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GLOBAL HEALTH LAW

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Final Report of the Global Health Law Committee of the International Law Association

Lessons for the Future of Global Public Health Law

April 7, 2026

I. OVERVIEW

1. The work of the GHLC has spanned 12 years. During that time medical science has advanced considerably. These advances should have resulted in major improvements in the health of populations around the world. In some respects, as evidenced in morbidity and mortality statistics, progress has been made. There are several factors that have impaired a more positive trajectory. Chief among them is the COVID-19 pandemic that resulted in a substantial spike in premature deaths and generally impacted health systems. By 2026 the international community has largely recovered from the impact of the pandemic, and mobility and mortality statistics have resumed an improving trend. Yet despite the negotiation of the Pandemic Agreement intended to remedy the shortcomings of the response to COVID-19 as well as the successful amendment of the International Health Regulations (IHR) in 2024, the international community remains underprepared for another large-scale pathogenic outbreak.

2. The predominance of non-communicable diseases in LMICs, well beyond the confines of ageing populations in developed countries as traditionally believed, has become the focus of global attention in the United Nations as well as WHO, with the General Assembly adopting a series of high-level declarations.[1] It should be noted that, despite a popular belief that infectious diseases are the main cause of global mortality and morbidity, the four main non-communicable diseases (cancer, diabetes, cardiovascular diseases and chronic respiratory diseases) account for over 70% of global mortality figures according to WHO, with most deaths occurring in developing countries.[2] Besides the sheer magnitude of the problem, the fact that common risk factors are mostly environmental or due to consumption of unhealthy products (tobacco, alcohol, ultra-processed food and sweetened drinks) raises immediate questions about the consistency between international economic law and overriding health objectives. Recent national and international litigations around the packaging of tobacco products are an apt illustration of that tension.

3. As the international community has fragmented, and attention has turned to bolstering military budgets, the funding available to address public health requirements and needs has decreased.

[1] See, e.g., Political declaration of the fourth high-level meeting of the General Assembly on the prevention and control of noncommunicable diseases and the promotion of mental health
and well-being, UN General Assembly, Eightieth session, Agenda item 127, Global health and foreign policy, A/80/L.34, 8 Dec. 2025; WHO News Release, World leaders adopt a historic global declaration on noncommunicable diseases and mental health, 16 Dec. 2025.

[2] Ndubuisi NE. Noncommunicable Diseases Prevention In Low- and Middle-Income Countries: An Overview of Health in All Policies (HiAP). *INQUIRY: The Journal of Health Care Organization, Provision, and Financing*. 2021;58. doi:10.1177/0046958020927885

Some of the budget cutbacks are based on the deliberate choice of governments, such as that of the United States under the current Trump administration, to minimize international cooperative mechanisms in favor of bilateral approaches. But the United States is not alone in reducing the budget resources available for public health initiatives. Western European countries that have counted as major funders of public health in developing countries, in particular, have also reduced their contributions in good part because of the political pressure to increase military spending as a consequence of the Russia's invasion of Ukraine. This situation puts in stark relief the risks and vulnerabilities of a global health system heavily dependent on a limited number of donors.

4. Over the course of its mandate, the Committee and its members have participated actively in the development of global health policy and norms and, in the Committee's estimation, has exerted a "material" positive influence in the development of the field. In the early days of its mandate, the Committee actively participated in international dialogues regarding improving access to medicines, promoting research and development (R&D), and addressing international public health emergencies, taking particular note of gaps in addressing Ebola outbreaks. The Committee anticipated and addressed important issues regarding access to pathogen materials and information, as well as surrounding concerns regarding the sharing of benefits flowing from such access. The Committee responded to Russia's invasion of Ukraine as a public health concern.

5. The COVID-19 pandemic occupied much of the attention of the Committee and its members from its inception through the negotiation of the Pandemic Agreement (and PBS Annex). In addition to the formulation of a formal Statement, members of the Committee were involved at WHO and with various delegations and interest groups in attempting to address obstacles in the development and supply of vaccines, therapeutics and diagnostics, in promoting a One Health approach, and in formulating proposals to improve any future global responses to international health emergencies.

6. The Committee and its members addressed a variety of other important issues including the relationship between global public health and international human rights norms, the relationship between health and international trade/investment rules, the relationship between health and environmental norms, disputes over attempts to regulate harmful products (such as tobacco), and the evolving role and impact of artificial intelligence (AI) on health systems (including intellectual property norms).

7. As the Committee concludes its mandate, it is evident that the subject matter of global health law remains an important one for international law and lawyers. The Committee envisions that the ILA will continue to address this subject matter with some new grouping of its members.

II. WORK OF THE COMMITTEE

A. 2015

8. The GHLC initiated its work program in 2015 specifically addressing the subject of health emergencies as the international community struggled to address an outbreak of Ebola in West Africa. It convened a meeting in Geneva among significant relevant actors, and prepared a report

based on its meeting.[3] There was a general consensus among the participants that improvements in national infrastructure to address public health and control sudden onset emergencies was the top priority. In addition, there was substantial discussion regarding gaps in the processes by which medical countermeasures (MCMs) are made available in response to outbreaks, and the need to develop "cross-pathogen" platforms that could accelerate the introduction of vaccines and therapeutics. This anticipated a major issue arising during the COVID-19 response, namely the time lag between an outbreak and the first availability of vaccines and treatments. From a legal and institutional standpoint, there was discussion regarding whether a new multilateral institution was required to focus on rapid response to pandemic and other emergency disease outbreaks. The balance of opinion was that adding another institution to the existing regimes might only complicate matters further. It could be argued that the recently concluded Pandemic Agreement points to possible multilateral solutions to that enduring problem.

9. Already in its report of 2015, the GHLC had identified key limitations in the implementation of the International Health Regulations (IHR) of 2005. The Committee noted how, prior to the onset of the West African Ebola crisis in 2014, multiple states parties to the IHR had reported a lackluster implementation of obligations to strengthen national capacities for health emergency preparedness and response.[4] The object and purpose of the IHR (2005) of fostering a coordinated international response to public health emergencies was arguably undermined, in so far as there was a clear lack of coordination between, for instance, the United Nations Security Council and the WHO.[5]

B. 2016

10. The GHLC responded to a call for submissions from the United Nations Secretary General's High Level Panel on Access to Medicines (HLP) with two proposals. The first was a proposal for the establishment of an essential medicines patent pool that would facilitate the introduction of low-cost versions of new medicines with a view to enhancing affordability and increasing access to such medicines.[6] As an alternative to pooling, the GHLC submission recommended that for products on the essential medicines list compulsory licensing be made effectively automatic, combined with a socially responsible royalty scale. The second was a proposal for a Framework Convention on Pharmaceutical Innovation and related protocols intended to improve with an integrated approach the regulatory environment in which pharmaceutical products are developed

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[3] Global Health Law Committee of the International Law Association and the Global Health Programme of the Graduate Institute|Geneva, *Global Health Security Challenges: towards strengthening global governance*, Summary of February 19, 2015 Meeting (Geneva), March 6, 2015.

[4] WHO, Report of the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation, EB136/22 Add. 1, 16 January 2015, 5.

[5] Despite lacklustre implementation of the IHR, UN Secretary-General Ban Ki-Moon did establish a United Nations Mission for Ebola Emergency Response (UNMEER), and this was welcomed by the UNGA (UN General Assembly. Measures to Contain and Combat the recent Ebola Epidemic in West Africa. A/RES/69/1, 23 September 2014) and Security Council (UN Security Council. Resolution 2177 (2014)). S/RES/2177 (2014). There was general consensus that WHO waited too long to declare a public health emergency of international concern. On September 16, 2014, the United States committed 3,000 military personnel to Operation United Assistance, based in Liberia, to oversee US relief efforts.

[6] *Submission to the UN High Level Panel on Access to Medicines* by the Global Health Law Committee of the International Law Association. Prepared by Ellen 't Hoen LLM, Prof dr Brigit Toebes, Katrina Perehudoff MSc, LLM, and Prof Frederick M Abbott, submitted Feb. 19, 2016.

and introduced.[7] Members of the Committee addressed the meeting of the HLP regarding these proposals. Though neither was incorporated among the specific recommendations of the HLP, GHLC members played a role in shaping the ultimate HLP report and recommendations. In conjunction with the public meeting of the HLP, the GHLC met in London to discuss topics included in its report for the Johannesburg ILA Biennial Meeting.

11. Members of the Committee participated in the Johannesburg Biennial meeting in 2016, presenting its Report. The Committee's 2016 Report focused on issues surrounding global health security, including preparations for potential pandemics, and issues surrounding access to essential medicines.[8] It linked the internationally recognized right to health with the need to improve access to essential medicines for a large part of the world's population.[9] These ideas were consistent with those made by the Committee to the U.N. Secretary General's High-Level Panel. The Committee Report paid particular attention to the mechanisms by which biological and digitally encoded genetic information is made available for research purposes, an issue which is a major outstanding element within the Pandemic Agreement negotiations. The Committee's recommendations are echoed in the current Pathogen Access and Benefit Sharing (PABS) Annex negotiations, including that the earlier-adopted Pandemic Influenza Preparedness (PIP) Framework be expanded to address pathogens other than those relating to pandemic influenza, or that a new international agreement be negotiated to provide for the sharing of pathogen materials and information. The Report suggested that the IHR (2005) be amended to include a clear obligation to share pathogens. It is noteworthy that these recommendations preceded the COVID-19 pandemic, and the contentious negotiations regarding PABS. It has been the general perspective among members of the GHLC that obligations to share pathogenic materials in order to rapidly advance the development of diagnostics, vaccines, prophylactics and/or treatments for disease outbreaks should not be burdened with cumbersome bureaucratic requirements. Such requirements may have been incorporated in the national legislation of some countries aimed at implementing the Convention on Biological Diversity and/or its Nagoya Protocol, but they may well impede effective response to pandemic outbreaks. The two subject matters should be treated distinctly from a legal and administrative standpoint.

C. 2018

12. The Committee addressed several major themes in its Report for the ILA Sydney Biennial meeting in 2018.[10] These included addressing global health law as a field of international law, the intersection of human rights and access to healthcare and medicines, the WTO dispute and related investment disputes involving tobacco plain packaging legislation in Australia, the relationship between global health law and protection of the environment, and transparency as a concept in international law. In addition to presenting its Report, the Committee hosted a separate panel session addressing the WTO-Australia Tobacco Plain Packaging dispute.

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[7] *The Framework Convention on Pharmaceutical Innovation and Its Related Protocols*, Submission to the United Nations High Level Panel on Access to Medicines by the Global Health Law Committee of the International Law Association Prepared by Xavier Seuba, submitted Feb. 19, 2016.

[8] Global Health Law Committee, International Law Association, First Report of the Committee, Johannesburg Conference 2016.

[9] Inter alia, Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR, 1966).

[10] Global Health Law Committee, Second Report, International Law Association, Sydney Conference (2018)

1. The evolution of global health law

13. Altogether we look back on more than a decade of developments in global health law since the establishment of our Committee in 2014. In retrospect, this period has been marked by significant progress, both in scholarly engagement and in terms of standard-setting. The field has attracted sustained academic attention, evidenced by the publication of several handbooks and the creation of a dedicated journal. New perspectives have emerged concerning the scope of global health law, the interaction between its various norms and standards, and its place within the broader legal landscape. Over the course of the past twelve years, the term "international health law" has been gradually replaced by "global health law". The term *global health law* potentially reflects the consequences of globalization in the health field, including the increasing role and power of multiple actors in global health governance.

14. As mentioned, there have been significant developments in global health standard-setting. Notably, the 2005 International Health Regulations (IHR) have been revised,[11] and a second framework convention — the Pandemic Agreement[12] — has been adopted. While neither instrument is without shortcomings, both represent important milestones in the evolution of international norms in global health. In particular, the Pandemic Agreement acknowledges equity and solidarity as "principles", and it is the first time that an intergovernmental treaty has recognized the concept and approach of "One Health." The COVID-19 pandemic has, of course, served as a major catalyst for these developments.

15. Politically, global health lawyers have had to navigate an increasingly turbulent landscape. We are witnessing power struggles among assertive political leaders who at times sideline or openly disregard international legal norms. The decision of the Trump administration to withdraw the United States from the WHO has significantly constrained the organization's room for maneuver. At the same time, recent armed conflicts have been marked by serious violations of human rights and humanitarian law, including breaches by various actors of medical neutrality and broader infringements of the right to health — affecting access to care and undermining the conditions necessary for people's livelihoods.[13]

16. Questions of framing global health law have been addressed over the course of the past 12 years. Is global health law just an approach or a field of international law? In our 2018 report we suggested that:

> "(…) it seems clear that global health law is not a "field" of international law comparable to other broad issue areas on which states have adopted a relatively large number of dedicated treaties with a coherent object and purpose - for example, human rights law, environmental law or international economic law."[14]

17. We also discussed the scope of global health law. It was also suggested in the 2018 report that:

> "(…) global health law can be seen holistically not only from a positivist perspective as a set of international rules and standards sharing a coherent object and purpose, but

[11] International Health Regulations (2005), as amended in 2014, 2022 and 2024. Amended International Health Regulations enter into force, WHO News Release, 19 Sept. 2025.
[12] WHO Pandemic Agreement, Agenda item 16.2, WHA78.1, adopted by the World Health Assembly on 20 May 2025.
[13] Inter alia, Medecins San Frontieres, https://www.msf.org/attacks-medical-care-armed-conflict-reach-record-levels
[14] Second Report, Sydney, supra note 10, at para.15.

> also from a normative perspective as an approach to international law aiming at placing human health interests on the same plane as other recognized international interests, including security, international monetary system, international economics and trade, and international environmental regulation."[15]

18. When it comes to rules, as far as global health law is concerned, there is little binding law at the international level. The WHO has not been very proactive in adopting treaties and regulations. While the reasons for this relative scarcity of dedicated global "health treaties" and similar binding instruments are subject to discussion,[16] there is a growing number of regional health instruments in particular in the context of the Council of Europe (prominent examples being the Oviedo Convention on Human Rights and Biomedicine and the "Medicrime Convention"), of the European Union that has also established dedicated agencies such as the E-CDC, the European Medicine Agency and the European Food Safety Agency, the African Union that has established AfricaCDC, and the Pan American Health Organization (PAHO) that serves as the Regional Office for the Americas of WHO and the specialized health agency of the Inter-American System.

19. Next to standards and norms, scholars in the field have suggested that we should talk about *institutions* and *communities of practice* shaping the field of global health law. In addition to the WHO, many other organizations and bodies, international, regional, governmental as well as non-governmental, play a role in creating and shaping global health law. When it comes to communities of practice, global health lawyers comprise an emerging community of practice assuming an increasingly important role in the development of global health law.[17]

2. Human rights as the foundation of global health law

20. Some scholars have expressed concern that the development of global health law could undermine human rights, particularly economic, social, and cultural rights.[18] While this concern is important, it appears that it has not materialized. Rather, it seems that global health law as a field and community of practice is an excellent platform for exploring the interactions between human rights law and other dimensions of global health law. One reason for this is the strong involvement of the health and human rights community in shaping global health law. For example, academic literature has extensively examined the relationship between human rights—particularly children's rights—and tobacco control, including the Framework Convention on Tobacco Control (FCTC).[19] Most global health law scholars will recognize human rights as a key foundation of global health law.

21. A concern that merits further attention is the role of broader principles such as equity. Although equity has proven to be a powerful concept in discussions on equitable access to medicines, it lacks the level of conceptual and normative sophistication found in the right to health, particularly as

[15] Second Report, id.
[16] E.g. David Fidler, 'The Future of the World Health Organization, What Role for International Law?' (1998) 31(5) *Vanderbilt Journal of Transnational Law* 1079.
[17] Roojin Habibi, "'Someone call a global health lawyer': global health law as an emerging community of practice", in Journal of Global Health Law, Vol. 1 No. 1, May 2024, pp. 71–87, at,p. 72.
[18] Therese Murphy, 'Hardwired human rights: a health and human rights perspective on global health law', in Gian Luca Burci and Brigit Toebes, Research Handbook on Global Health Law, 2018, pp. 82-103,
[19] WHO Framework Convention on Tobacco Control, entered into force 27 Feb. 2005.

elaborated in the General Comments. The Pandemic Agreement and its PABS annex are intended to address this gap in the field of infectious diseases.

22. In practice, health-related human rights have often been neglected over the past decade. It is therefore essential to highlight the interaction between IHL and Human Rights Law (HRL).

3. Global health and the environment

23. It is evident that the environment and health are integrally related. The Committee's 2018 Report addressed this relationship in some detail from a legal standpoint. It suggested that there is a need for greater integration among the various instruments and approaches addressing the relationship between health and the environment, and that improved approaches for allowing legal claims to be pursued in this area should be adopted. To this effect, the Committee noted the need to further explore the links between health, the environment and human rights, including a then-emerging trend towards the right to a healthy environment in regional human rights systems and its potential justiciability. We observed how various procedural laws across different jurisdictions shaped access to courts. Thus, regional human rights courts have adopted diverging stances on permitting judicial review of violations of the right to a healthy environment.

4. The tobacco plain packaging disputes

24. Several Committee members actively followed the plain packaging disputes in WTO and under ICSID which represented a potential clash between international trade rules, intellectual property rules and rules to protect public health.[20] From the outset, the challenges brought against rules restricting tobacco promotion did not appear to be well grounded in trade or IP law, and in that sense the "conflict" was largely the creation of tobacco industry lawyers. There seemed to be little doubt that the TRIPS Agreement rules on trademarks did not prevent a country (here Australia) from prudently regulating promotional materials (i.e. tobacco packaging). Similarly, rules regarding technical barriers to trade do not preclude governments from taking legitimate measures to protect public health, and there was no reason to believe that WTO rules would be interpreted to block Australia. Ultimately, the WTO Panel (and subsequently the Appellate Body)[21] firmly rejected the tobacco industry challenges, as did the arbitrators in various investment-related disputes such as the ICSID claim by Philip Morris against Uruguay under the Switzerland-Uruguay Bilateral Investment Treaty.[22] Whether there is a "lesson" from this set of disputes is not clear, other than to confirm that industries with great financial resources can and will use those resources to delay the implementation of rules that affect their businesses. This might suggest the need for

[20] The Global Health Law Committee organized an expert panel in connection with the Sydney Conference to assess the Panel Report. This was a timely and "geographically appropriate" occasion given Australia's central role in the dispute, and the Committee was fortunate to include among the panelists several individuals who directly participated in the dispute settlement process, both from a legal and scientific angle. The Sydney panel was comprised of Jonathan Liberman (McCabe Centre for Law and Cancer, Australia), Edward Kwakwa (World Intellectual Property Organisation, Switzerland), Natasha Spisbah (Department of Foreign Affairs and Trade, Australia), Prof. Brigit Toebes (University of Groningen, Netherlands) and Prof. Tania Voon (University of Melbourne, Australia). Prof. Abbott chaired this expert panel session.

[21] Australia – Certain Measures Concerning Trademarks, Geographical Indications and Other Plain Packaging Requirements Applicable to Tobacco Products and Packaging, AB-2018-4, AB-2018-6, Reports of the Appellate Body, 31 Mar. 2020.

[22] Philip Morris Brands Sàrl, *Philip Morris Products S.A. and Abal Hermanos S.A. v. Oriental Republic of Uruguay*, ICSID Case No. ARB/10/7, 8 July 2016.

greater vigilance against abuse of rights, but that is a challenging avenue. At the same time, the resounding message arising from tobacco litigations is that even very powerful industries can be defeated in court and that dispute settlement mechanisms sometimes considered biased in favour of economic law considerations are prepared to accept the overriding importance of legitimate public health objectives.

25. The Committee Report identified that the absence of strong transparency rules affects access to medicines and other health products and services. Policymakers do not have good information regarding the costs underlying R&D in the medicines space, making it difficult to assess whether patients and public health systems are paying reasonable prices for what they receive. Governments conduct negotiations on trade agreements having significant impact on the pharmaceutical and health sectors in secret, ultimately seeking approval of those agreements in circumstances that make it difficult for the public to challenge the terms that have been agreed. This is despite the fact that access to information is a determinant of health and, therefore, falls within the scope of obligations under the right to health. The Committee recommended that a general principle of transparency should be recognized in global health law, recognizing that in some circumstances restrictions on information sharing are appropriate (e.g., personal health data).

D. 2020 (2022, 2024)(an extended period encompassing the COVID-19 Pandemic)

26. The global outbreak of COVID-19 in 2020 occupied the work of the Committee and its members, as it occupied the international community.[23] Reflecting this global focus, the Committee's work program leading up to the Kyoto Biennial meeting paid close attention to the unfolding pandemic and its impact. The Report of the Committee for the Kyoto Biennial[24] also included a detailed discussion of legal issues arising out of the use of artificial intelligence (AI) in new drug development, legal issues surrounding access to the data used in training AI's, and the impact that evolving AI will have on pre-existing norms with respect to intellectual property rights.

27. Much of the Committee's attention in 2020 was devoted to the practical aspects of developing medical countermeasures (MCMs), including vaccines, therapeutics and diagnostics, with particular regard to the COVID-19 pandemic. Associated with that was the issue of how those MCMs would be allocated. In the early stages of the pandemic, we emphasized there was a clear rationale for issuing compulsory licenses in cases where those MCMs were patent-protected and alternative mechanisms for production and equitable distribution were needed. There were a range of additional issues needing to be addressed, including the impact of travel restrictions and requirements to stay in place; debate over masking requirements; limitations on trade, including in foodstuffs; identification of the origin of the SARS-CoV-2 virus, including whether it may have originated in a laboratory; trying to cope with the proliferation of online misinformation regarding the nature of the pandemic and the role of MCMs in addressing it.

28. In early March 2020, the Committee supported the proposal by Costa Rica at the WHO to create a voluntary pooling mechanism for technologies that might be used in developing COVID-related MCMs.[25] That proposal resulted in the creation of the WHO C-TAP Program. Committee members on April 5, 2020, adopted a Statement regarding the pandemic, urging international

[23] See Statement of the Global Health Law Committee of the International Law Association regarding the COVID-19 pandemic, adopted by the Committee on 5 April 2020,

[24] Global Health Law Committee, Third Report, Kyoto Conference 2020, International Law Association.

[25] See Statements of Support by Frederick Abbott and Ellen 't Hoen.

cooperation to address it; making the technology needed to develop and produce vaccines widely available; welcoming the efforts being made to provide financing to assist LMIC's in acquiring MCMs; recognizing the importance of emergency measures to restrict movement, while at the same time seeking to avoid unnecessary interference with human rights, and; supporting efforts to encourage the cessation of hostilities to avoid inflaming the scope of the pandemic.

29. The full-on response to the COVID-19 pandemic largely took place between January 2020 and the spring of 2023. It was heavily criticized, particularly among LMIC's and supporters, because of differential treatment in terms of availability in particular of new mRNA vaccines that had been developed and manufactured in high income countries, and that were initially provided to US and EU citizens. The "inequitable distribution" was attributed by some groups to the impact of exclusive intellectual property rights, though it is doubtful that IP played a significant role in the quantities produced or the allocation of their distribution.[26] Developing countries, on the initiative of India and South Africa, requested a waiver of the requirements of the TRIPS Agreement for COVID-19 vaccines at the WTO[27] that led to prolonged negotiations and an inconsequential result. Some Committee members were skeptical of the grounds for requesting a waiver given that TRIPS Agreement rules provide various options for overcoming IP rights that present obstacles to addressing public health issues, and include flexibility to adopt emergency measures.[28] In that regard, the waiver request could be viewed as a "step backward" because it implied that WTO (and WHO) members needed to ask permission from the WTO and its members in order to address urgent public health needs, rather than moving forward based on the sufficiency of existing flexibilities.[29] Some other Committee members viewed the waiver request as a useful proposal that might have successfully addressed an underutilization of TRIPS flexibilities.

30. Despite criticism of the vaccine development and distribution programs, through the cooperation of the Gates Foundation and Oxford University, along with AstraZeneca, a large quantity of AZD1222 vaccine was made available at an affordable price throughout much of the developing world through a manufacturing arrangement with India's Serum Institute (notwithstanding a period of export restriction imposed by India).[30] Moreover, China met its internal vaccine needs entirely with its own domestically produced vaccines and exported (and

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[26] See Frederick M. Abbott, Intellectual Property and Technology Transfer for COVID-19 Vaccines: Assessment of the Record, World Intellectual Property Organization, 2023 | Geneva, Switzerland.

[27] WTO, Waiver from certain provisions of the TRIPS Agreement for the prevention, containment and treatment of COVID-19, IP/C/W/669, 2 October 2020.

[28] See, e.g., Frederick M. Abbott,The TRIPS Agreement Article 73 Security Exceptions and the COVID-19 Pandemic, Research Paper 116, South Centre, Geneva (August 2020).

[29] It is noteworthy that the cosponsors of the waiver proposal, South Africa and India, following the adoption of the disappointing waiver issued a statement effectively stating that they will resort to the Article 73 security exemption to address future pandemic emergencies:

"1.8. Failure to deliver on a multilateral outcome to effectively address concerns on equitable and affordable access to health products including therapeutics and diagnostics, casts a dim light on the ability of the WTO to act in solidarity during an international emergency as recognized by the WHO. The IP barriers that challenge equitable and affordable access have prolonged this pandemic and remain unaddressed, threatening us in the next pandemic. The co-sponsors remain committed to addressing these concerns of developing countries including the LDCs in the context of health emergencies such as pandemics by advancing policy space for Members, along with full utilization of existing flexibilities in the TRIPS Agreement including Article 73." Submission by TRIPS Waiver Co-Sponsors at The Thirteenth Wto Ministerial Conference, Communication From South Africa, WT/MIN(24)/W/21, 29 February 2024, Ministerial Conference, Abu Dhabi, 26-29 February 2024.

[30] See F. Abbott, WIPO, supra note 26.

cooperated in LMIC manufacturing) of its vaccines in what has been dubbed a "vaccine diplomacy campaign". In the final analysis and despite criticism of the disparities in availability, many billions (13-16 billion) of vaccine doses were distributed worldwide and the pandemic was brought under control. Although SARS-CoV-2 remains as an endemic virus, fatalities from the virus today are relatively low, exceeded by those from seasonal flu virus. There remains a persistent impact of "long-Covid" for which an understanding of the mechanisms of action and the development of new treatments has so far proven elusive.[31]

31. It remains that a large number of individuals died or suffered serious health impairment from the COVID-19 pandemic. Estimates vary widely, but "excess deaths" are estimated in a range from 15 million to 35 million individuals.[32] The prevalence of long-Covid remains an issue of concern for healthcare systems around the world. Moreover, the global economy suffered substantially during the COVID-19 pandemic. LMIC economies suffered proportionately more than high income countries as they were more vulnerable to economic shocks than the latter. As of 2026, however, the global economy has largely recovered from the COVID-19 pandemic.

32. In 2021 Member states of WHO initiated efforts to improve global prevention, preparedness and response to pandemic outbreaks by launching a process to negotiate what has eventually been named the WHO Pandemic Agreement.[33] This was a relatively lengthy process conducted through the institutional format of an Intergovernmental Negotiating Body (INB) meeting in successive rounds of negotiation and exchanging proposals and drafts.[34]

E. 2022

33. The negotiation of the Pandemic Agreement was accompanied by parallel negotiations on amendments to the International Health Regulations (2005). Triggered by an initiative of the United States in January 2022 and formally launched by the World Health Assembly in May of the same year,[35] these amendments were negotiated by an Intergovernmental Working Group (WGIHR) and were adopted by the 77th WHA on 1 June 2024.[36] Several additions reflect the push for a more equitable prevention, preparedness and response against future public health emergencies of international concern that can avoid some of the major limitations in the distribution of MCMs during the COVID-19 pandemic. A new definition, "relevant health products", was created to include such MCMs as part and parcel of any coordination between States Parties to the IHR (2005). With this category, the WHO now has the explicit legal mandate

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[31] Hannah E Davis, Lisa McCorkell, Julia Moore Vogel, Eric J Topol, "Long COVID: major findings, mechanisms and recommendations" (2023) 21 Nature Reviews Microbiology 133-146.

[32] Compare deaths reported to WHO at approximately 7 million, "Number of COVID-19 deaths reported to WHO (cumulative total)" WHO COVID-19 Dashboard, widely understood to be undercounted based on government underreporting; with 14.83 million excess deaths globally per Msemburi W, Karlinsky A, Knutson V, Aleshin-Guendel S, Chatterji S, Wakefield J. *The WHO estimates of excess mortality associated with the COVID-19 pandemic*. Nature. 2023 Jan;613(7942):130-137. doi: 10.1038/s41586-022-05522-2, and; per The Economist as of early 2026, cumulative global excess deaths associated with COVID-19 are estimated to be between approximately 20 and 35+ million ("Estimated excess mortality from The Economist" as reported in Our World in Data.

[33] See note 12, supra, for text of Pandemic Agreement. For negotiating history documentation see WHO Pandemic Agreement home page.

[34] See WHO Intergovernmental Negotiating Body, established by the World Health Assembly in December 2021,

[35] WHO, Eight Plenary Meeting, Committee A, fifth report, Seventy-fifth World Health Assembly (28 May 2022).

[36] WHO, International Health Regulations (2005), 77th World Health Assembly, Agenda item 13.3, A77/A/CONF./14, 1 June 2024.

to gather information on medical goods that may be useful against diseases that pose a cross-border threat. Notably, there is now an agreed upon purpose to aim for the equitable distribution of these medical goods between countries, even though there are no specific obligations to furnish specific amounts of said goods either to the WHO or to other states. Instead, this prospect is being negotiated in the Pandemic Agreement. Moreover, a new alert category of a "pandemic emergency" was adopted to refer to those public health emergencies of international concern that, similar to COVID-19 and unlike past Ebola outbreaks, have a global reach or represent a risk thereof. The WHO Director-General now has the explicit legal authority to declare a "pandemic emergency", which could be directly linked to the Pandemic Agreement if and when the latter enters into force.

34. The 2022 report of the Committee referred to the lack of mechanisms for monitoring and fostering compliance with obligations under the IHR (2005).[37] To address such a limitation, new provisions included in the 2024 amendments to the IHR (2005) focus on incentivizing and assessing States Parties' compliance with different obligations. Firstly, a new States Parties Committee for the Implementation of the International Health Regulations has been created. This body will meet at least every two years to examine, in a non-adversarial and non-punitive manner, the persistent limitations in the implementation of the IHR (2005). Furthermore, a major factor undermining the fulfillment of obligations to strengthen core capacities of disease surveillance and reporting is the scarce funding available to low- and middle-income countries for such purpose.[38] A new Coordinating Financial Mechanism under the IHR (2005) has been tasked with the role of identifying and mobilizing funds to support States Parties in meeting their obligations, albeit without establishing any new devoted financial commitments. The latter was a compromise reached by negotiators of these amendments, given the prevailing strain over national budgets that persists to date.

35. The 2024 amendments to the IHR (2005) entered into force for most States Parties on 19 September 2025.[39] Nevertheless, 11 Member States rejected the amendments and are consequently not bound by them as of the writing of this report. Most of the rejections - those by Austria, Brazil, Canada, Germany, Czechia, the Philippines and the Netherlands - were justified by the need to secure parliamentary approval before accepting new international obligations, while others - namely those by Argentina, Italy and the USA - were motivated by a perceived threat to the sovereignty of the countries concerned.[40] The latter group of countries, in particular, also expressed an open rejection of the object and purpose of the amendments, in particular equity in the global distribution of MCMs during public health emergencies of international concern. In separate statements, these countries also criticized the WHO for what they deemed to be its ineffective response to the COVID-19 pandemic. Beyond the substance, or lack thereof, of these criticisms, these rejections by States Parties of the 2024 amendments to the IHR (2005) are poised to make their future implementation even more difficult to oversee.

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[37] Global Health Law Committee, Fourth Report, Lisbon Conference 2022, International Law Association.

[38] WHO, Report of the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation, EB136/22 Add. 1, 16 January 2015.

[39] See note 11, supra.

[40] United States Department of State, Joint Statement by Secretary of State Marco Rubio and Secretary of Health and Human Services Robert F. Kennedy on the United States Rejection of 2024 Amendments to the International Health Regulations (2005)', Media Note (18 July 2025); Marzio Bartoloni, "Italy rejects changes to WHO emergency regulations, like the US: Too binding", *Il Sole 24 Ore* (19 July 2025).

36. In terms of timeline, the Pandemic Agreement discussions and later negotiations spanned the ILA Biennial meetings in Tokyo (2020) (conducted principally through remote facilities), Lisbon (2022) and Athens (2024). The Report of the Committee for the 2022 Lisbon Biennial considered a range of the issues to be taken up during the INB negotiations, as well as for negotiation of amendments to the IHR.

F. 2024

37. The Report of the Committee for the 2024 Athens Biennial discussed in depth some of the core issues surfaced in the INB negotiations, including issues surrounding the incorporation of a One Health perspective in the pandemic agreement, issues surrounding the development and distribution of MCMs and the contentious pathogen access and benefit sharing provisions.[41] The 2024 Report also included detailed discussion of the IHR amendment negotiations still pending at the time of finalizing the report, but concluded between that point in time and the actual convening of the Athens Biennial meeting.

38. Ultimately, there were a few core matters addressed by the Pandemic Agreement negotiations. First, the improvement of health systems to better prepare for and respond to pandemics. Second, facilitating promotion of and access to the research and development needed for new MCMs, and to facilitate the clinical testing and approval of new products. The third was to encourage the geographical distribution of production capacity for vaccines, treatments and diagnostics to avoid the differential distribution patterns that characterized the response to COVID-19. The fourth was to strengthen supply chains, including with the development of up-to-date and comprehensive supply chain data (including materials, equipment and transport). Fifth, and the one subject of negotiations that are not yet concluded, is to develop a new framework for assuring access to pathogen materials and related digital information, on one hand, and making available resulting benefits including products, on the other. This is the subject matter of the Pathogen Access and Benefit Sharing (PABS) negotiations still underway at the time of finalizing the present report.[42] Sixth was the inclusion in a multilateral agreement for the first time of the "One Health approach" for pandemic prevention, preparedness and response together with relatively detailed provision on the strengthening of pandemic prevention and surveillance at national and international level. This development reflected global awareness that an increasing number of infectious diseases are of zoonotic origin, i.e. they jump from animals, both wildlife and livestock, into human populations.[43]

39. The Pandemic Agreement text reflects a mixed result. Although the text acknowledges the challenges that its parties need to confront in preparing for and addressing pandemic outbreaks,

[41] Global Health Law Committee, Fifth Report, Athens Conference 2024, International Law Association.

[42] WHO Member States agree to extend negotiations on key annex to the Pandemic Agreement, WHO News, 28 Mar. 2026.

[43] International work on the One Health approach is being carried out by the so-called Quadripartite (i.e. FAO, UNEP, WHO and WOAH) that has adopted a 2022-2026 Joint Plan of Action as its main operational output. The Quadripartite is supported by a One Health High-Level Expert Panel (OHHLEP) that adopted in 2022 a very influential definition of One Health and a set of underlying principles.

most of the obligations are weak and highly qualified by using expressions such as "take measures as appropriate",[44] "promote and otherwise facilitate and incentivize"[45] or by subjecting obligations to "available resources and applicable law".[46] It remains to be seen whether a treaty which is mostly couched in hortatory terms will have a significant impact, though indeed most treaty implementation takes place voluntarily. The less obligatory language may not make a great practical difference. One of the most extensive discussions surrounded the issue of transfer of technology, and the language that would be used to address the burdens, if any, placed on pharmaceutical industry intellectual property right holders. Ultimately the parties adopted "as mutually agreed" as the guiding principle for technology transfer licensing[47] and defined it in a footnote to the Agreement as "willingly undertaken and on mutually agreed terms, without prejudice to the rights and obligations of the Parties under other international agreement".[48] Through this highly compromised but bitterly fought interpretation, Member States reduced the risk of unilateral coercive measures while at the same time preserving the flexibilities of the WTO TRIPS Agreement.

40. Members of the Committee had identified early on the potential for controversy regarding the package of pathogen access and benefit sharing measures. The current negotiations on a "PABS Annex" to the Pandemic agreement reflect a "north-south divide", with developing countries insisting on access to technology and financing on top of vaccines and other MCM products during pandemics or public health emergencies in exchange for providing access to pathogen materials, including digital data. Developed countries instead prioritize timely and unimpeded access to pathogen samples and genetic sequences and try to limit the obligations of the pharmaceutical industry to providing MCM during pandemics or emergencies rather than committing them to transfer technology or assume burdensome obligations including during inter-pandemic times.

41. It should be evident that rapid access to pathogen materials is fundamental to quickly responding to an outbreak, and that compliance with cumbersome access regulatory requirements is contrary to achieving public health objectives. The Committee encourages WHO members to ensure expeditious access to materials while promoting equity in the sharing of benefits, as this is the better way to effectively protect the global population.

42. The United States withdrew from the WHO in late January 2026 and ceased participating in the Pandemic Agreement negotiations in February 2025.[49] As the up-till-now global center for

[44] See, e.g., Article 5 One Health approach for Pandemic Prevention, Preparedness and Response.
[45] See, e.g,, Article 10 Sustainable and geographically diversified local production, and Article 11 Transfer of technology and cooperation on related know-how for the production of pandemic-related health products
[46] See, e.g., Article 11 Transfer of technology and cooperation on related know-how for the production of pandemic-related health products.
[47] Article 11 Transfer of technology and cooperation on related know-how for the production of pandemic-related health products.
[48] See footnote 12 to Pandemic Agreement, supra note 12..
[49] See The White House, Withdrawing The United States From The World Health Organization, Jan. 20, 2025. WHO, WHO statement on notification of withdrawal of the United States, 24 January 2026.

pharmaceutical R&D, the lack of US participation necessarily will hamper the utility of the Pandemic Agreement.

43. The principal shortfall of the Pandemic Agreement is its lack of focus on financing, albeit it provides mechanisms for addressing financing issues following its entry into force. Objectives such as improving health systems in LMIC's and promoting the construction of local pharmaceutical and vaccine manufacturing facilities can only be accomplished with adequate financial resources. So far this element remains dramatically under-addressed. As high income country governments have increasingly withdrawn or scaled back commitments of financial support, the financing gap may not be filled soon.

44. It may be that only balanced economic development in LMIC's that allows them to address their own public health requirements will fundamentally shift the equation, together with seeking regional or sub-regional cooperative arrangements to pool financial and other necessary resources.

1. Artificial Intelligence

45. A number of committee members share an interest in the evolving role of artificial intelligence in the field of health, especially with respect to its potential to accelerate the development of new pharmaceutical treatments and diagnostic capabilities. Some of the important elements, addressed in greatest detail in the 2020 Kyoto Report, include legal issues surrounding access to the data that is needed to train large language models (LLMs) and to facilitate machine learning. While data-related issues are important to many fields, they take on a particular importance in the field of public health because of the sensitive nature of individual personal data on health conditions, as well as affecting industry interests in protecting the proprietary nature of certain data such as those compiled in the course of clinical studies.

46. Business entities such as Google's DeepMind and its Isomorphic spin off have made truly astounding progress in modeling protein structures and working on programs to model interactions with human physiology. Though the key importance of these developments is scientific and the promise of alleviating human suffering and perhaps prolonging life, on the legal side the developments being made present challenges to existing intellectual property legal frameworks, including that encompassing patents. Although not specifically addressed in the Kyoto Report, but addressed by various Committee members elsewhere, this includes basic questions such as whether AI may be considered an inventor from the standpoint of patent law, and complex questions regarding how the criteria of patentability will adapt to inventions created by thinking machines.[50]

47. At a meta-level an important legal and institutional question is whether intellectual property law applicable to AI will be re-formulated in national legislatures, through case-by-case court decision-making, or by a combination of both. Because of the sensitive issues involved, including security implications, it appears doubtful at this stage that international legal negotiations will chart

[50] See e.g., Research Handbook on Intellectual Property and Artificial Intelligence, ed. Ryan Abbott, Edward Elgar (2022).

the progress of AI-related legal adaptation. Countries are currently locked in a battle for AI supremacy and it seems doubtful that this situation will change in the near to medium term future.

2. Climate Change and Global Health

48. The relationship between climate change and global health has for a long time constituted an element of the Committee's work program. Committee members have taken note of the adoption with very broad support at COP28 in 2023 of the UAE Declaration on Climate and Health. The Declaration acknowledges the fundamental intersection between health and the external environment, and represents one of the first strong "calls to action" linking the two subject matters.

49. The Committee's 2022 Lisbon Report delved most deeply into the relationship between global health norms, and particularly those deriving from international human rights instruments, and environmental norms, suggesting that the right to a healthy environment constitutes a concrete element of human rights promotion and protection. It concluded with reference to European litigation in particular that has relied on international human rights standards to reinforce demands for protection and redress regarding the impact of climate change.

3. The Changing Institutional Landscape

50. During the past decade at least the cohesiveness of the international community has been deteriorating. This can be attributed to various factors, including a rise in populist political sentiment that manifests itself in nationalist ideology, and to increased military-security concerns. Some part of this trend can be attributed to fall-out from the COVID-19 pandemic, including worrying levels of disinformation and misinformation on social media and in political discourse and the equally worrying spread of vaccine skepticism which is directly responsible for the resurgence of deadly preventable diseases such as measles. The pandemic precipitated the closing of borders, contentious decisions regarding allocation of MCM's, accusations regarding the withholding of important information and created economic stress. Without going through the longer history, immediately following the inauguration of President Donald Trump in his current second term, the United States notified the WHO that it would be withdrawing from the organization on one year's notice, would no longer be sending its representatives to attend meetings or participate in activities, and would no longer be paying both its assessed and voluntary contributions.

51. The consequences of the U.S. notice of withdrawal and cessation of contributions were dramatic. Almost immediately WHO announced that it would reorganize itself, focusing more attention on its regional office capacity than headquarters and cutting back staffing.[51]

52. At the same time as it announced withdrawal from WHO the United States practically abolished USAID, folded its remaining programmes into the State Department along with drastic

[51] See, e.g., Elaine Ruth Fletcher, EXCLUSIVE: WHO Chief Names New Team of Directors – Mostly Familiar Faces, Health Policy Watch, 1 July 2025.

cuts to its foreign aid budget.[52] These cutbacks will have a material adverse impact on access to HIV-AIDS medicines and programs benefiting LMICs and other public health programs benefiting those countries and their populations.

53. As important as the US withdrawal and defunding was and is, the United States is not alone. The European Union, at least in part in reaction to Russia's invasion of the Ukraine, has dramatically increased budgetary allocations towards European defense capabilities, and has announced cutbacks to foreign aid programs, including those relating to public health.

54. The reasons the United States has given for withdrawing from WHO are pretextual. The United States has argued that WHO is making decisions that usurp US sovereignty together with previously stated criticism that it mismanaged the COVID-19 pandemic. But it is difficult to point to a circumstance in which that might be the case. The United States has asserted that WHO did not do enough to force China to provide information regarding the outbreak of SARS-CoV-2 more expeditiously. And while it may be true that China could have acted somewhat faster, this was not behavior that was under WHO control and, moreover, United States intelligence agencies had good information concerning what was taking place in China before its government started sharing information with WHO. This is not to suggest that WHO is by any means a perfect international institution. Those closest to it are well able to identify faults. These faults are not the reason for the United States withdrawal which is instead grounded in a distrust or dislike of international institutions in general, and broader decisions to cut back on commitments to those institutions, including the United Nations.

55. The decision by the US to withdraw from the WHO does not mean that there is no longer any budgetary or other influence of actors based in the United States at the organization. The Gates Foundation has been and apparently intends to remain a major source of WHO funding, although it has not indicated an intention to "fill the gap" left by the US government withdrawal. Moreover, a number of the major pharmaceutical industry actors are based in the United States and there is as yet no indication that they intend to cease their interaction with WHO. Finally, several state governments in the United States have approached WHO to collaborate on sharing information regarding pathogen outbreaks.[53]

56. With that said, the United States is among the countries least likely to be adversely affected by its own withdrawal from WHO because it has a well-developed and resourced public health system; and the United States is home to a dynamic research-based pharmaceutical sector (including for vaccines). Since it possesses domestic resources such as the Centers for Disease Control and capacity to monitor and evaluate disease outbreaks, the United States is not so dependent on external contributions to ensure its health security.

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[52] Jennifer Kates, Anna Rouw, and Stephanie Oum, U.S. Foreign Aid Freeze & Dissolution of USAID: Timeline of Events, KFF, Oct 24, 2025.

[53] California, Illinois, and New York, along with New York City, have joined the World Health Organization's (WHO) Global Outbreak Alert and Response Network (GOARN). Kerry Cullinan, WHO Welcomes US States to its Global Disease Outbreaks Network, Health Policy Watch, 12 Feb. 2026.

57. The withdrawal of the United States from WHO and more generally from multilateralism has been accompanied by a process, based on the "America-First Global Health Strategy" announced in September 2025, in which it is negotiating bilateral agreements with various countries, initially in Sub-Saharan Africa but then expanding into Latin America, to inter alia secure information about outbreaks as well as samples and genetic sequences, provide for detailed and prescriptive burden-sharing measures on health system development, and so forth. While there has been recent pushback from some of these countries based on the alleged imbalanced nature of the agreements being proposed by the United States, it remains that the latter will gain access to resources and information by alternative means to the WHO. The European Union, United Kingdom, Switzerland, Japan and other high income countries are in similar situations to the United States. They have been supporting WHO and its efforts to improve conditions in LMICs, and are less in need of reciprocal assistance.

58. It is conventional wisdom that by helping LMIC's improve their public health posture, the high income countries help themselves because LMIC's left without resources might act as the sources of global disease outbreaks. This may well be true, and it may provide a solid foundation on which to base cooperation. But, the possible negative effects on high income countries of cutting back assistance to LMIC's may not be felt immediately. What the current situation does is encourage self-reliance among LMIC's, and perhaps realignment and strengthened bilateral and/or regional ties with countries such as China and India whose political perspectives are different.

III. CONCLUDING CONSIDERATIONS

A. Sustaining and Strengthening Multilateralism

59. In the aftermath of the Second World War the international community of states established a set of multilateral institutions designed to keep the peace, to promote prosperity, and to support human well-being. The establishment of the World Health Organization (WHO) represented a commitment to protecting the health and promoting the well-being of individuals without regard to nationality, ethnicity or gender. The WHO represents the highest aspirations of the international community in the field of health, recognizing that achieving those aspirations may be a long and difficult endeavor.

60. Underlying the mission of the WHO is a recognition that disease does not respect international boundaries. Protecting the health of the population of each member state may best be achieved by protecting the population of all member states so as to minimize the risk of transborder outbreaks and the consequent impact on health, trade as well as the rights and livelihood of persons.

61. Lessons learned from the COVID-19 pandemic include that individual countries, however well-resourced, are not prepared or capable of responding to pandemic outbreaks without

assistance from collaborative science and transborder flows of materials and commodities, as well as from flows of information that enable effective response measures.

62. Acknowledging that WHO's role in responding to the COVID-19 pandemic suffered from limitations, the organization was nevertheless vitally instrumental in alerting the global public to the outbreak, to the changing characteristics of the SARS-CoV-2 virus, and in monitoring the effectiveness of medical countermeasures (MCMs). WHO does not itself provide the personnel, materials and equipment needed to address pandemic outbreaks, but it plays a critical role in supporting Member States in identifying and taking measures to address those outbreaks.

63. With the shortcomings of the global response to the COVID-19 pandemic in view, WHO Member States undertook to address those shortcomings through an international instrument that would establish a framework for improved prevention, preparedness and response to future pandemics. After lengthy and detailed negotiations, WHO member states adopted the Pandemic Agreement that addresses the elements of pandemic prevention, preparedness and response with equity and solidarity as guiding principles and parameters. Similarly, in 2024 States Parties adopted by consensus several amendments to the International Health Regulations (IHR) of 2005. Some of these new provisions refer to the need to cooperate for the identification, and the equitable distribution, of effective MCMs against public health emergencies of international concern. These amendments entered into force for most WHO Member States in September 2025.

64. While establishing a framework and acknowledging the equity and solidarity principles, the Pandemic Agreement and the amendments to the IHR (2005) do not seek to compel member states or their constituencies to act in specific ways. They rely on cooperation. They lay the groundwork for continued dialogue and refinement in areas such as the improvement of national and regional health systems; research and development of new vaccines, treatments and diagnostics; establishing a geographically distributed system for production and distribution of MCMs, and; with the pending completion of the Pathogen Access and Benefit Sharing (PABS) Annex, an agreed framework for sharing pathogen materials and genetic sequences with related provisions for equitable supply of resulting MCM products and other benefits.

B. Human Rights as Core Foundation

65. Given their normative value, human rights standards play an important role in giving expression to the normative foundations of global health law. By recognizing entitlements to health, privacy, physical integrity and other interests of individuals, they give further substance to concepts such as health equity, justice, and health capability. As binding norms, they have the power to generate accountability.

66. The key right in this context is of course the right to health. In general, 'health-related rights' refers to all the human rights that are relevant to health. This includes the right to life, the right to privacy, but also the right to information and education. In principle, all human rights can somehow

be important to health. Human rights are also closely connected to - and to a large extent overlap - with patient rights. While human rights primarily regulate the relation between the state and the individual, patient rights permeate the patient-doctor relationship and offer protection to patients. Furthermore, health-related rights interact with other fields of international law, for example international humanitarian law and international environmental law, when it comes to protection of health on the battlefield and in the context of safeguarding a clean environment, respectively.

67. It is not a new phenomenon that around the world human rights are often ignored and violated. This also goes for health-related rights. In many places people are unable to receive adequate healthcare services. Environmental pollution and climate change impact heavily on the health of individuals and communities. Recent armed conflicts have exacerbated threats to health. The industry plays a problematic role in the sense that part of it produces products that are damaging to our health, such as tobacco and unhealthy food products.

C. Assuring Balanced Role for Intellectual Property

68. Research and development (R&D) on new pharmaceutical and other health products is financed in various ways, including through government subsidies and foundation grants. Private sector pharmaceutical and other health product companies use patents and other forms of intellectual property (IP) to protect or securitize the results of investment in innovation, using exclusive rights to exploit inventions and innovations to allow supra-competitive-market pricing. R&D originator companies invest a portion of the higher-than-market pricing returns to finance future R&D.

69. While recognizing the contribution and value of the research-based pharmaceutical industry, high prices of pharmaceutical products may have the effect of limiting access to medicines by negatively affecting government health procurement, health insurance schemes and personal budgets. For this reason it is necessary that controls be put in place to limit the pricing power of pharmaceutical suppliers. Such controls may take different forms, including direct price controls, reference pricing systems, parallel importation, facilitation of generic market entry, and enforcement of competition law. In addition, governments can and should retain the flexibility to authorize the production of pharmaceutical products without the consent of IP owners in circumstances where such authorization serves the public interest.

D. Encouraging a One Health Approach

70. The COVID-19 pandemic has propelled to the highest level of international policy-making the increasing risk of zoonotic spillover of deadly viral diseases from both wildlife as well as livestock. Environmental degradation and human encroachment into animal habitats are by now widely recognized as leading causes of this problem, while unregulated and unhealthy husbandry practices increase the risk of antimicrobial resistance reaching humans through the food chain. It is clear that this is a multifaceted problem grossly exceeding a purely anthropocentric dimension and requiring an intersectoral approach.

71. The international community has been focusing on “One Health” as a coordination and collaboration approach at the national and international level that includes human, animal and plant health as well as environmental protection. The four international institutions most involved (WHO, FAO, UNEP and WOAH - the World Organization on Animal Health) have scaled up their coordination through the creation of the Quadripartite Alliance and jointly issued a landmark Joint Plan of Action in 2022. However, their respective mandates on this point are inconsistent and there is no intergovernmental decision to create a formal joint programme along the line of the IPCC or the Codex Alimentarius.

72. The Pandemic Agreement has for the first time embodied in a legally binding instrument the One Health approach as an integral component of pandemic prevention and preparedness. This is an important step to elevate the very concept of One Health beyond the current situation. However, on the one hand a holistic One Health approach requires actions going beyond WHO’s mandate, and on the other hand many developing countries have expressed reservations out of concern of financial and economic implications as well as possible obstacles to their agricultural trade.

73. The Committee encourages progress on the development and strengthening of One Health as a holistic approach to balance and reconcile the promotion and protection of human, animal, plant and environmental health thus strengthening upstream prevention of zoonotic diseases and facilitating equitable outcomes for communities and populations most exposed to that problem.

E. Maintaining or Increasing Budgetary Support for Public Health

74. At least in part precipitated by Russia’s unlawful invasion of Ukraine, countries around the world have increasingly perceived a need to increase their military/defense expenditures in preparation for threats or actual military conflict. National budgets are not unlimited, and in the process of substantially increasing budget allocations to defense expenditure, governments look to reduce expenditures elsewhere. Public health budgets are a target for reduced spending. Programs for example designed to improve domestic capacity to develop and manufacture medicines may well suffer as governments seek to bolster spending on military/defense preparation.

75. The Committee acknowledges the importance of the security of states and their inhabitants, and that increased spending on military/defense may be appropriate, but it strongly encourages governments to maintain and even increase levels of financial support for public health programs, recognizing that the ultimate objective of a secure state is to preserve the health and safety of its inhabitants.

F. Reinstating Foreign Aid that Supports Critical Programs

76. One of the most important public health developments arising out of the HIV-AIDS epidemic that spread in sub-Saharan Africa and Asia in the 1990s was the creation in the early 2000s of financing vehicles that were used to support procurement of antiretroviral medicines (ARVs), and treatments and prophylactics for malaria and tuberculosis. This included establishment of the Global Fund to address HIV-AIDS, Malaria and Tuberculosis, as well as the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). PEPFAR has provided more than $120 billion

cumulatively for HIV/AIDS treatment, prevention, and research since its inception, while cumulative worldwide contributions to the Global Fund have exceeded $75 billion, At about the same time as PEPFAR and the Global Fund were created, so too was the GAVI vaccine alliance that receives contributions from public and private sources for procuring and distributing primarily childhood vaccines.

77. The Second Administration of President Trump proposed to dramatically cut funding for each of the programs just described, and at least initially included them within a general freeze of foreign aid funding. As of March 2026, it appears that a portion of the previous funding levels have been restored to some programs, though continued cutbacks are under discussion. In all events, without substitute sources of funding for procurement of treatments and vaccines, significant numbers of lives will be lost.

G. Final Considerations

78. This is the Final Report of the Committee on Global Health Law. Members of the Committee have engaged with diverse and challenging topics during the last 12 years ranging from the core of global health law - in particular the IHR and the Pandemic Agreement - to the role of health in other international legal regimes - for example environmental and intellectual property law - and the challenges raised by new issues such as the rapid development of artificial intelligence.

79. We hope to have contributed with our work to the scholarly, intellectual and practical development of global health law and more generally to a better awareness of the role of health as a normative value in international law. At the same time, the current historical moment projects a mixed picture in terms of achievements and challenges for global health law and governance and is characterized by much uncertainty in terms of prospects for future development.

80. On the one hand, the COVID-19 pandemic has triggered important legal and institutional developments, in particular the adoption of the WHO Pandemic Agreement, the amendment of the IHR and the establishment in 2022 of the "Pandemic Fund". From a broader perspective, the global and regional human rights systems have reacted to disproportionate and discriminatory control measures introduced during the pandemic with a view to clarifying the proper balance between the protection of community values and of personal freedom and dignity. Even beyond pandemic response, the development of biodiversity governance - in particular recent progress on the sharing of digital sequence information and related benefits as well as disclosure requirements for traditional knowledge - may have a positive impact on global health. On the other hand, the institutional and financial crisis triggered by the second Trump administration, the rise of nationalism in many countries and the deep mistrust and entrenched divisions between developed and developing countries that have hampered the Pandemic Agreement negotiations show the limits of multilateralism to address open issues and challenges in global health.

81. Finally, and despite the current feeling of generalized crisis and insecurity in the institutions and values of global health, the Committee wishes to underline the enduring resilience and relevance of those institutions and values. Even though it is undergoing a painful exercise of cost-

cutting and reorientation, WHO remains the undisputed central institution in global health governance and will serve as the main framework of global health security through the IHR and the Pandemic Agreement. Even considering recent retrenchments, the GAVI Alliance and the Global Fund, together with the World Bank as well as the recently established Pandemic Fund, continue to disburse significant resources to strengthen health systems, address urgent health crises and improve preparedness. More generally, health has made important inroads into political agendas that seemed impervious to it until recently; environmental law and governance offer significant examples, such as the above-mentioned work under the Biodiversity Convention and the 2024 Declaration on Climate adopted by the 28th COP of the Framework Convention on Climate Change. The agenda of the UN General Assembly regularly includes items related to public health at almost every session, spanning from HIV-AIDS to non-communicable diseases and anti-microbial resistance. These developments justify a moderate optimism on the evolution of global health law as a field of international law in its own right as well as an approach that promotes the importance of human health as a normative value in international law and global governance.