binding multi-lateral agreement	Surveillance; counter-measures; financing	Security framing
TRIPS Agreement (2001)	World Trade Organization	Neoliberal trade reform	Binding agreement	Intellectual property	Security framing (trade stabilization); charity

Conventions, Institutions, and Other International Agreements in the Global COVID-19 Response: Implications for the Future, KFF (Jan. 24, 2023), <https://www.kff.org/global-health-policy/issue-brief/assessing-the-role-of-treaties-conventions-institutions-and-other-international-agreements-in-the-global-covid-19-response-implications-for-the-future> [https://perma.cc/9Y4N-N2B6].

					framing (reliance on private actor bene- volence)
Pandemic Emerg- ency Financing Facility (2016)	World Bank	Ebola outbreak	Voluntary	Cash and insurance assistance for poor countries facing pandemic	Charity framing (voluntary contributio ns)

1. *International Health Regulations*

The International Health Regulations (IHR) is the world’s most central pandemic-fighting instrument and the paradigmatic example of a security-based global health law.¹³⁶ Originating from legal agreements made in early European sanitary conferences, the IHR was adopted into the new UN system as an Article 21 regulation in 1969 and revised into its modern form in 2005.¹³⁷ The IHR’s primary impact was to consolidate earlier public health controls into a modern-day legal instrument, including requiring member states to report public-health events and setting out criteria for deciding whether a particular event constitutes a “public health emergency of international concern” (PHEIC), which triggers additional obligations.¹³⁸

136. WORLD HEALTH ORGANIZATION, INTERNATIONAL HEALTH REGULATIONS (2005) (3d ed. 2016) [hereinafter IHR]; Annelies Wilder-Smith & Sarah Osman, *Public Health Emergencies of International Concern: A Historic Overview*, 27 J. TRAVEL MED. 1 (2020) (“The International Health Regulations (IHR) have been the governing framework for global health security since 2007.”).

137. See Lawrence O. Gostin & Rebecca Katz, *The International Health Regulations: The Governing Framework for Global Health Security*, 94 MILBANK Q. 264 (2016).

138. *International Health Regulations Overview*, WORLD HEALTH ORG., https://www.who.int/health-topics/international-health-regulations#tab=tab_1 [https://perma.cc/W38Z-5QPD]. The definition of public health emergency of international concern (PHEIC) further bakes in security-based, statist concerns by defining a PHEIC as an event that in part: (1) poses a risk to other states (2) through the international spread of disease. IHR, *supra* note 136, art. 1.

The IHR's history evidences its security focus. The IHR's origins are strongly rooted in European fears of border-hopping infectious diseases and attempts to contain such infectious diseases' impacts (including on trade and economic security).¹³⁹ Infectious-disease emergencies (such as the HIV/AIDS and SARS epidemics) and their concomitant calls for security also drove the IHR's later developments, culminating in its 2005 reform.¹⁴⁰ The very history of its revisions supports the conclusion that the IHR retained and reinforced its essential character as a security-based instrument¹⁴¹ that focused on the detection, reporting, and containment of infectious disease for the purpose of states' stability.

A focus on security norms is also apparent throughout the IHR text. The 2005 IHR's stated purpose to "prevent, protect against, control, and provide public health response to the international spread of disease . . . [and] avoid unnecessary interference to international traffic and trade" hints at twin goals of containment and trade protection, rather than protecting health systems or specifically protecting population health.¹⁴² Most of the IHR's provisions focus on the buildup to the declaration of an outbreak and putting the world on alert—not on caring for the unlucky few visited by a novel pathogen. For example, Articles 5-11 set out requirements for the surveillance and notification of potential epidemic disease. Only once these obligations are fulfilled do secondary factors kick in—such as balancing containment aims with trade, travel, and human rights.¹⁴³ Even when these secondary factors come into play, there is a security-driven focus on stabilization of global trade; Parts IV and V of the IHR focus on states' borders (through travel and trade).¹⁴⁴ Article 43 requires that countries justify the legitimacy of their health responses by explaining how they have

139. See Fidler, *supra* note 88 (linking the sanitary conferences and International Sanitary Regulations of 1951 and the IHR); Lucia Mullen, Christina Potter, Lawrence O. Gostin, Anita Cicero & Jennifer B. Nuzzo, *An Analysis of International Health Regulations Emergency Committees and Public Health Emergency of International Concern Designations*, 5 *BMJ GLOB. HEALTH* art. no. e002502, at 2, 9 (2020) (noting concerns about the potential negative impacts of the IHR on travel).

140. Fidler, *supra* note 88, at 338-39 (describing the HIV/AIDS crisis as sparking IHR reforms); *id.* at 343 (describing the SARS pandemic as a "tipping point" for the WHO's embrace of global health-security perspectives).

141. See generally Gostin & Katz, *supra* note 137 (describing the origins of the IHR in powerful countries' self-protection, and describing generally the IHR's development along security lines); Fidler, *supra* note 88, at 343 (describing the IHR as embodying a strategy of global health security).

142. LAWRENCE O. GOSTIN, *GLOBAL HEALTH LAW* 182-83 (2014).

143. IHR, *supra* note 136, art. 12.

144. *Id.* pts. IV & V.

sought to avoid interference with travel and trade,¹⁴⁵ language repeated throughout the IHR body. The vast majority of the IHR's actual text is focused on how to protect states' borders and protect international trade – paradigmatic security concerns.

This is not to say that the IHR's approach is entirely unfeeling or lacks a sense of global responsibility most characterized by cosmopolitanism. It is important to remember, for example, that Article 21 processes carry the WHO's second-highest level of legal weight and that the IHR did set up a system of increased global collaboration. However, its current text remains primarily rooted in the instrument's security-based history.

In addition to these issues, the particular enforcement mechanisms in the current security-based IHR raise additional concerns about potentially disparate impacts on Global South states. The security-based imperative to contain infectious disease expresses itself within the IHR through a bevy of deadlines and tight timetables.¹⁴⁶ But with countries' international obligations only kicking in once a disease threatens to hop borders and a PHEIC is declared, it is difficult to tell whether a country's delay in reporting is due to malice, insufficient resources, or some combination of the two. This, in turn, frustrates attempts at accountability critical for the IHR's legitimacy, especially for certain low- and middle-income countries in the Global South who have been historically excluded from international financing.¹⁴⁷ Countries also have no access to funding support for meeting IHR obligations. Deadlines and requirements are imposed from the international level¹⁴⁸ with no variation for countries' individual capacities,¹⁴⁹ reflecting an interest in containment without an attendant commitment to resource-sharing or developing local-health institutions.

2. *Global Health Security Agenda*

While the majority of this Note's discussion focuses on truly international legal instruments established via international governing bodies, the Global

¹⁴⁵ *Id.* art. 43.

¹⁴⁶ Countries that detect a novel pathogen must notify the WHO within twenty-four hours of evidence of a public-health risk, the WHO must reply to submitted information in the twenty-four hours after that, and finally, the WHO must distribute information to intergovernmental organizations “as soon as possible.” Phelan & Ramakrishna, *supra* note 128.

¹⁴⁷ See *infra* note 199 (discussing the impact of structural readjustment loans).

¹⁴⁸ Given the historical roots of the IHR and the United States's role as the modern champion of security-focused norms, it would be fair to say “imposed from the Global North.”

¹⁴⁹ See generally Dhruv M. Shah, Mrunmayi Kulkarni & Poonam Mathur, *The Impact of Neocolonialism on India's COVID-19 Response*, 88 ANNALS GLOB. HEALTH art. no. 33 (2022) (arguing for country-specific pandemic responses).

Health Security Agenda (GHSa) is important enough in the pandemic space to justify an exception.¹⁵⁰ The GHSa is a U.S.-led, voluntary international collaboration¹⁵¹ designed to improve compliance with the IHR and further health security norms.¹⁵² Similar to the way that HIV/AIDS and SARS motivated the creation of the 2005 IHR, the United States' concerns about SARS, H1N1, and Ebola sparked interest within U.S. leadership in shoring up IHR compliance capability in lower-income (primarily Global South) countries.¹⁵³ Like the IHR, the GHSa is primarily focused on infectious disease surveillance and response and, as evidenced by its title, has an explicit security framing.¹⁵⁴ This is supported by the GHSa's substantive recommendations, which focus on improving countries' health-security capacities—the GHSa explicitly attempts to create a biosecurity system in every country.¹⁵⁵ However, there are some aspects of the GHSa that expand beyond the IHR's single-minded focus on borders, trade, and PHEICs.¹⁵⁶ Finally, the GHSa signals an emphasis on building general health

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150. Another potential example of highly influential country-led action lies in the health-related aspect of China's Belt and Road Initiative. See generally Moritz Rudolf, *China's Health Diplomacy During Covid-19: The Belt and Road Initiative (BRI) in Action*, GERMAN INST. FOR INT'L & SEC. AFFS. (Jan. 9, 2021), https://www.swp-berlin.org/publications/products/comments/2021Co9_ChinaHealthDiplomacy.pdf [<https://perma.cc/SAH3-L87T>] (describing China's goal of building international cooperation in the health sector through its "health silk road").
151. Sara Beth Wolicki et al., *Public Health Surveillance: At the Core of the Global Health Security Agenda*, 14 HEALTH SEC. 185 (2016).
152. See Josh Michaud, Kellie Moss & Jennifer Kates, *The U.S. Government and Global Health Security*, KFF (May 21, 2021), <https://www.kff.org/global-health-policy/issue-brief/the-u-s-government-and-global-health-security> [<https://perma.cc/3FFT-SS4P>] (describing the GHSa as a mechanism focused on "identifying and addressing gaps in basic global health security capacities").
153. Bonnie Jenkins, *Now Is the Time to Revisit the Global Health Security Agenda*, BROOKINGS INST. (Mar. 27, 2020), <https://www.brookings.edu/blog/order-from-chaos/2020/03/27/now-is-the-time-to-revisit-the-global-health-security-agenda> [<https://perma.cc/VZS2-W46D>]. For example, biodefence capacities. See, e.g., Press Release, White House, Fact Sheet: The Global Health Security Agenda (July 28, 2015), <https://obamawhitehouse.archives.gov/the-press-office/2015/07/28/fact-sheet-global-health-security-agenda> [<https://perma.cc/TB3R-7SET>] (announcing U.S. efforts to help African countries "prevent, detect, and respond to biological threats" following the Ebola outbreak).
154. See *Strengthening Health Security Across the Globe: Progress and Impact of U.S. Government Investments in the Global Health Security Agenda*, WHITE HOUSE (2020), <https://www.whitehouse.gov/wp-content/uploads/2021/10/Global-Health-Security-Agenda-Annual-Report.pdf> [<https://perma.cc/AR25-GE7K>].
155. See Press Release, White House, *supra* note 153.
156. For example, the GHSa addresses underlying resource challenges via funding. *Strengthening Health Security Across the Globe: Progress and Impact of U.S. Government Investments in the Global Health Security Agenda*, *supra* note 154, at 2; see also *What Is the Global Health Security Agenda?*,

capacities outside of emergency contexts.¹⁵⁷ Nonetheless, the GHSA's voluntary structure, the dominance of a single (Global North) country's perspective in its planning,¹⁵⁸ and the relative rigidity of its top-down imposed rules¹⁵⁹ confirm its focus on security as a defining normative framework.

Finally, the voluntary nature of the GHSA and its congressional funding suggests the additional norm of charity. Despite their relative consistency,¹⁶⁰ congressional appropriations for the GHSA follow no binding obligation, and congressional funding for global health security has historically waxed and waned over time.¹⁶¹ These features typify charitable mechanisms. The GHSA therefore proceeds from both security and charity norms.

CTRS. FOR DISEASE CONTROL & PREVENTION (May 20, 2022), <https://www.cdc.gov/globalhealth/security/what-is-ghsa.htm> [<https://perma.cc/L4C7-4K73>] (describing the GHSA). It also expands the IHR's scope by including concerns posed by antimicrobial resistance, environmental degradation, and nonstate actors. Compare IHR, *supra* note 136 (excluding any mention of these subjects), with *Global Health Security Agenda: Action Packages*, CTRS. FOR DISEASE CONTROL & PREVENTION (Sept. 2014), https://www.cdc.gov/globalhealth/healthprotection/ghs/pdf/ghsa-action-packages_24-september-2014.pdf [<https://perma.cc/M8SW-K2WV>] (showing that GHSA action packages include antimicrobial resistance and environmental issues). See generally Wolicki et al., *supra* note 151 (describing the GHSA's security and surveillance focuses). The GHSA's goals are operationalized in the form of action packages: eleven focus areas with benchmarks and discrete aims to aid in country uptake. *Global Health Security Agenda: Action Packages*, *supra*. One of these goals explicitly focuses on legal preparedness and the need for domestic legal provisions to allow equitable access to countermeasures such as diagnostics, vaccines, and therapeutics. *Id.* at 26.

157. See *About Global Health Security*, CTRS. FOR DISEASE CONTROL & PREVENTION (Dec. 17, 2021), <https://www.cdc.gov/globalhealth/healthprotection/ghs/about.html> [<https://perma.cc/483E-VLKN>] (noting some expanded scope such as generalized laboratory capacity support and workforce development).
158. The United States, or any country for that matter, serving as the singular driver of an international mechanism is an inherent limitation in a consensus-based space. In contrast, the pandemic treaty is supported by a wide coalition of countries from both the Global North and South and will be inherently multilateral in its WHA adoption structure.
159. See generally Daniel Stowell & Richard Garfield, *How Can We Strengthen the Joint External Evaluation?*, 6 *BMJ GLOB. HEALTH* art. no. e004545 (2021) (describing challenges to the IHR such as the lack of attention on subnational capacity).
160. Jennifer Kates, Josh Michaud, Ashley Kirzinger & Cailey Muñana, *A Check Up on U.S. Global Health Policy, After One Year of the Trump Administration*, KFF (Jan. 29, 2018), <https://www.kff.org/global-health-policy/issue-brief/a-check-up-on-u-s-global-health-policy-after-one-year-of-the-trump-administration> [<https://perma.cc/SLE7-VB8K>].
161. Michaud et al., *supra* note 152.

3. TRIPS Agreement

The Trade-Related Aspects of Intellectual Property Rights (TRIPS) Agreement¹⁶² is another important framework in global health law that emphasizes security and charity, this time in the intellectual property (IP) space. Negotiated at the peak of neoliberal influence in the 1986-94 Uruguay Round, the TRIPS Agreement is a multilateral agreement on intellectual property covering subjects such as copyrights, trademarks, and (importantly for global health) patents.¹⁶³ The TRIPS Agreement sets a high level of international protection for IP, strengthening the position of IP holders. While written from the perspectives of rightsholders, without global health necessarily in mind, the TRIPS Agreement is crucial to health because of the centrality of IP in the health space. TRIPS constrains the discretion countries have to establish their own domestic approach to IP, including to prioritize health, and instead gives power to the private sector.

The TRIPS Agreement's strong IP protections express security and charity norms, as do many details of its implementation. First, the TRIPS Agreement emphasizes trade stabilization—a form of economic security—over potential competing priorities, including health. Before TRIPS, countries had more flexibility to loosen IP protections and increase access to lifesaving medicines and vaccines.¹⁶⁴ However, updates to the WTO's trade frameworks in the neoliberal era of the 1990s all but eliminated this option by setting a high floor for global IP protections. This change created the security-based TRIPS Agreement we know today—legally obliging countries to protect IP rights and trade stabilization above almost all other policy priorities, including access to vaccines and medicines critical for global health equity—initiatives that countries might otherwise seek in their IP regimes.¹⁶⁵

The TRIPS Agreement expresses charity norms in its reliance on companies' willingness to voluntarily loosen IP protections for the public good. If TRIPS prioritizes pharmaceutical companies' IP rights (and those of the Global North countries where they are based), and those rights block generic markets, then the only way for Global South countries to access critical vaccines and medicines during a pandemic is by the goodwill of these high-wealth, high-privilege actors—in other words, by charity. On paper, there are workarounds to this donor-recipient dynamic. Article 31 of the TRIPS Agreement and the related WTO

162. Agreement on Trade-Related Aspects of Intellectual Property Rights, Apr. 15, 1994, Marrakesh Agreement Establishing the World Trade Organization, Annex 1C, Legal Instruments—Results of the Uruguay Round, 33 I.L.M. 1125, 1197 (1994) [hereinafter TRIPS Agreement].

163. *Id.*

164. GOSTIN, *supra* note 142, at 290.

165. See SARAH JOSEPH, BLAME IT ON THE WTO?: A HUMAN RIGHTS CRITIQUE 241-43 (2011) (providing a prototypical example of this argument).

Doha Declaration allow countries to establish compulsory licenses,¹⁶⁶ including in public-health emergencies.¹⁶⁷ However, these “flexibilities” are quite limiting. For example, declaring compulsory licenses is politically risky for countries dependent on the WTO trade system. The only remaining option is to rely on wealthy countries’ charitable donations of key pandemic-fighting supplies – an assumption of goodwill that is risky to make in the midst of an active pandemic response.

4. Pandemic Emergency Financing Facility

The World Bank’s Pandemic Emergency Financing Facility (PEF) provides a final major example of the pre-COVID landscape.¹⁶⁸ Like the GHSA, the PEF arose in response to broader concerns about the ability of Global South countries to meet global health security goals,¹⁶⁹ and specifically the challenges of Ebola outbreak responses.¹⁷⁰ Housed in the World Bank, the PEF was designed to pool and then distribute financing directly to eligible aid-receiving governments and

166. TRIPs Agreement, *supra* note 162, at 1231-32; World Trade Organization, Ministerial Declaration of 14 November 2001, WTO Doc. WT/MIN(01)/DEC/2, 41 I.L.M. 755 (2002). Compulsory licenses are government licenses that grant the government itself or a third party the right to produce a patented product without the patent holder’s permission.

167. See *Compulsory Licenses, the TRIPs Waiver, and Access to COVID-19 Medical Technologies*, MÉDECINS SANS FRONTIÈRES ACCESS CAMPAIGN 1, 2 (May 26, 2021), <https://msfaccess.org/compulsory-licenses-trips-waiver-and-access-covid-19-medical-technologies> [<https://perma.cc/V73U-UXXN>].

168. Again, other similar examples are also worth attention, such as the COVAX vaccine-sharing mechanism’s charity-based structure. See Felicitas Holzer, Tania Manríquez Roa, Federico Germani, Nikola Biller-Adorno & Florencia Luna, *Charity or Empowerment? The Role of COVAX for Low and Middle-Income Countries*, 2022 DEVELOPING WORLD BIOETHICS 1 (characterizing COVAX as a charity-based mechanism).

169. For example, following the Ebola epidemic in West Africa, the World Bank explicitly took up global-health-security framing in a series of reports on pandemic readiness and the establishment of the International Working Group on Financing Preparedness. *From Panic and Neglect to Investing in Health Security: Financing Pandemic Preparedness at a National Level*, INT’L WORKING GRP. ON FIN. PREPAREDNESS, at xii (2017), <http://hdl.handle.net/10986/26761> [<https://perma.cc/832J-7KJV>] (describing the pandemic fund’s focus on health security). Its recommendations focused primarily on short-term containment goals with particular focus on IHR compliance, reducing infectious illnesses’ spread across borders, and defending against “malicious” attacks of biological weapons. See *id.* at 14, 20-21. These are explicit appeals to a security-based view of health, which is also visible in the World Bank’s uneven governance.

170. See *PEF Allocates US \$195 Million to More than 60 Low-Income Countries to Fight COVID-19*, WORLD BANK (Apr. 27, 2020), <https://www.worldbank.org/en/news/press-release/2020/04/27/pef-allocates-us195-million-to-more-than-60-low-income-countries-to-fight-covid-19> [<https://perma.cc/K8QP-HYMA>]; *Fact Sheet: Pandemic Emergency Financing Facility*, WORLD BANK (Apr. 27, 2020), <https://www.worldbank.org/en/topic/pandemics/brief/fact-sheet-pandemic-emergency-financing-facility> [<https://perma.cc/8WJA-VHPK>].

frontline-responder organizations to help improve their ability to respond to infectious-disease outbreaks.¹⁷¹ The Fund was filled via a trust-fund model made up of contributions from sovereign (state) and other donors, with fund distributions (in the form of bonds and cash) then managed by the World Bank.¹⁷² The funding was slated for “high-severity infectious disease outbreaks” that would trigger a PEF “[i]nsurance [w]indow” and thus funding for low-resource countries to access funding to contain the infectious disease threat.¹⁷³

The PEF addressed a major concern of global health security preparedness by seeking to even out funding resources for countries – a major concern of the IHR. However, the PEF still worked within the normative core of charity. Funding was entirely voluntary for donor countries, a limitation that bore out in the Fund’s financials. By 2019, pledges totaled \$192.33 million (USD).¹⁷⁴ While in theory this funding is better than nothing, the concern over low funding in donor-based systems can be quickly illustrated by the fact that the American Rescue Plan amounted to \$1.9 trillion, of which New York City alone gained access to \$5.88 billion.¹⁷⁵ Even before the COVID-19 pandemic hit countries’ financial systems, it was apparent to commentators that such a voluntary structure would likely not hold in the face of a major crisis.¹⁷⁶

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In summary, each of the above legal instruments displays the centrality of historical security and charity norms in shaping pandemic-response mechanisms. The International Health Regulations largely repackaged pre-WWII

171. *Pandemic Emergency Financing Facility*, WORLD BANK, <https://www.worldbank.org/en/topic/pandemics/brief/pandemic-emergency-financing-facility> [<https://perma.cc/9A5F-GSTQ>].

172. *Pandemic Emergency Financing Facility (PEF) Framework*, WORLD BANK, at art. III 3.01-02 (June 27, 2017), <https://thedocs.worldbank.org/en/doc/24dce6fdf04a1313a07f7c24f539f4c7-0240012017/original/PEF-Framework.pdf> [<https://perma.cc/S5WM-82JB>].

173. *Id.* pmb1.

174. *Pandemic Emergency Financing Facility Financial Report*, THE WORLD BANK GRP. 4 (Dec. 31, 2019), https://fiftrustee.worldbank.org/content/dam/fif/funds/pef/TrusteeReports/PEF_TR_12_19.pdf [<https://perma.cc/8NZK-PVPM>].

175. *President Biden Announces American Rescue Plan*, WHITE HOUSE (Jan. 20, 2021), <https://www.whitehouse.gov/briefing-room/legislation/2021/01/20/president-biden-announces-american-rescue-plan> [<https://perma.cc/9EAX-DF7S>]; *New York City Recovery Plan: American Rescue Plan Act State and Local Fiscal Recovery Funds*, N.Y.C. 3 (2022), <https://www.nyc.gov/assets/covid19fundingtracker/downloads/NYC%20SLFRF%20Annual%20Recovery%20Plan%20-%202022%20Report.pdf> [<https://perma.cc/AG7X-79YH>].

176. Bangin Brim & Clare Wenham, *Pandemic Emergency Financing Facility: Struggling to Deliver on Its Innovative Promise*, 367 *BMJ* art. no. 15719, at 3 (2019) (describing the concern of the PEF being beholden to investor interests).

health conventions into a World Health Organization Article 21 regulation that set out global priorities around containing and surveilling infectious diseases. The Global Health Security Agenda reemphasized the International Health Regulation's security norms with an even more explicit normative frame by emphasizing biosecurity throughout its structuring and acting through a nonbinding mechanism. The World Trade Organization's TRIPS Agreement set up a direct conflict between health and trade by granting trade relatively strong international legal protections while leaving only a few charity-based outlets for achieving important public-health goals. Finally, the Pandemic Emergency Financing Facility's attention to achieving Global North-led national-security goals via a primarily voluntary contribution structure served as an emblematic example of security and charity-based logics, respectively. These four core legal mechanisms made up the global health system available to the world as COVID-19's virus¹⁷⁷ first began to multiply. By the time the pandemic reached full force, it had become clear that a security-charity normative system could not hold.

II. COVID-19 AND THE NEED FOR NORMATIVE SHIFT

Part I established that despite multiple attempts at establishing cosmopolitan recognition of mutual obligation and cooperation, the history of global health law skews toward expressions of security and charity norms. But that was before COVID-19. This Part explores COVID-19's ignoble distinction as one of the most catastrophic public-health events of recent memory (Section II.A), and then describes the argument for a more cosmopolitan approach in its treaty design (Section II.B).

A. *Failures of the Security-Charity Normative Status Quo*

At the time of this writing, the failures of the COVID-19 pandemic and its governance are still playing out; almost seven million people have died from COVID-19 since the pandemic's start.¹⁷⁸ Although effective vaccines were developed and manufacturable by January 2021, many low-income countries had fewer than twenty percent of their populations vaccinated two years later,¹⁷⁹

177. For simplicity, this paper lumps the virus SARS-CoV-2 and the COVID-19 disease that it causes together, but the concepts should be noted as distinct within public health.

178. WHO *Coronavirus (COVID-19) Dashboard*, *supra* note 37.

179. Josh Holder, *Tracking Coronavirus Vaccinations Around the World*, N.Y. TIMES (Mar. 13, 2023), <https://www.nytimes.com/interactive/2021/world/covid-vaccinations-tracker.html> [https://perma.cc/YM8Q-43B6].

overwhelmingly due to inequities that have been described as “vaccine apartheid.”¹⁸⁰ And states were aware of these inequities within days of the pandemic response in 2020 – the WHO reported on shortages of personal protective health equipment due to market manipulation on March 3, 2020.¹⁸¹

With the crisis ongoing, it is impossible to provide a complete explanation of how pre-COVID-19 global health law contributed to these outcomes. Instead, this Section forwards one narrow critique: a normative orientation toward national security and a sense that other interventions were optional “nice-to-haves” exacerbated COVID-19’s harms.

First, security-based mechanisms privileged containment over care, placing the law’s focus away from those affected by actual illness. As described above, security-based mechanisms tend to focus their intervention on containing infectious disease “elsewhere” (often in the Global South) to protect other, yet-unaffected populations.¹⁸² One exemplar of this trend is the IHR, which activates via declaration of a public health emergency of international concern (PHEIC) only when a disease “threat” seems likely to spread internationally—usually from a

180. Zain Rizvi, *Vaccine Apartheid*, PUB. CITIZEN (Nov. 29, 2021), <https://www.citizen.org/article/vaccine-apartheid> [<https://perma.cc/HQT2-6NWQ>]. This phenomenon of vaccine nationalism and vaccine apartheid has elements both of security and isolationist framings, differences which can be teased out conceptually. Security-based vaccine hoarding occurred insofar as countries looked to vaccine production and stockpiling from both in-country sources (e.g., preferential access to vaccines developed domestically even where there was greater need elsewhere), as well as seeking to secure vaccines from companies based abroad. Isolationist vaccine hoarding under Table 1’s definitions would display only the domestic aspect of this observation, where countries in which vaccine-developing companies were housed might seek to gain exclusive access to that company’s vaccines. Similar statistics can be quoted ad nauseam, and the horrors of the COVID-19 pandemic will doubtless continue even if new variants cease tomorrow. For example, from ongoing impacts of “long COVID.” See Editorial, *The Pandemic After the Pandemic: Long Covid Haunts Millions of People*, WASH. POST (Feb. 8, 2023, 2:31 PM EST), <https://www.washingtonpost.com/opinions/2023/02/08/long-covid-challenges-economy-health-care> [<https://perma.cc/G88S-XVCK>].

181. *Shortage of Personal Protective Equipment Endangering Health Workers Worldwide*, WORLD HEALTH ORG. (Mar. 3, 2020), <https://www.who.int/news/item/03-03-2020-shortage-of-personal-protective-equipment-endangering-health-workers-worldwide> [<https://perma.cc/SZ5V-4DE7>].

182. To illustrate this dynamic, consider examples of quarantine laws, the IHR’s emphasis on providing for disease checkpoints at border crossings, and the deployment of Global North military personnel to enforce containment centers in West Africa. See *supra* note 113 and accompanying text.

Global South state.¹⁸³ This was the exact dynamic of COVID-19's PHEIC designation, where an IHR panel considered COVID-19 reports and declared a PHEIC when they considered the coronavirus to pose a threat of international spread.¹⁸⁴ While covering illness or medical conditions “irrespective of origin or source,” the IHR does not extensively consider important sources of infectious diseases, such as zoonoses.¹⁸⁵ Further, the IHR dedicates the vast majority of its focus to requirements to share information about emerging threats, containment, and avoiding impacts on travel and trade¹⁸⁶ –not squarely on ensuring equitable access to resources or caring for vulnerable populations who might become ill. This illustrates the misalignment between a security-based frame for global health law and real necessities of caring for many simultaneously ill people, which require greater emphasis on access to therapeutic materials (such as medicines or vaccines), and less focus on disruption to trade.¹⁸⁷

Second, this emphasis on security and containment led to the deployment of blunt-force containment tools that were less effective for the particular needs of the COVID-19 pandemic.¹⁸⁸ As discussed above, many IHR obligations come into effect once the World Health Organization declares a PHEIC.¹⁸⁹ However,

183. See David N. Durrheim, Laurence O. Gostin & Keymanthri Moodley, *When Does a Major Outbreak Become a Public Health Emergency of International Concern?*, 20 LANCET INFECTIOUS DISEASES 887, 888 (2020) (describing infectious disease threats triggering IHR obligations, including an IHR's panel that COVID-19 was “an emergency in China, but it had not yet become a global health emergency”); *Health Emergencies List*, WORLD HEALTH ORG., <https://www.who.int/emergencies/situations> [<https://perma.cc/6VHQ-GVBQ>] (describing emergencies, including PHEIC-designated emergencies, all but one of which were identified by the WHO in a Global South country).

184. See Durrheim et al., *supra* note 183.

185. IHR, *supra* note 136 (containing generally no mention of zoonoses).

186. See *id.* pt. II (covering surveillance, notification, and verification of an emerging health threat, declaring a health emergency); *id.* pt. III (covering recommendations regarding containment and surveillance, but not treatment); *id.* pt. IV (elaborating on points of entry such as airports and ports); *id.* pt. V (discussing impacts on travel and trade). These parts make up the majority of the IHR's substantive content.

187. This is not to discount the important and devastating impacts that pandemics can have on people's livelihoods, but merely to emphasize that even these important interests first require the resources and protections that people require to stay alive in a pandemic.

188. Luke Taylor, *Covid-19: WHO Treaty Hopes to Overcome “Catastrophic Failures” of Pandemic Response*, 380 BMJ 357 (2023).

189. Katherine F. Ginsbach, John T. Monahan & Katie Gottschalk, *Beyond COVID-19: Reimagining the Role of International Health Regulations in the Global Health Law Landscape*, HEALTH AFFS. (Nov. 1, 2021), <https://www.healthaffairs.org/doi/10.1377/forefront.20211027.605372/full> [<https://perma.cc/MWF4-JHJH>] (suggesting the establishment of better warning systems within the IHR to provide options beyond the Public Health Emergency of International Concern declaration).

a PHEIC declaration triggers broad, undifferentiated¹⁹⁰ response measures. It leaves little room for states to gradually ramp up action items to respond to a pandemic, instead forcing them to immediately lock their doors.¹⁹¹

In the COVID-19 response, states had no roadmap until COVID-19 became a PHEIC, at which point a full array of containment measures were triggered. The potential harshness of such restrictions contributed to the WHO's hesitation in declaring a PHEIC—delays which likely further limited the IHR's ultimate effectiveness in containing disease.¹⁹² In other words, the IHR's focus on strict containment-based obligations actually limited its potential effectiveness by creating a stark black-and-white choice for the WHO's response to initial pandemic concerns.¹⁹³

Finally, containment logics also help to explain inequitable implementation of global health law. Like many areas of international law, obligations in global

190. Mark Boyd & Nick Wilson, *Failures with COVID-19 at the International Level Must Not Be Repeated in an Era Facing Global Catastrophic Biological Risks*, 45 AUSTL. & N.Z. J. PUB. HEALTH 184 (2021) (critiquing the “one size fits all” approach of the pandemic); see also Barbara von Tigerstrom & Kumanan Wilson, *COVID-19 Travel Restrictions and the International Health Regulations* (2005), 5 BMJ GLOB. HEALTH art. no. e006392, at 3 (2020) (describing legal structures that would allow for more flexibility in pandemic response, such as gradations of alert levels).

191. The extent of border controls' effectiveness or the effectiveness of other similar containment measures is highly contested in the public-health literature. See, e.g., Kelley Lee, *Rethinking Border Management and Global Health Security After the Pandemic*, COUNCIL ON FOREIGN RELS. (Sept. 1, 2021), <https://www.thinkglobalhealth.org/article/rethinking-border-management-and-global-health-security-after-pandemic> [<https://perma.cc/2V35-Y9ET>] (describing disapproval of restrictions and offering differing evidence). This Note does not make a definitive statement about what degree of containment intervention is optimal or even suggest that containment be entirely absent from legal mechanisms. Instead, this Section merely points to the use of security logics as a controlling perspective, which can be harmful in a multifaceted pandemic-response context.

192. von Tigerstrom & Wilson, *supra* note 190, at 2.

193. The IHR and other security-based legal mechanisms were also weakened by the assumption that pandemics would be most likely to arise from laboratory leaks due to bioterrorism. The intensity of the focus on laboratory leaks as the “source” for COVID-19 aligns with the punitive, containment-focused vision of security that has been traditionally reflected in global health law's priorities (e.g., IHR reforms being at least partially motivated by discrete security threats such as concerns over bioweapons in the Cold War era and in post-9/11 anthrax scares in the United States). Fidler, *supra* note 88, at 341-42. See generally Richard Falk, *Revisiting Westphalia, Discovering Post-Westphalia*, 6 J. ETHICS 311 (2002) (describing a shift toward security after 9/11 in international law). This national-security-type view and focus was not effective at addressing widespread population-based illness in a pandemic. See Sakiko Fukuda-Parr, Paulo Buss & Alicia E. Yamin, *Pandemic Treaty Needs to Start with Rethinking the Paradigm of Global Health Security*, 6 BMJ GLOB. HEALTH art. no. e006392, at 1 (2021) (describing the failures of global health security as enacted during the pandemic and the need for greater focus on people's security (a cosmopolitan view) versus the security of national borders (the status quo perspective)).

health law tend to be disproportionately enforced against Global South countries. This pattern continued in the COVID-19 response, such as when a variant of concern identified in South Africa led to swift and harsh travel restrictions not only against South Africa, but other Southern African states.¹⁹⁴ That countries like the United States might place an analogous ban on German travelers based on a new variant's discovery in London,¹⁹⁵ for example, is almost unfathomable. While there are many legitimate reasons to consider travel restrictions as a general matter, it is important to note how negative impacts on travel and trade applied asymmetrically to the disadvantage of Global South countries. Though trade-offs between travel, trade, and health are often necessary in public health, this asymmetry damaged the system's global legitimacy. Security's containment-based approach had limited effectiveness while exacerbating inequitable enforcement trends within international law.

One potential counterargument to these critiques of security-based global health law is that challenges to national security and containment approaches were merely matters of imperfect implementation, funding, or some other regrettable-yet-inevitable practical feature of geopolitics. But such shoulder shrugging understates the problem. The dominance of national-security framings in global health law and its domestic analogs led to a veritable cottage industry of security rankings, indexes, and action plans. And during COVID-19, the countries with the "best" rankings on pandemic preparedness—and the most resources to carry out such planning—ranked amid the worst impacted by

194. See Benjamin Mason Meier et al., *Travel Restrictions and Variants of Concern: Global Health Laws Need to Reflect Evidence*, 100 BULL. WORLD HEALTH ORGAN. 178, 178 (2022); Rosebell Kagumire, Opinion, *The Colonial Undertones of Omicron Travel Bans*, AL JAZEERA (Dec. 6, 2021), <https://www.aljazeera.com/opinions/2021/12/6/the-colonial-roots-of-western-responses-to-omicron> [<https://perma.cc/GL4W-82HZ>]; Zolan Kanno-Youngs & Sheryl Gay Stolberg, *Covid News: Biden Restricts Travel from Southern Africa*, N.Y. TIMES (Dec. 9, 2021), <https://www.nytimes.com/live/2021/11/26/world/covid-vaccine-boosters-variant> [<https://perma.cc/4FRH-YZ8K>]. This is not a one-off pattern but observable across multiple infectious-disease emergencies where sanctions and other punitive "containment"-type interventions were applied to Global South countries in the extreme. See, e.g., Reena Pattani, *Unsanctioned Travel Restrictions Related to Ebola Unravel the Global Social Contract*, 187 CAN. MED. ASS'N J. 166, 166-67 (2015) (describing harsh travel restrictions against West Africa used by Canada and Australia).

195. Michaelen Doucleff, *What We Know About the New U.K. Variant of Coronavirus—and What We Need to Find Out*, NPR (Dec. 22, 2020, 3:56 PM ET), <https://www.npr.org/sections/goatsandsoda/2020/12/22/948961575/what-we-know-about-the-new-u-k-variant-of-coronavirus-and-what-we-need-to-find-o> [<https://perma.cc/JM6J-57BY>].

COVID-19.¹⁹⁶ The United States and the United Kingdom topped the charts in excess deaths from COVID-19,¹⁹⁷ despite consistently earning top scores on global health security-preparedness metrics. Domestic pandemic preparedness in these countries, including the creation of national stockpiles, emphasized prepping for bioterror attacks but neglected more routine medical equipment with mundane, but lifesaving, salience to a wide variety of infectious disease emergencies.¹⁹⁸ Underscoring all of this is the chronic underfunding and hollowing out of healthcare systems in the name of neoliberal trade and finance, which overwhelmingly de-emphasized health needs.¹⁹⁹

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196. See Manjari Mahajan, *Casualties of Preparedness: The Global Health Security Index and COVID-19*, 17 INT'L J.L. CONTEXT 204, 204 (2021) (showing the United States's and the United Kingdom's COVID-19 health failures in contrast with their top Global Health Security Index scores); Enoch J. Abbey, Banda A.A. Khalifa, Modupe O. Oduwale, Samuel K. Ayeh, Richard D. Nudotor, Emmanuella L. Salia, Oluwatobi Lasisi, Seth Bennett, Hasiya E. Yusuf, Allison L. Agwu & Petros C. Karakousis, *The Global Health Security Index Is Not Predictive of Coronavirus Pandemic Responses Among Organization for Economic Cooperation and Development Countries*, 15 PLOS ONE art. no. e0239398, at 5-7 (2020) (showing the lack of alignment between such scores and actual pandemic performance). There are many relevant factors to observed morbidity and mortality (e.g., data collection, demographics etc), but the salient point is that seemingly well-prepared countries performed so poorly compared to expert predictions.
197. See Faisal Islam, *US Overtakes UK as Hardest Hit by Covid Deaths in G7*, BBC (June 10, 2021), <https://www.bbc.com/news/business-57421886> [<https://perma.cc/9HCQ-SDBV>]; Gavin Yamey & Clare Wenham, *The U.S. and U.K. Were the Two Best Prepared Nations to Tackle a Pandemic—What Went Wrong?*, TIME (July 1, 2020, 6:00 AM EDT), <https://time.com/5861697/us-uk-failed-coronavirus-response> [<https://perma.cc/8WY3-RT36>]; Mahajan, *supra* note 196, at 204.
198. See Berkeley Lovelace, Jr., Tonya Bauer & John Torres, *Inside the Strategic National Stockpile—and How It Went Wrong at the Start of the Pandemic*, NBC NEWS (July 28, 2022, 12:46 PM ET), <https://www.nbcnews.com/health/health-news/rare-look-strategic-national-stockpile-went-wrong-start-pandemic-rcna32603> [<https://perma.cc/F4JN-3NMY>] (describing how decisions surrounding the national stockpile left the United States with a store of materials prepped for an anthrax or smallpox bioterror attack); see also NAT'L ACADS. SCI., ENG'G, MED., ENSURING AN EFFECTIVE PUBLIC HEALTH EMERGENCY MEDICAL COUNTERMEASURES ENTERPRISE 11 (2021) (describing the lack of input on the context of the strategic national stockpile).
199. See Lee Jones & Shahar Hameiri, *Explaining the Failure of Global Health Governance During COVID-19*, 98 INT'L AFFS. 2057, 2064 (2022) (attributing some of the failures of COVID-19 to the neoliberal “hollowing out” of health governance). The decades-long devaluation of basic healthcare capacities in line with securitized and neoliberal austerity legal and policy priorities (e.g., structural readjustment loans) has been widely recognized as contributing to the severity of the COVID-19 crisis. See, e.g., Elias Nosrati, Jennifer B. Dowd, Michael Marmot & Lawrence P. King, *Structural Adjustment Programmes and Infectious Disease Mortality*, 17 PLOS ONE art. no. e0270344, at 1-2 (2022) (linking infectious-disease harms with neoliberal structural-adjustment loan policies).

When security-based mechanisms faltered, then failed,²⁰⁰ they opened a governance gap insufficiently addressed by charity-based measures. First, global health institutions and legal mechanisms, which operated on entirely voluntary-funding models, were deeply insufficient for the needs of an actual pandemic. The charity-based financing structures built to face pandemics, such as the PEF, were depleted almost immediately once COVID-19 hit,²⁰¹ leaving little support for countries striving to meet both internationally set containment goals while also supporting domestic populations through lockdowns. Companies implemented predatory pricing on critical supplies such as masks and sanitizers,²⁰² making it difficult for even wealthy actors to obtain goods and thus leaving little room or opportunity for voluntary resource sharing. This tendency toward resource hoarding reached a zenith once vaccines were available. The TRIPS Agreement's strong protections for IP holders²⁰³ and relatively weak provisions for health-emergency exceptions enabled Global North countries (where most IP-holding companies were housed) to hoard vaccines in an act of "vaccine nationalism" using the legal mechanism of advanced-purchasing agreements.²⁰⁴ The pharmaceutical companies holding the IP were harsh negotiators²⁰⁵ absent requirements for sharing vaccine benefits. Attempts by countries to gain access

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200. See Fukuda-Parr et al., *supra* note 193, at 1 (arguing that the "the prevailing paradigm [of global health security] is antithetical to the core purpose of global-pandemic preparedness").
201. The PEF was almost immediately depleted as COVID-19 hit in real time, and by April 2021 was entirely closed. *Pandemic Emergency Financing Facility*, WORLD BANK, <https://www.worldbank.org/en/topic/pandemics/brief/pandemic-emergency-financing-facility> [<https://perma.cc/HVJ8-A642>] (showing the PEF's closure by April 2021).
202. See Penelope Giosa, *Exploitative Pricing in the Time of Coronavirus – The Response of EU Competition Law and the Prospect of Price Regulation*, 11 J. EUR. COMPETITION L. & PRAC. 499, 499 (2020).
203. See, e.g., Sharifah Sekalala, Lisa Forman, Timothy Hodgson, Moses Mulumba, Hadijah Namyalo-Ganafa & Benjamin M. Meier, *Decolonising Human Rights: How Intellectual Property Laws Result in Unequal Access to the COVID-19 Vaccine*, 6 BMJ GLOB. HEALTH art. no. e006169, at 1 (2021) (comparing the strong protections of IP holders with the inequities experienced during the pandemic).
204. See Alexandra L. Phelan, Mark Eccleston-Turner, Michelle Rourke, Allen Maleche & Chenguang Wang, *Legal Agreements: Barriers and Enablers to Global Equitable COVID-19 Vaccine Access*, 396 LANCET 800, 800-02 (2020).
205. See, e.g., Madlen Davies, Ivan Ruiz, Jill Langlois & Rosa Furneaux, *'Held to Ransom': Pfizer Plays Hardball in Covid-19 Vaccine Negotiations with Latin American Countries*, STAT (Feb. 23, 2021), <https://www.statnews.com/2021/02/23/pfizer-plays-hardball-in-covid19-vaccine-negotiations-in-latin-america> [<https://perma.cc/BK5E-U657>] (demonstrating a fairly typical model of pharmaceutical companies' negotiation actions).

to critical IP through TRIPS waivers and to manufacture vaccines themselves²⁰⁶ were blocked outright by countries who already had ample access²⁰⁷ – arguably causing millions of deaths²⁰⁸ and resulting in charges of systematic racial discrimination against Global North governments.²⁰⁹ The existing system, where global health goals were met only on the whims of donation-based priorities, turned up empty-handed²¹⁰ when it was needed most, sacrificing health equity in the process.²¹¹

Defenders of charity-based structures might argue that existing structures could have worked only if they were sufficiently funded. Of course, more donated funding would have been better than less, but even if wealthy nations and

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206. See Council for Trade-Related Aspects of Intellectual Property Rights, *Waiver from Certain Provisions of the TRIPS Agreement for the Prevention, Containment and Treatment of Covid-19: Communication from India and South Africa*, WTO Doc. IP/C/W/669 (Oct. 2, 2020). One popularly cited concern about inadequate vaccine-manufacturing capacities in the Global South has been debunked. See Stephanie Nolen, *Here's Why Developing Countries Can Make mRNA Covid Vaccines*, N.Y. TIMES (Oct. 22, 2021), <https://www.nytimes.com/interactive/2021/10/22/science/developing-country-covid-vaccines.html> [<https://perma.cc/KET5-9NQC>].
207. See Hassan, *supra* note 25; Brook Baker, *Bad Faith from Big Pharma, Rich Countries and the WTO Poison WTO TRIPS Waiver Negotiations*, HEALTH GLOB. ACCESS PROJECT (June 14, 2022), <https://healthgap.org/bad-faith-from-big-pharma-rich-countries-and-the-wto-poison-wto-trips-waiver-negotiations%ef%bf%bc> [<https://perma.cc/U9RG-FB2H>]; Andrew Green, *Europe Still Can't Get on Board with the TRIPS Waiver*, DEVEX (May 31, 2021), <https://www.devex.com/news/sponsored/europe-still-can-t-get-on-board-with-the-trips-waiver-100027> [<https://perma.cc/CG6N-AYPA>].
208. See Heidi Ledford, *COVID Vaccine Hoarding Might Have Cost More than a Million Lives*, NATURE (Nov. 2, 2022), <https://www.nature.com/articles/d41586-022-03529-3> [<https://perma.cc/K6E7-SDQQ>]; Sam Moore, Edward M. Hill, Louise Dyson, Michael J. Tildesley & Matt J. Keeling, *Retrospectively Modeling the Effects of Increased Global Vaccine Sharing on the COVID-19 Pandemic*, 28 NATURE MED. 2416, 2416 (2022) (showing that inequitable distribution increased death tolls).
209. See UN: *Countries Blocking the TRIPS Waiver Guilty of Racial Discrimination*, CTR. FOR ECON. & SOC. RTS. (Apr. 29, 2022), <https://www.cesr.org/un-countries-blocking-the-trips-waiver-guilty-of-racial-discrimination> [<https://perma.cc/M784-VNCY>].
210. See *New International Instrument on Pandemic Prevention, Preparedness and Response: Contributing to the Second Round of Public Hearings*, WHO COUNCIL ON ECON. HEALTH FOR ALL (Sept. 26, 2022), https://cdn.who.int/media/docs/default-source/council-on-the-economics-of-health-for-all/who_council_statement-26september2022-iii.pdf [<https://perma.cc/9NUV-Y9E3>] (describing the failure of a “charitable” response model during COVID-19).
211. See, e.g., Clare Wenham, Rebecca Reisdorf & Sumegha Asthana, *Pandemic Treaty: A Chance to Level Up on Equity*, 377 BMJ art. no. 01279, at 1 (2022) (describing equity impacts); Timothy Fish Hodgson, Roojin Habibi, Benjamin Mason Meier, Sharifah Sekalala, Ian Seiderman, Tomaso Falchetta, Thomas Schwarz, Letta Taylor, Sean Tait, Gerald Staberock, & Sara (Meg) Davis, *Human Rights Must Guide a Pandemic Treaty*, HEALTH & HUM. RTS. J. (Nov. 20, 2021), <https://www.hhrjournal.org/2021/11/human-rights-must-guide-a-pandemic-treaty> [<https://perma.cc/D5JP-AZSQ>] (describing the poor equity of the COVID-19 response across several grounds, including human rights, vaccine access, and sexual and reproductive rights).

donors were to become completely unlimited in their generosity, this still would make millions upon millions of people's health largely dependent on a single set of actors' whims. This is concerning for the same reason that there was temporary panic about the Gates Foundation's prominence in WHO funding despite the Foundation's seeming constancy²¹² – what can be given can always be taken away. Against the deadly backdrop of these charity-based failures, exclusive reliance on Global North governments' donations of vaccines after COVID-19 appears almost nonsensical.

These many failures were amply noticed, documented, and criticized in the global sphere. Public statements and a flood of postmortem COVID-19 governance assessments pushed for normative reform to global health practice and global health law from even the early days of 2020. Heads of state, academics,²¹³ civil-society leaders, and formal institutional working groups²¹⁴ offered robust critiques of the COVID-19 response's normative failings, with the WHO Director-General even calling the current COVID-19 response a “catastrophic moral failure.”²¹⁵ These COVID-19-specific critiques were, of course, not new. Anti-imperialist global health reformers, activists, and Global South leaders had long pointed out the harms of charity norms in global health's practice. However, the

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212. See, e.g., Annalisa Merelli, *The WHO Has a Worrisome Reliance on the Bill & Melinda Gates Foundation*, QUARTZ (Dec. 16, 2021), <https://qz.com/2102889/the-who-is-too-dependent-on-gates-foundation-donations> [<https://perma.cc/LER9-59UM>] (expressing skepticism of the Gates Foundation's dominance in global health funding); Catherine Cheney, *'Big Concerns' over Gates Foundation's Potential to Become Largest WHO Donor*, DEVEX (June 5, 2020), <https://www.devex.com/news/sponsored/big-concerns-over-gates-foundation-s-potential-to-become-largest-who-donor-97377> [<https://perma.cc/USP9-QYKN>] (same); Julia Belluz, *The Media Loves the Gates Foundation. These Experts Are More Skeptical*, VOX (June 10, 2015, 1:20 PM EDT), <https://www.vox.com/2015/6/10/8760199/gates-foundation-criticism> [<https://perma.cc/8BFA-B3CV>] (same).
213. See, e.g., Alicia Ely Yamin, Joelle Grogan & Pedro Villarreal, *International Pandemic Lawmaking: Conceptual and Practical Issues*, PETRIE-FLOM CTR. & MAX PLANCK INST. 5-9 (Nov. 2021), [https://petrieflom.law.harvard.edu/assets/publications/International_Pandemic_Lawmaking_\(November_2021\)_-_Final.pdf](https://petrieflom.law.harvard.edu/assets/publications/International_Pandemic_Lawmaking_(November_2021)_-_Final.pdf) [<https://perma.cc/2X4K-H2X6>] (academic commentary); Jeffrey D. Sachs et al., *The Lancet Commission on Lessons for the Future from the COVID-19 Pandemic*, 400 LANCET 1224, 1225 (2022) (same).
214. See, e.g., *From Worlds Apart to a World Prepared: Global Preparedness Monitoring Board Report 2021*, GLOB. PREPAREDNESS MONITORING BD. (2021) [hereinafter GPMB Report], <https://www.gpmb.org/annual-reports/annual-report-2021> [<https://perma.cc/D2ER-B6GF>] (offering an example of institutional-group analyses); *COVID-19: Make it the Last Pandemic*, INDEP. PANEL FOR PANDEMIC PREPAREDNESS & RESPONSE (May 2021) [hereinafter IPPPR Report], https://theindependentpanel.org/wp-content/uploads/2021/05/COVID-19-Make-it-the-Last-Pandemic_final.pdf [<https://perma.cc/WER4-QJ6M>] (same).
215. Tedros Adhanom Ghebreyesus, Director-General, WHO, WHO Director-General's Opening Remarks at 148th Session of the Executive Board (Jan. 18, 2021), <https://www.who.int/director-general/speeches/detail/who-director-general-s-opening-remarks-at-148th-session-of-the-executive-board> [<https://perma.cc/Z2BZ-XEVY>].

unique failures of the COVID-19 response²¹⁶ drew new attention to the need to reform global health and its law, leading to the commencement of the Article 19 process.

B. Benefits of Pursuing (New) Cosmopolitan Reform

If security and charity are insufficient normative bases for a system of global health law, as this Note has argued, then some other fundamental norm must take their place. This Section argues that the global health law system should embrace a cosmopolitan normative baseline as an alternative to security and charity approaches and begin such an embrace with the pandemic treaty's design. The present moment of post-COVID-19 reflection and treaty negotiation creates a viable opening for new modes of pandemic governance, and adopting a cosmopolitan baseline that is not only necessary, but practical for facing the challenge of pandemics.

1. The Need for a Cosmopolitan Shift in Global Health Law

In light of the failures documented above, cosmopolitanism immediately presents as a potentially appropriate alternative. Cosmopolitan norms encourage global solidarity, which was sorely missing from the COVID-19 response, via a focus on building mutual cooperation and obligation.²¹⁷ As described above, one of cosmopolitanism's key implications is that countries should follow mutual obligations to maintain global public health and organize internationally to deliver on this obligation. Such an approach directly answers some of the most severe harms presented by the nationalistic urges seen during the COVID-19 pandemic and holds comparative advantages for addressing these harms over other possible normative baselines in Table 1.

Therefore, the first argument for the embrace of cosmopolitanism is that cosmopolitanism addresses the failures that other dominant normative frameworks presented in Table 1 displayed in the COVID-19 response. The previous Section laid out how a security approach to pandemic response through containment and preserving economic stability does not address the need to actually provide care to those who need it. The previous Section also illustrated that reliance on wealthy countries' goodwill, as charity norms would promote, is fundamentally

216. See Karunakara, *supra* note 33.

217. See, e.g., Lawrence O. Gostin, Kevin A. Klock, Sam F. Halabi, Katie Gottschalk, Katherine Ginsbach & Kashish Aneja, *What Nations Owe Each Other Before the Next Pandemic*, COUNCIL ON FOREIGN RELS. (July 13, 2022), <https://www.thinkglobalhealth.org/article/what-nations-owe-each-other-next-pandemic> [https://perma.cc/85S3-C4GD] (offering an example of calls for mutual obligation).

unstable ground on which to build a pandemic response.²¹⁸ These critiques, while strongly illustrated by COVID-19's harms, are not exclusive to a singular case study. Nor is isolationism an option – the health emergencies posed by communicable disease like COVID-19, especially, demand some sense of international obligation. Acquiescing to isolationist-driven calls to completely withdraw from global health law systems²¹⁹ is simply unworkable. Indeed, true isolationism is essentially impossible given the current entrenchment of international law into state practice. This leaves cosmopolitanism as the most viable starting point for global health law after the specific harms of a security- and charity-driven COVID-19 response.²²⁰

A second, related argument for cosmopolitanism is that the global health challenges illuminated by the pandemic are exactly the kinds of challenges that cosmopolitan reforms – at their best – are designed to address. As COVID-19 demonstrated, health concerns are fundamentally global in nature. Infectious diseases travel swiftly across borders, making international coordination paramount – coordination that goes beyond protecting any single country's national-security interests. This global focus extends not only to viral pathogens and borders but also to the structural systems which underlie various aspects of global health responses. The quip that infectious diseases know no borders also applies

218. See Mariana Mazzucato & Alan Donnelly, *The World Is Still Failing at Pandemic Preparedness and Response*, PROJECT SYNDICATE (Nov. 18, 2022), <https://www.project-syndicate.org/commentary/health-investment-failing-at-pandemic-preparedness-response-by-mariana-mazzucato-and-alan-donnelly-2022-11> [<https://perma.cc/H7C5-SSSN>] (describing the status quo's outdated donor-beneficiary charity model).

219. Many of the most prominent examples of this isolationism came from the United States. See, e.g., Katie Rogers & Apoorva Mandavilli, *Trump Administration Signals Formal Withdrawal from W.H.O.*, N.Y. TIMES (Sept. 22, 2021), <https://www.nytimes.com/2020/07/07/us/politics/coronavirus-trump-who.html> [<https://perma.cc/WH5V-FC5X>] (describing Trump's attempt to withdraw from the WHO); Brianna Kraemer, *Global Pandemic Treaty Draft Empowers Federal Gov't to Expand Health Authority*, CONVENTION STATES (Feb. 14, 2023), <https://conventionofstates.com/news/global-pandemic-treaty-draft-empowers-federal-gov-t-to-expand-health-authority> [<https://perma.cc/7TRS-GH76>] (calling for total rejection of the pandemic treaty on inaccurate grounds). Russia's illegal invasion of Ukraine may similarly motivate skepticism of a pandemic instrument along isolationist grounds.

220. As noted above, there are many potential ways to articulate the need for normative reform in global health law, not all of which map on precisely to the articulations by Lencucha and Ooms common in global health literatures. See Lencucha, *supra* note 50; Ooms, *supra* note 50. However, the utility of the four-part framework in Table 1, and the significant overlap between cosmopolitanism as this paper argues it and other possible competing frames (e.g., economic, social, and cultural rights and cosmopolitanism, in this Note's view, similarly place people at the center of concern) warrant maintaining this focus.

to global corporate actors²²¹—from tobacco and food companies, to mass farming enterprises, to vaccine manufacturers who operate in the international space. These structural features make a globally oriented approach of cosmopolitanism practically preferable. Cosmopolitanism's movement beyond a statist, border-bound view of health actors and obligations helps it to address such structural features of infectious diseases. This conclusion is supported by cosmopolitanism's traditional applications to other large, complex, international challenges, such as human rights and climate change.²²² In these subjects, as in global health, a normative approach based on mutual obligation is necessary for addressing complex challenges with immense barriers to collective action. International legal instruments based on cosmopolitan principles fill a governance gap left by other normative positions.

Finally, cosmopolitanism starts from a fundamental assumption that the health of any given individual is intrinsically valuable, regardless of its instrumental value. This moral focus on the individual, not just the nation-state and its strategic interests, allows cosmopolitanism to better address the equity challenges which have plagued global health law.²²³ A more cosmopolitan approach to global health has the potential to shift discussions about global health preparedness from macro indicators that sit at the national level (e.g., military preparedness for setting up emergency quarantine measures), to deeper understandings of health that place value on people's experiences of a health system (e.g., the likelihood that any given person has access to primary care) and alignment with rights-based understandings of health.²²⁴ As noted above, this shift has practical implications in the kinds of pandemic-fighting policies pursued. But critically, the benefits of cosmopolitan policies that look to support pandemic preparedness across the globe are oriented toward identifying the areas of most human need. This creates equitable outcomes, where policies are geared toward

221. Public health's discussion of this phenomenon focuses on so-called "commercial determinants of health." Ilona Kickbusch, Luke Allen & Christian Franz, *The Commercial Determinants of Health*, 4 LANCET GLOB. HEALTH e895, e895 (2016) (describing the internationalization of trade and investment and specific impacts on low- and middle-income countries).

222. Though, again, these are not applications without their disputes. See, e.g., José-Manuel Barreto, *Decolonial Thinking and the Quest for Decolonising Human Rights*, 46 ASIAN J. SOC. SCI. 484, 484 (2018) (offering an example of critiques of human-rights law as Eurocentric).

223. See Fukuda-Parr et al., *supra* note 193, at 1 (arguing for a movement away from the "national security" approach of previous global health law).

224. Individual human rights are among the key examples of cosmopolitan approaches. See Robert Fine, *Cosmopolitanism and Human Rights: Radicalism in a Global Age*, 40 METAPHILOSOPHY 8, 8 (2009) (noting that cosmopolitanism sees human rights as an operative principle of justice).

individuals in greatest need, rather than instrumentalist concerns such as national security.²²⁵ From this equity argument, we can say that the value cosmopolitanism places on individuals should make it the preferred normative baseline in global health law for the simple, moral reason that “it is right.”²²⁶

Of course, simply slapping on a label of cosmopolitanism is no guarantee of equity, of the development of a right to health, or of any other “goods” the world might desire from the new pandemic treaty. History shows otherwise. The idealized form of cosmopolitan argued for in this Note does not have a ready historical analog. As noted previously, “cosmopolitanism” has historically presented in a variety of ways in international legal practice. Legal reforms pursued under the banner of cosmopolitanism have ranged from idealistic one-country, one-vote structures dominated by a few countries’ politics,²²⁷ to forced trade and structural adjustments,²²⁸ to human rights treaties of uneven application,²²⁹ to visions of empowered postcolonial cosmopolitanism.²³⁰ Each of these examples varied in the degree to which they were able to actualize a cosmopolitan ideal of mutual obligation in meeting global problems and equitable approaches to meeting need. Failures could be accounted for with explanations ranging from duplicitous policy effort and imperial meddling to simple lack of resources, to name a few causes. The history of wide-ranging attempts at cosmopolitanism and their similarly wide-ranging critiques could create a stumbling block for treaty negotiators as they seek to articulate cosmopolitanism in the pandemic-treaty context. It is therefore important that treaty drafters and negotiators avoid uncritically invoking “cosmopolitanism” in their efforts.

In summary, the cosmopolitanism that emerges from COVID-19 cannot be neocolonial centralization of power.²³¹ It cannot place profits over people, and it cannot demand the views of the few in power be placed unilaterally on the rest of the world. Instead, COVID-19 shows the need for a “new” cosmopolitanism in global health law, one that returns to the core of the normative position in a truly global recognition that pandemic governance seeks to protect people, not

225. Or, where policies can only act on the aggregate level, countries or regions with populations of greatest need.

226. Lencucha, *supra* note 50, at 2 (similarly describing cosmopolitanism as his preferred normative frame for global health governance).

227. For example, the World Health Assembly voting structure. *See supra* note 116 and accompanying text.

228. *See supra* notes 69 & 108 and accompanying text.

229. *See supra* note 203 and accompanying text.

230. *See supra* note 104 and accompanying text.

231. *See* Karunakara, *supra* note 33 (describing the need to resist neocolonial centralization of power); GETACHEW, *supra* note 104, at 23.

the powerful. It is a tall order, and one that demands mutual obligation and effort. However, as the following Section argues, such a transformation may be more practicable in the current landscape than any other moment in the near past or near future.

2. *The Potential for New Cosmopolitan Reform in the Current Landscape*

This Section posits that the adoption of an Article 19 treaty is a strong opportunity for practicable cosmopolitan change.²³² Creating a transformative treaty of this kind certainly poses a challenge, but attempting this transformation now best answers the recent moral challenge of the pandemic and informs a practical strategy of limiting future pandemics' harms.

First, international law in general is replete with examples of crises that gave rise to new international legal instruments.²³³ Global health law is no different. Cholera, HIV/AIDS,²³⁴ Influenza,²³⁵ SARS,²³⁶ and Ebola²³⁷ – to name just a few examples – have sparked reforms up and down the global health legal landscape. In this way, reform often follows a stepwise pattern, with each new crisis sparking a reform or new legal instrument that ratchets up international obligations

232. See Tamara Luciana Bustamante, Josefina del Rosario Lago, Mariana Magliolo & Lucas Javier Segal, *A New Treaty on Pandemics: Some Key Issues from a Global South Perspective* (Nov. 23, 2021) (unpublished manuscript) (on file with author) (supporting the treaty as an opportunity with qualification). *But see* Clare Wenham, Mark Eccleston-Turner & Maike Voss, *Is a Pandemic Treaty Really the Solution to the Problems We Face?*, LONDON SCH. ECON. & POL. SCI. (Nov. 9, 2021), <https://blogs.lse.ac.uk/covid19/2021/11/09/is-a-pandemic-treaty-really-the-solution-to-the-problems-we-face> [<https://perma.cc/WL94-ZD5E>] (noting the gaps between ambition and reality in global health law).

233. For example, heads of state signed the Convention on Early Notification of a Nuclear Accident within five months of the Chernobyl disaster. Elliot Hannon, Layth Hanbali, Susanna Lehtimäki & Nina Schwalbe, *Why We Still Need a Pandemic Treaty*, 10 LANCET GLOB. HEALTH e1232, e1232-33 (2022). Environmental treaties, including those addressing climate change, offer another analog. See Katharina Kummer Peiry, *Triggers for Treaty Negotiations: Could Lessons from Environmental Protection Inform a Prospective Pandemic Treaty?*, 375 BMJ art. no. e068903, at 3 (2021).

234. Fidler, *supra* note 88, at 338-39 (describing the HIV/AIDS crisis as sparking IHR reforms).

235. V. AYANO OGAWA, CECILIA MUNDACA SHAH & ANNA NICHOLSON, *EXPLORING LESSONS LEARNED FROM A CENTURY OF OUTBREAKS: READINESS FOR 2030*, at 91-100 (2019); *see also* Amy Kapczynski, *Order Without Intellectual Property Law: Open Science in Influenza*, 102 CORNELL L. REV. 1539, 1562 (2017) (discussing how the 1918 flu pushed the creation of the WHO Flu Network).

236. Gostin & Katz, *supra* note 137, at 267.

237. See Michaud et al., *supra* note 152 (discussing the role of Ebola in shaping the GHSA).

for health.²³⁸ This is not to say that every post-crisis legal reform is successful—concerns around decision makers' bounded rationality limit how much one can imagine systemic change, or look beyond the most recent crisis.²³⁹ But there is undeniable agenda-setting momentum in post-crisis periods, momentum that could be well-embraced in the current moment as COVID-19 remains fresh in our collective minds.

The massive mutual catastrophe of COVID-19—felt across all countries with unprecedented simultaneity and similarity²⁴⁰—could lead to change within the international legal system. Indeed, two important legal reforms already arose during the ongoing COVID-19 crisis: revisions to the IHR and the creation of a new pandemic treaty.²⁴¹ Both are undergoing simultaneous review, with major benchmarks in 2023.²⁴² But while reforms to the Article 21 power of the IHR are

238. There is a real and valid counterargument that the stepwise progression described here is actually one of mere “panic-neglect,” where there is no material change to health practice. See Gavin Yamey, Marco Schäferhoff, Kaci Kennedy McDade & Wenhui Mao, *Preparing for Pandemics Such as Coronavirus – Will We Ever Break the Vicious Cycle of Panic and Neglect?*, BROOKINGS INST. (Feb. 11, 2020), <https://www.brookings.edu/blog/future-development/2020/02/11/preparing-for-pandemics-such-as-coronavirus-will-we-ever-break-the-vicious-cycle-of-panic-and-neglect> [https://perma.cc/6CRA-VZ5N] (describing panic-neglect cycles); Ed Yong, *America Is Zooming Through the Pandemic Panic-Neglect Cycle*, ATLANTIC (Mar. 17, 2022), <https://www.theatlantic.com/health/archive/2022/03/congress-covid-spending-bill/627090> [https://perma.cc/MYK6-BQZ9] (describing panic-neglect cycles in the U.S. domestic context). *But see* OGAWA ET AL., *supra* note 235, at 101-20 (offering a perspective of pandemic preparedness not as panic-neglect, but of periods of intense focus followed by relative inattention). This Note agrees that material actions in the global space have severely lagged and contributed to panic-neglect cycles, but it proceeds from the position that simultaneous stepwise increases in legal obligations still have an important role to play in establishing improved global health governance.
239. Bounded rationality is observed in both the health-policy and international-law spaces. See, e.g., Deirdre McCaughey & Nealia S. Bruning, *Rationality Versus Reality: The Challenges of Evidence-Based Decision Making for Health Policy Makers*, 5 IMPLEMENT. SCI. art. no. 39, at 3 (2010); Eva van der Zee, *How Insights on Bounded Rationality Could Inform the International Law of Environmental Assessments*, 23 GERMAN L.J. 395 (2022); Bryan D. Jones, *Bounded Rationality*, 2 ANN. REV. POL. SCI. 297, 311 (1999). This can result in limited reform where more preferential, but difficult-to-imagine, options might otherwise exist.
240. Thomas Hale et al., *A Global Panel Database of Pandemic Policies (Oxford COVID-19 Government Response Tracker)*, 5 NATURE HUM. BEHAV. 529, 530 (2021) (describing the “striking degree of commonality” between countries’ policy responses to COVID-19).
241. Eric A. Friedman, Alexandra Finch & Lawrence O. Gostin, *Pandemic Treaty: The Conceptual Zero Draft*, O’NEILL INST. FOR NAT’L & GLOB. HEALTH L. (Dec. 5, 2022), <https://oneill.law.georgetown.edu/pandemic-treaty-the-conceptual-zero-draft> [https://perma.cc/Q3HK-QFPV].
242. *Timeline of Efforts to Strengthen Global Pandemic Preparedness and Response in Light of the COVID-19 Crisis*, GENEVA GRADUATE INST., <https://www.governingpandemics.org/timeline>

familiar to global health law, an Article 19 treaty (the focus of this Note) has been pursued only once before – with the 2003 WHO Framework Convention for Tobacco Control.²⁴³ That a pandemic treaty proposal has come this far is itself significant, creating a new opportunity for global health law.

The treaty developed quickly from the landscape of COVID-19 crisis. Calls for a pandemic treaty began almost alongside the pandemic itself, gaining purchase in late 2020 first among academics and individual country leadership, and then in international forums.²⁴⁴ A turning point came in March 2021 when dozens of country and international-organization leaders from across the Global North and South co-signed a letter advocating for a pandemic treaty, which was then published in newspapers around the world.²⁴⁵ By December 2021, the WHO had formally agreed to begin the Article 19 process.²⁴⁶ The WHO formed an intergovernmental negotiating body (INB) to begin drafting processes for a pandemic treaty, with a check-in planned for May 2023 and a final deadline of May 2024.²⁴⁷ The INB held multiple sessions throughout 2022 to solicit input on the treaty's content focus, culminating in a conceptual “zero” draft released at the end of December 2022 negotiations,²⁴⁸ and finalized in early February 2023.²⁴⁹

[[https://apps.who.int/gb/wgihr/e/e_wgihr-1.html](https://perma.cc/57X2-7B]9]; <i>A/WGIHR/1</i>, WORLD HEALTH ORG. (Nov. 14-15, 2022), <a href=) [<https://perma.cc/B72K-69TK>]; *Review Committee on the Functioning of the International Health Regulations (2005) during the COVID-19 Response*, WORLD HEALTH ORG., <https://www.who.int/teams/ihr/ihr-review-committees/covid-19> [<https://perma.cc/26BF-6ZLA>].

243. See *supra* note 12.

244. Kerry Cullinan, *Pandemic Treaty: US Proposes Amending Existing International Health Rules First; Germany Presses For Sanctions*, HEALTH POL'Y WATCH (Mar. 9, 2021), <https://healthpolicy-watch.news/pandemic-treaty-us-proposes-amending-international-health-regulations-and-civil-society-excluded-from-negotiations> [<https://perma.cc/4MRF-9548>]; European Council Press Release, *EU Supports Start of WHO Process for Establishment of Pandemic Treaty: Council Decision*, EUR. COUNCIL (May 20, 2021, 1:35 PM), <https://www.consilium.europa.eu/en/press/press-releases/2021/05/20/eu-supports-start-of-who-process-for-establishment-of-pandemic-treaty-council-decision> [<https://perma.cc/R95C-4BZ9>]; GPMB Report, *supra* note 214, at 5; Nikogosian, *supra* note 88, at 9; IPPPR REPORT, *supra* note 214, at 47.

245. See *Global Leaders Unite in Urgent Call for International Pandemic Treaty*, *supra* note 7.

246. See *World Health Assembly Agrees to Launch Process to Develop Historic Global Accord on Pandemic Prevention, Preparedness and Response*, *supra* note 16.

247. *INB Process*, *supra* note 16. This assumes, of course, no delays in negotiations – a tenuous assumption in international law.

248. *Zero Draft*, *supra* note 21.

249. *Id.*

Negotiations began in earnest by early 2023, with countries continuing to negotiate language over the next year.²⁵⁰ That the treaty has received serious consideration and dedicated advocacy indicates that the treaty has a chance at passing in at least some form.²⁵¹ Because of the value-articulating power of treaties, even a relatively modest pandemic treaty could be vitally important in furthering a normative shift in global health law away from predominant security-charity frames and toward cosmopolitanism. Any global health treaty necessarily has cosmopolitan qualities, and a treaty recognizing mutual and global responsibility as to pandemic preparedness could do norm-setting work for future reformers.²⁵² The global health legal community should seize the opportunity of the post-crisis moment and the immense political momentum currently supporting the pandemic treaty to assert cosmopolitan norms while the chance is here.

Despite this current opportunity, the path toward a cosmopolitan treaty is not easy. There are many ways that even a well-meaning treaty could be nothing more than another iteration of the inequitable security-charity status quo. Given the intense tension between the self-interested actions of states during the pandemic and the cosmopolitan ambitions of the treaty being negotiated,²⁵³ drafters

250. *Countries Begin Negotiations on Global Agreement to Protect World from Future Pandemic Emergencies*, WORLD HEALTH ORG. (Mar. 3, 2023), <https://www.who.int/news/item/03-03-2023-countries-begin-negotiations-on-global-agreement-to-protect-world-from-future-pandemic-emergencies> [https://perma.cc/2GWQ-U2QS].

251. *See Global Leaders Unite in Urgent Call for International Pandemic Treaty*, *supra* note 7; Layth Hanbali, Analyst, Spark Street Advisors, Panel at the University of Southern California Institute on Inequalities in Global Health on Global Pandemic Prevention, Preparedness and Response: Negotiating the Future (Feb. 8, 2023) (notes on file with author) (noting that highly affected countries are continuing to push for strong language in the pandemic treaty, and are therefore optimistic that existing strong language will remain). While many of the observations in the remainder of this Note pertain to both the IHR and the Article 19 pandemic-treaty discussions, the rest of this Note's analysis will focus on the Article 19 pandemic treaty because of its potential to serve as a stronger, more transformative influence in global health law practice. The Article 19 pandemic treaty has the potential to serve as a stronger, more transformative influence because of the increased scope available to the WHO under Article 19 compared to Article 21.

252. Any global treaty necessarily has cosmopolitan qualities. *See generally* Wenham et al., *Futility*, *supra* note 51 (describing the fundamental cosmopolitan orientation of the pandemic treaty's ambitions, using the terminology of "globalist"). International treaties further a cosmopolitan ethos insofar as they recognize mutual, global responsibility within a subject matter. Simply having a WHA-accepted treaty on the books stating that pandemic preparedness was a mutual global responsibility would inherently further a cosmopolitan approach to global health law. This premise aligns with treaties' dual roles in international law of articulating normative values and imposing specific technical agreements. *See* Haik Nikogosian & Ilona Kickbusch, *The Legal Strength of International Health Instruments – What It Brings to Global Health Governance?*, 5 INT'L J. HEALTH POL'Y MGMT. 683, 684 (2016) (describing the domestic and international benefits that arise from having an international treaty focusing on a specific subject matter).

253. Wenham et al., *Futility*, *supra* note 51, at 838.

will need to work carefully to create a treaty that demands more of states while still having a chance of passage. At its worst, a pandemic treaty could constitute little more than an elaborate bait-and-switch tactic by the Global North to claim they “did something” to improve global health law – while essentially maintaining the status quo and diverting global efforts away from transformative demands such as compulsory IP waivers.²⁵⁴ The difference comes down to the decisions made during the treaty negotiations process – where the focus of this Note now turns.

III. STRUCTURING A COSMOPOLITAN TREATY

The INB’s next stages of drafting and negotiation therefore must undertake an immense balancing act if a truly cosmopolitan vision of the treaty is to succeed, creating a mechanism that could gain global consensus while also furthering the meaningful cosmopolitan shifts required to avoid the pandemic treaty sinking into old, security-charity ruts. Success will require a frank confrontation of the gaps between states’ (often intransigent) behavior during the pandemic and the aspirations of a truly cosmopolitan system of mutual commitment to preventing the pandemic’s harms, for all people.²⁵⁵ This is especially a concern given that the zero draft, throughout its development, has displayed a somewhat underwhelming assortment of cosmopolitan features at different times.²⁵⁶

This Part provides concrete examples of how careful treaty design could balance strategic and aspirational interests of the pandemic treaty. These recommendations are summarized in Table 3 below.²⁵⁷ This Part does not assert to be a definitive roadmap for drafting an effective treaty, nor does the citation of existing international-law mechanisms imply an endorsement of those instruments as perfectly effective or equitable. Rather, this Note’s goal is to provide helpful, guiding examples for how a treaty structure can practicably bridge the gap between the old, security-charity view of the world that failed during the

254. See Karunakara, *supra* note 33.

255. See Wenham et al., *Futility*, *supra* note 51 (emphasizing the contradictions of the statist status quo and the aim of a globalist treaty mechanism).

256. Friedman et al., *supra* note 241 (describing the December 2022 zero draft as “robust,” but also lacking key features – such as the cosmopolitan feature of human-rights protections). This concern is somewhat lessened given the most recent draft’s inclusion of human-rights language. See *Zero Draft*, *supra* note 21, art. 14. However, until the treaty is finalized in May 2024, concerns that existing cosmopolitan features might still be excised remain.

257. See *infra* Section III.B.

pandemic and a new cosmopolitan view of pandemic governance that might serve the world better in the future.²⁵⁸

A. *Translating Cosmopolitan Aims to Specific Treaty Structures*

Before diving into specific prescriptive recommendations, it is important to understand generally what a cosmopolitan treaty would entail. While all treaties create mutual obligations to some extent, appropriate treaty mechanisms should identify particular cosmopolitan goals (e.g., promoting global cooperation, respecting human rights, or articulating mutual obligations); identify treaty structures that might further these goals; and then determine how to enshrine these goals in the treaty structures given practical and political considerations, precedent in international law, and other salient features.

To that end, this Section summarizes five major areas that commentators, activists, and treaty drafters themselves have identified as ripe for cosmopolitan reform. These are: (1) expanding global health law's mandate,²⁵⁹ (2) strengthening global health financing,²⁶⁰ (3) sharing benefits among signatory countries,²⁶¹ (4) ensuring compliance and enforcement,²⁶² and (5) reducing fragmentation.²⁶³ These broad goals roughly align with the five substantive chapters of the pandemic treaty's December 2022 and February 2023 drafts, providing an illustrative touch point for each major aspect of the pandemic treaty under development. Each of these five goals is similarly well-represented in broader global health literature.

The first goal concerns expanding global health law's mandate beyond the narrow, security-driven concerns of containing infectious diseases. This furthers cosmopolitan principles by shifting the frame of concern from the self-interested priorities of countries to the realities of individuals' health risks, both during pandemics, and in "inter-pandemic" periods.²⁶⁴ For example, instead of trying

258. This Part especially acknowledges the contested nature of the overall term of cosmopolitanism, and that aspects of the existing international legal instruments drawn on below may, in parts, be critiqued on those grounds.

259. *Zero Draft*, *supra* note 21, chs. IV-V (addressing capacity building across health systems, a form of expanding involvement of global health law in such capabilities).

260. *See id.* ch. VI (focusing on financing directly).

261. *See id.* ch. III (focusing on equity, in general and specifically on access to technology and development of Research & Development capacities).

262. *See id.* ch. VII (relating to oversight through the creation of monitoring mechanisms and institutional bodies).

263. *See id.* chs. V-VII (relating to the structure of the pandemic treaty's governance).

264. *Id.* art. 1 (using this phrasing to describe nonpandemic periods).

to predict what specific pathogens might be used in a bioterror event and stockpiling specific medicines accordingly, a broader view of global health might pull attention toward focusing on improving planetary health and people's living conditions to avoid zoonotic spillover. Expanding what global health law cares about would allow the treaty to address the failures of the COVID-19 pandemic and ensure that the treaty goes beyond the status quo.²⁶⁵

The second goal is to strengthen global health financing. This goal would further the cosmopolitan recognition of the importance of mutual financial obligation, eschewing the purely voluntary, charity-based structure that has so far dominated the global health law space. Strengthening global financing that operates along multiple nodes, including country-level, is necessary to avoid creating dependency²⁶⁶ on the kinds of charity-based structures shown to fail during the COVID-19 pandemic. This goal draws directly from the kinds of goals articulated by NIEO scholars in their descriptions of postcolonial cosmopolitanism²⁶⁷ and has been advocated in subsequent treaty reform efforts.

The third goal is to ensure that benefits of pandemic preparedness and response are shared. This goal embraces cosmopolitanism's belief that access to critical pandemic resources, such as medicines and vaccines, should be provided based on the health needs of individuals rather than hoarded by governments to protect national-security interests or related isolationist impulses. In turn, this obligates member states to mutually assist one another to facilitate need-based benefit sharing. This goal finds roots in past movements for increased benefit sharing, both within past global health law reform efforts,²⁶⁸ as well as in the specific, recent failures of the COVID-19 pandemic.

265. See Nithin Ramakrishnan, Consultant, Third World Network, Remarks at the USC Institute on Inequalities in Global Health Panel on Global Pandemic Preparedness and Response: Negotiating the Future (Feb. 8, 2023) (notes on file with author) (noting that there is currently missing an explanation of how pandemic preparedness differs from health more generally and emergency preparedness, and encouraging the articulation of a clear objective in the pandemic treaty).

266. See Matsoso, *supra* note 27 (noting the importance of financing at the national level to avoid creation of dependency on potentially unstable international structures); Michel Kazatchkine, Member, Independent Panel for Pandemic Preparedness and Response, Remarks at the USC Institute on Inequalities in Global Health Panel on Global Pandemic Preparedness and Response: Negotiating the Future (Feb. 8, 2023) (notes on file with author) (describing the Independent Panel on Pandemic Preparedness and Response (IPPPR) recommendation for pandemic preparedness that starts at the country level, but also implements international obligations for finance sharing on a need-to-pay basis).

267. See GETACHEW, *supra* note 104 and accompanying text.

268. See, e.g., OGAWA ET AL., *supra* note 235, at 91-100 (describing Indonesia's efforts at ensuring access to benefit sharing via the PIP Framework).

The fourth goal is to ensure compliance and enforcement. This goal operationalizes the “obligation” aspect of cosmopolitanism’s oft-cited norm of mutual obligation. For mutual obligation to be a reality, cosmopolitan requirements claimed by the overall treaty must be backed with at least some semblance of authority. Such accountability mechanisms are critical for ensuring that country signatories actually live up to their lofty goals but remain underdeveloped in the most recent treaty draft.²⁶⁹

The fifth and final goal looks at the pandemic treaty’s position within the larger global health law landscape to attempt to reduce the fragmentation currently facing the space. Cosmopolitan principles demand, at the very least, that the pandemic treaty supports, rather than sabotages, existing agreements. Namely, the treaty’s structure should not undercut the IHR, GHSA, Doha Declaration protection of the TRIPS Agreement, or other international law governing global health.²⁷⁰ The treaty, no matter its final form, must proceed with these additional mechanisms in mind to ensure that it does not undo hard-fought progress.

B. Prescriptive Recommendations

This Section offers specific prescriptive recommendations for treaty drafters as they continue negotiations into 2023 and 2024, using comparisons to global health legal scholarship and international law as necessary. Each recommendation is intended to bridge the gap between the grim realities of the status quo and a cosmopolitan vision of what cosmopolitan global health law could be.²⁷¹

269. See Hanbali, *supra* note 251.

270. See Wenham et al., *Futility*, *supra* note 51, at 846-47 (discussing compatibility with the IHR as a critical factor for avoiding fragmentation of the global health space).

271. Throughout this Section, references are made to content that is included in the conceptual zero draft. Because this content will be significantly negotiated, nothing currently included in the zero draft should be affirmatively included, but rather should be viewed as a starting point for negotiations.

TABLE 3. SUMMARY OF RECOMMENDED TREATY FEATURES

GOAL	POTENTIAL RECOMMENDATIONS	INTERNATIONAL LAW ANALOGS	CONTRIBUTION TO A NEW COSMOPOLITAN NORM
Expand global health law's mandate	Move beyond biosecurity framing to include other leading causes of pandemics (zoonoses, AMR); maintain focus on infectious illness emergency; anticipate later "right to health" legal norm	Human rights law and International Humanitarian Law (IHL) <i>lex specialis</i> relationship; NDC goal-setting; existing support for a right to health in international law	Expand country global health obligations; solidify pandemic response norms; create space for future "right to health" norms
Strengthen global health financing	Build in treaty financing mechanism; utilize COP and NDC structures in treaty financing governance	UNFCCC and Green Climate Fund and related COP	Further common obligation; move away from charity-based financing
Share benefits among signatory countries	Expand PIP Framework to infectious disease response;	PIP Framework (WHA resolution)	Establish norm of pandemic benefit sharing; strengthen

	support ex- tratreaty trade law reforms		existing obligations
Ensure compliance and enforcement	Create an ex- pert review committee and self-assessment structure to im- prove on IHR JEE; create NDC baselines; outsource puni- tive enforce- ment to other international bodies	CAT/human rights treaties, FCTC, UN- FCCC monitor- ing; NDC goal- setting; trade and financing penalties	Centralized en- forcement structure; create new standard for a health treaty with “teeth”
Improve coordination across global health law	Explicitly reaffirm IHR throughout pandemic treaty process and within	[None identified]	Align global health law governance and expectations to avoid weakening existing and new obligations

1. *Expanding Global Health Law’s Mandate*

The key aim of the pandemic treaty focuses on a broadened mandate for global health law. A common theme of critiques of the existing global health system during COVID-19 was that existing global health law does not adequately address upstream factors²⁷² that make infectious-disease emergencies so devastating. For example, existing security-focused global health law is preoccupied

272. See, e.g., Jorge Vinales, Suerie Moon, Ginevra Le Moli & Gian-Luca Burci, *A Global Pandemic Treaty Should Aim for Deep Prevention*, 397 LANCET 1791 (2021) (encouraging a more comprehensive preventative global health regime).

with specific issues around diseases crossing borders or national security issues,²⁷³ but does not focus on questions about universal healthcare access, planetary health, or other factors that may appear remote to acute infectious-disease emergencies but are in fact critical for limiting harm during a pandemic.

The treaty could expand global health law's mandate along several axes. Two potentially relevant areas might include (1) going beyond national security framings of pandemic origins, and (2) expanding global health law's coordination with everyday domestic healthcare capacity.²⁷⁴ For example, the IHR focuses on containment of illness,²⁷⁵ and other global health law mechanisms, such as the Biological Weapons Convention, address only one main source of infectious illness: accidental or purposeful release from laboratory settings.²⁷⁶ This explicit security framing could be expanded by instituting legal obligations around the other two sources of pandemics identified in global health literature: antimicrobial-resistant pathogens and zoonoses (animal-to-human spread). Attendant reforms in the treaty-making process might focus on the "One Health" principle, which advocates for an explicit linkage of environmental, animal, and human health.²⁷⁷ A second class of reforms might similarly address upstream factors on the health-system side by looking to improve health services, as well as associated social and economic systems.²⁷⁸ This recognition of health's far-reaching connections with other societal systems finds strong backing in the lessons of past health emergencies including HIV/AIDS and listeriosis.²⁷⁹ Overall, an expanded scope of action in the pandemic treaty would contribute to cosmopolitan goals by promoting health as a shared global responsibility.

The most recent treaty draft indicates that such expansion is possible. The February 1 pandemic treaty draft generally takes a broad view of global health's

273. See *supra* Section I.B.1.

274. See Ramakrishnan, *supra* note 265 (noting a historic prioritization on surveillance and information over health facilities and capacities).

275. See *supra* Section I.B.1.

276. Current, security-based global health law only has a legal mechanism to address accidental and purposive release of pathogens as part of the Biological Weapons Convention and containment of infectious illness in the narrow security-based contexts described by the IHR/GHSA. Convention on the Prohibition of the Development, Production and Stockpiling of Bacteriological (Biological) and Toxin Weapons and on Their Destruction, Apr. 10, 1972, 1015 U.N.T.S. 163 (entered into force Mar. 26, 1975).

277. See Anishka Cameron et al., *Antimicrobial Resistance as a Global Health Threat: The Need to Learn Lessons from the COVID-19 Pandemic*, 13 GLOB. POL'Y 179 (2022).

278. Hanbali, *supra* note 251 (encouraging broader transformation of social and economic systems).

279. See Matsoso, *supra* note 27.

mandate and acknowledges (at least textually) a wide variety of relevant upstream and system-wide factors for pandemic preparedness. For example, the draft features explicit references to antimicrobial resistance, One Health, the potential for zoonotic spillover, and the importance of considering environmental considerations in health.²⁸⁰ The draft also frequently discusses health systems (integrated in four of the draft's five substantive chapters), including outlining concerns such as the need for well-trained health workers, gender equity in the health workforce, and the need for "whole-of-society" and "whole-of-government" approaches to health.²⁸¹ Finally, the pandemic treaty brings universal-health coverage and right-to-health discussions into the realm of international obligation in perhaps the most significant way in decades.²⁸² Movements to ensure a universal right to health arguably reached their peak with the landmark declaration of Alma-Ata in 1978, but the ambitions of universal healthcare eroded thereafter.²⁸³ While subsequent efforts have been made to bolster right-to-health obligations existed, none have made it as far into development as the current pandemic treaty.²⁸⁴ There are reasons to be optimistic.

Still, there are challenges to delivering on such a cosmopolitan-minded expansion. If an expanded mandate is not approached carefully, countries might decry the sovereignty costs of the proposal and reject the project altogether—leaving only the status quo of security-based protection. Specifically, because a universal-healthcare provision generally refers to a country-level obligation to its citizens (either through direct provisions of national providers and players, or through regulation of private healthcare actors), states might balk at the sovereignty costs involved in complying with international regulation.²⁸⁵ High costs involved in delivering such broad-minded focus frequently contribute to a lack of uptake in similar international initiatives.²⁸⁶ To succeed in expanding global health law's mandate, treaty drafters therefore must create a broad enough mandate to achieve meaningful prevention of pandemic-causing events while avoiding the perception that they are needlessly piling on international obligations. If

²⁸⁰. *Zero Draft*, *supra* note 21, art. 18.

²⁸¹. *Id.* art. 12.

²⁸². *Id.* pmb., arts. 3, 4, 11.

²⁸³. See Declaration of Alma-Ata, International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 (Sept. 1978); Abihiro & De Allegri, *supra* note 97 (describing Alma-Ata's broad conception of universal healthcare alongside other, more scaled back versions).

²⁸⁴. *About*, *supra* note 13 (describing the overall project and 2019 efforts).

²⁸⁵. See Abihiro & De Allegri, *supra* note 97, at 3.

²⁸⁶. See, e.g., Emilie M. Hafner-Burton, Edward D. Mansfield & Jon C.W. Pevehouse, *Human Rights Institutions, Sovereignty Costs, and Democratization*, 45 BRITISH J. POL. SCI. 1, 2 (2013) (giving an example of how sovereignty costs in the human rights space limit uptake in certain kinds of actors).

an expanded mandate is not approached carefully, it could sink the entire treaty. Indeed, commentators on the February 1 treaty draft have cautioned the need to consider the role of pandemic preparedness more precisely from other related frames, and that such definition may be critical to the success of the pandemic treaty.²⁸⁷

International law related to human rights and climate offers suggestions for how to broaden the scope of an international legal instrument that must address both emergency situations and the upstream factors that cause them. First, there is the longstanding example of human-rights law and humanitarian law. Human-rights law generally addresses violent abuses of power that implicate states' daily functions (e.g., police brutality), whereas humanitarian law deals with similar topics (e.g., military's mistreatment of prisoners of war) but in the specific context of international armed conflict. This creates a dilemma in international law of how to separate out emergency contexts where international obligations apply, compared to more routine state responsibilities. International law deals with this problem by the creation of two interlocking bodies of law – international humanitarian law (IHL) and human-rights law – each with its own scope and practices. IHL governs in discrete cross-border emergency scenarios such as war, while human-rights law addresses a country's treatment of people within its own borders. The two bodies navigate their scope using the principle of *lex specialis*, with IHL usually complementing human-rights law and sometimes supplanting it under narrowly defined circumstances where the presence of international armed conflict triggers IHL obligations.²⁸⁸ The two legal regimes are therefore in constant communication with one another, a core feature that the pandemic treaty would do well to emulate.

This general dual-scope feature of the IHL/human-rights relationship²⁸⁹ offers a potentially useful analogy for how the pandemic treaty can pursue an expanded mandate without claiming to tackle the complete project of establishing an international right to health, which the current treaty language is woefully inadequate to do (and indeed does not seem to be its project). Specifically, the

287. Ramakrishnan, *supra* note 265 (describing how the global health law space currently lacks fundamentals about how “pandemic preparedness” differs from “health” and “emergency preparedness”).

288. See, e.g., Nancie Prud'homme, *Lex Specialis: Oversimplifying a More Complex and Multifaceted Relationship?*, 40 ISR. L. REV. 356 (2007) (articulating the traditional *lex specialis*/human-rights view).

289. This analogy is entirely novel within literature on the pandemic treaty. This analogy is made in general terms for the proposition of interlocking emergency and nonemergency regimes, not to necessarily endorse a direct import of features, such as the legal determination of *lex specialis* by courts.

pandemic treaty could be framed as analogous to IHL – complementing domestic-health responses and occasionally imposing temporary additional responsibilities in the unusual case of international-health emergencies. The pandemic treaty could help define the scope of “pandemic preparedness” (versus “health” overall or less ambitious “emergency preparedness”) as primarily geared toward specific preconditions of infectious-disease emergencies that contribute to, but do not fully encompass, a complete right to health.

The pandemic treaty, then, would seek to contribute to an overall goal of a right to health and universal health coverage²⁹⁰ in its language and recommendations, but focus its concrete obligations to those actions within the pipeline of pandemic preparedness rather than all of the services and actions that might be needed to establish a complete right to health on the domestic level.²⁹¹ This would entail outlining more concrete obligations with respect to One Health, antimicrobial, and zoonotic factors (each of which is relatively traceable and amenable to threshold-triggered obligations²⁹²) while using less particularized language for more general aspects of health governance (that could otherwise be perceived as meddling in a country’s internal affairs).²⁹³ Additional aspects of a right to health could then be pursued in broader terms in additional protocols or treaties to more robustly support a general right to health.

Climate treaties provide an additional example of how an emergency-response framework might expand the international coordination and commitment for a complex global problem, while still structuring in protections for state

290. At present, the zero draft includes, but does not define, the term universal health coverage (UHC). *Zero Draft*, *supra* note 21, art. 1. Considering the historical neoliberal weakening of UHC’s scope, treaty drafters should avoid imposing an infectious-disease-focused definition in the pandemic treaty that would inadvertently limit future attempts to secure UHC. See Anne-Emanuelle Birn, Laura Nervi & Eduardo Siqueira, *Neoliberalism Redux: The Global Health Policy Agenda and the Politics of Cooptation in Latin America and Beyond*, 47 DEV. CHANGE 734 (2016) (describing the cooptation of UHC by private interests).

291. For example, a full right to health might encompass country provision of health services, which a pandemic-preparedness treaty may simply not be well-advised to tackle if hoping to gain wide acceptance. However, a pandemic treaty’s broader scope that includes asking countries to commit to continue improving access to some bundle of universal healthcare services (e.g., vaccinations, care for immunity-affecting illnesses such as HIV/AIDS and diabetes) and improve national laboratory capacities furthers “pandemic preparedness” and is compatible with a right to health without asking countries to sign on for a complete guarantee of “health” in its broadest sense.

292. For example, a spike in hospital-reported use of last-resort antibiotics, or a certain number of unexplained animal deaths could create helpful thresholds from already collected information for use in pandemic response processes.

293. This approach is additionally compatible with the way other international treaties support a right to health. See, e.g., Birn et al., *supra* note 290.

sovereignty. Climate treaties, like the proposed pandemic treaty, are fundamentally cosmopolitan in nature in that they aim to help the world address a borderless problem affecting all global communities. Like health treaties, they also rely heavily on scientific markers and technical advice. Climate treaties such as the United Nations Framework Convention on Climate Change (UNFCCC) and the related Paris Agreement have therefore served as a strong source of comparative analysis for the pandemic treaty in global health scholarship.²⁹⁴

While certainly not without their own implementation challenges,²⁹⁵ climate agreements have been able to expand treaty scope while respecting differing national priorities and capabilities through a structure of nationally determined contributions (NDCs).²⁹⁶ NDCs are action plans for meeting climate-based goals required by treaty and are updated by states every five years.²⁹⁷ Through NDCs, the UNFCCC demands domestic change to meet some climate-change goals but softens the demand by creating space for countries to articulate exactly how they will meet those goals and determine their own markers and funding aims. By allowing individual country choice, the UNFCCC managed to gain support for its ambitious cosmopolitan ends and establish a system of mutual obligations.²⁹⁸ This suggests that if pandemic-treaty drafters do want to focus on more involved treaty provisions such as health-workforce capacities, they could do so by articulating goals and letting implementation and funding decisions fall to individual countries rather than imposing global demands (that are likely to

294. Phelan & Ramakrishna, *supra* note 128 (illustrating the interdisciplinary nature of the discussion around the pandemic treaty, with Phelan and Ramakrishna representing leading global health and climate perspectives, respectively); Chenguang Wang & Yi Zhang, *Common but Differentiated Responsibilities and Respective Capabilities as a Guiding Principle in International Health Law in Times of Pandemics*, in NETHERLANDS YEARBOOK OF INTERNATIONAL LAW 2020: GLOBAL SOLIDARITY AND COMMON BUT DIFFERENTIATED RESPONSIBILITIES 257, 272 (Maarten den Heijer & Harmen van der Wilt eds., 2022) (applying principles from the international climate change regime to global health).

295. See, e.g., Lindsay Maizland, *Global Climate Agreements: Successes and Failures*, COUNCIL ON FOREIGN RELS. (Nov. 4, 2022, 12:30 PM EST), <https://www.cfr.org/backgrounder/paris-global-climate-change-agreements> [<https://perma.cc/C8BW-ZAK7>] (discussing the limitations of climate law).

296. *Nationally Determined Contributions (NDCs). The Paris Agreement and NDCs*, U.N. CLIMATE CHANGE, <https://unfccc.int/process-and-meetings/the-paris-agreement/nationally-determined-contributions-ndcs/nationally-determined-contributions-ndcs> [<https://perma.cc/VN2G-R2JQ>].

297. *All About the NDCs*, UNITED NATIONS, <https://www.un.org/en/climatechange/all-about-ndcs> [<https://perma.cc/9X8A-HEUL>].

298. See Todd Stern, *The Paris Agreement and Its Future*, BROOKINGS INST. 3-4 (Oct. 2018), <https://www.brookings.edu/wp-content/uploads/2018/10/The-Paris-Agreement-and-Its-Future-Todd-Stern-October-2018.pdf> [<https://perma.cc/8QX4-HKGL>] (describing the treaty's "flexibility").

be tailored toward the needs of the Global North in any event). By borrowing this structural feature from climate treaties, the pandemic treaty could directly address skeptical countries' sovereignty concerns that might otherwise prevent the treaty from gaining key support in 2024.

2. *Strengthening Global Health Financing*

Creating sustainable funding and financial assistance is a second substantive goal that would improve on the global health law mechanisms available prior to the COVID-19 pandemic. Pandemic prevention and response implicate financing at nearly every level – international aid, maintenance of domestic health systems, purchase of diagnostics and vaccines, maintenance of stockpile supplies, etc. Moreover, any additional layer of international legal requirements established in the pandemic treaty above current legal obligations would require a corresponding increase in funding to upgrade health systems and create bureaucratic and monitoring structures that ensure compliance. This requirement poses a challenge since prevalent charity-based funding models rely on voluntary contributions that are often earmarked for specific purposes that do not coincide with these needs.²⁹⁹ To accomplish the goal of strengthening global health financing with at least some degree of international funding, pandemic treaty drafters must answer two key questions about the treaty structure: whether to create a legal obligation for financing and, if so, whether that legal obligation should sit in the new treaty or an old legal mechanism.

The first question arises from the reality that funding does not necessarily require legal backing within a treaty or other legal body. Indeed, treaties that impose country-level obligations (e.g., trade, human rights) often require financing not by explicit demand, but implicitly by imposing costly requirements.³⁰⁰ Funding may occur without an explicit obligation or be based outside of a treaty within an external organization.³⁰¹ However, there are strong reasons to incorporate funding in conjunction with a binding legal mechanism, whether that be a treaty, regulation, or multilateral legal agreement. Requiring funding

299. See Srikanth K. Reddy, Sumaira Mazhar & Raphael Lencucha, *The Financial Sustainability of the World Health Organization and the Political Economy of Global Health Governance: A Review of Funding Proposals*, 14 *GLOBALIZATION & HEALTH* art. no. 119, at 3 (2018) (describing the prevalence, and critiques of, earmarked funds in global health).

300. For example, a requirement to create a domestic plan for implementation and then update on that monitoring would require funding those administrative tasks, and a requirement to grow green-energy sectors, for example, would naturally require funding that sector.

301. Funding may also sit within an external body, such as the IPPPR-proposed Global Health Threats Board, or in a body such as CEPI, GAVI, or a renewed version of the World Bank's PEF (the approach suggested by the G20). Nikogosian, *supra* note 88, at 22-23.

within a legal mechanism would ensure that the ability to deliver on the treaty's obligation does not break down along wealth lines, with rich countries able to fund their efforts to meet their treaty obligations while less wealthy countries – unable to self-fund³⁰² – rely on voluntary charity mechanisms. A different system is needed.³⁰³ And while some argue that external bodies provide more flexibility for funders and thus are more politically attractive, an external-funding framework would make the pandemic treaty's efforts to secure funding for global health just another expression of charity-based global health governance, reliant on voluntary contributions. An in-treaty financing mechanism is therefore preferable.

The second question addresses whether treaty drafters should create a new funding mechanism within the pandemic treaty itself or add a funding provision to one of the existing (albeit weaker) legal mechanisms of the International Health Regulations or the Global Health Security Agenda.³⁰⁴ This choice is less clear-cut. Both the IHR and GHSA hold greater power to bind countries than would an entirely external, voluntary funding source. They also have the advantage of being preferred by countries that have previously been large global health donors. The United States, for example, has expressed a strong preference for IHR-based mechanisms and is the lead party in the GHSA's formation and implementation; conceding that funding be channeled through the IHR or GHSA may greatly improve the odds that the United States contributes treaty

302. Recall that diminished self-funding ability is linked to histories of neoliberal policies both domestically and internationally, as well as hollowing out of governments' health funding via structural-adjustment loans. See discussion *supra* Section I.A.2.

303. See Eric A. Friedman, *The Framework Convention on Global Health: An Empowering International Instrument to Advance the Right to Health*, O'NEILL INST. FOR NAT'L & GLOB. HEALTH L. (Sept. 4, 2019), <https://oneill.law.georgetown.edu/the-framework-convention-on-global-health-an-empowering-international-instrument-to-advance-the-right-to-health> [<https://perma.cc/478E-QC25>] (describing the need for agreed norms in international health financing).

304. See Haik Nikogosian & Ilona Kickbusch, *Confronting Future Pandemics: What Could a New Treaty Resolve Beyond the IHR?*, *BMJ* (Oct. 5, 2021), <https://blogs.bmj.com/bmj/2021/10/05/confronting-future-pandemics-what-could-a-new-treaty-resolve-beyond-the-ihl> [<https://perma.cc/A7VL-54MV>] (asking a similar question).

funding.³⁰⁵ This approach could have the added benefit of linking IHR and pandemic-treaty reform efforts, which could further bolster support from states who expressed early preference for the IHR.³⁰⁶

The zero draft's section on financing has thus far been somewhat scant,³⁰⁷ giving treaty drafters a wide breadth of potential possible action to follow these recommendations and set up such a financing system.³⁰⁸ The most recent treaty draft features frequent citation to the need for sustainable and predictable financing both on the international and the domestic level, including drafted commitments for domestic funding (e.g., committing a certain percentage of GDP for pandemic prevention).³⁰⁹ The treaty also gestures at the need for bilateral and multilateral funding mechanisms, indicating space for an in-treaty solution. These are positive developments, but the next round of treaty negotiations must go further to avoid a backslide into purely charity logics.

An in-treaty financing mechanism for international pooling and redistribution of resources is especially urgent, given that other aspects of the global health law system are already repeating the failed projects of the pre-COVID-19 period. For example, the World Bank in November announced the creation of a new Pandemic Fund for long-term pandemic preparedness funding³¹⁰ – a clear analog to the failed charity instrument of the PEF. The new fund has very little set structure, but it is already clear that, in a redux of the failed PEF, the fund will be premised on voluntary contributions,³¹¹ will cater to wealthy states' security

305. China, another major global health funder, has similarly expressed reservations about the pandemic treaty, but is already bound by the IHR, perhaps making the addition of an IHR-linked funding mechanism an easier pill to swallow. See Kerry Cullinan, *Keep Momentum on Pandemic "Treaty," Urges Tedros*, HEALTH POL'Y WATCH (May 12, 2022), <https://healthpolicy-watch.news/keep-momentum-on-pandemic-treaty-urges-tedros> [<https://perma.cc/X5C9-SYSW>]; see also Karen A. Grépin, Victoria Y. Fan, Gordon C. Shen & Lucy Chen, *China's Role as a Global Health Donor in Africa: What Can We Learn from Studying Under Reported Resource Flows?*, 10 GLOBALIZATION & HEALTH art. no. 84, at 1 (2014) (describing China's importance as a major player in global health).

306. See Adam Taylor, *Why the WHO Is Pushing for a Global 'Pandemic Treaty,'* WASH. POST (Nov. 11, 2021, 12:01 AM EST) <https://www.washingtonpost.com/world/2021/11/11/who-global-pandemic-treaty> [<https://perma.cc/J5Y3-4VKL>] (describing early opposition). However, note that any changes that seek to bolster support risk replicating the status quo.

307. See Friedman et al., *supra* note 241.

308. See *Zero Draft*, *supra* note 21, ch. VI, art. 18 (offering open-ended language).

309. *Id.* ch. VI.

310. See Peter Baker, Lydia Regan & Y-Ling Chi, *Problems with Prioritising: Where Should the Pandemic Fund Start?*, CTR. FOR GLOB. DEV. (Feb. 3, 2023), <https://www.cgdev.org/blog/problems-prioritising-pandemic-fund-where-should-it-start> [<https://perma.cc/4RW3-FES4>].

311. *Id.*

priorities,³¹² and will underdeliver on its ambitiously stated financing aims.³¹³ The pandemic treaty cannot rely on voluntary financing mechanisms which have so recently, and so definitively, proven to be wholly ineffective. The pandemic treaty has a chance to do better. It must develop a legally binding financial requirement, for broad use in pandemic preparedness, that activates immediately once a pandemic is declared.³¹⁴ Only with these basic interventions can global health law's approach to pandemic financing avoid repeating the mistake of COVID-19.

3. *Sharing Benefits and Ensuring Equitable IP*

The third cosmopolitan goal is benefit sharing. Given that outrage regarding inequitable distribution of vaccines and medicines highlighted the need for cosmopolitanism in the first place, it is important for advocates of cosmopolitanism that the structure of the pandemic treaty substantially improve countries' access to pandemic-fighting resources. Under existing global health law, even countries that comply perfectly with IHR and GHSA surveillance and pathogen-identification requirements have no guarantee that they will get access to the vaccines and medicines that they themselves helped make possible through sharing information and genetic samples. This leads to massively inequitable outcomes. For example, South Africa's efforts during the COVID-19 pandemic to detect new variants, collect samples given variants, and present its findings to the world per the IHR's requirements did not lead to any reduction of the "vaccine apartheid" – in which the high-income countries had expansive vaccine access even as lower-income countries, including South Africa, did not even have access to first doses.³¹⁵ Stringent IP protections under TRIPS coupled with wealthy states' reluctance to loosen those protections similarly undercut any potential proposals for the creation of, for example, a generic vaccine option produced outside of wealthy Global North countries.³¹⁶

312. Samantha Rick, (@hellosamrick), TWITTER (Feb. 6, 2023, 12:58 PM), <https://twitter.com/hellosamrick/status/1622655954520088577> [<https://perma.cc/7D2V-8HR7>] (citing surveillance measures being prioritized over access to benefits or healthcare workers).

313. *Id.*

314. Matsoso, *supra* note 27 (stating that financial mechanisms must kick in immediately in pandemic response).

315. Simar Singh Bajaj, Lwando Maki & Fatima Cody Stanford, *Vaccine Apartheid: Global Cooperation and Equity*, 399 LANCET 1452, 1452-53 (2022).

316. See Sakshi Prasad, Abia Shahid, Edzel Lorraine F. Co, Govinda Khatri, Huzaifa Ahmad Cheema, Ian Christopher N. Rocha, Mainak Bardhan & Mohammad Mehedi Hasan, *Vaccine Apartheid: The Separation of the World's Poorest and Most Vulnerable and the Birth of Omicron*, 10

That IP featured so prominently in the zero draft is a promising first step in the pandemic treaty addressing these harms,³¹⁷ but the lack of corporate accountability in the treaty draft indicates that there is still a long way to go if a pandemic treaty actually intends to further health-justice principles.³¹⁸ To address this failing of the pre-COVID-19 global health system, drafters must expand on their current language to determine (1) how countries should access the tangible benefits (e.g., vaccines, medicines) in compliance with global health law and (2) to what extent resulting technical details around intellectual property should be addressed within the treaty.

The first issue, known in international law as “benefit sharing,”³¹⁹ would be best pursued by extending existing legal mechanisms to cover more public-health-emergency scenarios. Specifically, the pandemic treaty drafters could extend the kinds of benefit sharing mechanisms used in the Pandemic Influenza Preparedness (PIP) Framework to ensure countries gain access to key tools such as vaccines and medicines.³²⁰ The circumstances that gave rise to the PIP Framework offer clear analogs to the inequalities of the COVID-19 response, leading much early literature around the pandemic treaty to mention PIP as a starting

THERAPEUTIC ADVANCES VACCINES & IMMUNOTHERAPY 1 (2022); Matiangai Sirleaf, *Omicron: The Variant that Vaccine Apartheid Built*, JUST SEC. (Dec. 2, 2021), <https://www.justsecurity.org/79403/omicron-the-variant-that-vaccine-apartheid-built> [<https://perma.cc/CCH2-ZVWS>].

317. Recent commentary highlights the zero draft’s focus on IP. See, e.g., Kerry Cullinan, *Pandemic Treaty ‘Zero-Draft’ Makes a Strong Case for Regional Production*, HEALTH POL’Y WATCH (Nov. 17, 2022), <https://healthpolicy-watch.news/pandemic-treaty-zero-draft-makes-a-strong-case-for-regional-production> [<https://perma.cc/YKV3-7PKK>]; Ashleigh Furlong, *A New Pandemic Playbook: Draft Treaty Sets Out Far-Reaching New Rules for Countries*, POLITICO (Nov. 17, 2022 3:17 PM CET), <https://www.politico.eu/article/new-pandemic-playbook-draft-treaty-far-reaching-rules-countries> [<https://perma.cc/9VCQ-R6NW>] (making special provisions and note of regional capacities, and recognizing the harms of IP).
318. See, e.g., *Release: Corporate Pressures Loom as Pandemic Treaty Talks Resume*, CORP. ACCOUNTABILITY (July 18, 2022), <https://corporateaccountability.org/media/release-corporate-pressures-loom-as-pandemic-treaty-talks-resume> [<https://perma.cc/W5DZ-TFSE>] (acknowledging this critique).
319. See, e.g., *Zero Draft*, *supra* note 21, art. 10 (setting out such a system).
320. World Health Assembly Res. WHA 64.5, *Pandemic Influenza Preparedness Framework for the Sharing of Influenza Viruses and Access to Vaccines and Other Benefits*, WORLD HEALTH ORG. 21 (2011) [hereinafter *PIP Framework*], https://apps.who.int/gb/pip/pdf_files/pandemic-influenza-preparedness-en.pdf [<https://perma.cc/SV9V-YCMK>]. Benefit sharing is not one concept, but many, and has been employed as a treaty objective, a right, an international obligation, and a mechanism in different areas of international law. While this Section focuses on the PIP Framework, benefit sharing is also highly utilized in treaties regarding biodiversity, agriculture, law of the sea, and genetic resources, to name a few fields. Elisa Morgera, *The Need for an International Legal Concept of Fair and Equitable Benefit Sharing*, 27 EUR. J. INT’L L. 353, 353-55 (2016).

point for analysis. During the 2006 H5N1 outbreak, Indonesia was required under the International Health Regulations to report cases of the novel pathogen and share viral samples with the world—and the country did so. However, the law did not require that Indonesia would, in exchange, gain access to vaccines or therapeutics made possible by its disclosure. Instead, the WHO informed Indonesia that advanced purchasing agreements had already led to a two-year stock-out on subsequent vaccines and that the WHO did not have a process to offer vaccines directly.³²¹ Indonesia subsequently announced its refusal to share future viruses with the WHO, sparking the impetus for the PIP Framework.³²²

The PIP Framework is a nonbinding WHA resolution built on the three pillars of virus sharing, benefit sharing, and governance.³²³ It creates an obligation that researchers and private entities seeking access to biological materials for novel pathogens must agree to a set of benefit sharing obligations, including reserving vaccines for lower-income countries and broadening licensing of biomedical-related intellectual property.³²⁴ And perhaps most importantly, the PIP Framework offers a valuable, real-life example of an “open science” system where creation without IP was shown to be reasonably effective without (and perhaps in spite of) strong IP protections.³²⁵ While the PIP Framework’s limited scope (flu) meant it did not govern the COVID-19 pandemic, the Framework could serve as a valuable model for increasing access to IP in the pandemic treaty.

The second, perhaps more difficult question of a benefit sharing requirement is how specifically it should be spelled out within the body of the treaty as opposed to in future negotiations. There are two broad options for the pandemic treaty’s scaffolding: a “normal” convention with most commitments (including benefit sharing) elaborated within the main treaty text; or a framework approach that spells out broad obligations with specific details elaborated in later protocols, which are negotiated and adopted in often lengthy processes.³²⁶ Of these two options, the framework-protocol structure offers several advantages for the

321. OGAWA ET AL., *supra* note 235, at 92.

322. *Id.*

323. *PIP Framework*, *supra* note 320, at 15.

324. See *Standard Material Transfer Agreement 2 (SMTA2)*, WORLD HEALTH ORG., [https://www.who.int/initiatives/pandemic-influenza-preparedness-framework/standard-material-transfer-agreement-2-\(smta2\)](https://www.who.int/initiatives/pandemic-influenza-preparedness-framework/standard-material-transfer-agreement-2-(smta2)) [<https://perma.cc/NFE2-PXNH>].

325. See Kapczynski, *supra* note 235, at 1548-49 (describing the effectiveness of the PIP Framework’s open-science approach).

326. See generally Daniel Bodansky, World Health Org., *Framework Convention on Tobacco Control: Technical Briefing Series Paper 1: The Framework Convention/Protocol Approach*, WHO/NCD/TFI/99.1 (1999), https://apps.who.int/iris/bitstream/handle/10665/65355/WHO_NCD_TFI_99.1.pdf [<https://perma.cc/2UT7-DZ97>] (describing the framework/convention approach).

purpose of promoting benefit sharing. First, it has precedent on its side, being the preferred choice of analogous treaties in health, climate and biosecurity,³²⁷ two other international legal subjects that must account for evolving science and technology by allowing more frequent updating of scientific information in subsequent protocols.³²⁸ Second, this approach lessens the need to address difficult issues within the tight deadlines of the WHA presentation. After all, it is easier to get countries on board with a basic framework with the promise of subsequent technical protocols than to try to encapsulate all relevant information in a treaty in time for a 2024 vote and win buy-in for the treaty's adoption.

The current pandemic treaty draft is relatively ambitious in its pursuit of reforms to benefit sharing – features that must be maintained going forward. First, the zero draft's initial embrace³²⁹ of PIP Framework principles, in Articles 9 and 10, is particularly strong in its breadth of application across a variety of relevant variables such as technology transfer, intellectual-property waivers, and manufacturing.³³⁰ This marks an excellent start in addressing head-on the particular moral, logistical, and epidemiological failures of the COVID-19 pandemic rooted in inequitable access to IP. The INB can go further with this line of protections, for example, by kicking in those protections immediately after the declaration of a PHEIC or similar trigger.³³¹ However, the real fight will likely be keeping these strong, ambitious provisions in the treaty draft at all considering the powerful corporate interests which will likely oppose such expansion of IP.³³²

As for how these principles might be adopted, the current treaty draft seems likely to follow this framework-protocol structure, given its listed provisions for enacting various aspects of the treaty. However, as commentators have noted, the protocol structure raises concerns of certain tricky tradeoffs between expediency (it is easier to implement a framework now, and additional technical protocols about IP later) and effectiveness (punting on IP might mean it never gets

327. Notably, the Framework Convention on Tobacco Control (FCTC), the United Nations Framework Convention on Climate Change (UNFCCC), the Convention on Biological Diversity (CBD), and its Nagoya Protocols. *See, e.g., id.* at 15-16; Kyoto Protocol to the United Nations Framework Convention on Climate Change, Dec. 10, 1997, 2303 U.N.T.S. 162.

328. Nikogosian, *supra* note 88, at 23. The issue of viral sovereignty and benefit sharing depends highly on scientific technologies for surveillance (including genetic sequencing), research, and vaccine and therapeutic development—highly technical subjects, which make it difficult to enumerate all the requisite scientific knowledge in a singular, central treaty.

329. *See* Friedman et al., *supra* note 241; *Zero Draft*, *supra* note 21, arts. 7, 9.

330. Friedman et al., *supra* note 241.

331. *See* Hanbali, *supra* note 251 (noting the need for automatic triggers within the pandemic treaty to ensure that equity-enhancing features are operationalized from the get-go).

332. *See, e.g., Release: Corporate Pressures Loom as Pandemic Treaty Talks Resume*, *supra* note 318 (discussing this pressure). It is not a foregone conclusion that such accountability is impossible – after all, the FCTC was able to directly take on tobacco companies. *Id.*

addressed). Assuming that the framework-protocol model maintains through future negotiations, drafters should publicize a tight schedule that ensures requisite protocols addressing the specifics of IP sharing and vaccine production are addressed in a timely fashion.³³³ Overall, benefit sharing seems to have gained the attention it deserves in early treaty drafts—now the question is whether the treaty can maintain its strength and resist weathering.

4. *Ensuring Accountability*

The pandemic treaty must also ensure it can enforce its obligations. Ensuring compliance with treaty terms is a constant challenge within international law. First, there is a need to decide what is actually being enforced: Concrete benchmarks? Moving targets? Ill-defined commitments? Then there is the need to monitor compliance where a central issue is discerning intent. How do we get information about country compliance? Did a country fail to deliver on its obligations out of knowing malfeasance or simple lack of resources?³³⁴ Next, we face the question of what enforcement mechanism to employ. There are many options for such mechanisms in the ether of international law, from arbitrating bodies, international courts, sanctions, outcasting tools,³³⁵ and countermeasures. Ask too little of countries, and the treaty goals never materialize. But ask too much, and no countries sign up in the first place—leaving no international law to enforce. This is not an insurmountable challenge. Countries have historically signed up for human rights and environmental obligations where there is no direct benefit to them. However, there are particular challenges in the global health context that deserve additional consideration.

Gaining compliance with an international treaty is difficult, especially in global health law. Effective health action requires that all parties contribute to the collective effort while also acknowledging differing levels of resources. Moreover, even when countries do act to improve global health systems, they see little positive reward to tout to their constituencies. Successful pandemic prevention manifests as a nonevent, not a positive outcome that countries can point to as evidence of their good governance. Finally, the borderless nature of disease

333. See Wenham et al., *Futility*, *supra* note 51, at 845 (suggesting that there are significant challenges to a framework convention, but that such a convention could be viable if protocol negotiations proceed in a timely fashion).

334. See Phelan & Ramakrishna, *supra* note 128 (posing this question and discussing the NDCs in the climate context as a way to address underlying resource constraints that might otherwise indicate noncompliance).

335. Oona A. Hathaway, Preston J. Lim, Alasdair Phillips-Robins & Mark Stevens, *The COVID-19 Pandemic and International Law*, 54 CORNELL INT'L L.J. 149, 222, 234-43 (2021) (applying outcasting techniques to the pandemic context).

spread cautions against punitive enforcement for fear it would rebound on the global community. A country that does not initially provide genetic samples in a timely fashion cannot and should not be completely cut off from later vaccine programs. The reasons for this are both ethical and practical. First, individuals' vaccine access should not depend on the arbitrary fact of their country leadership's negotiating skills. Practically preventative and therapeutic efforts must be truly global and accessible to quell a global health emergency.³³⁶ These issues – collective action, lack of visible reward, and constraints on punitive measures – make it difficult to see how compliance with a global health treaty can be achieved. With this context, it is understandable that INB drafters essentially left a blank space in the February 1, 2023 treaty draft.³³⁷ However, the importance of enforcement in the treaty's effectiveness means that the INB cannot kick the can down the road when it comes to enforcement.

These broader questions of compliance can be summarized in two major categories: monitoring and oversight, and enforcement in alignment with stages of the compliance process.³³⁸ Mandating that countries routinely report to a common-treaty body is a relatively basic mechanism but a potentially highly effective one – especially where those monitoring requirements are taken seriously and conducted by expert bodies. Monitoring should thus be seriously considered by treaty drafters, even as there is much specific material to determine. First, there is the question of what gets reported. In line with the NDC model, allowing countries to self-report and set their own compliance goals (versus imposing more invasive forms of review) seems like an especially promising tack here because it addresses the sovereignty concerns so commonly expressed by countries in compliance and enforcement discussions. Self-reporting structures run the risk that countries might set deliberately unambitious goals, or otherwise not be completely objective. However, member-wide goal-setting via the pandemic treaty's governing body³³⁹ could limit this effect. Further, there are real benefits

336. See, e.g., Håvard Thorsen Rydland, Joseph Friedman, Silvia Stringhini, Bruce G. Link & Terje Andreas Eikemo, *The Radically Unequal Distribution of Covid-19 Vaccinations: Predictable Yet Avoidable Symptom of the Fundamental Causes of Inequality*, 9 HUMANS. & SOC. SCIS. COMM'NS art. no. 61, at 5 (2022); Phelan et al., *supra* note 204, at 800 (generally describing the harms of uneven vaccine access).

337. See *Zero Draft*, *supra* note 21, art. 22 (leaving oversight mechanisms to the first governing-body meeting).

338. See Guilherme F. Faviero et al., *An Effective Pandemic Treaty Requires Accountability*, 7 LANCET PUB. HEALTH e730, e730 (2022) (distinguishing between transparency of information, and the monitoring and oversight mechanisms used to verify that information).

339. See *Zero Draft*, *supra* note 21, art. 20 (describing the governing body). Consider too that the current treaty draft provides for a one-country, one-vote structure – a more cosmopolitan governance structure that increases equitable state participation. *Id.* art. 28.

in self-reporting structures' contribution to overcoming information asymmetries of monitoring in that they give countries the opportunity to articulate the reasoning for their goals (e.g., balancing development of different sectors alongside health sectors) and to justify exactly why they did not meet a preset certain goal (e.g., because of lack of resources compared to deliberate inaction). This could have the net effect of making key information more accessible to monitoring bodies and making the treaty's governing body more responsive to real-time compliance barriers.

Next is the question of how reported information gets assessed via third-party oversight. Here, one primary recommendation could be not to develop an entirely new system but harmonize existing monitoring structures. Existing global health legal mechanisms described in Part I already offer a wide array of checklists and monitoring boards (e.g., the IHR's JEE board).³⁴⁰ The pandemic treaty could take advantage of these ongoing processes to (1) strengthen their authority (by incorporating the same informational requirements into a more powerful Article 19 treaty), and (2) serve an aggregating role in centralizing information gathering, rather than duplicating efforts.³⁴¹ Such coordination would better equip the world to more quickly recognize and act on pandemics' whole-of-society impacts.³⁴² The zero draft already offers some provision for this in its continued language describing a desire to harmonize its language and interpretation with that of other global health law mechanisms.³⁴³ The next draft could further strengthen these synergies by mentioning states' international obligations in other areas of international law (e.g., climate), and emphasizing existing health protections (e.g., the Doha Declaration) that are currently underutilized. To the extent that this existing oversight is consumed into a new structure, the pandemic-treaty governing body could consider implementing either a peer-review system of state evaluations (e.g., human-rights treaties) or an expert-re-

340. See *supra* Part I; *Joint External Evaluation (JEE)*, WORLD HEALTH ORG., <https://www.who.int/emergencies/operations/international-health-regulations-monitoring-evaluation-framework/joint-external-evaluations> [<https://perma.cc/E7X8-ULAV>].

341. See *Joint External Evaluation (JEE)*, *supra* note 340. Such aggregation, especially if explicit, could help to combat fragmentation in global health governance among a new pandemic treaty, the (potentially reformed) IHR, and other legal mechanisms.

342. See Hathaway et al., *supra* note 335, at 223 (identifying these coordination concerns).

343. *Zero Draft*, *supra* note 21, at 10 n.1 (stating the INB's intentions to "mak[e] explicit the synergies and concrete complementarity of the WHO CA+ with the International Health Regulations and other relevant mechanisms and instruments").

view mechanism of subject-matter experts (e.g., Framework Convention on Tobacco Control).³⁴⁴ Of these two options, global health's inherent technical focus makes an expert-review reporting structure particularly suitable. Expert review of quantifiable health goals (e.g., ICU capacity, laboratory technicians per capita) could especially help guide country compliance. As with monitoring provisions, the pandemic treaty should look to the structures that already exist and seek to coordinate review processes to lessen the burden of enforcement on states who will remain part of existing global health law mechanisms in addition to the new treaty.³⁴⁵

Finally, there is the issue of enforcement if and when states fail to live up to their expected pandemic preparedness.³⁴⁶ The question of enforcement mechanism perhaps has the least consensus among all pandemic-treaty commentaries and inputs thus far, with much of the dilemma resting on the fact that the WHO is fundamentally not a law-enforcing organization.³⁴⁷ It does not have the power to create criminal tribunals or run a court to punish those who shirk cosmopolitan responsibilities toward the global health community. Nor does the nature of global health allow the WHO to enforce obligations by turning on and off other

344. Neither of these mechanisms are without criticism. Like many international efforts, the quality and structures of peer-review mechanisms can be affected by political considerations of the countries involved. See, e.g., Cosette D. Creamer & Beth A. Simmons, *Ratification, Reporting, and Rights: Quality of Participation in the Convention Against Torture*, 37 HUM. RTS. Q. 579, 581 (2015) (describing the issue of quality of reporting). Human-rights treaties also face the specific challenge of asking countries to align their domestic policies and public-state interface with international standards, a challenge that a pandemic treaty would not completely avoid. Still, the pandemic treaty would operate at a higher level of action than human-rights treaties (regulating country systems, not its “what is ‘it’?” direct treatment of individuals), allowing it to avoid some of the most common criticisms leveled at those human-rights mechanisms around interference in domestic policies. That the pandemic treaty does not diminish state sovereignty is an especially important clarification given the recent hostility expressed by some public and private sector voices toward the pandemic treaty. See, e.g., Tulp, *supra* note 75; Elon Musk (@elonmusk), TWITTER (Mar. 23, 2023, 5:26 AM), <https://twitter.com/elonmusk/status/1638834687614541824> [<https://perma.cc/HD2U-P9M5>] (misleadingly implying that the pandemic treaty would require countries to cede authority to the WHO).

345. Faviero et al., *supra* note 338 (suggesting something similar with respect to Article IV of the International Monetary Fund).

346. See Steven J. Hoffman et al., *International Treaties Have Mostly Failed to Produce Their Intended Effects*, 119 PROC. NAT'L ACAD. SCI. art. no. e2122854119, at 1 (2022), (surveying studies of compliance with international treaties).

347. Michelle Rourke, Mark Eccleston-Turner & Stephanie Switzer, *Sovereignty, Sanctions, and Data Sharing Under International Law*, 375 SCI. 724, 725 (2022) (“The problem with sanctions in the context of global public health is that the WHO is not a policing or enforcement body . . .”).

benefits like a spigot—as the WTO does to mediate which countries get favorable trade privileges.³⁴⁸ Such punitive withdrawal of health resources would violate the WHO’s obligations to protect the health of the global citizenry. Sanctions, a common mechanism in international law, would be similarly undesirable for their potential unintended consequences and, at any rate, would likely be politically unpopular to the point of jeopardizing the treaty project altogether.³⁴⁹ Overall, purely punitive mechanisms seem undesirable. Instead, the treaty drafters should consider alternatives that allow for more positive incentives.

First, the pandemic treaty could encourage more normative forms of enforcement, such as naming-and-shaming, by making additional provisions for data transparency. By making clear which countries meet or shirk their obligations, the WHO could implicitly enforce treaty terms by making clear where countries stand in relation to their peers without policing its member countries. INB drafters could concretize this feature in subsequent treaty drafts by including language that enables the WHO to systematize and release global health information. This would also provide the basis for the WHO to play a more active normative role by providing the information necessary for accountability through naming-and-shaming. This may sound like an inconsequential form of enforcement, but the WHO has actually shown considerable potential influence via normative persuasion. For example, WHO Director-General Gro Harlem Brundtland’s naming-and-shaming tactics during the SARS outbreak sparked tangible change in reporting and national-outbreak control measures.³⁵⁰ Relatively modest enforcement provisions around data sharing could therefore have significant impact.

To back up naming-and-shaming, the WHO could strengthen enforcement through positive means, providing benefits and financial incentives for treaty members within the four walls of the treaty text.³⁵¹ For example, the treaty could work alongside other important international organizations such as the World Bank, International Monetary Fund, and World Trade Organization to offer positive incentives for compliance. For example, these organizations could give

348. *See id.*

349. *See* Wenham et al., *Futility*, *supra* note 51, at 848.

350. *See* David L. Heymann, John S. Mackenzie & Malik Peiris, *SARS Legacy: Outbreak Reporting is Expected and Respected*, 381 *LANCET* 779, 780 (2013).

351. Hathaway et al., *supra* note 335, at 236-45. This could be furthered by restructuring existing WHO and global health mechanisms (e.g., ACT Accelerator benefits) to become “club goods” available only to signatory countries. Note that the financial support and benefits sharing described above in this Section would also count amongst positive incentives for compliance, as this would lessen the sting of any resultant measures and threats to countries’ (economic) security from reduced trade and travel. *See* Wenham et al., *Futility*, *supra* note 51, at 847.

countries that sign the pandemic treaty (or meet a certain benchmark of compliance) preferential treatment in loans, financing, and trade agreements – including in future purchases of biomedical materials (both within and beyond pandemic emergencies).³⁵² While these features are less likely to tempt high-income countries, who largely secure global health benefits bilaterally, there is still strong diplomatic power in being seen to be in compliance with treaty obligations that could motivate even where finances are not an immediate solution.³⁵³ While positive incentives are preferable, there may also be space for exploring mixed positive and negative economic incentives, whether by establishing “club goods” available to party states (as was utilized in the Montreal Protocol on Substances that Defeat the Ozone Layer),³⁵⁴ or looking more broadly at international economic-law bodies such as the United Nations Commission on International Trade Law (UNCITRAL) or the United Nations Conference on Trade and Development (UNCTAD) to incorporate health-system investment considerations (as advocated for by some in the climate space).³⁵⁵ Overall, a mix of positive and negative incentives can shift global health law toward a treaty regime that avoids counterproductive punitive applications, while still enabling enforcement.³⁵⁶

5. *Combatting Fragmentation in Global Health Law*

A larger metaquestion of treaty structure arises from the relationship between existing global health law and the pandemic treaty. This is an especially salient question when it comes to the IHR, given that some view attention on the WHO pandemic treaty as harmful to the ongoing IHR revisions.³⁵⁷ Looking outside the four corners of the treaty’s text in this way therefore raises one final,

352. Similar knock-on obligations already exist in the realm of human rights, such as consideration of country membership in human-rights treaties for favorable loan and financing decisions. Further, the inclusion of the WTO (with its comparative focus on wealthy countries) specifically could ensure that wealthy countries, not just poor ones, are incentivized to sign and ratify a pandemic treaty.

353. See Heymann et al., *supra* note 350, at 780-81 (providing an example of this diplomatic motivation).

354. See Hathaway et al., *supra* note 335, at 236-37.

355. *The Pivot Point*, UN CLIMATE CHANGE HIGH LEVEL CHAMPIONS 47-48 (2022), <https://climatechampions.unfccc.int/wp-content/uploads/2022/09/R2Z-Pivot-Point-Report.pdf> [<https://perma.cc/K9CA-UTU5>].

356. Other important, if less involved, improvements on the current zero draft could include generally encouraging strong language, such as maintaining obligations indicated by what signatories “shall” do. See, e.g., *Zero Draft*, *supra* note 21, arts. 6, 7, 8.

357. See Wenham et al., *Risks*, *supra* note 51.

important question: how can the Article 19 process avoid undercutting the historical importance of the IHR³⁵⁸ and clashing with ongoing IHR reforms?

This is a critical concern if only to ensure a stopgap is in place in case the treaty fails in its ambitious aims (and disappointment at some level is assured). Specifically, the treaty could serve as a stopgap insofar as it offers focal point to strengthen and affirm the existing IHR without either denouncing the existing legal mechanism (and thus weakening it), or offering completely empty language. Simply casting aside the IHR would not only be politically unpopular, but it would also risk undercutting the line of legally binding global health law mechanisms that, normatively limited as they may be, reflect important ongoing change in global health law. And considering the practical difficulties of ensuring support of an Article 19 treaty, maintaining a stopgap is key. While a successful pandemic treaty may ultimately allow the IHR's importance to fade naturally, treaty drafters should not bet on this possibility. Instead, the IHR should be affirmed in the pandemic treaty, at minimum in its language, and at maximum by adopting line-by-line IHR obligations into subsequent protocols where the treaty and the IHR's content overlap.³⁵⁹ The IHR's existing provisions could, in other words, offer a floor of establishing pandemic obligations. If all the treaty manages to do is reaffirm the IHR's importance, that could be a win for a cosmopolitan vision of global health by reaffirming mutual obligations. The zero draft currently passes this minimum bar with its discussion of the IHR in its preamble, its stated intention of compatibility with the IHR in Article 2, and other provisions that reference alignment with regulations generally.³⁶⁰ Drafters should build on this to continue to act on their stated intentions of finding synergies between the treaty and the IHR.³⁶¹

358. Wenham et al., *Futility*, *supra* note 51, at 847 (“[T]he mandate and legitimacy of the IHR are built upon a long history of international cooperation to minimize and prevent the international spread of disease, and the results of this historic work should not be cast aside too easily.”).

359. For example, even a cosmopolitan treaty will likely need to address some aspect of public-health surveillance at national borders, a subject area to which the IHR is substantially dedicated. Making sure that the pandemic treaty at least contains the IHR's minimum obligations on this ground would help to align the two legal instruments.

360. *Zero Draft*, *supra* note 21, at 10 n.1 (stating the INB's intentions to “mak[e] explicit the synergies and concrete complementarity of the WHO CA+ with the International Health Regulations and other relevant mechanisms and instruments”).

361. *Id.*

CONCLUSION

Global health law orthodoxy reflects ideas that infectious illnesses are a distant concern to be contained or, perhaps, pitied (and funded) halfheartedly from afar. Legal structures in global health law have long reflected these attitudes. The COVID-19 pandemic impacted all countries and especially illuminated inequities perpetuated by the security-charity status quo, showing the harms of a system underpinned by security and charity normative frames. Accordingly, the wide-reaching prospect of an Article 19 treaty has immense cosmopolitan potential at a moment of post-crisis focus. The world must seize this moment to avoid slipping back into the security-charity status quo.

This Note outlined the normative transition that the treaty should represent and provided practical suggestions to help move toward a more cosmopolitan future. This is not to say that a pandemic treaty will cure all the ills of global health law.³⁶² A realization of cosmopolitan ideals will require constant, difficult work. But this work is vital and, this Note argues, possible. Amid the density of proper nouns and UN document numbers that define global health law's practice is the threat of massive human suffering. The reforms underway are not only for COVID-19 — they are for mpox, polio, flu, and unimagined pandemics to come. What action we take to head off these threats will have immense implications on all levels of health governance.

362. See Press Release, Address by Secretary-General Dag Hammarskjöld at University of California Convocation, Berkeley, California, U.N. Press Release SG/382 (May 13, 1954) (“It has been said that the United Nations was not created in order to bring us to heaven, but in order to save us from hell.”). Perhaps we can view the pandemic treaty similarly.