CHAPTER 3

# A Stress-Test for Global Health Multilateralism: The Covid-19 Pandemic as Revealer and Catalyst of Cooperation Challenges

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## 1 Introduction

In December 2021, Member States of the World Health Organization (WHO) convened for a special session of the World Health Assembly and officially opened multilateral negotiations aimed at drafting a "Pandemic Treaty": a new legal instrument for preventing, preparing for and responding to pandemics. This multilateral impulse came after the worldwide spread of Covid-19 in 2020 severely challenged multilateralism in general and in the global health field in particular. From the withdrawal of the United States from the WHO, to the race for vaccines and questions about China's role in international health, the 2020 Covid-19

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pandemic acutely tested the strength and scope of multilateral cooperation in global health. Because of its multidimensional nature, its global scale and the magnitude and diversity of measures taken by governments and international organizations (IOs) (including the stockpiling of vaccines, the implementation of lockdowns, and exceptional spending aimed at stimulating economic recovery), the Covid-19 pandemic can at first sight appear as a "great event", a "critical juncture" and a crisis with the potential to reorder significant aspects of the global health order. This perception was certainly reinforced by the controversies that emerged regarding the role of the WHO in 2020 and by the repeated calls from governments to improve global mechanisms for preventing and responding to pandemics.

However, even a brief look over the recent past reminds us that while epidemics are experienced and perceived as exceptional, they are in fact both common and recurrent. Global health crises and controversies around their management also occur repeatedly, as well as the institutional innovations that follow after them. For instance, in 1996, the WHO was deprived of its leading role in the international coordination of the response to the HIV/AIDS pandemic, which was then entrusted to a dedicated organization, UNAIDS, which was considered better suited to providing the necessary multisectoral response (including, for example, that pandemic's economic, human rights and gender dimensions). In 2003, the WHO was criticized for its delay in proving that a SARS (severe acute respiratory syndrome) epidemic was underway, owing to the Chinese authorities' concealment of the earliest cases, which had the consequence of accelerating the adoption of a revised version of the International Health Regulations (IHR) in 2005. In 2014, the failure of the international community to act quickly during the Ebola epidemic in West Africa resulted in the creation of a WHO Contingency Fund for Emergencies. Thus, on the one hand, as Tana Johnson puts it, the "political patterns [of Covid-19] are quite ordinary" (Johnson, 2020: E150). But, on the other hand, the pandemic saw not only a continuation, but in some cases an "expansion" of cooperation (Davies, 2022: 236), and health initiatives proliferated, often with the help of non-state actors. In this context, how can we understand the impact of the Covid-19 pandemic on global health multilateralism?

### *1.1 Defining and Analyzing Global Health Multilateralism: An Overview*

Multilateralism in health can be defined as a form of institutionalized cooperation between several actors, including both state and non-state actors, aimed at solving common problems related to health. Multilateralism is part of the institutional framework of global politics, that is, in the words of Kalevi Holsti, of the "context and arrangements in which states conduct their mutual relations" (Holsti, 2004: 305). Cooperation in global health increased enormously at the turn of the twenty-first century and gave rise to a proliferation of institutions of various forms (IOs, ad hoc alliances, public–private partnerships, etc.), which may in practice duplicate roles, enter into competitive relationships, work in silos, etc. Global health multilateralism appears fragmented, with a great number of actors, who sometimes have divergent interests, and who interact in an ill-defined architecture of global health governance that is plagued by "chaotic pluralism" (Van Belle et al., 2018: 1). As a result, it tends toward a dynamic of permanent reforms.

In this context of institutional proliferation, academic literature on global health in the field of international relations (IR) has been developing rapidly.[1] Research before the 1990s rarely focused on global health cooperation. This field of international action was largely perceived as being technical and of secondary importance, belonging to the domain of "low politics" or even being a-political in nature, and therefore lying outside the field of interest of political science and IR. The integration of health issues in the study of IR was achieved through the development of three main lines of research.

The first of these involves linking health issues to the process of globalization. The proliferation of globalized interdependencies affects both the systemic determinants of health and the health of individuals, while facilitating the circulation of diseases and the involvement of non-state actors (Lee, 2003). This line of research analyzes in particular the transition from international dynamics of health governance to global ones, and links health issues to other fields of global cooperation (development, trade, security, etc.). Recent academic publications in this field also tackles the issue of decolonizing global health (Richardson, 2020). The second line

[1] Owing to the focus and scope of this chapter, only a few selected works are cited here, but there is a much larger academic literature available.

of research analyzes health issues in terms of foreign policy and diplomacy. It was initially linked to the question of the securitization of health issues (Elbe, 2010) and their integration into national defense policies, and, by extension, into foreign policies (McInnes & Lee, 2006), but it later developed through the study of the foreign policies of individual countries or regional blocs, as well as through the study of global health negotiations and diplomatic practices (Kickbusch et al., 2021). Finally, the third line of research deals with global health governance and the role of IOs. The "architecture" of global health governance—and its complexity—lies at the heart of these debates, owing to the proliferation of actors, the increasing number of identified health problems and objectives, the overlapping of mandates and the successive relocations of authority (Buse et al., 2009; Fidler, 2007). Different approaches and concepts are used to account for these phenomena: for example, variously treating them in terms of interfaces, networks, regimes and complexity theory. Some works focus on the competing visions that can develop (which may be dominated, for example, by biomedical, economic, human rights, security, or neoliberal perspectives), and which can be endorsed by various kinds of actors (Kay & Williams, 2009; Rushton & Williams, 2011).

The analysis of global health multilateralism cuts across these three lines of research. As an institutionalized form of cooperation between numerous actors, it is implicated in globalization, foreign policy and diplomatic practices, as well as governance systems. But multilateralism is also an international institution, that is, "a set of practices and rules that define appropriate behavior for specific groups of actors in specific situations" (March & Olsen, 1998: 948). This means that multilateralism rests on a normative basis (see also Chapter 5 in this book): in order to be functional, it requires agreement on some foundational principles (universality, equality, reciprocity, support for legal rules and respect for international commitments, solidarity, etc.). The fragmentation that characterizes contemporary global health is not only institutional but also normative. Finally, as with every institution, multilateralism is subject to dynamics of institutional change.

### *1.2 Dynamics of Change in Multilateralism and the Covid-19 Pandemic*

The scope and nature of these changes, and indeed the type of change in question, are the subject of major and recurrent debates in IR. Scholars

often disagree on the significance of empirically observed changes, and in particular on whether or not they are transformational, and amount to either minor or major change. For instance, a large number of studies build on the punctuated equilibrium model and tend to see significant change in the form of historical ruptures: they accordingly conceptualize major, transformative change as being "abrupt and discontinuous", while minor, incremental change is seen as supporting "institutional continuity through reproductive adaptation" (Streeck & Thelen, 2005). For example, the study conducted by Lundgren et al. (2018) finds that the multilateral agenda, as defined by the policy agenda of IOs, is stable most of the time, apart from periodic interruptions marked by abrupt change—a view that is coherent with an understanding of IOs as institutions that are generally resistant to change.

To better analyze the scope of change, Holsti (2004) identifies "markers of change", which are supposed to signal when change takes place: this pertains both to "trends" (quantitative change, an accumulation of many little acts) and to "great events" (a huge interruption in a typical pattern, including significant social change or technical innovation). Holsti does not attribute any specific significance to technical innovation, unlike others, such as the French sociologist Marcel Merle (1986), who considers that other factors of change in IR (such as demography, geopolitics, trade, the economy and culture) are "overdetermined" by technical progress, which is "the main agent of world transformation". Views are also divided with regard to the impact of Covid-19 on international relations in general (and not only on global health). For example, whereas Drezner (2020: E19) argues that the Covid-19 pandemic "is unlikely to have […] transformative effects on international relations" and "is likely to be relegated to a footnote in international relations scholarship", Kaplan (2020) asserts that it is a "historical marker between the first phase of globalization and the second", while McNamara and Newman (2020) contend that "the pandemic exposes underlying trends already at work and forces scholars to open the aperture on how we study globalization".

But rather than the scope and nature of change and the factors enabling it, it might be more enlightening to focus on the form or type of change itself. For example, Holsti (2004) differentiates between six main "concepts or types of changes": change as novelty or replacement, change as addition or subtraction, change as increased or decreased complexity,

change as transformation, change as reversion and change as obsolescence. Focusing on gradual change only, Streeck and Thelen (2005) propose to distinguish between five types: displacement (close to Holsti's change as subtraction), layering (close to Holsti's addition and growing complexity), drift, conversion and exhaustion (close to Holsti's obsolescence). More typologies could be mentioned, but what is interesting here is that these attempts to differentiate between forms of change underline that significant change often "results from an accumulation of gradual and incremental change" (Streeck & Thelen, 2005) and through processes of "addition or growing complexity" rather than novelty or replacement (Holsti, 2004). Consequently, great care should be taken when undertaking an analysis aimed at defining what sort of marker of change pertains to a "great event". And, most importantly, what is interesting is to analyze how that "great event" relates to previous dynamics.

In light of the definitions mentioned above, and building on the findings of the academic literature on institutional change, our goal here is not to determine whether the Covid-19 pandemic was a "great event", or a "critical juncture", or will be perceived as one in the future, nor to consider whether it will trigger significant change in global health. The aim of this chapter is to show that while the Covid-19 pandemic appeared as a crisis with the potential to reorder global health multilateralism, it did so precisely because it occurred in an environment marked by fault lines and an accumulation of incremental change. This chapter will show that the Covid-19 pandemic acted both as a revealer of long-term trends in global health cooperation and as a catalyst of the changes that it precipitated. Through this perspective, it will provide a broad overview of the dynamics of health multilateralism and help identify the challenges created by this specific crisis. I will first briefly analyze the historical dynamics of global health multilateralism that led to a fragmented cooperation both at the organizational and normative levels. I will then focus on the tensions and challenges created by the Covid-19 pandemic, which partly explain why it is often perceived as a major crisis. Finally, I will address new developments in global health multilateralism, and how they relate to previous dynamics.

## 2 Global Health Multilateralism as a Fragmented Institution

### *2.1 The Role of Epidemics and Organizational Fragmentation in the Development of Multilateral Cooperation*

The fight against contagious diseases and the organization of the response to epidemics were central to the development of multilateral cooperation in the field of health. It started to develop in the nineteenth century, when the plague and cholera epidemics that threatened Europe, combined with the development of international trade, encouraged states to cooperate on matters of health. From 1851 to 1938, fourteen international health conferences were held, aimed at harmonizing measures to fight epidemics, such as quarantine procedures for ships entering ports. These efforts also gave rise to the earliest permanent intergovernmental health organizations: the Pan American Sanitary Bureau in 1902, the International Office of Public Hygiene in 1907 and the Hygiene Organization of the League of Nations in 1920. Multilateral cooperation increased after World War II, when all these organizations were integrated in 1948 into the World Health Organization (WHO), the agency of the United Nations system that assumed overall directing and coordinating authority in the field of international health. Previous measures aimed at fighting contagious diseases were unified under the auspices of the WHO, as defined in 1951 in a new normative document, the International Health Regulations (the IHR, which were later revised in 1969 and 2005, and are undergoing new modifications in 2023). Since the end of the twentieth century, the acceleration of globalization and the rediscovery of the threat of epidemics (in light of the discoveries of the Ebola virus in 1976 and of HIV/AIDS in 1983 in particular) have increased awareness of the possibility of a truly global epidemic, which has, therefore, reactivated a sense of vulnerability that had been obscured by scientific progress (Guilbaud & Sansonetti, 2015). The renewed imperative to bring about universal cooperation in order to respond to epidemics and prevent pandemics can be summarized by the increasingly popular motto "no one is safe until everyone is safe".

However, since the nineteenth century, there has been a significant enlargement of the global health agenda. This reflects both the fact that there is a huge need to tackle other health problems and also an understanding that the response to and prevention of epidemics is linked to larger health issues. It is worth noting that the WHO has a very broad

mandate: its Constitution defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity", and its goal is to provide every human being with "the highest attainable standard of health". Although the interpretation of this mandate is subject to political battles, the WHO's normative activity touches on a wide range of topics, including smoking reduction, mental health, universal health coverage and the strengthening of health systems. The reduction of health inequalities between developed and developing countries is also an important global health goal, especially since the 1978 Alma-Ata Declaration.

The field of global health has undergone major transformations since the end of the twentieth century, particularly following the global mobilization against the HIV/AIDS pandemic and the inclusion of health objectives in the United Nations development goals (the Millennium Development Goals in 2000 and then the Sustainable Development Goals in 2015). Between 1999 and 2019 there was a spectacular increase in funding for health interventions at the international level (in total, this increased from about US$10 billion per year to US$40 billion per year, amounting to a fourfold increase in 20 years), coming mainly from state donors (the United States, the UK, Germany, France, Canada, etc.) and philanthropic foundations, especially the Bill and Melinda Gates Foundation.[2]

These funds are increasingly devoted to projects of multilateral cooperation—although not to the work of the WHO, whose budget for 2019 was only US$2.8 billion. They are mostly channeled instead to new multilateral cooperation forums in the field of health, such as public–private partnerships, or vertical funds that provide funding targeted at specific diseases. This is the case, for example, of GAVI (the Global Alliance for Vaccines and Immunization), which finances immunization programs in developing countries, and whose members are both public (states and intergovernmental organizations) and private (companies, philanthropic foundations and civil society organizations). Another example is that of CEPI (the Coalition for Epidemic Preparedness Innovations), which was launched in 2017 at the World Economic Forum in Davos, with the support of Norway, India, the Gates Foundation and the Wellcome Trust

[2] Data on global health financing can be found at: Institute for Health Metrics and Evaluation: https://vizhub.healthdata.org/fgh/ (Accessed 28 April 2023).

(another philanthropic foundation), and which aims to fund the research and development of vaccines against emerging infectious diseases.

Furthermore, intergovernmental organizations primarily devoted to other domains have come to exert a major influence in the field of global health, such as the World Bank, which grants loans to finance health systems, and the World Trade Organization (WTO), which defines the regime of intellectual property rights and therefore determines the price of drugs and access to medicines. This has led to dynamics of competition between multilateral organizations, including some overlapping of roles and above all a greater complexity in their relations. The architecture of global health governance, therefore, appears both complex and nebulous, which hinders multilateral cooperation, and is the object of recurrent calls for "reforms" to enhance both its effectiveness and its legitimacy.

### *2.2 The Normative Fragmentation of Global Health Multilateralism*

This organizational fragmentation of global health multilateralism has gone hand in hand with a process of normative fragmentation.[3] Divergent visions of health multilateralism have developed over time, which vary in the importance that they attribute to certain principles, such as universality, effectiveness, trust, or reciprocity (Guilbaud, 2022b).

The first such division can be seen between, on the one hand, the perspective of universal multilateralism, which prevails within international intergovernmental organizations such as the WHO, and, on the other hand, the perspective of restricted multilateralism, which characterizes new forms of multilateral cooperation, notably the public–private partnerships and vertical funds described above. The WHO's universal mission stems from the fact that it aims to bring together all states that are recognized by the international community (including both developed and developing countries) based on the principle of "one state, one vote". It also stems from its very broad mandate, which means that it intervenes in a multidimensional way in many fields, which allows for a certain reciprocity between members of the organization. Reciprocity is key for multilateral cooperation: it means that states do not need to be treated in a strictly equal way during each negotiation, but only over the long

[3] The section of this chapter on normative fragmentation is based on work published in French by the author: see Guilbaud (2022b).

term, and this is made possible thanks to mechanisms such as equality in terms of votes, and inter-temporal and inter-sectoral bargaining. All of these factors give the WHO the legitimacy for facilitating global cooperation, even if it does not erase the differences in terms of governmental resources and capabilities.

Public–private partnerships and vertical funds, on the other hand, are restricted forms of multilateral cooperation: they are organized around a specific sectoral objective, although this may be ambitious in its scope (such as the objective of providing funding to developing countries to buy drugs for treating HIV/AIDS), they bring together a limited number of actors, and their legitimacy is based above all on their effectiveness in achieving the objectives they set themselves. Donors occupy a specific and influential place in such organizations, although in some cases they allow for representation from the countries receiving the funding or from the target population for the health intervention.

However, this division between the perspectives of universal and restricted multilateralism can also be seen within IOs that have a universal vocation. Indeed, their budgets are also dependent on their donors. In 2020, 80% of the WHO budget was made up of so-called voluntary contributions, that is, contributions that are earmarked according to the priorities of the donors (Member States and private organizations).[4] Devi Sridhar and Ngaire Woods (2013) call this situation "*Trojan* multilateralism", where donors' contributions to the budget of IOs create the illusion of support for multilateralism, whereas they are really using voluntary contributions as a tool to impose their national priorities on multilateral bodies. At the WHO, this state of affairs has been identified as a crucial problem for decades, prompting member states in 2022 to commit to gradually increasing their "assessed" contributions, which are not earmarked for any particular use (the goal is to reach a situation by 2030–2031 in which 50% of the approved program budget will be financed through assessed contributions). However, this commitment was followed a few months later, in early 2023, by a suggestion to establish a "replenishment fund" for the WHO, that is, a special fund financed by donors, on a voluntary basis, aimed at supporting certain actions of the organization. This measure would effectively perpetuate the cycle of donor-dependency.

[4] The WHO website provides details of its budget: http://open.who.int/2018-19/contributors/contributor (Accessed 6 March 2023).

Since the end of the twentieth century, new principles have also come to guide multilateral cooperation in the domain of health: those based on market mechanisms and those based on the multi-stakeholder model. The former refers to the inclusion within universal or restricted multilateral organizations of instruments and constraints that were previously limited to the for-profit market sector, such as the omnipresence of cost-effectiveness calculations (Bull & McNeill, 2007). The latter refers to mechanisms allowing the participation of individuals or groups who have an interest in a particular issue, on the grounds that they may either affect or be affected by decisions on that issue (Guilbaud, 2022a). In both cases, this is a consequence of the opening up of multilateral cooperation to the participation of non-state actors, including for-profit ones, thereby moving multilateralism toward either multi-stakeholder multilateralism or market multilateralism. This change can have consequences on how multilateral organizations understand values such as effectiveness or solidarity. And, once again, this additional line of normative fragmentation can be seen within both universal and restricted multilateral organizations. Although the latter have seemed to be more keen to embrace these new instruments of cooperation, IOs with a universal vocation are not immune to them.

Coordination between universal and restricted multilateral organizations, as well as consistency in the various principles underlying multilateral action, are crucially important for avoiding the duplication of actions, or even actions that counteract one another, as well as for preventing actions that are deemed to be illegitimate. This fragmentation of health multilateralism leads to a number of tensions, such as those that came to a head in the difficulties encountered by the WHO in fulfilling its role, in this context, as "the directing and coordinating authority in matters of international health" (as defined in its Constitution), including with regard to restricted multilateral cooperation organizations. Those issues have resurfaced as a result of the Covid-19 pandemic, whose impact can be analyzed through the perspective of the pre-existing dynamics of global health multilateralism.

## 3 The Covid-19 Pandemic as a Revealer of Pre-Existing Tensions and Challenges in Global Health Multilateralism

The 2020 Covid-19 pandemic has often been described as a "great event" or a "major crisis" owing to its multidimensional nature (affecting human health, the economy, travel flows, gender inequalities, etc.), its global scale (every country experienced Covid-19 cases),[5] the magnitude and diversity of measures taken by governments and IOs (including lockdowns, the stockpiling of vaccines and exceptional spending aimed at stimulating economic recovery), as well as the rapidity of scientific and technological innovations to which it gave rise (the virus's genetic sequence was decoded almost instantly, new diagnostics and vaccines were developed quickly, etc.). Although the Covid-19 pandemic brought about a major interruption in existing arrangements in various domains, the following section focuses on three main sets of problems that it brought to the fore in global health multilateralism, and which are linked to the organizational and normative fragmentation analyzed above: the limited authority of the WHO, geopolitical tensions and issues of equity and solidarity.

### *3.1 The WHO's Limited and Contested Authority in the Coordination of the Response*

Despite the proliferation of institutions in the global health field, during the early days of the Covid-19 pandemic the WHO found itself alone on the front line. Other IOs that had sometimes been seen as competitors to the WHO's leadership were unable to step up. The United Nations Security Council (UNSC) was unable to agree on an ambitious resolution, whereas it had done so for the HIV/AIDS pandemic and for the Ebola epidemics in West Africa, which had been declared "threats to international peace and security" (the UNSC only managed to adopt a very limited resolution in July 2020 calling for the "cessation of hostilities" to enable humanitarian efforts against Covid-19). This stalemate was the result of the power play between two UNSC members with a veto power the United States and China (see also Chapter 6 and Chapter 7

[5] Every country except Turkmenistan and North Korea reported Covid-19 cases to the WHO, although it is generally recognized that these two countries did in reality experience cases of Covid-19. https://covid19.who.int (Accessed 22 February 2023).

in this book). The Trump administration demanded that a UNSC resolution should contain a reference to the supposed "Chinese" origin of Covid-19, which the latter could not accept. To get around this political stalemate, the United Nations tried to develop a humanitarian response, with a "Global Humanitarian Response Plan" launched by UN Secretary-General Antonio Guterres aimed at helping the world's poorest countries, but this plan ultimately failed to attract sufficient funding and political attention.

The World Bank, whose role in global health had grown substantially since the 1980s, mobilized to respond to the economic crisis, but as for its response to the health crisis in particular, its efforts were initially hampered by the failure of its own instruments that were intended to provide funds in the event of a pandemic. In 2017 it had developed "pandemic catastrophe bonds"[6] in preparation for such an event, but it was only revealed at the end of April 2020 how much funding could finally be released: US$195 million for 64 of the world's poorest countries, which was too little too late. It is worth noting, however, that the World Bank later returned to the forefront of global action, when countries of the G20 launched a "Pandemic Fund" in 2022, hosted by the World Bank, aimed at providing financing for pandemic prevention, preparedness and response.

The WHO, therefore, appeared in early 2020 as the organization with the clearest mandate to coordinate the global response to the pandemic by analyzing countries' responses to Covid-19. It drew on its normative mandate and its technical expertise to regularly publish guidelines (how to manage sick travelers, how to test, etc.). This expert role gives the WHO a "competitive advantage" and is a powerful factor of legitimation (interestingly, Dellmuth et al. (2022) show that, right before the Covid-19 crisis, the WHO benefited from a high degree of legitimacy among elites and citizens). However, despite its resources and its leading role at that time, the WHO was not in a position to compensate for the dynamic of fragmentation that already existed in global health multilateralism, which led to it being criticized for several shortcomings and for the apparent limits of its capacities (see also Chapter 12 in this book).

[6] Investors who buy these bonds run the risk of no longer receiving interest or of losing part of their capital if an epidemic breaks out. However, as long as no epidemic breaks out, they receive a very high return.

The Covid-19 pandemic highlighted the WHO's political and legal constraints in relation to its member states. For example, the need to respect state sovereignty constrains the WHO's responsibilities in the event of an epidemic. These responsibilities are codified in the IHR, which detail reciprocal obligations aimed at "prevent[ing] the international spread of disease". On the one hand, states are obliged to prepare for epidemics by developing certain minimum capacities in the field of health, particularly in the area of disease surveillance, and must notify the WHO of public health events that occur on their territory. On the other hand, it falls to the WHO to coordinate the notification mechanism, to determine whether the event constitutes a public health emergency or not, and to issue recommendations. However, there is no binding mechanism (the WHO possesses no power of investigation or sanction mechanism). For instance, the WHO had to wait for months for the Chinese authorities' approval to send a team to investigate the origins of the SARS-CoV-2 virus that causes Covid-19. The composition of the team was subject to intense bargaining, and once it was on Chinese soil its access was restricted. In 2023, "ongoing challenges over attempts to conduct crucial studies in China" prompted the WHO to rethink their plans on how to proceed with their investigation (Mallapaty, 2023).

The Covid-19 pandemic also confirmed what previous epidemics and subsequent investigations had already shown: that states do not respect their commitments specified in the International Health Regulations (IHR). For example, a report published in September 2019 by a joint WHO-World Bank council noted that only 59 states (out of 194) had developed an adequate preparedness and response plan, as required by the IHR, and even among those 59 none had provided sufficient funding for its implementation (Global Preparedness Monitoring Board, 2019). The IHR were, therefore, not able to break the well-known circle of "panic and neglect" in relation to pandemic financing (whereby states spend considerable sums at the height of the pandemic panic but fail to invest once this moment has passed). The IHR also require that the response to an epidemic be "proportionate, […] avoiding unnecessary interference with international traffic and trade". States are still allowed to take any measures they wish, even if these diverge from the WHO's recommendations, provided that they notify the organization within 48 hours and justify them. However, even this requirement was overlooked in more than a third of the border closures implemented by governments in response to Covid-19.

Furthermore, coordinating the international response involves not only disseminating good practices, but also pooling resources. Although most countries were not sufficiently prepared to respond to the pandemic, some of them responded well in certain respects, such as testing treatments, procuring personal protective equipment, and securing supplies of oxygen, while certain countries also had experience from managing previous epidemics. However, the WHO proved to be largely unable to play a role in this regard. For example, a mechanism aimed at pooling technological developments, known as the Covid-19 Technology Access Pool or C-TAP, which was launched by the WHO following prompting from Costa Rica, went largely unused. In order to raise political awareness and political accountability to help prepare for future pandemics, a group mandated by WHO member states (the Independent Panel for Pandemic Preparedness and Response, co-led by Helen Clark and Ellen Johnson Sirleaf) proposed the creation of a Global Health Threats Council with a rotating membership of heads of state and governments, and with expert panelists from civil society, academia, and the private sector, which would be independent from the WHO—which, unsurprisingly, resisted the proposal (Horton, 2023).

### *3.2 Geopolitical Tensions, from Power Struggles to Vaccine Nationalism*

The WHO's authority was also diminished by broader geopolitical tensions. For example, in early 2020, the WHO was criticized for having adopted an overly conciliatory attitude toward China, and in particular for failing to publicly condemn the Chinese government's lack of transparency and diligence at the beginning of the epidemic. It can be considered that this was a strategic, diplomatic choice on the part of the WHO Director-General, aimed at seeking China's cooperation through conciliation rather than confrontation. This politically cautious approach is fairly typical of intergovernmental organizations, which rarely seek confrontation with one of its member states, although it can happen. In April 2003, after six months of frustration with China's uncooperative attitude in relation to the SARS epidemic, and as international media pressure mounted on the WHO, the organization's Director-General, Dr. Gro Harlem Brundtland, publicly criticized the Chinese authorities, stating that "it would certainly have been helpful if the WHO had been called upon to help more quickly" (Crampton, 2003). The Covid-19 pandemic

reinforced political tensions between China and other countries, especially Taiwan (who lost its observer status at the WHO in 2016, as a consequence of China's response to the election of a new pro-independence president on the island) and the United States. The conflict between the US and China was largely transposed into the organization, and was further aggravated by the context of strong criticism in the United States of the Trump administration's unpreparedness in dealing with the epidemic. The US president then sought not only to deflect the blame onto the WHO (King & Luug, 2023), but also to make his confrontation with China one of the central elements of his strategy for the November 2020 US presidential election.

This US withdrawal from the WHO in summer 2020 (a decision of the Trump administration, which was reversed by the Biden administration once it was elected in November 2020) prompted the European Union (EU) to step in to defend the WHO and global health multilateralism. The EU hosted a "Global Pledging Summit" in June 2020 in order to support access to Covid-19 vaccines and treatment via the ACT-Accelerator initiative. The President of the EU Council, Charles Michel, proposed to draft a new Pandemic Treaty, which received enthusiastic support from the WHO Director-General (see below). These were strategic decisions from the EU, which saw an opportunity to assert its place on the global scene. It found allies in some countries from Latin America, Asia and Africa (some of which belonged to the "Friends of the Treaty" group, which formed with the aim of supporting the negotiation of a new Pandemic Treaty), but many developing countries also condemned the inequities in access to Covid-19 vaccines and treatments. Although these were being developed rapidly, access was restricted to countries that were able to pay and to negotiate bilateral deals with pharmaceutical companies.

A global vaccine race took place, in which developed countries had an unassailable advantage. In September 2021, only 3% of people in low-income countries had been vaccinated with at least one dose of a Covid-19 vaccine, compared to 60% in high-income countries(Kaizer, 2022). This call for more equity in the distribution of vaccines and treatments was put forward at the World Trade Organization (WTO), where countries led by India and South Africa requested a "TRIPS waiver", that is, a suspension of intellectual property rights (which are governed by the TRIPS Agreement overseen by the WTO) relating to treatments and vaccines against Covid-19. Other countries, such as the United States,

Japan, Canada, Brazil and Mexico, as well as the EU, initially opposed it, thereby replaying a classic situation of fragmentation that has existed in health multilateralism since the late 1990s, when divisions were particularly concerned with the fight for access to anti-HIV/AIDS drugs. A first compromise for a limited waiver (only for vaccines and for a period of five years) was reached in June 2022, but this was still seen as insufficient by many (Kohler et al., 2022).

### *3.3 Solidarity at Stake: The ACT-Accelerator as an Attempt to Bridge the Gaps Caused by Fragmentation*

These shortcomings in the coordination of the global response and in handling geopolitical tensions resulted in a lack of solidarity—whereas fostering solidarity is one of the main *raisons d'être* of multilateral organizations and a crucial component in the fight against pandemics. This is why in 2020 the WHO, through the voice of its Director-General, made a plea for scientific, financial and political solidarity. This resulted in the creation of a new mechanism, the Access to Covid-19 Tools Accelerator (known as the ACT-Accelerator or ACT-A) in spring 2020. This mechanism, which was supported from its inception by the EU, aims to ensure "the equitable distribution and delivery of vaccines, treatments and diagnostic tools on a large scale".[7] It is a collaborative framework involving the "usual global health power brokers" (Horton, 2023): philanthropic foundations (the Gates Foundation, the Wellcome Trust), vertical funds and public–private partnerships (CEPI, FIND, GAVI, the Global Fund, Unitaid) and intergovernmental organizations (the WHO and the World Bank). These nine organizations "co-lead" workstreams in four areas: diagnostics, treatments, health systems strengthening and vaccines. The workstream devoted to vaccines, which was also known as COVAX and was co-led by GAVI, CEPI and the WHO, set up a mechanism for the pooled advance purchase of vaccines (using donor funding), with the intention that the purchased doses would be distributed to countries according to certain priorities, in a way that would include poor countries that were unable to buy vaccines with their own resources. In order

[7] https://www.who.int/initiatives/act-accelerator/faq (Accessed 6 March 2023).

to do that, the WHO has developed an equitable and universal vaccine allocation scheme (e.g., its initial aim was to distribute doses until the point when all countries would possess sufficient quantities to cover 20% of their population) (WHO, 2020).

The WHO, as a universal health organization, is specifically responsible for the issue of access within the ACT-Accelerator. It is also very strongly involved in the ACT-Accelerator in general: in addition to co-leading two of its axes, it participates in the other two, leads a cross-cutting axis on "access and allocation" and hosts the ACT-Accelerator's administrative structure. However, the governance structure chosen places other actors, including restricted multilateral organizations, on an equal footing with the WHO in terms of their responsibilities, leadership and coordinating roles. This mechanism was criticized on the grounds that it is donor-lead, that it limits low- and middle-income countries to the role of beneficiaries, and that it has an ill-defined mechanism for accountability (Horton, 2023). The ACT-Accelerator governance structure reflects the forms of fragmentation, inequalities and coordination difficulties in health multilateralism that were analyzed above. It could be argued that the ACT-Accelerator design, which acknowledges the role played by powerful actors without establishing a clear hierarchy between them, is unlikely to provide a model capable of resolving the above-mentioned problems.

Furthermore, this attempt at vaccine multilateralism encountered three particular obstacles: first, the approach of "vaccine nationalism", which left few doses available to COVAX; second, the unilateralism of some countries that initially refused to join the initiative, such as the United States under President Donald Trump; and third, the bilateral strategies adopted by some other countries, which preferred to instrumentalize vaccines and conduct a form of vaccine diplomacy by making bilateral deals, such as China and Russia. Yet, even if the ACT-Accelerator mechanism was far from successful in many aspects (such as the low vaccination rates that were achieved in developing countries), it is important to recognize the symbolic significance of the WHO's decision to devise an equitable and universal distribution mechanism, at a time when national public opinions were primarily concerned with their own security. It serves as a reminder that, in order to survive, multilateralism has to find ways to address the challenge of solidarity.

# 4 Burgeoning Multilateralism: The Covid-19 Pandemic as a Catalyst for Future Directions in Global Health Cooperation

Although the Covid-19 pandemic did not immediately change the architecture of global health governance (pledges were made to strengthen the WHO and member states agreed on new financing objectives for the organization, restricted multilateralism organizations were acknowledged as playing a co-leading role, the World Bank remains the financial organization hosting the newly created Pandemic Fund, etc.), it nonetheless led to a major revival of multilateral negotiations and to the opening of official discussions on topics that had been debated for years in smaller and less visible areas. Some principles of global health multilateralism are being "reworked", as we see debates emerging on the role of international law, solidarity and equity, integrated approaches to multilateral cooperation and the intangibility of sovereignty.

## *4.1 International Law: A Powerful Instrument for the Revival of Multilateralism*

Although global health multilateralism is not restricted to the production of legally binding instruments, the negotiation of such instruments nevertheless plays a crucial role in the strength and vitality of multilateralism, as this forum provides an opportunity to define common goals and make commitments to achieve them. The launch of multilateral negotiations in 2021 to draft a new treaty under the auspices of the WHO aimed at preventing pandemics is in itself remarkable. It was recommended by evaluation panels set up to investigate the response of the international community to the Covid-19 pandemic. Yet the WHO, over its 75 years of existence, had previously only negotiated one treaty as permitted by article 19 of its Constitution: the 2003 Framework Convention on Tobacco Control. The idea for a Framework Convention on Global Health, put forward in 2007 by some experts and civil society organizations (Gostin, 2007), never came to fruition. Most norms adopted by the WHO are recommendations (as permitted under article 23 of the WHO Constitution). The regulations detailed in the IHR, which constitute the

WHO's legally binding instrument for preventing the spread of contagious diseases, are a specific kind of norm permitted by articles 21–22 of the WHO Constitution, which does not require ratification by member states.

Following the Covid-19 pandemic, two negotiation processes unfolded in parallel. First, the IHR are being amended—a process favored and heavily invested in by the United States, since amendments to the IHR enter into force for all states simultaneously unless they explicitly reject them. Second, a new Pandemic Treaty, which was initially an EU initiative before gathering wider support, is being drafted (the initial hope is that it will be adopted in May 2024). After some reluctance, the United States also invested in this process—their initial lack of enthusiasm for a Pandemic Treaty can be explained by the fact that the ratification of international agreements is always a challenge for US Administrations owing to US domestic constraints. The rationale is that, even if certain states, such as the US or China, do not ratify the treaty, the visibility of the negotiation process and the political commitment that it generates, as well as the symbolic force of the final treaty, will exert pressure on every government to invest in the prevention, preparedness for and response to pandemics. There is also the expectation that a specific governance or even monitoring mechanism of the treaty (such as a Conference of the Parties (COP)) will sustain multilateral cooperation in the long term. Finally, there is the hope that a treaty will widen the scope of multilateral cooperation, as it can address in the form of a legal instrument certain issues that are not covered by the IHR, such as the sharing of pathogens and vaccines, and the links between health and climate change (Nikogosian, 2021). In any case, it is interesting to note that some low- and middle-income countries are taking some of the issues being discussed during the Pandemic Treaty negotiations (such as equity or compliance) back into the IHR negotiations (Third World Network, 2023). These transfers between the two negotiation processes show the importance of the negotiation of legal instruments for the revival of multilateralism.

### *4.2 One Health: A New Global Principle for Multilateral Cooperation*

The Covid-19 pandemic focused particular attention on the fact that pandemics emerge from an "animal-human–environment interface" (Le Moli et al., 2022: 7). Consequently, the "One Health" approach, which

promotes an integrated approach to human health, animal health and the environment, gained momentum and is now being discussed in the Pandemic Treaty negotiations. This approach is not new: the interconnection between human and animal health was being studied as early as the beginning of the twentieth century. The concept of "one medicine" was used to link human and animal health, before the concept of One Health was formulated in the early 2000s (Zinsstaga et al., 2011). The recognition that climate change is now under way, which increases the proximity between human habitats and animals (since animals see their natural habitats shrinking) and therefore increases the occurrence of zoonoses (diseases transmitted from animals to humans, which is the case for three-quarters of emerging infectious diseases in humans), has played an important role in the dissemination of the concept.

As a result, the Office International des Epizooties (OIE), created in 1924—and which, in the 1940s, seemed destined to be dissolved in the wake of the creation of the WHO and the Food and Agriculture Organization (FAO), which took over the transmission of information on animal diseases and zoonoses—came to be revitalized, becoming the World Organization for Animal Health in 2003 (while keeping the same acronym, OIE). In 2010, a tripartite collaboration between the WHO, the FAO and the OIE was established, which was later joined by the United Nations Environmental Program (UNEP). This "Quadripartite" launched the One Health High Level Expert Panel in 2020 (Le Moli et al., 2022: 10) in order to implement the concept, which until then had remained a rather theoretical approach, used for describing mechanisms or analyzing situations.

What is interesting is that One Health is not only an epistemic or scientific approach, but also an organizing principle for multilateral cooperation. Its operationalization promotes an approach that is trans-sectoral (highlighting the importance of the science-policy interface, links with multilateral negotiations on biodiversity, etc.), trans-organizational (it can be implemented by a myriad of organizations, even beyond the Quadripartite, and it is already used by the World Bank, for instance (Berthe et al., 2018)), and trans-level (there is no separation between the local, national and international levels). Thus, One Health appears as a global approach with the potential to play a revitalizing role for multilateral cooperation.

### *4.3 Sovereignty: Non-State Actors and the Protection of Populations Beyond States*

States are at the core of the international system of pandemic prevention, preparedness and response (PPPR). The international instruments that already exist and those that are in development are designed by states and also take states as their primary target. Health in general and PPPR in particular are sensitive areas with regard to state sovereignty, as any health issue or intervention affects the three defining elements of statehood: a state's population (its perpetuation and well-being), a state's territory (the surveillance and control of epidemics require actions on the state's territory and at its borders), and a state's government (the provision of health services to and protection of the population is a means of legitimation for the state authorities). Yet the Covid-19 pandemic was a reminder of the importance that has been assumed by non-state actors in global health governance and the response to pandemics: private pharmaceutical companies developed tests, treatments and vaccines; NGOs distributed medical and food supplies and drew attention to human rights violations during the pandemic; philanthropic foundations funded initiatives, etc. NGOs and charities also stepped in to care for populations that were not protected by states and were, therefore, particularly vulnerable to pandemics, such as people living in areas outside state control (such as in conflict zones) or populations that were disadvantaged or discriminated against (such as migrants). Beyond these "orthodox" non-state actors, the Covid-19 pandemic also saw interventions from "heterodox", (or "unusual and unconventional") ones, such as rebel groups or vigilante movements (Elbe et al., 2023).

The contribution of non-state actors in global health and in PPPR is not only recognized in practice, but also embedded in international law. NGOs can make use of certain aspects of humanitarian law to help them reach vulnerable populations. Since the 2005 revision, the IHR recognize that, in the case of an epidemic, non-state actors can play a role in raising the alert. This development followed the cover-up by China in 2002–2003 during the SARS crisis, when the country's authorities were very slow to cooperate with the WHO. States that are parties to the IHR are obliged to notify the WHO of events likely to constitute a public health emergency, but the WHO can also rely on unofficial

sources, including non-state sources to declare it. In 2016, more than 60% of initial reports of outbreaks came from "informal sources", such as Internet sites and forums, social networks and Internet surveillance programs (Davies, 2018).

This is the culmination of a process begun in the 1990s, which has seen the WHO consolidate its use of non-governmental sources in epidemiological alerts (Kamradt-Scott, 2015: 84). ProMED (the Program for Monitoring Emerging Diseases), created in 1994 and managed by the International Society for Infectious Diseases, is an example of a system monitored by the WHO, which uses both big data algorithms and human analysis to detect emerging infectious diseases. It was through ProMED that information about the existence of the MERS coronavirus was first disclosed in 2012 (Davies, 2018). Then, in 1998, the WHO established the Global Public Health Information Network with the Canadian Ministry of Health as its host. In 2000, the WHO created its Global Outbreak Alert and Response Network, linking various governmental and non-governmental actors and networks whose tasks include the collection and analysis of epidemiological surveillance data.

During the Covid-19 pandemic, GISAID (Global Initiative on Sharing Avian Influenza Data), a scientific platform created in 2006 by individuals as a not-for-profit association devoted to sharing access to genomic data from influenza viruses, which then received support from the WHO, the German government and the EU, became the platform hosting the largest number of genomic sequences of SARS-CoV-2 (Elbe et al., 2023: 17). The example of GISAID shows how some non-governmental initiatives can be co-opted by traditional actors in the global health field. Non-state actors make various contributions to PPPR, and despite the will of some states to strongly limit and control their roles, they are present in current negotiations in global health multilateralism.

### *4.4 Equity Measures: Renewing Solidarity and Ensuring the Effectiveness of Multilateral Cooperation*

As mentioned above, one of the most crucial and contentious issues that the Covid-19 pandemic brought to fore is that of equity between countries, and of the mechanisms that are needed to bring it about. Equity is necessary for creating a sense of solidarity, which is at the core of multilateralism, as it ensures both its universality and its effectiveness. For example, without any acknowledgment of the inequalities between

states and of the differences in their capacities, and without mechanisms to correct those inequalities, states are less likely to comply with multilateral treaties. This is why such treaties often provide for specific measures aimed at low- or middle-income countries. For example, the WHO Framework Convention for Tobacco Control provides for technical and financial assistance specifically aimed at developing countries, the WTO provides for "special and differential treatment" for lower-income countries, and environmental law recognizes the principle of "Common But Differentiated Responsibility" (Yu III, 2023). This last principle, whereby developed countries agree to undertake higher obligations to combat environmental challenges, is enshrined—among others—in the 1992 United Nations Framework Convention on Climate Change. Some developing countries (such as Pakistan, South Africa, Namibia and Malaysia) advocate for the inclusion of the principle of "Common But Differentiated Responsibility" in a Pandemic Treaty (Third World Network, 2022).

In global health multilateralism, the issue of equity has crystallized since the 2000s around the sharing of pathogens and access to treatments and vaccines (sometimes called "pathogen sample- and benefit-sharing" (PBS) or "access and benefit-sharing" (ABS)). Human pathogens (viruses, bacteria, parasites, fungi, etc.) are shared between laboratories with the aim of developing so-called countermeasures or "benefits", such as diagnostics, treatments and vaccines. As a result of scientific progress in this area, not only physical samples but also data are now shared (metadata and genetic sequence data, which can be shared via electronic files). There is no comprehensive framework of regulation organizing this sharing of pathogens and subsequent benefits. Historically, it was organized by communities of scientists working on a specific disease, and the most formalized and regulated such network was the one devoted to sharing influenza viruses (Aranzazu, 2013). However, developing countries have complained that pathogens were obtained unfairly by developed countries and/or pharmaceutical companies, which then produced treatments that were protected by intellectual property rights and sold at high prices, which were unaffordable to developing countries. In 2006–2007, a major crisis occurred when Indonesia decided to stop the sharing of H5N1 viruses with the WHO Global Influenza Surveillance Network for that very reason (Burci & Perron-Welch, 2021).

Negotiations took place to solve this issue, but these resulted in a complex and incomplete "patchwork of arrangements" for pathogen and

benefit-sharing (Strobeyko, 2023). There are two main legal arrangements in place: first, the 2011 Pandemic Influenza Preparedness Framework, a system based on multilateralism and reciprocity (countries share influenza viruses within the WHO-led network, and in exchange companies provide some access to vaccines), but which applies only to pandemic influenza viruses; and second, the 2010 Nagoya Protocol to the Convention on Biological Diversity, which is based on a bilateral and transactional approach. The Nagoya Protocol is centered around the recognition that pathogen samples are biological resources governed by national sovereignty, and that the sharing of those samples must respect national sovereignty—meaning that Prior Informed Consent and Mutually Agreed Terms have to be negotiated in each case. This means that bilateral and transactional negotiations must take place, which might take too long to allow an effective response to an epidemic outbreak.

One of the main challenges for the future of global health multilateralism is to develop an equitable pathogen sample- and benefit-sharing system. A first step in that direction was taken by the Conference of the Parties to the Convention on Biological Diversity in December 2022, which decided to establish a multilateral mechanism for benefit-sharing resulting from the use of digital sequence information (this includes genetic-data sequences, which until then were not explicitly governed by any arrangement) (Burci, 2022). But there is still a need for a more comprehensive framework for global health and pandemic response, which is why the topic is on the negotiating table of the Pandemic Treaty. Many challenges remain—especially since one underlying issue is that of intellectual property rights, which is governed by the TRIPS Agreement of the WTO. But taking into account the issue of equity, with enforceable measures, is key to strengthening solidarity and ensuring the effectiveness of multilateral cooperation.

## 5 Conclusion

These debates and ongoing multilateral negotiations attest, despite the challenges posed by fault lines and fragmentation, to the resilience of global health multilateralism. Several initiatives to improve multilateral cooperation were undertaken in 2020 (such as the creation of the ACT-Accelerator, demands for a TRIPS waiver, etc.). Subsequent multilateral negotiations have addressed foundational principles of multilateralism (equality, reciprocity, support for legal rules and respect for international

commitments, sovereignty, etc.). These discussions are rooted in previous developments in global health governance, as the topics on the table are not new. However, the emerging forums, frameworks and linkages between them are more novel. The results of the ongoing negotiations remain to be seen, but the strength and vitality of the processes are as important as the results (the production of new agreements or institutions, for instance, which will ultimately be put to the test by future crises and changes to the environment). Using Kalevi Holsti's terminology, mentioned above, if the Covid-19 pandemic is to be seen as a marker of change, it is both a "great event" (a marked interruption in a typical pattern) and the result of cumulative "trends" (an accumulation of many little acts). But what is more important is that the resilience of global health multilateralism can be explained in part by its permanent dynamics of change. Despite a political emphasis on the "special moment" of the Covid-19 crisis, the proliferation of new directions in global health cooperation results from an accumulation of gradual change, on which the Covid-19 pandemic acted as a catalyst by bringing about new linkages in the global health field.

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