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Abstract

This article illustrates the weaknesses of the current global health framework. It highlights two pillars[1] a new treaty regime ought to be built upon. The analysis seeks to establish how these pillars could have helped Africa during the pandemic and can indeed help Africa in future pandemics. The analysis suggests the need for a unified global health regime or pandemics' treaty that promotes a level legal and political playing field regarding future pandemics. The treaty could focus on coordination of research and development; build a stronger global framework that reinforces legal obligations and norms; provide for universal access to medicines, vaccines, and medical infrastructure.

[1] This is not an exhaustive list of pillars rather they are the 2 pillars this paper seeks to highlight.

1. Background

On 30 March 2021, twenty-five heads of government and international agencies came together and proposed that the international community ought to work collectively "towards a new international treaty for pandemic preparedness and response" (World Health Organization [WHO], 2021a). The call for an international treaty follows from the reality that the COVID-19 pandemic is the biggest challenge faced by the international community since WW2 (WHO, 2021b). This is not mere conjecture because the COVID-19 pandemic has had a profound and disastrous impact on human existence. The COVID-19 pandemic caused national, regional, and international shutdowns, ground global economic activity, and brought a virtual halt to human movement. Further, millions of lives have been lost worldwide.

Nonetheless, some observers argue that rather than developing a new global framework there is need to find ways to reform existing frameworks so that they serve the global community better (Svet Lustig Vijay, 2021). The argument against a pandemic's treaty is based on the observation that there is no shortage of frameworks or treaties, and these frameworks and treaties are adequate mechanisms for dealing with pandemics[2] and there are other political solutions, initiatives, not requiring a treaty, that would accelerate pandemic response.[3]

However, the experience of the COVID-19 pandemic demonstrates that the current international framework is insufficient to properly respond to global health crises (Grossman, 2021). As a result, "the international community must explore what can be done before, during, and after an epidemic to strengthen our collective ability to effectively respond to a health crisis" (Grossman, 2021, p.133). Moreover, in all likelihood, there will be other pandemics and health emergencies in the future, and it is necessary for the international community to be able to predict, prevent, detect, assess, and effectively respond (WHO, 2021b). These goals can be achieved by establishing a robust international health architecture – a legal and institutional regime such as a pandemics treaty.

2. The Weaknesses of the Current Global Health Regime

The management of global public health threats – such as health threats posed by pandemics – has long been regulated by international law (Oona Hathaway & Alasdair Phillips-Robins, 2020). The International Health Regulations (IHRs) are considered to be the governing framework for global health security (Lawrence O. Gostin & Rebecca Katz, 2016). The IHRs are the global rules on pandemics, and they set requirements for how states ought to report outbreaks, manage diseases within their national borders, and cooperate – amongst each

[2] According to Kelley Lee, Chair in Global Health at Simon Fraser University in British Columbia, Canada, the TRIPS agreement and accompanying TRIPS flexibilities create frameworks under which countries can gain access to lifesaving products during health emergencies. Additionally, according to Outi Kuivasniem, Finland's Director for International Affairs, the IHRs is a useful framework in that the IHRs is a legally binding framework that mandate states to report on disease outbreaks and share information with the World Health Organisation (WHO) and other member states (Svet Lustig Vijay, 2021).

[3] These "range from the WHO co-sponsored COVAX global vaccine facility to proposals for an IP waiver under the TRIPS rules of World Trade Organisation the COVID-19 Technology Access Pool (C-TAP), and tech transfer initiatives" (Svet Lustig Vijay, 2021).

other – to prevent the spread of diseases. The WHO and state parties to the IHRs are responsible for implementing the IHRs. (See Appendix A for an overview of the IHRs).

As the world has been ravaged by COVID-19, the IHRs have proven ineffective in shaping the response of states, and the WHO to the pandemic (Oona Hathaway & Alasdair Phillips-Robins, 2020). The COVID-19 pandemic has exposed the deficiencies – elucidated the ineffectiveness – of the IHRs and also illuminated the fragmentation of international law as concerns pandemic management and regulation. COVID-19 has exposed a multitude of problems concerning the current global health regime.

A. WHO Laxity

The WHO is an institution plagued by laxity. As been observed by Hathaway and Alasdair Phillips-Robins (2020), although the WHO serves as an invaluable role as a center for scientific expertise and a champion for global health it is often powerless in the face of its biggest funders and is unable to criticize them when they violate WHO rules – the WHO lives in fear of retaliation from its biggest funders obligations. For instance, it has been alleged that the Chinese government attempted to cover up the initial spread of the coronavirus. Further, the WHO took a whole month to declare a public health emergency after learning about the outbreak – this delayed response led to accusations that the WHO was acting too slow.

B. Flawed IHR Design

The IHRs are flawed in design. First, the IHRs take a siloed approach to health (that is the IHRs take a restrictive approach to managing a pandemic.) For instance, under IHR article 44 although states have an obligation to collaborate this obligation only applies to health issues (Jaemin Lee, 2020). In another instance, IHR article 2 provides that "[t]he purposes and scope of [the IHRs] are to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade." This is clear evidence that the IHRs are only to be applied to health issues (Jaemin Lee, 2020).

Second, by design, the IHRs delegate an unprecedented amount of legal authority to the Director-General of the WHO – the Director-General has the power to declare a public health emergency of international concern (PHEIC) and issue temporary recommendations of urgent measures to prevent or reduce the international spread of disease and avoid unnecessary interference with international traffic (Gian Luca Burci, 2020). Thus, the IHRs grant a single international figure – the Director-General of the WHO – great authority to undertake decisions that have considerable political implications outside an inter-governmental framework (Gian Luca Burci, 2020). The definition of a PHEIC is vague and thus provides flexibility to allow adaptation to an unpredictable range of events and specific factual contexts that are present during pandemics (Gian Luca Burci, 2020). On the one hand, the vagueness of what constitutes a PHEIC gives the WHO Director-General discretionary authority to intervene before this international spread occurs – the Director-General can in this sense preempt the international spread of a disease by declaring a public health emergency of international concern. On the other, history shows that WHOs practice has been inconsistent as to the criteria necessary for a PHEIC to be declared. This inconsistency has opened up the WHO to criticism for the WHOs apparent politicisation and for not providing much clarity for future disease spreads. "Even though the delegation of authority is premised

on a non-political role by the Director-General, PHEICS carry evident political implications for the country concerned and beyond. It seems legitimate that the Director-General takes the political context into account in managing specific risks, while ensuring the integrity and credibility of his technical role" (Gian Luca Burci, 2020, 209).

Fourth, the IHRs lack "teeth." Although the IHRs are binding on WHO member states the IHRs contain no enforcement mechanism and because the IHRs contain no enforcement mechanism the WHO is unable to hold states to their obligations – the WHO is unable (and sometimes unwilling) to discipline, or rather punish, states that have failed to meet their obligations (Oona Hathaway & Alasdair Phillips-Robins, 2020). The current IHR regime functions more as a system of recommendations than of binding obligations (Grossmann, 2021, p.133).

Fifth, The IHRs do not contain an effective dispute settlement mechanism issue (Jaemin Lee, 2020). Although IHR article 56 provides for the settlement of disputes it has been pointed out that: "The current WHO regime lacks sufficient mechanisms to solve disputes, and it functions more as a system of recommendations than of binding obligations" (Grossmann, 2021, p.133). This is because unlike other more well-developed dispute settlement regimes, IHR article 56 presents options that seem to be too unpredictable and unstructured such that they would be ineffective when handling the magnitude of issues that arise during a pandemic (Jaemin Lee, 2020).

C. Inadequate Cooperation

Although the IHRs do contain a couple of provisions that attempt to give effect to cooperation those provisions are either shallow or merely repeat principles – "the provisions do not provide adequate response guidelines for states or the WHO during an emergency." (Jaemin Lee, 2020).

In reality, the current global health regime lacks cooperation – be it between states or between states and the WHO. This is most likely because the IHRs do not contain provisions that can ensure meaningful cooperation and close coordination among states, between the WHO and states, and between the WHO and other international organizations in the specific context of a pandemic (Jaemin Lee, 2020). Global coordination and cooperation are essentially critical when dealing with pandemics, however, the absence of meaningful coordination and cooperation mechanisms in the IHRs impedes a robust global response to pandemics (Jaemin Lee, 2020).

Tied to inter-state cooperation is the need for cooperation between states and the WHO and this is because the efficient prevention of pandemic (with transboundary dimensions) requires that states comply with recommendations of the WHO. However, history shows that, as a general rule, states only half-heartedly follow WHO recommendations – states rarely comply with the IHRs. (Morten Broberg, 2020). Three reasons are often cited when trying to explain why states rarely follow WHO guidelines and these are: "Firstly, several [states] simply do not have the requisite resources to follow the rules. Secondly, certain states are either unable or unwilling to quickly notify the WHO of disease outbreaks. Thirdly, [states] may introduce travel and trade restrictions of their own, even if these initiatives may be unnecessary or may conflict with the recommendations of the WHO" (Morten B., 2020).

D. Fragmentation of International Law

The COVID-19 crisis has demonstrated pandemics implicate various aspects of international law. This is to necessarily say that when looking at the COVID-19 pandemic, through the lens of international law, the pandemic cannot be merely considered a health crisis –COVID-19 is an international law crisis of profound magnitude. The COVID-19 crisis is multifaceted and concerns various aspects of international law, including but not limited to: State responsibility; climate change; state obligations to refugees and migrants in detention; refugee law and the principle of non-refoulment; vaccine theft, disinformation, and the law governing cyber operations; human rights law concerning civil and political rights; human rights law concerning right to life; and international humanitarian law concerning the treatment of detainees and humanitarian access. These areas of international law are governed by different legal regimes. The international law landscape is fragmented. The COVID-19 pandemic has laid bare the fact that pandemics affect several distinct – but interlinked – rights. COVID-19 has affected multiple areas of human existence regulated by varied fields of international law.

The IHRs – as presently constituted – embed the principle of fragmentation in their structure. This is because: First, IHR (2005) article 56(4) provides that "[n]othing in these Regulations shall impair the rights of States Parties under any international agreement to which they may be parties to resort to the dispute settlement mechanisms of other intergovernmental organizations or established under any international agreement." Second, IHR (2005) article 57 provides that "the IHR and other relevant international agreements should be interpreted so as to be compatible" and that "the IHR shall not affect the rights and obligations of any State Party deriving from other international agreement." Third, under IHR (2005) article 3 states must act in accordance with the Charter of the United Nations. Taken together, the IHRs make it clear that the IHRs do not affect other treaties and agreements and that states ought to abide by the norms and rules found – or rather codified – in other treaties and agreements. This problem of fragmentation is also evident elsewhere in the IHRs. For instance, IHR article 3(4) – quoted above – "underscores all states sovereign right to legislate and to implement their health policies." *Prima facie*, IHR article 3(4) is an appropriate statement of sovereign discretion however, it nonetheless, confounds the states when, during a pandemic (such as the COVID-19 pandemic), the states are compelled to deal with a wide range of potentially conflicting obligations under different treaty regimes and other international agreements (Jaemin Lee, 2020).

As illustrated above, the current global health framework contains several defects, which should be cured so that pandemic management becomes more effective. One way of curing the defects of the current global health framework is the establishment of a treaty that: Addresses the issues plaguing the WHO; Repairs the IHRs flawed structure; Encourages – or even coerces – interstate cooperation and cooperation between the states and the WHO; and harmonises the law governing pandemics.

3. Pillars of A New Treaty & the Benefits to Africa

The COVID-19 pandemic exposed the deficiencies in the prevailing global health regime. This in itself should provide African States the impetus for a pandemic's treaty. If that is not enough, African states should be cognisant that a well-structured treaty can have a profound – positive – impact on African states health infrastructure and also provide African states means of redress when African States are not responsible for the outbreak of a pandemic (as

was the case with COVID-19). If these benefits are to be realised the pandemics treaty ought to be built on two pillars: the "right to health," and the principles of state responsibility and reparation. (This is not an exhaustive list of pillars, rather they are the 2 pillars this article seeks to highlight.)

A. Right to Health

If Africa is to benefit from a pandemics treaty, the pandemics treaty must be able to ensure that African nations are provided with tools and resources to minimise loss of life and protect and restore livelihoods if a pandemic ensues. Additionally, if Africa is to benefit from a pandemics treaty it is necessary for the treaty to contain mechanisms that ensure that African health systems have adequate capacity (that is public health infrastructure, trained medical professional, adequate funding, equitable vaccine access, among other things.) A pandemics treaty should provide for large scale domestic and international resource mobilization that will support fragile national health systems.

Any singular pandemic treaty regime should have the "right of health" as its core. The present framework – the IHRs – do many laudable things but it is not "right to health" centric. This is not mere conjecture but is based on the very articles of the IHRs. The IHRs are comprised of 66 articles and 9 annexes of which most of the subject matter relates to capacity building, communication, and available measures (Jaemin Lee, 2020). For example, the IHRs contain numerous provisions regarding "the core capacities of countries to detect, assess, notify, report, and respond to health risk events" (Jaemin Lee, 2020).[4] Regarding communication, the IHRs are comprised of multiple provisions that deal with notification to the WHO and a two-way dialogue procedural mechanism between nation-states and the WHO (Jaemin Lee, 2020). [5] As relates to other measures, the IHRs contain provisions that speak to the determination of a PHEIC[6] and national measures that deal with regulating health measures at ports of entry.[7] Further, as regards national measures, the IHRs contain provisions that regulate state conduct regarding travelers[8] and the IHRs also regulate health documents[9] and financial charges associated with national measures[10] (Jaemin Lee, 2020).

The preceding IHR framework is not useless, but it is not entirely useful either. A key component of a pandemic is the fact that it is a health crisis. (This is not to say it is solely a health crisis). As health is a central – a cardinal – aspect of a pandemic any pandemic treaty must be built upon the right to health. A pandemics treaty must be modeled on a human rights-based approach with the central right in question being the "the right to the enjoyment of the highest attainable standard of physical and mental health," a right which is one of the most important rights implicated (and/or affected) by a pandemic.

[4] Referring to IHR 2005. art. 5,1; art. 13; Annex 1, A, 1(a), 4, 5, 6; Annex 1, B, 1, 2.
[5] Referring to IHR 2005. art. 6, 7, 8, 9, 10, 11, Annex 2.
[6] IHR 2005. art. 12, 15.
[7] IHR 2005. art. 20,21,23.
[8] IHR 2005. art. 30,31.
[9] IHR 2005. art. 36-39.
[10] IHR 2005. art. 40,41.

Under contemporary international law, the right to health is considered a fundamental part of human existence (WHO, 2008). The right to the enjoyment of the highest attainable standard of physical and mental health found its initial codification in the 1946 WHO constitution. Therein, the preamble reads: "[t]he enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition" (WHO, 1948). This right was subsequently recognized and codified in the 1948 Universal Declaration of Human Rights and the 1966 International Covenant on Economic, Social and Cultural Rights (ICESCR). (The International Covenant on Economic, Social and Cultural Rights is widely considered as the central instrument of protection for the right to health) (WHO, 2008). Indeed, the right to health is a universal recognised right and has been codified in multiple other international human rights instruments [11] and regional human rights instruments (WHO, 2008). [12] Additionally, the right to health is codified and recognised in at least 115 state constitutions and some constitutions even set out duties in relation to health, such as the duty on the state to develop health services or to allocate a specific budget to them (WHO, 2008).

Using the right to health, as a structural pillar for a comprehensive treaty on pandemics, will ensure that states will have health-related obligations and duties which would entail those states do no harm in times of pandemics. This is because the right to health imposes three types of general – national – obligations on states. These obligations are the obligation to respect[13], protect[14] and fulfill.[15] In some sense, these obligations entail that states owe their respective citizenry and not inter-state obligations. Nonetheless, a pandemics treaty could

[11] See: The 1965 International Convention on the Elimination of All Forms of Racial Discrimination: art. 5 (*e*) (iv); The 1966 International Covenant on Economic, Social and Cultural Rights: art. 12; The 1979 Convention on the Elimination of All Forms of Discrimination against Women: arts. 11 (1) (*f*), 12 and 14 (2) (*b*); The 1989 Convention on the Rights of the Child: art. 24; The 1990 International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families: arts. 28, 43 (*e*) and 45 (*c*); and the 2006 Convention on the Rights of Persons with Disabilities: art. 25.

[12] "The right to health is also recognised in several regional instruments, such as the African Charter on Human and Peoples' Rights (1981), the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights, known as the Protocol of San Salvador (1988), and the European Social Charter (1961, revised in 1996). The American Convention on Human Rights (1969) and the European Convention for the Promotion of Human Rights and Fundamental Freedoms (1950) contain provisions related to health, such as the right to life, the prohibition on torture and other cruel, inhuman and degrading treatment, and the right to family and private life" (WHO, 2008, p.10)

[13] "In particular, States are under the obligation to *respect* the right to health by, *inter alia*, refraining from denying or limiting equal access for all persons" (CESCR General Comment No. 14, para 34).

[14] "Obligations to *protect* include, *inter alia*, the duties of States to adopt legislation or to take other measures ensuring equal access to health care and health-related services provided by third parties; to ensure that privatisation of the health sector does not constitute a threat to the availability, accessibility, acceptability and quality of health facilities, goods and services; to control the marketing of medical equipment and medicines by third parties; and to ensure that medical practitioners and other health professionals meet appropriate standards of education, skill and ethical codes of conduct" (CESCR General Comment No. 14, para 35).

[15] "The obligation to *fulfil* requires States parties, inter alia, to give sufficient recognition to the right to health in the national political and legal systems, preferably by way of legislative implementation, and to adopt a national health policy with a detailed plan for realising the right to health. States must ensure provision of health care, including immunisation programmes against the major infectious diseases, and ensure equal access for all to the underlying determinants of health, such as nutritiously safe food and potable drinking water, basic sanitation and adequate housing and living conditions… Further obligations include the provision of a public, private or mixed health insurance system, which is affordable for all, the promotion of medical research and health education, as well as information campaigns" (CESCR General Comment No. 14, para 36).

make sure these obligations are inter-state obligations. By doing so, states will have a collective responsibility to ensure the right to health is realised. Thus, states will thus have an obligation to ensure all states have adequate infrastructure to cope with pandemics and help mitigate the spread of disease vectors. Poorer African states will thus have access to a global network of resources that will help create more robust health systems.

Moreover, a pandemics treaty can be tailored so as to provide for more meaningful cooperation between states. Presently, the right to health also imposes international obligations upon states. Accordingly, states "should recognise the essential role of international cooperation and comply with their commitment to take joint and separate action to achieve the full realisation of the right to health" (CESCR General Comment No. 14, para 38). Further, "pursuant to respect for international obligations and the right to health states would be prohibited from imposing embargoes or similar measures restricting the supply of another state with adequate medicines and medical equipment" (CESCR General Comment No. 14, para 41). A pandemics treaty could make cooperation mandatory – as circumstances provide – and provide robust enforcement mechanisms that alleviate the earlier raised concerns regarding the current global health regime.

A health centric pandemics treaty can be a boon for African states because a well-structured pandemics treaty can ensure: the availability and accessibility to functioning public health facilities; that all health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned;" and health facilities, goods and services are scientifically and medically appropriate and of good quality[16] (CESCR General Comment No. 14, para 12).

It should be noted that a pandemics treaty that focuses on the right to health – by encouraging meaningful cooperation and imposing binding obligations – can help address a key issue that has long plagued the African continent: vaccine inequality. The COVID-19 pandemic highlighted the problems of vaccine inequity and vacation nationalism – these phenomena disproportionately affected African nations. African states ought to be in the forefront demanding a global health regime that will put an end to vaccine nationalism and inequitable vaccine access. (See Appendix B for a discussion on vaccine inequality).

B. Sate Responsibility & Reparation

Under contemporary international law, sovereignty is still a key principle and from sovereignty flows a cornerstone of public international law – the rules of state responsibility. The main goal of state responsibility is the pursuit of fair compensation for damages suffered by one state due to the acts of another state, the offending or responsible state. The aim of the rules on state responsibility is to ensure that a state is held responsible for unlawful acts, it undertakes, that run counter to the rules of international law. An unlawful act can be described as an act that is harmful to the rights and or dignity of another state. And an unlawful act triggers the right of the harmed state to seek reparation for the unjust losses and damages it suffers (Valerio De Oliveira Mazzouli, 2020). Against this backdrop, it can be said

[16] This is because upholding a right to health entails that a state must ensure that hospitals and health facilities are staffed with skilled medical personnel and the facilities are well stocked with scientifically approved and unexpired drugs and hospital equipment (CESCR General Comment No. 14, para 36).

that the rules of international responsibility serve a dual purpose, that is they aim to: "(a) psychologically coerce states to make sure they comply with their international commitments (preventive purpose);" and (b) attribute to the state which had suffered a loss, as a result of an unlawful act perpetrated by another, a just and due reparation (repressive purpose)" (Valerio De Oliveira Mazzouli, 2020, p.7).

Applying rules of state responsibility and reparation to pandemics will be a tricky endeavour and exploring the contours of what the applicable rules is subject matter beyond this article.[17] What is key here is that under the rules of state responsibility a state that commits a wrongful act (in this case not preventing the spread of pandemic) has an obligation to compensate harmed states.[18] If reparation were available during the COVID-19 pandemic, theywould be directed to solving economic devastation (see Appendix C for summary on economic devastation). Reparation would have been a boon to African states, whose already vulnerable health infrastructure was stressed and devasted by the COVID-19 pandemic. A pandemics treaty can thus embed the principles of reparation and state responsibility, and this can be of great aid to African states the next time Africa is devasted by a pandemic not of its own making.

The COVID-19 pandemic devasted Africa's economic landscape. Thus, African nations need a global health regime that will aid them in recover from COVID-19 and any future pandemics that negatively impact Africa's economy.

4. Conclusion

The COVID-19 pandemic exposed the stark disparities in the capacity of nations to prevent, prepare for and respond to pandemics. Moreover, the COVID-19 pandemic demonstrated that the current global health system is not adequate to combat future pandemics. The need for a pandemic's treaty has been made obvious – there is need for a unified global health regime that ensures a level legal and political playing field regarding future pandemics. In particular, the global health system would befit from a pandemics treaty because a pandemics treaty "would close gaps in the current legal framework, endorse principles for effective pandemic preparedness and response, establish norms and obligations of countries, and clarify the responsibilities between states and international organisations." (Singh et al., 2021, p.3).

In all, a well-structured pandemics treaty – one that is health centric and considers principles of state responsibility and reparation – can benefit African states in the following ways: coordination of research and development; build a stronger global framework that reinforces

[17] What constitutes a wrongful act? How exactly does attribution apply? What is a breach. How do we determine reparations – under international law different forms of reparation exist.

[18] It should be noted that state responsibility and reparation is a double-edged sword – while African states were not responsibly for the outbreak of COVID-19 they could be responsible for a future pandemic and that will entail responsibility and cost (reparation). One pillar of a pandemic's treaty, as this paper argues, is responsibility.

legal obligations and norms; provide for universal access to medicines, vaccines, and medical infrastructure.

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APPENDIX A

OVERVIEW OF THE INTERNATIONAL HEALTH REGULATIONS

(Excerpted from: World Health Organization. (N.D.*). International Health Regulations*. World Health Organization. https://www.who.int/health-topics/international-health-regulations#tab=tab_1 https://www.who.int/health-topics/international-health-regulations#tab=tab_2)

While disease outbreaks and other acute public health risks are often unpredictable and require a range of responses, the International Health Regulations (2005) (IHR) provide an overarching legal framework that defines countries' rights and obligations in handling public health events and emergencies that have the potential to cross borders.

The IHR are an instrument of international law that is legally-binding on 196 countries, including the 194 WHO Member States. The IHR grew out of the response to deadly epidemics that once overran Europe. They create rights and obligations for countries, including the requirement to report public health events. The Regulations also outline the criteria to determine whether or not a particular event constitutes a "public health emergency of international concern".

At the same time, the IHR require countries to designate a National IHR Focal Point for communications with WHO, to establish and maintain core capacities for surveillance and response, including at designated points of entry. Additional provisions address the areas of international travel and transport such as the health documents required for international traffic.

Finally, the IHR introduce important safeguards to protect the rights of travellers and other persons in relation to the treatment of personal data, informed consent, and non-discrimination in the application of health measures under the Regulations.

The responsibility for implementing the IHR rests upon all States Parties that are bound by the Regulations and on WHO. Governments are responsible, including all of their sectors, ministries, levels, officials, and personnel for implementing IHR at the national level.

WHO plays the coordinating role in IHR implementation and, together with its partners, helps countries to build capacities.

APPENDIX B
VACCINE INEQUALITY

Africa has long had problems with vaccine access. On one estimate, before the COVID-19 pandemic, Africa imported 99 per cent of its vaccines (Senthilingam, 2021) "despite the continent consuming over 25 per cent of vaccines globally" (Sidibe, 2022). Against this backdrop, the COVID-19 pandemic has "underscored the critical gap in vaccine manufacturing" and "exposed [Africa's] vulnerabilities in ensuring access to vital drugs, vaccines, and health technologies" (Sidibe, 2022).

As of January 24, 2022, more than 9 billion vaccine doses produced Africa had only received approximately 540 million and Africa had only administered 309 million doses Additionally, less than 10 percent of Africans were fully vaccinated and approximately 1.2 billion Africans had not received a single dose of vaccine. It is estimated that Africa may not be vaccinated until 2023 (Sidibe, 2022). (In economic terms, one study "estimated that, among other regions, sub-Saharan Africa will register the highest economic losses (3 percent of GDP from 2022-2025) due to slow vaccination rates" (Sidibe, 2022).

As the COVID-19 pandemic progressed, it became clear that supply of the vaccine took a backseat to unequal distribution of the vaccine. In January 202,1 it was observed that "[d]espite the acute vaccine supply shortage in Africa, global vaccine production [had] been

increasing at a secure rate, around 1.5 billion doses per month." (Sidibe, 2022). Distribution of the vaccine to poor countries was undermined by wealthier countries over-purchasing vaccine doses. As wealthier nations monopolised the global share of vaccines, Africa was disproportionately affected by this vaccine nationalism. Furthermore, many nations failed to live up to commitments to other vaccine-sharing schemes (The Lancet, 2022).

APPENDIX C
ECONOMIC DEVASTATION

As reported by Pierella Paci, Practice Manager and Equity Global Practice, World Bank, COVID-19 has taken a major toll on livelihoods, food security, and human capital in Sub-Saharan Africa. Further, the COVID-19 pandemic has caused widespread job losses (and female workers are among the population most affected). As countries restricted mobility, economic activity was disrupted and despite evidence of recovery employment remains below pre-pandemic levels. Beyond reduction in employment earning from other sources also fell dramatically (Paci, 2021). For instance:

> In Kenya, Nigeria, and Ethiopia almost 1 in 3 household enterprises closed at the outset of the pandemic. In Gabon, South Sudan, Malawi, Uganda, Mali, Madagascar, and Zambia, revenue declined for more than 70 per cent of household businesses (Figure 2). Agricultural income also fell due to declines in farm prices, the closure of weekly markets, and restricted transportation. The global economic impact of the pandemic has meant that remittance flows have also fallen, with affected countries including Mali, Nigeria, Uganda, Burkina Faso, Malawi, Zambia, and Kenya. (Paci, 2021).

The COVID-19 pandemic has also substantially increased food insecurity. In January 2021, it was reported that compared to 2020 "food insecurity tripled in Nigeria, Ethiopia, Uganda, and Malawi. In Malawi, Nigeria, Kenya, South Africa, and Sierra Leone, more than half of households ran out of food in the thirty days prior to the survey, with urban households being disproportionally affected. School closures across all countries aggravated the problem by limiting children's access to school feeding programmes." (Paci, 2021).

Furthermore, the COVID-19 pandemic severely affected access to education. In most countries, children living in rural or poor households were more affected by school closures due to more limited access to internet, affecting the accumulation of human capital of the worst off and hindering their intergenerational economic mobility. For reference "oonly 3 in 10 in Mali and less than 2 in 10 in Malawi" engaged in learning activities during school closures. (Paci, 2021).

As been stated by Akinwunmi Adesina, president of the African Development Bank, "we should not minimise the impact of Covid-19 ON African economies." In 2020, 30 million Africans were plunged into poverty because of COVID-19 (and this was despite decades of progress in Africa's fight against poverty). In all, on one estimate, "African nations need $424 billion this year to help them cope with the devastation caused by the coronavirus pandemic" (Hepker & Mackenzie).

As observed by UNESCO:

“The COVID-19 pandemic has triggered a severe economic contraction in many developing countries, especially those in Africa. It has exposed and exacerbated inequalities between countries just as it has within countries, leaving the most vulnerable groups further behind. To effectively counter the consequences of the pandemic, further international and national efforts are needed, including coordinated policy actions and reforms, creating an enabling policy environment” (UNESCO, 2021).