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Equity, International Cooperation, and Global Public Health: Use of the Common but Differentiated Responsibilities Principle in the Fight against COVID-19

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Equity, International Cooperation, and Global Public Health: Use of the Common but Differentiated Responsibilities Principle in the Fight against COVID-19

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Abstract

During pandemics, in which harm is universal, states find themselves under an obligation to cooperate within a global solidarity framework. However, because they do not have the same set of capabilities, their obligations should be differentiated and based on equity and distributive justice. As an effective tool of States' foreign policy, health diplomacy is being used by developing countries according to different priorities and interests. After a few months of relative calm, COVID-19 still poses a major challenge for African and Middle Eastern economies and societies where the vaccination rates are low across the board with healthcare systems in poor shape. If some Gulf countries can be considered exceptions due to active lockdowns, mobility restrictions, and considerable testing, their engagement abroad to help contain the pandemic, especially in North Africa, shows that, if the spirit of cooperation and justice is well taken care of at the regional level, this is not the case at the international level, where global health cooperation would clearly benefit from the application of a type of differentiated treatment such as the one provided by the Common but Differentiated Responsibilities (CBDR) principle.

Keywords: Health diplomacy, Vaccines, CBDR, Principle, Cooperation

Introduction

Contrary to a global public good[2], a so-called "global public harm[3]" is linked to a damage and not to the consumption of a good. To constitute a global public harm, there must be, first, a non-rivalry in the infringement; the damage to an individual or a particular area does not prevent another person or geographical zone from being affected. Second, a non-exclusion in the infringement: no person can be immune from a damage. Harms are universal.

In a period of pandemics, when a global public good such as public health[4] is threatened by a transborder infectious disease, human survival depends on the capacity of states to shape or restore a common well-being. The interconnectedness of health systems requires a global response and a full cooperation of states. As mentioned by Parmet:

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[2] Global Public Goods are non-rival and non-excludable: one country's enjoyment of a good does not affect its use by others and once produced, no country can be excluded from sharing its benefits. This definition is an extension of the notion of "collective consumption goods" by P. SAMUELSON. See Paul A. SAMUELSON, "The Pure Theory of Public Expenditure", *The Review of Economics and Statistics*, vol. 36, n°4, 1954, pp. 387-389. See also, Inge KAUL, Isabelle GRUNBERG, and Marc STERN (eds.), *Global Public Goods: International Cooperation in the 21st Century*, New York, Oxford University Press, 1999, 546 p.

[3] Inge KAUL, Isabelle GRUNBERG, and Marc STERN, "Defining Global Public Goods", in Inge KAUL, Isabelle GRUNBERG, and Marc STERN (eds.), *Global Public Goods: International Cooperation in the 21st Century*, *op.cit.* pp. 2-19.

[4] Jeremy YOUDE, "Global Public Goods, Cooperation, and Health", in *Biopolitical Surveillance and Public Health in International Politics*, New York, Palgrave Macmillan, 2010, pp. 41-61.

> "(…) infectious epidemics show that the health of an individual depends, to a great degree, on the health of others. (…) Likewise, humanity has long understood that an individual's ability to protect him or herself from disease was limited. An individual's risk of becoming ill depended in uncertain ways on steps that the community took and the environment and conditions in which the individual lived. Indeed, human experience with infectious diseases has long made clear the importance of collective action in preserving and protecting the health populations[5]".

Faced with the threat of global damage, states find themselves under an obligation to cooperate within a "compulsory" or global solidarity framework because "global health is in every nation's interest"[6]. Solidarity demands states' and other international actors' universal and fair participation.

States having different sets of capabilities. Developed and developing countries, however, cannot be considered alike to prevent, reduce, and control a pandemic. In other words, if all states have the same responsibility to prevent damages and participate in international response measures aimed at addressing health problems, their obligations should be differentiated and, for reasons of effectiveness, based on equity and distributive justice.

From previous outbreaks, such as the H1N1 influenza pandemic, or the current COVID-19 crisis, we already know that to put an end to a pandemic, the production of vaccines at scale is not enough. Varied ethical, public health, economic, and other diplomatic considerations are at stake. Fair and equitable access being the bottom line to fight a global infection, the key questions evolve around countries' access to vaccines, distribution schedule, and allocation of quantities.

Global Cooperation: Reality or Fiction?

To avoid "vaccine nationalism, or a 'my country first approach'[7]", international cooperation is needed to accelerate the development and production of pharmaceutical products (COVID tests, treatments, and vaccines) necessary to fight the SARS-CoV-2 infection and ensure their equitable distribution among countries. This is clearly reaffirmed by United Nations General Assembly Resolution 74/274 of April 2020[8], which also underlined the major role that the World Health Organization (WHO) can play in proposing options towards the coordination of international efforts and measures to fight the pandemic. In that regard, Resolution 74/274 advocates:

> "including approaches to rapidly scaling manufacturing and strengthening supply chains that promote and ensure fair, transparent, equitable, efficient and timely access to and distribution of preventive tools, laboratory testing, reagents and supporting materials, essential

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[5] Wendy E. PARMET, *Populations, Public Health, and Law*, Washington D.C., Georgetown University Press, 2008, p. 11.

[6] Lawrence O. GOSTIN, "Global Health Law Governance", *Emory International Law Review*, vol. 22, 2008, p. 39.

[7] Thomas J. BOLLYKY and Chad P. BOWN, "The Tragedy of Vaccine Nationalism. Only Cooperation Can End the Pandemic", *Foreign Affairs*, September/October 2020. Available at: https://www.foreignaffairs.com/articles/united-states/2020-07-27/vaccine-nationalism-pandemic.

[8] United Nations General Assembly, Resolution 74/274*: International Cooperation to Ensure Global Access to Medicines, Vaccines and Medical Equipment to Face COVID-19*, New York, United Nations, 20 April 2020, *A/RES/74/274*, https://undocs.org/fr/A/RES/74/274.

> medical supplies, new diagnostics, drugs and future COVID-19 vaccines, with a view to making them available to all those in need, in particular in developing countries".

Access to Covid-19 Tools (ACT) Accelerator

Covid-19 Tools (ACT) Accelerator, a tool developed by the World Health Organization, the European Commission, and France, is a direct response to this challenge. This global, limited in time, collaboration brings together governments, scientists and academic researchers, pharmaceutical manufacturers, philanthropists, and global health organizations. Led by the WHO, the initiative rests on three pillars: Vaccines, Diagnostics, and Therapeutics, and is supported by a Health Systems Connector (HSC) and a country Allocation and Access workstream[9].

The Vaccines component, known as *COVID-19 Vaccines Global Access Facility* or COVAX, was established by the Coalition for Epidemic Preparedness Innovations (CEPI), Gavi – the Vaccine Alliance, and the WHO. Its purpose is to combat the disease by acting as a platform supporting research, development, and manufacturing of the widest possible range of vaccines.

This pillar also aims at driving down the prices of products between governments by pooling governments' buying power to avoid competition. In regrouping their forces, states can invest in factories and thus share the risks and benefits of research and development processes. Consequently, self-financing countries (those who participate in the mechanism) maximize their chances to develop vaccines faster, increase production capacity, and secure early access to products for all. Additionally, with UNICEF as a key vaccine delivery partner, COVAX aims to ensure their fair distribution.

Within COVAX, the mechanism for allocating doses combines the basic principles of fairness and equity and is devised in two stages[10].

The first stage emphasizes fairness: vaccine doses are allocated proportionally, and participating countries receive them according to a gradual allocation scheme. Countries are first given doses to cover 3% of their population (the priority goes to workers involved in health and social care work) and then additional doses in tranches to cover 20% of their population.

The second one is based on the principle of equity to take into account differences in risk profiles across countries. Depending on countries' needs and global vulnerability, additional volumes can be delivered. In this case, proportional allocation is replaced by weighted allocation. This mechanism is in sync with the values framework for the allocation and prioritization of COVID-19 vaccination established by the WHO Strategic Advisory Group of Experts on Immunization (SAGE) which has delineated six core principles to guide the distribution of vaccine doses: human well-being, equal respect, global equity, national equity, reciprocity, and legitimacy[11].

Special attention is paid to low- and middle-income countries. A separate funding mechanism launched by the Vaccine Alliance, the *Gavi COVAX Advanced Market Commitment (AMC),* is to ensure access to COVID-19 vaccines. Due to their lack resources to

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[9] World Health Organization, *What is the Access to COVID-19 Tools (ACT) Accelerator, how is it structured and how does it work?*. Version of 6 April 2021. Available at: https://www.who.int/publications/m/item/what-is-the-access-to-covid-19-tools-(act)-accelerator-how-is-it-structured-and-how-does-it-work.

[10] World Health Organization, *WHO Concept for Fair Access and Equitable Allocation of COVID-19 Health Products*, September 2020. Available at: https://www.who.int/publications/m/item/fair-allocation-mechanism-for-covid-19-vaccines-through-the-covax-facility.

[11] World Health Organization, *WHO SAGE Values Framework for the Allocation and Prioritization of COVID-19 Vaccination*, September 2020. Available at: https://www.who.int/publications/i/item/who-sage-values-framework-for-the-allocation-and-prioritization-of-covid-19-vaccination.

buy adequate quantities of vaccines, these countries have reduced negotiating capacities with the pharmaceutical industries, and limited possibilities to establish and secure bilateral agreements with manufacturers. Through *COVAX AMC*, fragile states can nevertheless participate in the COVAX Facility as "funded countries" through official development assistance, private sector donations, or philanthropists.

While COVAX illustrates states' commitment to find a common solution to a global problem, its efficiency is being questioned.

A Semblance of Fairness

If the COVID-19 Vaccine Global Access Facility was designed to be fair and equitable, it does not only respond to a pure Rawlsian logic of distributive justice. In its first stage, proportional vaccine allocation is linked to demographical concerns and not to states' health needs or capacity to respond to the pandemic. In particular, the different impacts of COVID-19 on countries are not considered. By treating different emergency situations equally, fairness might not be achieved. Vaccines should be allocated according to the severity of situations and not based on strict equality.

The *Fair Priority Model* developed by researchers in ethics and philosophy and based on moral considerations appears more pragmatic. Their progressive approach comprises three steps: reducing the number of premature deaths, reducing social and economic impairments, and reducing community transmission[12]. Allocation of vaccine doses is calculated for each stage according to the following indicators: the standard expected years of life lost, the poverty gap and gross general income, and the transmission rate.

Morally more acceptable, this solution does not however always accord with states' interest and, to be successful, the COVAX Facility needs the largest possible involvement of participants[13]. The proportional allocation scheme is certainly justified by political reasons. A targeted distribution could discourage high-income countries (HICs) to participate in the COVAX Facility. This in turn would further reduce the chances of less wealthy countries to receive vaccines[14].

Another concession to ensure the participation of wealthier countries also calls into question the fairness of the mechanism. In the original scheme, once validated by health authorities, vaccines were to be distributed in an undifferentiated manner. This principle was bypassed when GAVI created another way for self-financing countries to participate in the COVAX Facility through an *Optional Purchase Agreement*. The participants can now choose to opt out from receiving a particular vaccine without endangering their ability to receive other products. This amounts to set up a differentiated treatment based on a double standards approach. Developed countries have the luxury of choosing their vaccines since they have the financial capacity "to pay a higher proportion of the total cost per dose upfront, making a down payment of US$ 3.10 per dose and a risk-sharing guarantee of US$ 0.40 per dose[15]". In other words, they can afford the vaccines with the highest rates of protection at the expense of the lowest income countries.

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[12] Ezekiel J. EMANUEL, Govind PERSAD, Adam KERN et al., "An Ethical Framework for Global Vaccine Allocation", *Science*, vol. 369, Issue 6509, September 2020, pp. 1309-1312.

[13] David MCADAMS, Kaci K. MCDADE, Osondu OGBUOJI et al., "Incentivising Wealthy Nations to participate in the COVID-19 Vaccine Global Access Facility (COVAX0: A Game Theory Perspective", *BMJ Global Health*, vol. 5, Issue 11, 2020. http://dx.doi.org/10.1136/bmjgh-2020-003627.

[14] For a comparison between schemes of allocation, see Siddhanth SHARMA, Nisrin KAWA, and Apoorva GOMBER, "WHO's Allocation Framework for COVAX: is it fair?", *J Med Ethics Epub*, vol. 0, 2021, pp.1-5. DOI: 10.1136/medethics-2020-107152.

[15] Seth BERKLEY, *COVAX Explained*, GAVI, 3 September 2020, https://www.gavi.org/vaccineswork/covax-explained.

A Persistence of Individualistic Behaviors

Despite the allocation scheme, COVAX faces competition from wealthier countries for securing preferential and priority access to vaccines. Many HICs have concluded bilateral agreements in advance to purchase directly abundant quantities of vaccines from manufacturers. This, inevitably, reduced the number of available doses for the COVAX mechanism.

By August 2020, according to the Duke University Launch and Scale Speedometer, the United States had already entered seven bilateral deals for more than 800 million doses, enough to vaccinate 138.6% of its population and the United Kingdom had concluded five bilateral deals to procure 270 million doses, sufficient to vaccinate 224.4% of its population. By June 2021, the USA secured 1.21 billion doses equivalent to 199.5% of its population and the UK secured 517 million doses for 409.2% of its population[16].

While participating in the COVAX Facility, other states increased their chances of obtaining vaccines by clinching deals with pharmaceutical industries. For instance, European Union Member States, which are part of the COVAX Facility, benefited from the advance purchase agreement negotiated by the European Commission and by the Inclusive Vaccine Alliance (IVA) gathering France, Germany, Italy, and the Netherlands. By June 2021, the European Union secured 2.79 billion doses through deals made with six companies which have the capacity to vaccinate 333.5% of its population[17]. This regional cooperation weakens international solidarity and can only reinforce criticisms against the European Union for its handling of the pandemic crisis[18].

Beyond the threat to global solidarity, such behaviors appear counterproductive in contributing to the worsening of the pandemic. The only way to roll out this global health crisis is to halt virus transmission by achieving herd immunity. This can only be accomplished by leaving no one behind through global access to vaccines at the same time.

Such behaviors illustrate wealthier states' skepticism about the reliability of the COVAX Facility for the deployment of vaccines. By satisfying their own national needs and protecting their own citizens, the mechanism has become a residual assistance tool to less developed countries. The various pledges of money and surplus doses by G7 countries at the Cornwall summit in June 2021 are an almost perfect but sad illustration of a shifting approach.

An Inoperative Distribution

Practical issues prevent a fair distribution of vaccines, especially in poor countries. The lack of health infrastructures and logistical means for the safe storage of products, such as cold-chain infrastructure, prevent them to attain herd immunity any time soon. Several African States have not been able to administer the vaccines received (The Democratic Republic of Congo, South Africa) and some have even been forced to destroy (Malawi, South Sudan) or return them before the expiry date[19].

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[16] Duke Global Health Innovation Center. Launch and Scale Speedometer, 2021, Duke University. Available at: https://launchandscalefaster.org/covid-19/vaccineprocurement.

[17] *Ibid.*

[18] Goran ILIK and Vesna SHAPKOSKI, "Coherence on Trial: The Coronavirus Outbreak as a Critical Test for the European Union", *Studia Europejskie – Studies in European Affairs*, vol. 24, n°4, 2020, pp. 25-43. DOI: https://doi.org/10.33067/SE.4.2020.2.

[19] Peter MWAI, "COVID-19 Vaccines: Why Some African States Can't use Their Vaccines?", *BBC Reality Check*, 8 June 2021. Available at: https://www.bbc.com/news/56940657.

As vaccine doses are a limited resource, it is necessary to prioritize countries according to their capacities or readiness to use vaccines to avoid any waste of products and maximize the chances of obtaining results in other countries. However, this approach goes against the principle of global equity on which the COVAX Facility rests. To avert any more discrimination, the WHO should upgrade its assistance to the poorest countries in the implementation of vaccine infrastructures[20].

While the COVAX Facility is already seen by the richest countries as a mechanism of assistance to developing countries, its inability to fulfill its objectives vis-à-vis the low- and middle-income countries reduces its usefulness even further. It appears from the above that the COVAX Facility suffers from uncertainties that hamper its effectiveness. It also reflects a "failure of moral imagination[21]" in the global health governance. The target of distributing 2.3 billion doses of vaccines to protect high-risk populations around the world by early 2022 sounds like wishful thinking and seems out of reach under current conditions.

Expansion of Health Diplomacy: An Interested Assistance

As accurately described by David P. Fidler, health diplomacy refers to the ability to respond to health concerns and to the capability of states to use medical levers to serve national interests, while extending their geopolitical influence[22], as an instrument of soft power[23]. The latter approach was notably developed in the 1970s by Peter Bourne, Special Assistant to the President for Health Issues during the Carter administration, when he urged the United States to give greater consideration to medicine and health in international relations. He stated that:

> "Certain humanitarian issues, especially health, can be the basis for establishing a dialog and bridging diplomatic barriers because they transcend traditional and more volatile and emotional concerns. Medical diplomacy can be the vehicle by which channels of communication can be established between nations when international relations are strained or severed. (…) Medical diplomacy can take many forms and, since this represents a relatively little used area in United States diplomacy, alternatives need to be carefully evaluated[24]".

This concept has since matured to become an effective tool of state foreign policy. If, in the past, it had been the privilege of only the most advanced countries, developing countries saw the COVID-19 crisis as an opportunity to use health diplomacy to play a more active role in the international arena, among them China, India, and Russia with—obviously—different priorities and interests.

China

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[20] Marc ECCLESTON-TURNER and Harry UPTON, "International Collaboration to Ensure Equitable Access to Vaccines for COVID-19: The ACT-Accelerator and the COVAX Facility", *The Milbank Quarterly*, vol. 0, n 0, 2021, pp. 1-24. DOI: 10.1111/1468-0009.12503.

[21] Laurence O. GOSTIN and R. ARCHER, "The Duty of States to Assist Other States in Need: Ethics, Human Rights, and International Law", *Journal of Law, Medicine & Ethics*, vol. 35, 2007, p. 531.

[22] David P. FIDLER, "Health Diplomacy", in Andrew F. COOPER, Jorge HEINE and Ramesh THAKUR (eds.), *The Oxford Handbook of Modern Diplomacy*, Oxford University Press, 2013, pp. 691-707.

[23] Joseph S. NYE JR., "Hard, Soft, and Smart Power", in Andrew F. COOPER, Jorge HEINE and Ramesh THAKUR (eds.), *The Oxford Handbook of Modern Diplomacy*, Oxford University Press, 2013, pp. 559-574.

[24] Peter G. BOURNE, "A Partnership for International Health Care", *Public Health Reports*, vol.93, n°2, March-April 1978, p. 121.

President Xi Jinping announced in 2013 an important shift in his foreign policy with the *Silk Road Economic Belt* and the *21st Century Maritime Silk Road*, collectively referred to as the *Belt and Road Initiative (BRI)*. The BRI is considered as an ambitious international investment program dedicated to strengthening China's connectivity by building ports, rails, and land infrastructures to link Asia, Europe, and Africa. This investment strategy has been extended to other sectors, such as science and technology, energy, culture, tourism, and health.

One of the objectives of the BRI is to enhance "people to people band". To that effect, China's proposal is to:

> "…strengthen cooperation (…) on epidemic information sharing, the exchange of prevention and treatment technologies and the training of medical professionals and improve (…) capability to jointly address public health emergencies. [China] will provide medical assistance and emergency medical aid to relevant countries and carry out practical cooperation in maternal and child health, disability rehabilitation, and major infectious diseases including AIDS, tuberculosis and malaria. [China] will also expand cooperation on traditional medicine[25]".

This strategy was further developed by different health-themed forums[26] and through a Memorandum of Understanding with the WHO setting up a joint *Health Silk Road* (HSR) in 2007[27]. Due to the Coronavirus pandemic and related economic difficulties, Beijing has since modified the BRI priorities. The *Health Silk Road*, now the spearhead of its foreign policy, has shifted "from a venue for sharing medical knowledge to a route for aid delivery[28]".

At the start of the crisis, China was criticized for not promptly reporting infections, contributing to the spread of the disease. After regaining control of the sanitary situation on its territory, Beijing sought to improve its reputation as a decisive actor in the fight against the virus and not, or no longer, as the source of the disease.

Due to the lack of health governance by world actors such as the United States and the European Union, China tried to present itself as a responsible and committed leader, concerned about the common well-being and wishing to promote international cooperation[29].

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[25] National Development and Reform Commission, Ministry of Foreign Affairs and Ministry of Commerce, *Vision and Actions on Jointly Building Silk Road Economic Belt and 21st Century Maritime Silk Road*, 28 March 2015. Document available at: https://www.fmprc.gov.cn/mfa_eng/zxxx_662805/t1249618.shtml.

[26] For example, the China-Central and Eastern European Countries Health Ministers Forum (2015), the China-Arab States Health Cooperation Forum (2015), the China-ASEAN Health Cooperation Forum (2016), and the Belt and Road High-Level Meeting for Health Cooperation: Towards a Health Silk Road (2017).

[27] An BAIJIE, "WHO, China Sign Pact Establishing 'Health Silk Road'", *China Daily*, 19 January 2017. Available at: https://www.chinadaily.com.cn/business/2017wef/2017-01/19/content_27993857.htm. See also, WHO, News Release, *New Vision and Strengthened Partnership for WHO and China*, 21 August 2017 https://www.who.int/news/item/21-08-2017-new-vision-and-strengthened-partnership-for-who-and-china.

[28] Cao JIAHAN, "Toward a Health Silk Road. China's Proposal for Global Health Cooperation", *China Quarterly of International Strategic Studies*, vol. 6, n°1, p. 25.

[29] Anna KOBIERECKA and Michal M. KOBIERECHI, "Coronavirus diplomacy: Chinese Medical Assistance and its Diplomatic Implications", *International Politics*, 2021, https://doi.org/10.1057/s41311-020-00273-1.

Commentators even suggested that Chinese health diplomacy during the pandemic was a way to ascertain the hegemon status[30] of the country and to reshape global order[31].

In that spirit, and having quickly succeeded in controlling the spread of the Coronavirus, Beijing showed a great interest in offering other countries advice and assistance. As Italy was in a critical situation, the Chinese President called its Prime Minister in March 2020 to assure him of his support, further indicating that "in the spirit of solidarity, China will send additional medical teams and experts to Italy and provide medical supplies and other assistance to the best of its ability[32]". President Xi Jinping also affirmed that China was "ready to work with Italy to contribute to international cooperation on epidemic control and to build the 'Health Silk Road'[33]".

With the spread of the virus, China has been able to play a major role as one of the largest suppliers of medical equipment since 44% of the world's exports of face masks originate from China in 2018[34].

From providing aid and assistance to other countries (*mask diplomacy*) China is now focusing on vaccines delivery (*vaccine diplomacy*)[35].

Mask diplomacy is the strategy led by China to deliver large quantities of medical equipment (testing kits, ventilators, masks, personal protective equipment (PPE), and other medical resources. Aiming to cultivate friendships and to "win hearts and minds[36]", Beijing acted like a benevolent actor and provided aid and assistance everywhere (Asia, Africa, Europe, Latin-American Countries), especially to developing countries: millions of facemasks and test kits were sent worldwide. China also sent medical teams and experts to support local initiatives to combat the virus. China thus emerged as a "high-profile humanitarian aid provider[37]" and did not hesitate to stage its donations for political communication purposes and to relay governments' testimonies of gratitude[38]. While appealing publicly to multilateral cooperation, this strategy was pursued throughout the whole vaccine research and development phase.

As to vaccine diplomacy, the starting point was the announcement by President Xi Jinping on May 18, 2020, in a speech to the WHO, of a call to recognize the future vaccine as

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[30] Priya GAUTTAM, Bawa SINGH, and Jaspal KAUR, "COVID-19 and Chinese Global Health Diplomacy: Geopolitical Opportunity for China's Hegemony?", *Millennial Asia*, vol. 11, Issue 3, 2020, pp. 318-340.

[31] Kurt M. CAMPBELL and Rush DOSHI, "The Coronavirus Could Reshape Global Order", *Foreign Affairs*, Mach 2020. Available at: https://www.foreignaffairs.com/articles/china/2020-03-18/coronavirus-could-reshape-global-order.

[32] Ministry of Foreign Affairs of the People's Republic of China, News Release, *President Xi Jinping Talked with Italian Prime Minister Giuseppe Conte over the Phone*, 16 March 2020. Available at: https://www.fmprc.gov.cn/mfa_eng/zxxx_662805/t1756887.shtml.

[33] *Ibid.*

[34] Andreas FUCHS et al., "Mask Wars: China's Exports of Medical Goods in Times of COVID-19", cege Discussion Papers n° 398, University of Göttingen, Center for European, Governance and Economic Development Research (cege), Göttingen. Document available at: http://wwwuser.gwdg.de/~cege/Diskussionspapiere/DP398.pdf.

[35] Mercator Institute for China Studies, "China's Vaccine Diplomacy. Partnering for Trials in at least 16 countries worldwide", 8 October 2020. Available at: https://merics.org/en/short-analysis/chinas-vaccine-diplomacy-partnering-trials-least-16-countries-worldwide.

[36] Nicholas R. SMITH and Tracey FALLON, "An Epochal Moment? The COVIS-19 Pandemic and China's International Order Building, *World Affairs*, vol. 183, n°3, pp. 235-255. DOI: 10.1177/0043820020945395.

[37] Priya GAUTTAM, Bawa SINGH, and Jaspal KAUR, "COVID-19 and Chinese Global Health Diplomacy: Geopolitical Opportunity for China's Hegemony?", *op.cit.*, p. 325.

[38] Bartosz KOWALSKI, "China's Mask Diplomacy in Europe: Seeking Foreign Gratitude and Domestic Stability", *Journal of Current Chinese Affairs*, 2021, pp. 1-18. Document available at: https://doi.org/10.1177/18681026211007147.

a "global public good" to ensure its "accessibility and affordability in developing countries[39]". The call strongly contrasted with the letter sent the same day by President Trump to the WHO threatening to permanently freeze its funding and to reconsider U.S membership. In pursuance of the HSR discourse on the need to work for international cooperation, China also joined the COVAX Facility.

After China's health authorities authorized several homegrown COVID-19 vaccines for general use, the United Arab Emirates was the first country to approve in 2020 the Chinese's vaccine *Sinopharm*. Bahrain, Egypt, and Morocco quickly followed suit, increasing Chinese influence in the Middle East and North Africa (MENA) region[40].

When two Chinese vaccines (*Sinopharm* and *Sinovac*) were added to the WHO's *Emergency Use Listing* (meaning that they passed quality, safety, and efficacy requirements and are following manufacturing and quality management standards), allowing their distribution in the COVAX Facility and increasing overall access to products, it was considered as a welcome recognition of the effectiveness of Chinese vaccines, long criticized for their lack of transparency on scientific data.

China continues to make every effort to carry out its strategy to ensure its leadership position in the fight against the virus. By June 2021, "China has provided more than 350 million doses of vaccines to the international community, including vaccine assistance to over 80 countries and vaccine exports to more than 40 countries[41]" with a total of 25 million doses donated[42]. China has also committed 10 million doses of COVID-19 vaccines to the COVAX Facility and has announced a donation of 200,000 doses of vaccines and USD 1 million to the United Nations Relief and Works Agency for Palestine Refugee in the Near East to help the Palestinians[43].

Chinese vaccine diplomacy is not limited to the supply of vaccines. Transfer of technologies and establishment of partnerships are also doing their part. The United Arab Emirates is on its way to manufacture and distribute the *Sinopharm* vaccine[44], and Morocco plans to do the same to make it accessible to the African continent[45].

India

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[39] Sarah WHETON, "Chinese Vaccine Would Be 'Global Public Good', Xi says", *Politico*, 18 Mai 2020. Available at: https://www.politico.eu/article/chinese-vaccine-would-be-global-public-good-xi-says/.

[40] Tin Hinane EL KADI and Sophie ZINSER, "Beijing's vaccine diplomacy goes beyond political rivalry", Chatham House, 22 February 2021. Available at: https://www.chathamhouse.org/2021/02/beijings-vaccine-diplomacy-goes-beyond-political-rivalry.

[41] Ministry of Foreign Affairs of the People's Republic of China, *Foreign Ministry Spokesperson Wang Wenbin's Regular Press Conference on June 2*, 2021. Available at: https://www.fmprc.gov.cn/mfa_eng/xwfw_665399/s2510_665401/2511_665403/t1880861.shtml.

[42] BRIDGE, China COVID-19 Vaccine Tracker, June 2021. Available at: https://bridgebeijing.com/our-publications/our-publications-1/china-covid-19-vaccines-tracker/.

[43] *Ibid.*

[44] Shireena AL NOWAIS, "UAE secures deal to manufacture Sinopharm vaccine ahead of major inoculation push", *The National*, 5 January 2021. Available at: https://www.thenationalnews.com/uae/health/uae-secures-deal-to-manufacture-sinopharm-vaccine-ahead-of-major-inoculation-push-1.1140999.

[45] Kingdom of Morocco, Ministry of Foreign Affairs African Cooperation and Moroccan Expatriates, News Release, *Mr. Nasser Bourita: The Cooperation Agreements Between Rabat and Beijing on the Clinical Trials of the Vaccine Against COVID-19 Consolidate and Strengthen the Dynamic of Cooperation Between the Two Countries*, 20 August 2020. Available at: https://www.diplomatie.ma/en/mr-nasser-bourita-cooperation-agreements-between-rabat-beijing-clinical-trials-vaccine-against-covid-19-%E2%80%9Cconsolidate-and-strengthen%E2%80%9D-dynamic-cooperation-between-two-countries.

With the adoption of the *Patent Act*[46] in 1970, India has become one of the most important generic pharmaceutical industries[47], supplying affordable medicines to a large number of countries. From the beginning of the COVID-19 outbreak, the country decided to participate in the global effort to guarantee access to vaccines to all in developing vaccine diplomacy. Known as being the "pharmacy of the world[48]", India has the material capacity to produce at low cost "over 3 billion coronavirus disease 2019 (COVID-19) vaccine doses annually[49]".

The *Vaccine Maitri* policy or the *Vaccine Friendship* policy is the public diplomacy initiative of the Indian government to provide vaccines to many countries. To that effect, Indian manufacturers signed exclusive license agreements with foreign factories to produce considerable quantities of COVID-19 vaccines. For example, in June 2020, the *Serum Institute of India*, the world's largest vaccine manufacturer, reached a licensing agreement with *AstraZeneca* to supply one billion doses of the Oxford's University vaccine for low- and middle-income countries.

India has also worked to consolidate its role of provider of humanitarian assistance and disaster relief as mentioned by Prime Minister Narendra Modi:

> "We have always prided ourselves as the first responder in our region – a friend in need. Be it earthquakes, cyclones, or any other natural or human-made crisis, India has responded with speed and solidarity. In our joint fight against COVID, we have extended medical and other assistance to over 150 countries. We also helped create a SAARC [South Asian Association for Regional Cooperation] COVID emergency fund in our neighborhood[50]".

If the Indian government is committed to providing vaccine doses to developing countries, it also favors regional diplomacy[51] distribution. In conformity with its *Neighborhood First* foreign policy, priority is given to South Asian neighbors. To ensure political stability, which is a fundamental condition for the development of the region,[52] and strengthen India's relations with its geographical environment, the government exports vaccines free of cost to Bhutan, Maldives, Bangladesh, Nepal, Myanmar, Mauritius, Seychelles, Sri Lanka, and Afghanistan.

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[46] The Patents Act 1970 (No. 39 of 1970), *Gazette of India*, 1970-09-21, Part II, Sec. 1.

[47] Biswajit DHAR and Reji K. JOSEPH, "The Challenges, Opportunities and Performance of the Indian Pharmaceutical Industry Post-TRIPS', in Kung-Chung LIU and Uday S. RACHERLA (eds.), *Innovation, Economic Development, and Intellectual Property in India and China*, ARCIALA Series on Intellectual Assets and Law in Asia, Singapore, Springer, 2019, pp. 299-323.

[48] Biswajit DHAR, "India's Vaccine Diplomacy", *Global Policy*, April 2021. Available at: https://www.globalpolicyjournal.com/blog/08/04/2021/indias-vaccine-diplomacy.

[49] Khan SHARUN and Kuldeep DHAMA, "India's Role in COVID-19 Vaccine Diplomacy", *Journal of Travel Medicine*, 2021, taab064, https://doi.org/10.1093/jtm/taab064.

[50] Government of India, Ministry of Foreign Affairs, Media Center, *PM's Address in ECOSOC Commemoration of UN's 75th Anniversary*, 17 July 2020. Available at: https://mea.gov.in/Speeches-Statements.htm?dtl/32838/PMs_Address_in_ECOSOC_commemoration_of_UNs_75th_Anniversary.

[51] Smurti S. PATTANAIK, "COVID-19 Pandemic and India's Regional Diplomacy", *South Asian Survey*, vol. 28, Issue 1, 2021, pp. 92-110. DOI: 10.1177/0971523121999293.

[52] Government of India, Ministry of Foreign affairs, Media Center, *Question n°3692 Neighbourhood First Policy*, 25 July 2019. Available at: https://mea.gov.in/rajya-sabha.htm?dtl/31673/QUESTION+NO3692+NEIGHBOURHOOD+FIRST+POLICY.

Health diplomacy is also useful to push back Chinese claims to regional dominance and thwart the *Belt and Road Initiative*[53] by securing the loyalty of close neighbors.

Those plans have since been reviewed following the deterioration of the sanitary situation in the country. India seems to have toned down, at least for now, its regional and global policy. It does not mean that the country's ambitions and reach out policy cannot return once the epidemics will be controlled nationally.

Russia

Russia has adopted a different "inner" approach in using health diplomacy to serve its own political and economic interests, in particular to call off Western sanctions though its appeals to international solidarity and cooperation. In a letter to the UN Secretary-General Antonio Guterres, eight countries[54], among them Russia, requested in March 2020 the lifting of unilateral sanctions imposed on them to fight the pandemic. They argued that such restrictions were hindering their ability to effectively combat the disease and had a disastrous impact on the economic and humanitarian situation[55].

Secretary-General Guterres obliged in the following terms:

> "sanctions imposed on countries should be waived to ensure access to food, essential supplies and access to COVID-19 tests and medical support. This is time for solidarity not exclusion[56]".

Without evoking the sanctions, the UN General Assembly Resolution 74/270 *Global solidarity to fight the coronavirus disease 2019 (COVID-19) pandemic*[57] only renewed its commitment "to help people and societies in special situations, especially the weakest and most vulnerable".

Russia threw itself headlong in the vaccine race to regain its reputation as a competitive leader in scientific research. Its efforts paid off when national authorities, the first in their class, approved, on 11 August 2020, a COVID-19 vaccine. Called *Sputnik* in reference to the first-ever artificial Earth satellite launched by the Soviet Union on 4 October 1957, Russia yearned to reiterate the exploit.

In the eyes of the international community, despite the fact that the vaccine was developed by the Gamaleya National Centre of Epidemiology and Microbiology, one of Russia's most renewed scientific institutes, the announcement was clearly premature. Third phase trials had not been carried out and the scientific community and foreign governments pinpointed the lack of data transparency. The *Russian Direct Investment Fund* (RDIF) had to launch a major media campaign to convince the international community of the effectiveness of the vaccine.

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[53] See Saroj Kumar ARYAL, "India's 'Neighbourhood First' Policy and the Belt & Road Initiative (BRI)", *Asian Journal of Comparative Politics*, May 2021. DOI: 10.1177/20578911211014282.

[54] Russia, China, Venezuela, Iran, Nicaragua, Cuba, North Korea, Syria.

[55] Ministry of Foreign Affairs of the Russian Federation, News Release, *Comment by the Information and Press Department on UN Secretary-General Antonio Guterres' Appeal to Revise Unilateral Sanctions*, 15 September 2020. Available at: https://www.mid.ru/en/foreign_policy/news/-/asset_publisher/cKNonkJE02Bw/content/id/4339840.

[56] United Nations, Shared responsibility, Global solidarity. Responding to socio-economic impacts of COVID-19, March 2020, p.15. Available at: https://www.un.org/sites/un2.un.org/files/sg_report_socio-economic_impact_of_covid19.pdf.

[57] United Nations General Assembly, Resolution 74/270, *Global solidarity to fight the coronavirus disease 2019 (COVIS-19) pandemic*, 2 April 2020, *A/74/L.52*, New York, United Nations, https://www.un.org/pga/74/wp-content/uploads/sites/99/2020/03/A-74-L.52.pdf.

In reaction, Russia preferred to address the European Union shortcomings towards its neighbors by distributing vaccine doses to Eastern Europe and the Balkans. It further stressed the great effectiveness of the national vaccine in comparison to those of the West, the "best in the world" according to President Putin. The RDIF relayed this information in advertising its 97.8% efficacy against COVID cases and 100% efficacy against severe cases of COVID in UAE[58] as well as its high 94.3% efficacy and high safety profile during the vaccination campaign in Bahrain[59]. For Krill Dimitriev, CEO of the RDIF:

> "Sputnik V complies with the highest healthcare standards while demonstrating safety and efficacy during the vaccination in UAE. Sputnik is one of the best COVID vaccines in the world as confirmed by data from Argentina, Serbia, San-Marino, Bahrain, Hungary, Mexico, and other countries. Administering the Russian vaccine helps create durable immunity among the population and provides for lifting the restrictions and returning to normal life".

Since then, Russia has been helping developing countries to obtain vaccine doses, especially in Latin America and Africa. *Sputnik V* is now approved by 67 States.

The Kremlin also favored the foreign production of the vaccine in Argentina, China, India, the Republic of Korea, and Belarus among several other countries. Pending the approval of the vaccine for distribution in Europe by the *European Medicines Agency*, deals have already been concluded with the RDIF to launch the production of *Sputnik V*. The Swiss pharmaceutical company Adienne Pharma & Biotech SA became the first Europe-based manufacturer to sign such agreements followed by companies from Spain, Italy, France, and Germany. Two EU Member States nevertheless stood out. Hungary and Slovakia have already granted emergency approval and began inoculation of the vaccine.

A peer-reviewed analysis in the prestigious medical journal *The Lancet* and confirming the safety and efficacity[60] of the *Sputnik V* vaccine has been largely used by the RDIF as a tool of communication. The marketing campaign appears to be working since more than 40 states have authorized the vaccine since the publication. According to commentators, however, the importance given to such reports cannot replace official regulatory authorities' analysis[61].

Cooperation to Rethink: The Principle of Common but Differentiated Responsibilities Against the Pandemics

International cooperation through the COVAX mechanism, or exercised by states' health diplomacy, is not up to expectations. It is more urgent than ever to find ways to revitalize

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[58] Sputnik V, Press Releases, *Sputnik V has demonstrated 97.8 % efficacy against COVID cases and 100 % efficacy against severe cases of COVID in UAE*, 29 June 2021. Available at: https://sputnikvaccine.com/newsroom/pressreleases/sputnik-v-has-demonstrated-97-8-efficacy-against-covid-cases-and-100-efficacy-against-severe-cases-o/.

[59] Sputnik V, Press Releases, *Sputnik V demonstrates high 94.3 % efficacy and safety profile during the vaccination campaign in Bahrain*, 10 June 2021. Available at: https://sputnikvaccine.com/newsroom/pressreleases/sputnik-v-demonstrates-high-94-3-efficacy-and-high-safety-profile-during-the-vaccination-campaign-in/.

[60] Ian JONES and Polly ROY, "Sputnik V COVID-19 Vaccine Candidate Appears Safe and Effective", *The Lancet*, vol. 397, Issue 10275, February 2021, pp. 642-643. DOI: https://doi.org/10.1016/S0140-6736(21)00191-4.

[61] Christoffer VAN TULLEKEN, "COVID Vaccines: the danger of journals being seen as substitute regulators", *The Conversation*, 20 May 2021. Available at: https://theconversation.com/covid-vaccines-the-danger-of-journals-being-seen-as-substitute-regulators-160575.

collaboration efforts towards greater efficiency. The central question remains whether states have a duty to show real solidarity in times of crisis, especially when public health is at stake.

In the United Nations Millennium Declaration[62], and in addition to their separate responsibilities to individual societies, it is expressly recognized that heads of states and governments "have a collective responsibility to uphold the principles of human dignity, equality and equity at the global level" and "have a duty therefore to all the world's people, especially the most vulnerable". It is further affirmed that:

> "Global challenges must be managed in a way that distributes the costs and burdens fairly in accordance with the principles of equity and social justice. Those who suffer or who benefit least deserve help from those who benefit most".

If the UN Declaration enunciates states' commitment to cooperate, it is devoid of obligation. It is more a moral or political duty rather than a legal one. No wonder the same also applies in matters of public health. The WTO Doha Declaration on the TRIPS Agreement and Public health[63] states that:

> "(…) while reiterating our commitment to the TRIPS Agreement, we affirm that the agreement can or should be interpreted and implemented in a manner supportive of WTO members' right to protect public health and in particular, to promote access to medicines for all.
> In this connection, we reaffirm the right of WTO members to use, to the full, the provisions in the TRIPS Agreement, which provide flexibility for this purpose".

While flexibility is accorded to the most vulnerable countries, which evidently do not have sufficient resources to protect public health, it is only granted in a hortatory manner.

If we assume that international cooperation should move beyond intentions, human rights law may provide in our view an adequate framework for increased if not mandatory international cooperation. The well-known "right to life" contains the necessary ideological and legal grounds which may allow such recognition. In its *General Comments*, the UN Human Rights Committee even provides an extensive interpretation of this right in considering it as a "supreme right from which no derogation is permitted[64]", a right "basic to all human rights[65]". Neither the Human Rights Committee, nor the law applicable to human rights explain however how this cooperation should be exercised. It is therefore essential to continue seeking legal tools that will permit effective implementation.

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[62] United Nations, General Assembly Resolution 55/2, *United Nations Millennium Declaration*, 8 September 2000. Available at: https://www.ohchr.org/EN/ProfessionalInterest/Pages/Millennium.aspx.

[63] World Trade Organization, *Ministerial Declaration on the TRIPS Agreement and Public Health*, 14 November 2001, *WT/MIN(01)/DEC/2*. Available at: https://www.wto.org/english/thewto_e/minist_e/min01_e/mindecl_trips_e.htm.

[64] UN Human Rights Committee (HRC), *General Comment n°6: Article 6 (Right to Life),* Adopted at the Sixteenth session, 30 April 1982, "Compilation of General Comments and General Recommendations adopted by Human Rights Treaty and Bodies", *UN. Doc. HRI/GEN/1/Rev.1(1994)*, p.6. Available at: https://undocs.org/en/HRI/GEN/1/Rev.1.

[65] UN Human Rights Committee (HRC), *CCPR General Comments n°14: Article 6 (Right to Life) Nuclear Weapons and the Right to life*, Adopted at the Twenty-third session, 9 November 1984. Available at: https://www.refworld.org/docid/453883f911.html.

For achieving international cooperation goals, states must not be treated unjustly, and their own situation should be fully recognized. According to international law, differentiated treatment grants the necessary equity. In the past, such a concept was used to rebalance economic relations between states. The first United Nations Conference on Trade and Development (UNCTAD) established a system of general preferences applicable to all developing countries without reciprocity, which was then reproduced in the General Agreement on Tariffs and Trade (GATT). By their decision of 25 June 1971 setting up a "Generalized System of Preferences[66]", the Contracting Parties granted a waiver from Article I of GATT (the most-favored-nation clause). During the Tokyo Round, the Contracting Parties gave a permanent legal basis to the preferential treatment of developing countries under the Generalized System of Preferences by Decision L-4903 of 28 November 1979 on the "Differential and more favorable treatment, reciprocity, and fuller participation of developing countries", otherwise known as the *Enabling clause*. This provision makes the preferential treatment lawful and authorizes double standards[67].

Since then, differentiation has been endorsed in environmental law, where it constitutes the cornerstone of the climate regime. Formalized for the first time by the United Nations Declaration on Environment and Development adopted at the Rio Conference in 1992, the principle of Common but Differentiated Responsibilities (CBDR)[68] has since been included in the United Nations Framework Convention on Climate Change, the Kyoto Protocol of 1997, the Paris Agreement of 2015, and other environmental treaties.

Because the protection of the environment is of common concern and a global public good, this principle organizes the cooperation of all States in the fight against climate change through common but differentiated (because they respond to a justice imperative) responsibilities.

As responsibilities refer to different national contexts and heterogenous economic situations in the context of climate change, states must be treated in a differentiated manner under the principle of equity[69]. It follows that states have differentiated obligations. Although responsibilities are only moral in nature, differentiation in obligations is proportional to the role of States in the environmental degradation and to their financial capacity to fight against all adverse effects of climate change. This is precisely where the notion of equity comes into play.

As a global public good, public health meets the same requirements. State participation must be universal. If a country disassociates itself from the efforts of the international community, or if it practices a *free rider* policy and hopes to benefit from the efforts of others without providing any, then the results would be detrimental to all.

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[66] GATT, 25 June 1971, "General System of Preferences", *GATT PC Decision L/3545*. Available at: https://www.wto.org/gatt_docs/English/SULPDF/90840258.pdf.

[67] See Eric CANAL FORGUES ALTER, "Propos introductifs", in Eric CANAL FORGUES ALTER (eds.), *Démocratie et diplomatie environnementales. Acteurs et processus en droit international*, Paris, Pedone, 2015, p. 15.

[68] Principle 7 of the Rio Declaration on Environment and Development of 1992 affirms that "States should cooperate in a spirit of global partnership to conserve, protect and restore the health and integrity of the Earth's ecosystem. In view of the different contributions to global environmental degradation, States have common but differentiated responsibilities. The developed countries acknowledge the responsibility that they bear in the international pursuit of sustainable development in view of the pressure their societies place on the global environment and of the technologies and financial resources they command". For an analysis of the CBDR principle see Maïa-Oumeïma HAMROUNI, *Les responsabilités communes mais différenciées. Contribution à l'étude de la structuration d'un principe général du droit international de l'environnement,* Paris, Pedone, 2018, 372 p.

[69] Maïa-Oumeïma HAMROUNI, "La participation des pays en développement aux accords environnementaux", in Eric CANAL FORGUES ALTER (eds.), *Démocratie et diplomatie environnementales. Acteurs et processus en droit international*, Paris, Pedone, 2015, pp. 29-47.

In accordance with the CBDR principle, richer countries having the financial and material capacities to fight a health crisis must assist the ones in need to help them comply with their obligations. In other words:

> "with CBDR, it becomes clear that there is a duty placed on the developed world, or on any nation that has the capacity to help, to ensure availability of critical life-saving equipment and treatments to those nations that are in need of the same. They also have a greater responsibility towards contributing resources to accelerating research into the coronavirus, finding a treatment, and building a long-term resilience compared to others[70]".

While it seems that this cannot be achieved under the current world health scheme, the COVAX Facility could have constituted a perfect illustration of an international health cooperation based on the CBDR principle. Developed States would have had a duty to cooperate adequately and fairly to the mechanism and vaccine distribution would have been based on a generalized targeted allocation scheme.

In an interconnected world, when a global public good is concerned, the CBDR should be applied quasi automatically as one of the most efficient tools to promote and implement international cooperation. Classic concepts such as cooperation or sovereignty are always poised to evolve. Faced with serious threats to public goods, sovereignty should be geared towards a clear "community interest" and not be confined to the endless solitary course it once enjoyed.

After a few months of relative calm, COVID-19 still poses a major challenge for African and Middle Eastern countries where the vaccination rates are low across the board with healthcare systems in poor shape. Several factors might explain why vaccination rates are at this level. Among them: limited deliveries from the COVAX facility, armed conflicts, other disease outbreaks, poor health management capacity, and inability of many countries to purchase doses for economic reasons.

In Libya for instance, the country has received an insufficient mix of Astra Zeneca and Pfizer vaccines via COVAX, as well as Sputnik and Sinopharm doses. Due to the ongoing financial crisis, Lebanon has been mostly focused on mitigating the economic effects of the pandemic and cases have surged with hospitals being unable to treat patients due to the lack of capacity and oxygen shortages. In August 2021 only, a deal was signed by a Lebanese pharmaceutical company to produce the vaccine locally. In Tunisia, even if the deadly wave recently abated, the country has the highest recorded death rate per capita in the Middle East and North Africa due to low adherence to public health and social measures as well as low vaccination coverage. The example of Yemen also shows that in conflict zones, rumor and misinformation can add to already dire situations and the India-produced Covishield, licensed by AstraZeneca, has reached the country via COVAX in very low quantities. The principle of CBDR would certainly be of use for those countries in need of health cooperation.

Well-to-do Gulf countries such the United Arab Emirates, who had secured vaccine supplies early, can be considered as exceptions due to their aggressive response to coronavirus

[70] Abhinav VERMA, "Adapting Common but Differentiated Responsibility to the Global Cooperation for COVID-19 Response", *Journal of International Affairs*, April 2020. Available at: https://jia.sipa.columbia.edu/online-articles/adapting-common-differentiated-responsibility-global-cooperation-covid-19-response.

cases. Containment, through activity lockdowns, mobility restrictions, and considerable testing for both residents and foreign visitors, has helped contain the spread of the virus. More importantly, from the point of view of health cooperation and taking stock of their experience in the fight against coronavirus, they have helped contain the pandemic in North Africa through massive vaccine delivery. While this is not intended to strictly reflect the implementation of the CBDR principle, the spirit of cooperation and justice is well taken care of.

In the Middle East for instance, the health crisis is already a critical test for the region's fragile resilience, for MENA economies and societies alike. Countries may want to capitalize on their innovative policy efforts to improve inclusiveness, sustain welfare provisions, and promote a structural reform agenda for more open and private sector-led economies, aligned with the sustainable development goals. Whatever the outcome of these efforts, countries would be well advised to just not turn a blind eye to already existing principles that can effectively further international health cooperation.