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COVID-19, International Law and the Sustainable Development Goals

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Introduction

Policy and discussion around the COVID-19 pandemic has centered on managing the current outbreak, developing a vaccine as quickly as possible and ensuring that it is distributed equitably. While these are the right priorities, one should not lose sight of the bigger picture –how to prevent and respond to future pandemics. The surest way to do that is by building resilient and equitable health systems around the world.

If COVID-19 has taught us anything, it is that the prevention, detection and control of infectious disease outbreaks cannot be separated from broader global health policy.[1] In this short essay I explore this proposition through the lens of international law. I argue

that the International Health Regulations reinforce the human right to health and, taken together, underpin Sustainable Development Goal 3, which seeks healthy lives for all. This legal framing can help to mobilize the political will not only to fight future pandemics but also to fulfill the promise of equitable access to quality healthcare in every society.

What are the legal obligations?

The International Health Regulations (IHR), binding on all 196 members of the World Health Organization (WHO), contain two key obligations. The most immediate is to notify the WHO of an “extraordinary event” that could constitute a public health emergency of international concern, and to share information with the WHO about that event (Articles 6 and 7). A more long-term obligation is for states to build “core capacity” in their health systems to detect infectious diseases outbreaks and to respond effectively (Articles 5 and 13). The core capacities were meant to be developed within five years of the IHR coming into force – namely by 2012. Despite numerous extensions, the WHO determined in 2016 that many countries had fallen short.[2] In September 2019, the Global Preparedness Monitoring Board (an independent entity established by the WHO) found that about two-thirds of States had poor or modest levels of preparedness.[3] Moreover, many states who supposedly had the core capacity failed to respond to COVID-19 effectively (while some who lacked it did comparatively better).

The IHR are not a human rights instrument (their main purpose is to stop the spread of disease, not protect human rights) but they are tied to the international human right to health. That right dates back to the preamble of the WHO Constitution (1946), which declared health to be an individual “right” two years before the Universal Declaration of Human Rights was adopted and decades before the International Covenant on Economic and Social Rights (ICESCR) came into force (in 1976). Moreover, it defined health in holistic terms as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” - marking a revolutionary shift in how we think about health.[4]

Yet exactly what the right to health requires is contested.[5] Article 12 (1) of the ICESCR stipulates: “The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.” Article 2(1) states that given the lack of capacity of most states to fulfill their economic and social rights immediately, they are to be realized “progressively”, calling on each party to use “the maximum of its available resources.” The Committee on Economic, Social and

Cultural Rights, following 34 years of state practice, sought to give content to the right by specifying four essential elements: availability; accessibility; acceptability; and quality. The Committee stated about Article 2(1):

A State which is unwilling to use the maximum of its available resources for the realization of the right to health is in violation of its obligations under article 12. If resource constraints render it impossible for a State to comply fully with its Covenant obligations, it has the burden of justifying that every effort has nevertheless been made to use all available resources at its disposal in order to satisfy, as a matter of priority, the obligations outlined above. [6]

In this authoritative interpretation of the Covenant, the Committee also made clear that the right's achievement depended on shared responsibility among developed and low-and middle-income countries and other actors for implementation.[7]

Sustainable Development Goal 3

As the right to health was gaining substance in the human rights world, a comprehensive vision of health was emerging as a central feature of development policy. Sustainable Development Goal 3, adopted in 2015 alongside 16 other goals, calls for global action “to ensure healthy lives and promote well-being for all at all ages”. It sets out nine targets to be met by the year 2030, including an end to known communicable diseases as well as achieving universal health coverage. Universal health coverage has been a key feature of WHO's mission for many years, defined to mean not that everyone is entitled to free healthcare but that “all individuals and communities receive the health services they need without suffering financial hardship.”[8] The definition embodies three related objectives: equity in access to health services; adequate quality of those services; and protection against financial harm from using those services. That idea has now been enshrined in the SDGs.

Unlike the Millennium Development Goals of the year 2000, the SDGs are universal in their application, meaning that all states – those from the Global North and Global South – are expected to take action both at home and internationally. Gender equality and climate action are two examples where developed countries have a distance to go. The response to COVID 19 demonstrates that good health is a third. Many states with advanced health care systems have fallen tragically short in managing the pandemic.

Meanwhile, sub-Saharan Africa has done well, recording some of the lowest rates in the world.[9]

How are the legal obligation and development goals connected?

That building core capacity for pandemic response cannot be separated from building health care systems is implicit in how both the right to health and development policy have been articulated. Article 12(2) of the ICESCR lists four steps states must take to achieve the full realization of this right, two of which are:

- (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
- (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

Meanwhile, SDG3 sets out three non-time limited targets that suggest the goals of combatting disease and strengthening health systems are two sides of the same coin:

3.B Support the research and development of vaccines and medicines for the communicable and noncommunicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines...

3.C Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries...

3.D Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks.

SDG 3 is not framed in legal terms, but it is underpinned by global health law.[10] Tying that to the IHR, the legal obligation on states to build core capacity to prevent and respond effectively to infectious disease outbreaks can be seen as one element of the right of individuals to demand that their governments commit the maximum possible resources to ensure that health facilities, goods and services are available, accessible, acceptable and of good quality. That in turn implies the need for global cooperation.

When it comes to infectious disease, countries and communities are only as strong as the weakest link: weak health systems abroad leave us all exposed.

Escaping the prisoner's dilemma

Just as many states had fallen short on their 'core capacity' obligation before COVID-19 struck, progress on the SDGs had been disappointing too. The sense of global solidarity that made their adoption possible in 2015 quickly dissipated for a number of reasons, including the rising tide of inward-looking populism around the world.

The onset of COVID-19 exacerbated the problem in three ways. First, the social and economic impact of the disease and the response to it (such as lockdowns) have been a major setback for some of the goals, not only health but those related to poverty, education, livelihoods and hunger.[11] Priorities in many countries are being realigned. Second, the most vulnerable in many societies are disproportionately affected by COVID 19. Third, not surprisingly, the reaction of many governments has been "my country first." The hoarding of personal protective equipment is the best evidence of this; the "tragedy of vaccine nationalism" may be next.[12] While ending the pandemic as soon as possible is in the interest of all, the prisoner's dilemma suggests that states will find it difficult to cooperate, undermining efforts to distribute vaccines in the most efficient manner (for example, to health care workers and the most vulnerable). Pre-purchase agreements by the wealthy countries are already occurring;[13] hoarding of the vaccine is likely to follow. Governments will naturally feel a responsibility to meet the needs of their citizens first, even if that means prolonging the global pandemic by not cooperating on vaccine distribution.

To counter that impulse, incentives must be altered. COVAX is trying to do precisely that by securing financial and other commitments to ensure the equitable allocation of vaccine. Led by the Vaccine Alliance (GAVI), the WHO and the Coalition for Epidemic Preparedness Innovations, this alliance of governments, international organizations, the private sector and civil society is seeking to leverage the resources of philanthropists like the Gates Foundation to tip the scales away from 'my country (and my company) first' to treat the vaccine as a global public good.[14] But so far, the level of commitment have not altered the incentives enough to overcome the short-sightedness of vaccine nationalism.

Fortunately, there is another dynamic at work, driven by a sense of mutual vulnerability. The "leave-no-one behind" mantra of the SDGs is reinforced by the "we are only as strong

as the weakest link” reality of pandemics. COVID-19 has undermined conventional wisdom about who is the weakest link. Countries in the Global South lack the sophisticated health systems of the Global North, but arguably have made better use of what they have at their disposal. The Pasteur Institute, a bio-medical research organization in Senegal, developed a \$1 testing kit that can deliver results in 10 minutes.[15] In Uganda, an automobile firm and the Makerere School of Public Health developed low-cost ventilators.[16] Meanwhile, health care systems in Europe risked being overwhelmed by the disease, while in the US inequities in the social determinants of health have resulted in a disproportionate impact on racial and ethnic minority groups. [17]

How can international law help?

In the current political (and geo-political) climate, it does not seem possible to develop robust new accountability mechanisms to enforce the legal obligations associated with the right to health, even in the face of emergencies like COVID. Determined to hold onto their sovereign prerogatives, states will not set up a COVID court, let alone a pandemic police force. Ultimately, the impact of international law is more diffuse as an advocacy tool. It can help to translate the sense of collective vulnerability into collective responsibility. Invoking the law in diplomatic conversation, multilateral debates, NGO activism, and on the opinion pages of major media outlets is a way of pressuring governments to balance long-term interest against short-term gains. “Naming and shaming” may seem like a weak enforcement tool but it sends the signal that what is at stake is not a policy choice but a legal obligation. Declaring something to be a right or an obligation impacts the political dynamics around an issue, generating pressure on governments to practice what they preach. Conjoining the IHR core capacity requirement with the human right to accessible, acceptable and quality health care signals that building resilient and equitable health systems is not only a development goal but a binding commitment.

Notes

[1] A recent study demonstrated that countries whose health policies were aligned with *both* the global health security framework and the universal health coverage framework generally fared better in managing COVID than those aligned with only one of them. Arush Lal et al, “Fragmented health systems in COVID-19: rectifying the misalignment between global health security and universal health coverage”, *The Lancet*, Published online December 1, 2020 [https://doi.org/10.1016/S0140-6736\(20\)32228-5](https://doi.org/10.1016/S0140-6736(20)32228-5).

[2] WHO, Report of the Director-General “Implementation of the International Health Regulations (2007)”, A69/20, 18 May 2016, paras 16 and 26.
https://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_20-en.pdf

[3] Global Preparedness Monitoring Board, “Thematic Paper on the Status of Country Preparedness Capacity”, September 2019,
https://apps.who.int/gpmb/assets/thematic_papers/tr-2.pdf. See also, Guilio Bartolini, “Are you Ready for the Next Pandemic? The IHR Put to the Test of their Core Capacity Requirement”. *EJIL:Talk* (blog of the *European Journal of International Law*), June 1, 2020
<https://www.ejiltalk.org/are-you-ready-for-a-pandemic-the-international-health-regulations-put-to-the-test-of-their-core-capacity-requirements/>.

[4] WHO Constitution, preamble. Gian Luca Burci, “Global Health Law: Present and Future”, in *Research Handbook on Global Health Law*, edited by Gian Luca Burci and Brigit Toebs (2018)

[5] The United States has not ratified the ICESCR in part because the Reagan administration saw these so-called “second generation” rights as goals rather than enforceable obligations. It was worried about being required to provide universal health care for example. Republican administrations in the US have agreed. Democrats do not, but because of the challenge of getting Congress to ratify the treaty, neither the Clinton nor Obama administrations tried.

[6] General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12), 2000. 11 August. Doc. E/C.12/2000/4. Para. 47.

[7] Claire Brolan et al, “Did the right to health get across the line? Examining the United Nations resolution on the sustainable development goals”, *BMJ Global Health*, no. 2 (2017): pp. 1-6, at 3.

[8] [https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-\(uhc\)](https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc))

[9] <https://www.ft.com/content/cobadd91-a395-4644-a734-316e71d60bf7>.

[10] “International human rights law (which includes right to health law) permeates, and is fundamental to, the SDG document and realisation of the SDG agenda unanimously agreed by the UN Member States.” *Id.*, at 5. The third paragraph of the preamble to Agenda 2030 states that the SDGs “see to realize human rights for all.” United Nations General Assembly Resolution, “Transforming our World: the 2030 Agenda for Sustainable Development”, A/Res/70/1, 21 October 2015. See also the Declaration paras 3, 8, 10, 19, 20, 29, 35 and 74.

[11] United Nations, *Sustainable Development Goals Progress Report 2020*,
<https://unstats.un.org/sdgs/report/2020/>.

[12] Thomas Bollyk and Chad Brown, “The Tragedy of Vaccine Nationalism: Only Cooperation Can End the Pandemic”, *Foreign Affairs* September/October 2020, www.foreignaffairs.com/articles/united-states/2020-07-27/vaccine-nationalism-pandemic

[13] Launch and Scale Speedometer, “Mapping COVID-19 Vaccine Pre-Purchases Across the Globe”, accessed on November 15, 2020 <https://launchandscalefaster.org/covid-19>.

[14] Ngozi Okonjo-Iweala, “Finding a Vaccine is only the first step: no-one will be safe without the whole world being safe”, *Foreign Affairs* April 30, 2020. See also Priti Panai, “A strong call for COVID-19 treatments and vaccines to be global public goods – World Health Assembly”, *International Health Policies*, May 20, 2020

[15] Aisha Salaudeen, “This \$1 made-in-Africa testing kit could revolutionize testing on the continent”, CNN Nov. 10, 2020 <https://www.cnn.com/2020/11/10/africa/senegal-coronavirus-rapid-testing-spc-intl/index.html>.

[16] <https://allianceforscience.cornell.edu/blog/2020/05/african-science-steps-up-to-covid-challenge/>

[17] US Centers for Disease Control and Prevention, “Health Equity Considerations and Racial and Ethnic Minority Groups”, July 24, 2020, <https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/race-ethnicity.html>

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