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Eighty years of postwar multilateralism: Global health law's emergence and its contemporary challenges

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ABSTRACT

Founded on the postwar conviction that health is 'fundamental to the attainment of peace' and that its enjoyment constitutes 'a fundamental human right', the WHO has embodied the UN's ambition to constitutionalise solidarity through law. Nearly eight decades later, this normative order faces a profound legitimacy crisis. The tension between sovereignty and universality has reemerged, and the ethical foundations of global health law are increasingly contested and fragmented. From several revisions of the International Health Regulations to the WHO Framework Convention on Tobacco Control and, most recently, the post-COVID Pandemic Agreement, the WHO's authority has been tested by populist nationalism, market logics, and the erosion of multilateralism, exposed most visibly during the US withdrawal under the Trump administration. Through a genealogical reading of the WHO as legal infrastructure, this article examines it as a postwar legal experiment in transforming international health cooperation into a form of global constitutionalism. It asks whether contemporary regressions toward security-driven governance mark a return to the prewar logic of exceptionalism. It concludes that the future legitimacy of global health law depends on a decolonial approach to what counts as 'global' and what constitutes 'health' through plural, equitable, and interdependent forms of governance for justice.

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Introduction

In 1946, when delegates gathered in New York to draft the Constitution of the World Health Organization (WHO), they envisioned more than a technical body for epidemic control. They sought to rebuild the moral architecture of the postwar order. Emerging from the ruins of war and empire, the WHO was born as a normative agency, embodying the conviction that 'the health of all peoples is fundamental to the attainment of peace and security' and that its enjoyment is 'a fundamental right of every human being' (Gostin and Meier, 2024; Lee, 2008). Health, law, solidarity, and sovereignty were thus bound together in a constitutional experiment aimed at transforming international health cooperation into global health justice (Gostin and Meier, 2023b).

This experiment was immediately constrained by the WHO's establishment as a specialised agency in Geneva, which was 'determined by the Health Assembly after consultation with the United Nations' (WHO Constitution, Article 43), due to Switzerland's status as a politically neutral country and its inherited assets from the League of Nations. As a result, the WHO has not been under the direct oversight of the United Nations' (UN) Economic and Social Council (ECOSOC) in New York. This geographical and administrative distance siloed the WHO from the broader diplomatic networks of the UN headquarters. Early governance was often dominated by national health ministers and clinical practitioners without legal training, potentially leading to a general perception of the right to health as an ethical imperative rather than a framework for binding legal obligations.

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Nearly eight decades later, that experiment faces a profound legitimacy crisis. Market logics, geopolitical rivalries, and technocratic authority have reconfigured the universalist and egalitarian ideals that once animated the right to health. The COVID-19 pandemic exposed these tensions: states invoked shared vulnerability yet reverted to national exceptionalism, deepening inequalities within and across borders. Multilateralism appeared indispensable but distrusted; the WHO, long regarded as the moral centre of global health, became a mirror of the contradictions eroding the postwar legal imagination.

This article reads the WHO as a legal infrastructure that archives competing ideas about sovereignty, solidarity, and human rights, and as a site where these conflicts continue to unfold. It argues that the organisation's constitutional promise has been strained by three overlapping transformations: the reassertion of sovereignty over solidarity, the marketisation of health under neoliberal globalisation, and the rise of technocratic governance that privileges expertise over accountability. Together, these shifts, compounded by a historical reluctance to exercise treaty-making authority, have hollowed out the cosmopolitan vision that once defined global health law, replacing normative universalism with a focus on procedural and administrative legitimacy (Cueto et al., 2019).

The crisis also invites renewal, opening space to rethink the epistemic foundations of global health law. Reclaiming the WHO's constitutional role requires confronting the colonial, economic, and epistemic hierarchies that have shaped its authority and reimagining what counts as 'global' and what constitutes 'health'. A decolonial reframing can root legitimacy in pluralistic, equitable, and relational forms of governance. This requires addressing 'medical neocolonialism'—the extraction of resources from the Global South without shared benefits—and pursuing transformative reparations to restructure global health manufacturing and South-South collaboration (Sirleaf, 2025).

This critical evaluation considers the WHO's role in global health law, as a field of study developing from foundational conceptualisations of global health and its governance methods and categories (Gostin, 2014) to recent inquiries into justice-based policy and the legal determinants of health over the past decade (Gostin & Meier, 2023a). The 2024 launch of the *Journal of Global Health Law* further signals a move to non-doctrinal, cross-disciplinary, and genuinely 'global' approaches to the scoping, contextualisation, and implementation of legal norms (Meier & Finch, 2024) and assessing their impact, including intended and unintended consequences (Toebes and Negri, 2024).

Methodologically, this article adopts a genealogical approach to global health law. The analysis proceeds by tracing selected moments in the development of global health law, including the WHO Constitution and its articulation of health as a human right; the adoption and revision of the International Health Regulations (IHR); the Framework Convention on Tobacco Control (FCTC); the Pandemic Influenza Preparedness (PIP) Framework; the Pandemic Agreement; WHO programmes on primary health care, the HIV/AIDS response, social determinants of health, non-communicable diseases, and public health emergencies.

Rather than constituting an exhaustive corpus, these materials are treated as key legal and policy sites through which the normative architecture of postwar global health governance has been constructed, contested, and reconfigured. The article reads them alongside scholarship in global health law, health and human rights, global health governance, political economy, and decolonial global health, focusing on works that have shaped debates on the WHO's legal authority. The aim is to reconstruct the historical trajectory of global health law and identify the recurring fault lines that continue to shape its contemporary legitimacy crisis.

Following this interpretive genealogy, the article first revisits the postwar embedding of human rights within global health legal architecture, acknowledging the historical gap between technical guidance and legal obligation. It then examines the tensions between sovereignty and solidarity, and marketisation and equity, before exploring the rise of technocracy and interpreting COVID-19 as a threat to multilateral health governance. Finally, it proposes a decolonial foundation rooted in relational accountability.

Beyond coordination: Postwar global constitutionalism and human rights

The creation of the WHO in 1948 was more than a redesign of international sanitary cooperation. It signalled an ambition to constitutionalise global solidarity through law at a moment when the UN was being constructed as the juridico-political architecture for peace. The WHO Constitution translated the trauma of World War II into a new vocabulary, proclaiming 'the health of all peoples' fundamental to peace

and security and recognising 'the highest attainable standard of health' as a universal right. These words might read as symbolic gestures to some, but, as a legally binding treaty per se, such constitutional clauses reflected a postwar imagination seeking to weave health and human rights into the fabric of international law (Gostin et al., 2018, Gostin and Meier, 2024).

The WHO's establishment marked the culmination of a transition that began with the nineteenth-century International Sanitary Conferences and the Health Organisation of the League of Nations. Those earlier fora treated health as a technical coordination—encompassing disease notification, quarantine, and trade protection—grounded in reciprocity among sovereign states and shaped by imperial interests. The WHO Constitution elevated health from a matter of pragmatic cooperation to a project embodying global constitutionalism (Hoisington, 2013). However, evidence from *travaux préparatoires* shows gaps between this constitutional imagination and institutional reality. It might be risky to assume the 1946 drafters understood that the right to health would eventually entail extensive legal obligations claimed by contemporary advocates.

The postwar articulation of the right to health emerged from a convergence of constitutionalism, the broadening human rights discourse, and the welfare internationalism of the 1940s (Steffek & Holthaus, 2017). The WHO became the institutional bridge between the UN Charter's collective security paradigm and the Universal Declaration of Human Rights, adopted in the same year. It was both a functional agency and a constitutional experiment: authorised by the UN Charter to act as a specialised organisation while endowed with autonomous regulatory powers under Articles 21–22 of its own Constitution, which enable the adoption of binding regulations by majority vote.

Yet, for nearly fifty years, the WHO was reluctant to exercise these unrivalled normative authorities, revealing a preference for technical consensus over formal legal regulation. The WHO's Article 19 treaty-making authority has been exercised only twice: for the FCTC in 2003 and the Pandemic Agreement in 2025. This historical reluctance illustrates a challenge of cross-disciplinary dialogue: while technical experts view their outputs as practical and ethical guidance, rights advocates often seek to frame them into legal obligations. A salient example is the WHO Model List of Essential Medicines (EML); though submitted as 'recommendations', human rights lawyers have taken it as part of states' obligations in progressively realising the right to health, which was reiterated by the UN Committee on Economic, Social and Cultural Rights (CESCR) in its General Comment 14 adopted in 2000.

Embedding health as a human right also linked the WHO to the wider postwar project of reestablishing an international legal order grounded in humanity, alongside the principle of sovereignty. The right to health gave substantive meaning to the idea that peace required social justice. It tied biological existence to a moral community in which securing the conditions for the health of all was integral to human dignity. But this cosmopolitan imagination bears its own paradox. While professing universality, it emerged within a world structured by empire and racial hierarchy. The drafters of the WHO Constitution included representatives of colonial powers, and decolonisation had scarcely begun. The postwar 'international' was simultaneously a trans-imperial formation that translated European tropical medicine's modernisation ethos into the language of human rights (Brazelton, 2021).

The universal right to health is thus embedded in exclusionary structures, but this paradox opened new possibilities. By framing health as a collective entitlement rather than a charitable provision, the WHO provided a platform for new states to reinterpret the right to health in terms of decolonial claims. As states in Africa, Asia, and the Caribbean joined the organisation in the 1950s and 1960s, they broadened the right to health to include equitable access to medicines, technology, and resources as matters of international justice. Early WHO initiatives—malaria eradication, smallpox control, and technical assistance—were therefore both biomedical and constitutional: they grounded the moral claim that peoples, not only states, were subjects of international law (Cueto et al., 2019).

However, constitutional ambition soon met institutional constraint. The WHO's authority rested on the voluntary compliance of states and the political will behind assessed contributions. Unlike the UN Charter, the WHO Constitution contained no enforcement mechanisms or adjudicatory bodies to translate its principles into binding obligations. Consequently, international health law evolved not as a cohesive legal system, but as a 'patchwork' of regulations, recommendations, and codes, whose legitimacy derives from consensus rather than coercion (Toebes, 2015). This evolution reflects a persistent 'containment bias'

in the IHR, which have historically focused on outbreak response rather than the underlying disease-prevention systems required for genuine global health (Le Moli, 2023).

This institutional fragility also enabled constitutional pluralism. The absence of a single hierarchy allowed the WHO to become a site where international, administrative, humanitarian, and human rights law intersect. The 1951 International Sanitary Regulations and their subsequent revisions institutionalised duties of notification and cooperation as expressions of solidarity, transforming surveillance into a legal manifestation of mutual care through the sharing of data and early warning.

From the outset, the WHO's authority depended on its human rights grounding. Health programmes were justified not simply by efficiency but by justice. The founders viewed the universality of the right to health as an approach to technical expertise with normative purpose (Gostin and Sridhar, 2015). This vision resonated with broader developments in social rights constitutionalism across Europe and Latin America, where administrative governance increasingly became the means of realising rights across different domains of life (Ooms & Hammonds, 2016).

But the very framing that lent the WHO moral authority also constrained its adaptability. Because the right to health was conceptualised primarily as an individual entitlement within a state-centric order, the question of collective responsibility across borders remained underdeveloped. Human rights universalism, while cosmopolitan in ethos, remained tethered to the concept of sovereignty. Reliance on government consent meant that rights were continually mediated—and often diluted—by political compromise. The constitutional promise of solidarity thus coexisted uneasily with geopolitical inequalities.

Even so, the concept of 'health as a human right' has proven resilient. It provided the normative foundation for the revised IHR 2005 after SARS and continues to shape debates on pandemic preparedness, universal health coverage, and climate justice. Yet its postwar origins reveal that human rights were not neutral tools but vehicles for a vision of world order (Gostin and DeBartolo, 2015). The WHO's constitutional project aimed to promote peace and human flourishing through health and developmentalism, while operating within a political economy of dependency that rendered some populations more governable than others. Such ambivalence is evident in the WHO Director-General's testimony at the International Court of Justice (ICJ) on 13 December 2024, in which Dr Tedros affirmed the health impacts of climate disruption but stopped short of explicitly linking states' climate responsibilities to health rights obligations.

Understanding the WHO in these terms is essential for grasping today's legitimacy crisis. Current struggles over authority, financing, and representation echo long-standing tensions between the universality of rights and inequalities of power. The postwar constitutional project established the normative infrastructure of global health law, as well as the contradictions that would later destabilise it. As subsequent sections show, the dynamics between sovereignty and solidarity, marketisation and equity, and expertise and accountability can all be traced to this fundamental paradox.

Between solidarity/sovereignty: Cosmopolitan ideal's potentials and limits

The WHO's constitutional vision rested on a delicate compromise that sovereign equality among states could coexist with a universalist conception of humanity. This dual commitment became the organisation's normative anchor and structural limitation. For the drafters of 1946, solidarity among states was the vehicle through which the right to health of all peoples would be realised. Such solidarity stemmed from the collective trauma of the two world wars, an experience that foregrounded a common recognition of human moral frailty and created a compelling motive for cooperation (Dershowitz, 2004).

A solidaristic sentiment was enacted among major state actors, recognising the dangers of self-destruction and being willing to bear the costs of collective actions to prevent it (Prainsack & Buyx, 2017). However temporary or thin this state-based solidarity may be, this postwar ethics led to a global consensus to institutionalise global human protection. And the WHO was a cosmopolitan project born out of this context and administered through a club of nation-states, whose structure encodes solidarity as a function of sovereignty.

The organisation's legal personality derives from the collective will of states rather than the agency of peoples. Its architecture entrenched exclusion: colonised, trusted, and occupied territories, and non-member polities such as Taiwan and Somaliland remain structurally invisible within global health governance. This invisibility is compounded by the World Health Assembly's (WHA) reluctance to collaborate with

nongovernmental organisations (NGOs). This irresponsiveness to, and limited engagement with, a diverse civil society stands in contrast to other UN specialised agencies' practices, for instance, the International Labour Organization's (ILO) tripartite system, which integrates non-state actors into core governance.

Even binding regulations adopted under Articles 21–22 require endorsement and domestic implementation. Sovereignty remains the hinge on which solidarity turns, and this state-based solidarity exemplifies the tension between the UN system's international and cosmopolitan legal orders (Taylor, 2002). With these limits to prevent the WHO from pursuing its cosmopolitan imagination, early technical programmes and field missions fostered transnational epistemic communities, and the experience of regional offices offers a different trajectory. Powerful regional bodies such as the Pan American Health Organization (PAHO), founded in 1902, have often worked rather autonomously, reflecting progressive politics and local activism that unshackle centralised technocracy and procedural restraints, and, for another example, the Regional Office for the Western Pacific (WPRO), with strong leadership managing diverse initiatives, is home to 38 countries and areas with over one-quarter of the world's population.

The constitutional claim that 'the health of all peoples is dependent upon the fullest cooperation of individuals and states' marked the emergence of a relational version of cosmopolitanism that emphasises duties of cooperation—obligations to assist, share knowledge, and refrain from transboundary harm. Yet this cosmopolitan ideal quickly collided with geopolitical realities. During the Cold War, global health became an arena of ideological competition, with Western actors privileging technological intervention and eradication campaigns while the Soviet bloc advanced statist welfare models. The WHO's dependence on assessed contributions and its deference to regional arrangements also limited its capacity to reconcile competing values (Birn, 2009). Although the 1978 Declaration of Alma-Ata, which condemned gross inequalities in health as 'politically, socially and economically unacceptable', miraculously bridged these divides, the subsequent neoliberal turn weakened the WHO's normative leadership, as high-income states increasingly pursued health initiatives outside the organisation.

The HIV/AIDS crisis first exposed this institutional inadequacy. While Jonathan Mann's early leadership prioritised human rights, the WHO ultimately struggled to manage a truly multi-sectoral response. This prompted ECOSOC to bypass a WHO-only approach and establish the Joint UN Programme on HIV/AIDS (UNAIDS), involving various UN agencies, civil society actors, and private-sector stakeholders and integrating human rights principles as a guiding framework. In contrast, the WHO maintains tighter control over the response to non-communicable diseases. The resulting UN Inter-Agency Task Force (UNIATF) on NCDs, established in 2013, has since been criticised for failing to challenge the commercial interests driving the NCD epidemic and lacking accountability mechanisms (Collins et al., 2025).

Solidarity remained circumscribed by sovereignty. The exclusion of Taiwan illustrates this structural trap. Since 1972, following the UN seat change, Taiwanese participation has been limited to conditional observer arrangements. The realpolitik of state recognition overshadows the organisation's universalist mandate. Paradoxically, the WHO has developed elements of functional sovereignty. Through specialised expertise and delegated authority, it claims to act on behalf of humanity and science, promulgating binding regulations and declaring global health emergencies. Yet this technocratic autonomy remains bounded by the member states' political will. The resulting tension between delegated authority and state control highlights the fragile equilibrium between liberal institutionalist and realist legal orders (Klabbers, 2019).

Human rights discourse has played a dual role in stabilising this balance. It provides the WHO with a moral language through which to assert legitimacy, while also reminding the organisation that individuals and communities—not bureaucracies—are the subjects of rights. The right to health thus operates as both a mandate and a constraint: it empowers global action but demands sensitivity to local autonomy. This ambivalence captures the 'bounded cosmopolitanism' of international health law—an aspiration to universality constantly mediated by state power and cultural difference (Toebes, 2015).

A comparative glance at treaty practice shows that sovereignty in global health law is historically contingent rather than fixed. During the FCTC negotiations in 2003, the first preambular clause affirmed the right of Parties to protect public health—an equity-oriented claim advanced by low- and middle-income countries in their resistance to transnational tobacco corporations. By contrast, the 2025 Pandemic Agreement repeatedly invokes the 'sovereign right of States' to safeguard domestic autonomy over policymaking and biological resources, reflecting anxieties about geopolitical influence. In both contexts, sovereignty functions as a defence against external domination, but what once served as a bulwark against

corporate power now raises concerns that expansive sovereignty claims may provoke populism or justify non-cooperation and isolationism (Gostin et al., 2020).

The failure to resolve this tension is evident across the four primary global health legal instruments. The IHR focus on outbreak notification but lack enforcement against travel bans; the FCTC regulates commercial determinants yet has been struggling with transnational industry interference and disputes before the World Trade Organization (WTO); the PIP Framework provides a voluntary virus-sharing system that nonetheless left vaccine access to market discretion; the Pandemic Agreement seeks to mandate technology sharing but remains constrained by clauses that allow states to prioritise national biological resources over global equity.

Against this backdrop, one durable achievement of bounded cosmopolitanism has been the codification of solidarity as a legal obligation—from the IHR's default binding force to the PIP Framework's virus- and benefit-sharing model—marking a shift in the grammar of global health law where cooperation becomes a legal duty. However, the design of these instruments continues to channel responsibility through governments. Obligations are addressed to states, not directly to the people whose health is governed, or to non-state actors whose representation and voices remain limited, in which the cosmopolitan ideal risks reproducing paternalism under the guise of universalism.

Recent debates on pandemic preparedness, intellectual property, and vaccine equity have repeatedly reminded the world of the tension between solidarity and sovereignty. The COVID-19 crisis exposed how quickly national self-interest can eclipse global commitments and how dependent the WHO is on the consent of its most powerful members. The persistence of these conflicts affirms the continuing relevance of the cosmopolitan ideal. The aspiration to protect the health of all peoples, however compromised, remains the moral horizon against which governance failures are measured (Prah Ruger, 2018). To address these challenges is not to abandon cosmopolitanism but to re-ground it in a more pluralistic and equitable understanding of solidarity that acknowledges interdependence without erasing difference, thereby ameliorating the tension between cosmopolitan solidarity and parochial sovereignty.

Recentring equity in a neoliberal age: Marketisation and erosion of rights

By the late twentieth century, the universalist aspirations that once animated the postwar 'health–human rights' project confronted a profound structural shift. The neoliberal turn of the 1980s reframed health from a collective entitlement into an individualised commodity, positioning efficiency as the organising principle of global governance. This transformation did not eliminate the language of rights; it reinterpreted it through market logics. As global health became entangled with trade liberalisation, intellectual property regimes, and austerity reforms, the WHO's commitment to social justice was progressively narrowed to a technocratic calculus of cost-effectiveness and public–private partnership.

The debt crises of the 1980s and the rising influence of the Bretton Woods institutions ushered in an era of 'conditional solidarity'. Structural adjustment programmes (SAPs) compelled many states in the Global South to privatise public services, reduce social spending, and introduce user fees in healthcare. These interventions operated as a form of moral and fiscal discipline: citizens were recast as consumers, and health systems reconceived as markets (Meier & Fox, 2008). Far from accidental, these policies systematically dismantled public health systems in the Global South, forcing a retreat from comprehensive care toward a model in which 'investing in health' was justified as a route to economic productivity rather than as a realisation of human rights, as iterated by the World Bank's 1993 *World Development Report*.

Global health governance shifted to targeted interventions—vertical programmes financed by governments, philanthropy, and global health initiatives—rather than comprehensive public-sector strengthening. A managerial logic of measurability displaced the rights-based logic of universality. Within this environment, the WHO's constitutional commitment to 'the highest attainable standard of health' was reinterpreted as an aspiration circumscribed by budgetary realism (Kim et al., 2002). The emerging global order emphasised domestic responsibility, entrepreneurial opportunity, and market facilitation despite the framing of the right to health under the International Covenant on Economic, Social and Cultural Rights (ICESCR) as imposing international legal obligations regarding cross-national assistance and cooperation (MacNaughton & Ahmed, 2023).

Social protection receded as economic competitiveness became the measure of good governance, and this transformation has been described as the structural violence of globalisation, in which national competitiveness erodes social determinants of health. Trade agreements, intellectual property rules, and investment arrangements have prioritised capital mobility over people's mobility. The WTO's 1995 Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) epitomised this reversal by making medicines from public goods into proprietary technologies, constraining states' capacity to fulfil the right to health (Labonté & Schrecker, 2007).

Investment arbitration under bilateral and regional treaties, including claims before the Investor-To-State Dispute Settlement Mechanism challenging public health measures, further illustrates how fragmented legal regimes can constrain health protection unless cross-regime coordination is pursued. The legal entrenchment of medicines and vaccines imperialism has trapped postcolonial states in perpetual dependency as customers for drugs produced in the Global North, rather than participants in medical innovation (Ragavan & Vanni, 2021).

The WHO was often reactive in this shifting landscape, mediating between public health exceptions and corporate interests. The WHO FCTC marked a notable countermovement. As the first treaty negotiated under WHO auspices, it imposed binding obligations to restrict advertising, taxation, packaging, and liability exposures, reaffirming that commercial expression and trade interests may be limited to protect the right to health. The FCTC demonstrated the organisation's capacity to discipline markets through law rather than merely guide them through technical advice.

Neoliberal globalisation also prompted new articulations of human rights. Throughout the 1990s and 2000s, coalitions of states in the Global South invoked the right to development as a corrective to market excess. First proclaimed in 1986, this right asserted that economic relations must be oriented toward the equitable fulfilment of all human rights. Unlike the individualistic focus of the right to medicine, the right to development offers a collective framework to obligate states and the international community to allocate public goods for the public's health (Meier & Fox, 2010). Within the WHO, this ideal found partial expression in initiatives such as Health for All by the Year 2000 and the Commission on Social Determinants of Health. Although they did not systematically engage human rights treaties, both efforts sought to restore distributive justice to global health policy by linking health outcomes to poverty, education, and social protection.

The right to development and the principle of self-determination reframed equity not as charity but as collective sovereignty, the capacity of peoples to shape their own health systems free from external domination. This re-politicisation of health marked a partial return to the postwar ethos of solidarity. Yet without parallel financial and legal reforms, rhetoric outpaced institutional change. Structural adjustment had eroded the fiscal foundations of many health systems, leaving them dependent on donor cycles and the shifting priorities of philanthropy. Sovereignty and solidarity alike were subordinated to the market.

Neoliberalism also reconfigured the workforce, exposing a new inequity: the extraction of care labour from low- to high-income economies. In response, the WHO adopted the voluntary *Global Code of Practice on the International Recruitment of Health Personnel* in 2010, which, however, highlights the limitations of soft law in addressing global inequalities. Its emphasis on 'mutuality of benefits' could not conceal the power asymmetry between labour-exporting and labour-importing states.

This dynamic illustrates the broader global care chain, a system in which the right to health in one country is secured through the depletion of rights in another (Yeates, 2004). Market integration has globalised dependency rather than solidarity. Even universal health coverage (UHC), celebrated in the 2010s as a rights-based objective, risks becoming a managerial instrument unless paired with redistributive financing and labour justice mechanisms (Ranabhat et al., 2023). Recentring equity in a neoliberal age thus requires recovering the radical content of the right to health, which challenges market dominance rather than accommodating it. Health must be understood as both outcome and infrastructure of justice, a domain where trade, finance, care, and welfare intersect.

The human rights framework, when expansively interpreted, still offers tools for re-politicisation. CESCR's General Comment 14 affirmed that the right to health encompasses its underlying determinants and that international assistance constitutes a duty, not an act of benevolence (Prah Ruger, 2006). Realising this requires a commitment to equity being built into upstream processes, including financing, trade, and procurement rules, rather than added as a corrective after markets have already sorted winners and losers.

Hence, the task of the WHO and its member states is not merely to 'partner' with markets, but to govern them in accordance with human rights principles. Equity cannot be restored through efficiency metrics alone; it must be embedded in fiscal, trade, and labour policies that prioritise social justice. This requires global health law to evolve from managerial coordination toward normative governance.

But neoliberal rationalities persist. The Sustainable Development Goals, despite emphasising equity, rely heavily on voluntary financing and public–private partnerships (Ranabhat et al., 2023). Initiatives such as GAVI, the Global Fund, and Coalition for Epidemic Preparedness Innovations (CEPI) have fragmented authority and consolidated a competitive aid marketplace. The WHO, seeking to maintain its influence, often mediates rather than challenges this order, lending its legitimacy to a cosmopolitan language that masks persistent inequalities (Clinton & Sridhar, 2017).

Therefore, the erosion of rights under neoliberalism is not merely a policy failure but a constitutional one. It exposes the fragility of the postwar legal imagination when confronted with the distributive asymmetries of global capitalism. Recentring equity requires more than institutional reform; it demands reclaiming the moral economy of human rights as a counter-logic to market governance (Meier, 2006). Only then can global health law fulfil its original purpose: governing interdependence for the flourishing of all rather than the optimisation of the few.

Good global governance? Expertism, technocracy, and accountability web

If the postwar constitutional imagination grounded global health in universal human rights, the late twentieth and early twenty-first centuries witnessed the rise of a new legitimating paradigm: *good governance*. Emerging from development economics and administrative law, this framework promised to reconcile efficiency with accountability and expertise with participation. Within the WHO, it became both an ethical horizon and a managerial doctrine—a way of discussing justice without directly addressing politics. The proliferation of governance discourses has not resolved the organisation's legitimacy crisis; instead, it has reframed it. The central question now is not only *what* the WHO does but *how* and *for whom* decisions are made—and who is accountable when expert authority substitutes for democratic deliberation.

The organisation's reliance on technical expertise was present from its inception, but the drift toward technocracy intensified after the neoliberal reforms of the 1980s. Pressured to demonstrate measurable outcomes, the WHO restructured itself into a performance-oriented bureaucracy built around monitoring and evaluation. Decision-making gravitated toward expert committees, advisory groups, and evidence-based protocols. Concerns over efficiency and risk management overshadowed questions of distribution and justice. Although these mechanisms produced valuable knowledge, they narrowed the scope of normative debate: health is not only a scientific concern but also a political choice (Kenny, 2015). Rather than a deliberative order animated by the right to health, governance became associated with procedural rationality—transparent budgeting, monitoring frameworks, indicators, and audits.

In practice, good governance has depoliticised inequality. Tools meant to enhance accountability recast obligations as managerial performance; expertise became a proxy for legitimacy. The COVID-19 pandemic revealed the double-edged nature of scientific authority. When the WHO declared a PHEIC in early 2020, its technical guidance carried substantial weight. The same reliance on 'evidence-based' decision-making made the organisation vulnerable to accusations of delay or bias. Governments weaponised scientific uncertainty to contest their authority. The crisis did not erode expertise as much as expose its fragility when detached from political accountability.

This quasi-normative authority of science reflects the rise of informal rulemaking. Much of global health law is now produced through guidance, frameworks, and technical documents rather than treaties. These soft law instruments enable rapid response but blur the boundary between advice and obligation (Lee, 2025). Against this backdrop, the FCTC and the 2025 Pandemic Agreement are outliers that demonstrate the WHO's ability to translate expertise into binding obligations. Yet the effectiveness of these treaties ultimately depends on financing, technology transfer, and the enforcement practices embedded in routine WHO monitoring.

Because compliance generally relies on persuasion rather than coercion, the legitimacy of expertise depends on trust—an increasingly scarce resource in an era of disinformation and populist backlash. In

response, the WHO and its partners have promoted transparency and stakeholder participation as key elements of good governance. This rhetoric parallels developments in international law, where participation is framed as a procedural right (Sommerer et al., 2022). However, the WHA has historically avoided broad collaboration with ECOSOC-accredited NGOs, instead establishing a restrictive accreditation process for major health-focused organisations. This approach loses the potential for extensive contributions from civil society—such as women's and youth groups, Indigenous and minority communities, faith organisations, and labour unions.

Participation often remains symbolic. Consultations with civil society or affected groups are typically episodic and have limited impact on decision-making. They legitimise decisions already framed by expert consensus. Transparency likewise tends to be retrospective, publishing information after decisions are made rather than enabling deliberation beforehand. Accountability thus expands horizontally (to more actors) but not vertically (to those most affected). Under this proceduralising, the right to health risks devolving into a 'right to be informed' (Williams & Hunt, 2017).

Global governance exacerbates this problem because it lacks a single locus of accountability. Formally, the WHO answers to its member states; substantively, it is accountable to donors, partners, and civil society organisations. This multiplicity produces diffuse accountability—everyone is responsible, so no one is. The expansion of public–private partnerships such as GAVI, the Global Fund, and CEPI has further fragmented authority, creating a networked architecture with opaque lines of responsibility. Within this web, human rights principles serve as the only normative anchors, but their enforceability remains largely aspirational.

Indeed, the WHO's invocation of human rights varies across issues and audiences, with the rights language appearing largely muted, except for mental health, and in the development of the Convention on the Rights of Persons with Disabilities (CRPD), in which the WHO was involved. Notably, the WHO's 14th General Programme of Work (2025–2028) expresses a commitment to human rights and gender equality, although its realisation is yet to unfold. The organisation's moral authority depends on whether its internal governance embodies the rights it promotes externally. And surely, rights cannot be realised through institutions that do not themselves practise rights-based governance (Williams & Hunt, 2017).

The International Health Regulations 2005 illustrate this dilemma. Although the Joint External Evaluation and core capacity obligations introduced peer-review monitoring, the regime's leverage remains reputational. States must notify and cooperate, but the WHO cannot compel compliance or impose sanctions for non-cooperation. The Secretariat can name and recommend, but it cannot enforce. Accountability is hence both political and juridical, sustained by the expertise's authority—an authority that trembles when questioned, as during the COVID-19 pandemic. Moreover, technocracy also hierarchises knowledge. The WHO's epistemic infrastructures—epidemiological models, surveillance systems, and evidential hierarchies—privilege data produced by well-resourced states and institutions in the Global North.

This asymmetry is an epistemic injustice: whose knowledge counts becomes a political question disguised as a methodological issue, whereas human rights frameworks offer tools to challenge these inequities (Lee, 2023). The principles of participation and non-discrimination imply a duty to recognise diverse epistemologies as legitimate. Yet procedural reforms rarely overcome entrenched biomedical paradigms. As Erondu et al. (2025) argue, decolonising global health requires re-politicising expertise, treating it not as a neutral truth but as a social practice rooted in power relations. Only then can 'good governance' avoid becoming a technocratic form of self-regulation.

A genuine rights-based conception of good governance would invert the hierarchy between efficiency and equity. Accountability would shift from auditability to *answerability*: institutions would be obliged to justify their actions to the people whose lives they govern. Transparency would facilitate deliberation, not merely disclosure (Gostin et al., 2020; Lee et al., 2025). Fair representation and meaningful participation would entail shared authority, not just consultation, and expertise would be accountable to actors expressing concerns from the plane of civil society rather than insulated from them (Forman, 2014; Kickbusch & Reddy, 2015). Realising such a transformation requires a change in institutional culture. Proposals for independent global health accountability agencies or for integrating human rights review mechanisms into WHO monitoring illustrate possible pathways. But structural redesign is insufficient without an epistemic transition from *governance of health* to *governance for justice*, which guarantees personal and community capacity to self-sustain and flourish (Prah Ruger, 2018).

The discourse of good governance thus captures a central paradox of the contemporary moment: it promises legitimacy through transparency while often perpetuating technocratic opacity. The WHO's legitimacy crisis is not only about performance, but also about representation (Sommerer et al., 2022). Expertism without accountability reduces human rights to procedure; accountability without power reduces them to rhetoric. The challenge is to weave a web of accountability that links scientific authority to democratic responsibility, and global expertise to local experience. Only through such relational governance can the normative project of global health law move beyond management toward emancipation.

National/human security? The pandemic and regression of multilateralism

The COVID-19 pandemic posed the most existential challenge to the WHO since its founding. States reasserted their sovereign supremacy, regional exceptionalism proliferated, and human rights were again subordinated to national security concerns. What began as an attempt to restore confidence in multilateralism culminated in the WHA's adoption of the Pandemic Agreement in 2025—an historic instrument whose authority will ultimately depend on financing, technology sharing, and human rights–based accountability in emergencies.

The pandemic triggered not only a public health disaster but also a legitimacy crisis for the global health legal order. When the WHO declared COVID-19 a PHEIC, it invoked the IHR 2005's solidarity mechanisms, but the worldwide response quickly fractured into unilateralism. Border closures, export bans, and vaccine hoarding defined a resurgence of epidemiological nationalism (Lee, 2023). This 'shared vulnerability' proved uneven; every state claimed to safeguard its own population, often through unsupported laws that deepened inequalities and limited space for dissent (Roberts et al., 2025).

The phenomenon of the securitisation of health revived early twentieth-century sanitary logics, in which disease control justified the exercise of exceptional state powers. What distinguished COVID-19 was the speed and scale of regression. Emergency rhetoric eclipsed decades of global public goods discourse and the rights-based framing of health. The world shifted from 'human security'—a vision of peace grounded in collective well-being—to national security, where the state reemerged as both protector and threat.

WHO's predicament illustrates the fragility of multilateral governance. Its dependence on state consent and voluntary funding left it vulnerable to political manipulation. The US withdrawal under the Trump administration demonstrated how domestic populism can undo global commitments (Yazdi-Feyzabadi and Haghdoost, 2025). Meanwhile, rival powers projected influence through health diplomacy: China via vaccine shipments; the EU through regulation; and Taiwan and Somaliland through bilateral assistance.

In this contest of sovereignties, the WHO oscillated between technical coordination and moral arbitration. Early praise of China's containment efforts was interpreted by some as political appeasement and by others as scientific prudence, underscoring how global authority depends less on formal competence than on perceived neutrality—a quality difficult to maintain amid geopolitical polarisations. The organisation was indispensable but institutionally constrained: it could advise, warn, and convene, but it could not compel.

The regression of human rights language was particularly stark, resulting in what UN Secretary-General António Guterres decried as a 'pandemic of human rights abuses'. Emergency powers, surveillance technologies, and mobility restrictions were implemented with limited scrutiny, often exceeding constraints under international law. Vulnerable groups (e.g. migrants, refugees, prisoners, people with disabilities, and informal workers) experienced multiple and intersecting obstacles to their fundamental rights (de Mesquita et al., 2021). The rights-based discourse that shaped earlier crises such as HIV/AIDS was conspicuously muted (Beyrer et al., 2024).

Even the Pandemic Agreement negotiations reflected this dilution. Early drafts referenced equality, participation, and non-discrimination; later versions substituted these with technical terms such as 'equitable access' and 'capacity building'. This linguistic shift marked not just a political compromise but also an epistemic one: in an era of global risk management, human rights were increasingly cast as impediments to rapid action rather than as the foundations of legitimate governance.

Vaccine distribution offered the clearest expression of this regression. Conceived as a solidaristic framework to ensure equitable access, COVAX deteriorated into a hierarchy of privilege. High-income

countries pre-purchased vast stocks, relegating low-income regions to last-resort donations. The mantra 'no one is safe until everyone is safe' has become a moral rallying cry rather than a guiding policy. Market contracts and political relations—not legal obligation—determined who would receive vaccines first (Brown & Rosier, 2023). Global health law lacked sufficient enforceability to mandate equitable resource distribution.

This 'vaccine apartheid' was not a failure of coordination but a symptom of a postcolonial legal architecture that systemically privileges trade and intellectual property monopolies over collective health (Sekalala, 2025). It also exposed the structural continuity between neoliberalism and nationalism. Both view health as a scarce resource to be allocated, rather than a right to be fulfilled (Bajaj et al., 2022). COVID-19 revealed the limits of both cosmopolitanism and capitalism: the former lacked coercive power, while the latter lacked resilience. Multilateralism became a language of moral gesture, with its institutions trapped between the politics of blame and the pragmatics of dependence.

Public health responses increasingly adopted a war metaphor: 'front-line workers', 'battle plans', 'war on the virus'. Such language legitimised exceptional measures while concentrating executive power. Governments imposed states of emergency, militarised quarantines, and digital surveillance, while the WHO occasionally reinforced the martial narrative. These imaginaries produced compliance but undermined solidarity, as they encouraged citizens to sacrifice for the nation rather than cooperate for the greater good of humanity (Li & Lee, 2023).

The securitisation of health also revived colonial resonances. Global surveillance infrastructures expanded through technologies and data flows controlled predominantly by corporations and states in the Global North. The pandemic accelerated processes of digital population management, entrenching epistemic dependencies of the Global South on Northern expertise. Security became a new idiom of inequality, legitimising intervention without redistribution. The negotiation of the Pandemic Agreement between 2024 and 2025 aimed to restore confidence in global cooperation, but it also highlighted the enduring nature of hierarchies. Debates centred on sovereignty clauses—affirming states' authority to declare emergencies, control information, and allocate resources—rather than on shared obligations grounded in human rights.

Proposals for accountability mechanisms or redistributive financing met with resistance. While the final text addresses pandemic governance asymmetries more than earlier drafts, its transformative potential will depend on future interpretive and operational developments. Yet the negotiations sparked renewed normative consciousness. Civil society coalitions, Global South negotiators, and scholars advanced decolonial and human rights perspectives, insisting that preparedness must be grounded in justice and obligation rather than charity or optional cooperation. The question is not whether it can persist but whether it can be remade around principles of mutual care rather than strategic interest.

The regression of multilateralism during COVID-19 should not be mistaken for its demise. It revealed fault lines in a system that never fully reconciled sovereignty with solidarity. The pandemic reinforced global interconnectedness even as it stripped away the rhetoric of universality, exposing underlying material dependencies and epistemic hierarchies. It also reopened the possibility of transformation. As crises multiply—from climate change to antimicrobial resistance—the need for a people-centred rather than state-centric multilateralism becomes ever clearer that recognises that security without justice is fragile, and health without rights is untenable.

Reclaiming human security necessitates a constitutional reimagining of global health law—one that views human rights not as constraints on sovereignty, but as conditions of its legitimacy and accountability. The next section explores how decolonising global health may provide the ethical and institutional foundation for such renewed legitimacy.

Decolonising global health: Legitimating governance plurally and equitably

The legitimacy crisis exposed by the pandemic is not only institutional but also both ontological and epistemological. The WHO and global health governance remain tethered to a modernist paradigm that equates knowledge with technocratic expertise, universality with uniformity, and solidarity with a postwar ethical expression of institutionalising humanity. Addressing this impasse requires more than procedural

reform or new treaties. It demands a decolonial rethinking of what constitutes *global*, how health and well-being are defined, and whose voices and values shape governance.

Colonial continuities have long overshadowed the postwar order. While founded on sovereign equality, WHO operations often reproduced asymmetry: donor priorities shaped agendas, and local knowledges were subordinated to biomedical authority. As Abimbola et al. (2021) argue, global health remains a 'colonial enterprise in moral disguise', sustained by unequal flows of capital, data, and authority. This is evident concerning 'medical neocolonialism', where resources such as data, blood samples, and participation in clinical trials are extracted from the Global South to develop treatments that these communities generally do not share equitably (Sirleaf, 2025). This instrumentalisation relies on treating Black, Indigenous, and other subaltern bodies as 'useful' yet expendable and 'available' subjects for experimentation (Lakoff, 2010).

This coloniality is both epistemic and material—evidence hierarchies privilege quantification, erasing relational, communal, and ecological understandings of health. Indigenous frameworks understand well-being through the concept of human/more-than-human harmony; feminist and disability movements conceive of health as interwoven with autonomy, care, and interdependence. But these epistemologies remain peripheral. Decolonising global health, therefore, requires decolonising epistemology itself, as universality without plurality becomes domination (Affun-Adegbulu & Adegbulu, 2020).

Conventional reform rarely confronts these deeper epistemic concerns. Decolonial constitutionalism would transform the normative foundations of global health law, replacing vertical donor–recipient relations with horizontal mutual accountability. In this vision, legitimacy arises from the meaningful inclusion of those most affected by policies in the creation of the rules that govern them. Such constitutionalism recognises multiple sovereignties—national, Indigenous, communal, and epistemic—as sources of resilience rather than disorder. It calls for moving from 'capacity building', which presumes a hierarchy of knowledge, to capacity sharing and mutual recognition (Erondu et al., 2025).

Tracing this historical trajectory reveals that inequities in access to medicines are not aberrations but symptoms of a postcolonial legal framework that sustains racialised exclusion to further global trade. Redressing this requires a framework of reparative justice. Effective reparations must go beyond symbolic apologies to institute material changes, encompassing new legal consensuses centring the Global South experiences, structural reforms to enable local innovations and productions even if frugal, and South-South collaborations like the Health Development Partnership for Africa and the Caribbean (HeDPAC) to tackle a culture of dependency (Sekalala, 2025). The WHO's authority would shift from central command to inclusive convening, creating a space where diverse normative orders can interact. Agonism and disagreement become a method of justice rather than a failure of governance.

Decolonisation also means releasing the right to health from its technocratic domestication. The right must be understood not only as an individual entitlement but also as a collective claim to self-determination over social, cultural, and ecological determinants of well-being. For many formerly colonised communities, achieving the 'highest attainable standard of health' is inseparable from resisting extractivism, displacement, and environmental degradation. Linking the right to health with the rights to development and a healthy environment restores its juridico-political force (Lee & Antonio, 2022).

Within this expanded frame, the WHO could act as custodian of interdependent rights rather than a regulator of narrow health outcomes. Decolonising the right to health entails shifting from outcome-oriented legitimacy to process-based legitimacy: what matters is not only what is achieved, but how and by whom. This aligns with feminist and Indigenous understandings of justice, which emphasise participation in shaping the meanings and priorities of health and care.

Plural and equitable governance requires epistemic justice, which involves redistributing authority over what counts as evidence and whose experiences inform policy (Affun-Adegbulu & Adegbulu, 2020). The dominance of 'evidence-based' paradigms marginalises experiential and community-based knowledge. A decolonial approach would demand evidentiary diversity, which combines statistical data with narrative testimonies, community epidemiology, and local monitoring, and makes transparent how these inputs shape decisions.

Institutionally, such justice could be reflected in multi-chambered deliberative structures across the WHO system—forums where scientific experts, Indigenous leaders, disability and human rights advocates, and representatives from social movements deliberate on an equal epistemic footing. This is not symbolic

inclusion; it expands the cognitive map of global health, enabling governance responsive to lived realities rather than abstract averages. As Chaudhuri et al. (2021) note, decolonising global health requires 'transformative solidarities' that treat difference as the basis for collective action.

The ethical centre of decolonial global health is solidarity as co-responsibility. Mere recognition of common dangers is insufficient. Humans must enact a shared responsibility derived from interconnectedness and its unjust outcomes. As Young (2011) argues, this shared responsibility applies to every participant, state or non-state, in the global social structure. It requires those who benefit from global economic, ecological, and epistemic arrangements to address the structural injustice they produce, regardless of individual wrongdoing. Re-legitimating global health governance depends on further institutionalising people's solidaristic sentiment into structure (Bosha et al., 2025).

The recently adopted Principles and Guidelines on Human Rights and Public Health Emergencies, developed by the Global Health Law Consortium and the International Commission of Jurists, aptly articulate this shift: solidarity is not charity, but an ethico-legal principle that generates redistributive duties (GHLC–ICJ, 2024). This perspective transforms the WHO's basis of authority. Instead of asserting universality from above, the organisation can derive legitimacy from transnational alliances among those who share vulnerabilities—frontline workers, migrants, women and girls, queer and disabled persons, Indigenous peoples. These networks already practice forms of grassroots multilateralism, yet they are largely unrecognised by formal institutions.

The future of the right to health may depend less on new treaties than on institutionalising these voices without forcing them into rigid accreditation models. At its core, decolonising global health affirms interrelatedness and interdependence as constitutional principles. Interdependence is not a weakness, but rather a recognition that autonomy is relational and that justice requires reciprocal vulnerability (Bosha et al., 2025). The pandemic made this undeniable: the health of one population depends on the health of others, but the means to secure it remain unequally distributed. A decolonial approach treats this interdependence not as a pragmatic necessity but as a moral and legal foundation.

This ethic also redefines expertise. To know responsibly is to be accountable to those about whom knowledge is produced; to govern legitimately is to share authority over the definitions and distributions of health. The WHO's renewal depends on adopting this ethic as institutional design, embedding plural participation, equitable financing, and shared epistemic authority into its governance (Prah Ruger, 2018). The pursuit of universality need not be abandoned but reinterpreted. A decolonial approach grounds universality not in assimilation but in dialogue across differences—a 'pluriversal' order where multiple worlds coexist and collaborate. Legitimacy derives not from abstraction but from reciprocal accountability across asymmetries.

Decolonising global health is therefore not the end of multilateralism but its re-foundation. It offers a path to re-legitimise governance by grounding it in plural solidarities that acknowledge history, redress inequality, sustain planetary well-being, and allocate responsibility. The concluding section then turns back to the central question: does the crisis of postwar global health law mark a return to the beginning, or the opening of a more equitable and pluralistic future?

Conclusion

This article views the WHO as a postwar legal experiment that sought to elevate interstate coordination into a form of global constitutionalism grounded in peace and the right to health. The tensions traced throughout—sovereignty and solidarity, equity and marketisation, expertise and accountability, human and national security—are not new. COVID-19 exposed them as the cumulative result of institutional design, neoliberal political economy, and entrenched epistemic hierarchies that have steadily eroded the moral authority of multilateralism.

The pandemic revived the logic of sanitary protectionism—borders, exceptionalism, and technocratic paternalism—revealing how easily the postwar imagination can regress toward its early-20th-century antecedents. It also reminded us of what that postwar moment sought to transcend: a world in which people's health depends on the security, discretion, and development of states. Preventing a full regression requires returning not to the institutions of 1948, but to the normative core that animated them—human rights as the architecture of care—while rebuilding them for a plural and unequal world.

Three implications follow. First, legitimacy must be re-anchored in interdependent rights. The right to health must be reclaimed as both an individual and collective right, linked to self-determination, a healthy environment, equitable development, and other enabling conditions. Human rights are not obstacles to preparedness, but rather the foundation of its credibility.

Second, accountability must be understood as answerability. All participants in the global social structure share a responsibility. Good governance cannot rely solely on audits and guidance; it must also incorporate effective oversight mechanisms. It requires shared authority with those most affected—standing participatory fora, rights-based review within surveillance and emergency procedures, and enforceable duties to share knowledge, technologies, and resources.

Third, preparedness must be treated as a distributive project. Equity cannot be added after market mechanisms have already sorted winners and losers. It must be built upstream into financing, trade, labour mobility, and intellectual property rules so that future arrangements resemble global commons rather than queues.

Across these shifts lies a decolonial ethic: plural universality. Universality should emerge from negotiated coexistence among diverse sovereignties, knowledge traditions, and affected publics—not from assimilation to a single normative baseline. In this model, the WHO functions less as a sovereign regulator and more as a convening constitutional platform, a custodian of processes through which heterogeneous publics deliberate, negotiate, and contest global health norms.

One way is to accept a future in which security eclipses justice and expert authority remains detached from those it governs. The alternative is to begin again—this time from the premise that interrelatedness and interdependence are not vulnerabilities to be managed but constitutional principles to be realised. The postwar order provided global health law with its vocabulary; the task ahead is to furnish it with a future in which solidarity is institutionalised obligation rather than charity, evidence is shared power rather than distant authority, and the health of all peoples becomes, in law and in practice, the measure of our common peace.

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Data availability statement

Data sharing does not apply to this article as no data were created in this study.

Declaration of generative AI and AI-assisted technologies

During manuscript revisions, the authors used OpenAI ChatGPT (GPT-5.5 Thinking) and Grammarly to support proof-reading and reference-list reformatting. These tools were used to improve grammar and APA-style formatting. They were not used to generate the manuscript's substantive argument and legal analysis. All AI-assisted suggestions were reviewed, verified, and revised by the authors, who remain fully responsible for the content, accuracy, integrity, and final form of the manuscript.

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