Africa, COVID-19, and International Law: From Hegemonic Priority to the Geopolitical Periphery?

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Abstract One of the most striking features of the COVID-19 pandemic is how balance-of-power politics have shaped U.S. and Chinese responses to this global health crisis. The geopolitical reactions of China and the United States to the pandemic have implications for global health, including global health endeavors focused on Africa. This chapter explores how the return of balance-of-power politics might affect global health, Africa's place in global health, and the international law used in this policy area. Global cooperation and international law on health will be more politically contested, and geopolitics will shift Africa towards the periphery of global health from the priority position it had in global health during the post-Cold War period when the United States was the unrivalled great power. These changes will transform the context in which African governments conduct health diplomacy through the remainder of the COVID-19 pandemic and beyond.

1 Introduction

At the beginning of March 2020, the World Health Organization (WHO), the specialized health agency of the United Nations, issued its first report on COVID-19 for the African region, reporting 11 cases and 0 deaths.[1] At the end of April, WHO recorded 22,376 cases and 899 deaths in the region related to COVID-19.[2] Yet, the spread of this disease across Africa barely qualified as news around the world.

Once upon a time, such an increase in cases and fatalities in Africa caused by a dangerous infectious disease would have captured the global health community's

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[1] World Health Organization (2020a), p. 2.

[2] World Health Organization (2020c), p. 2.

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attention and rung alarm bells in high-income countries. Indeed, in the years preceding the emergence of a novel coronavirus in China, Ebola outbreaks in West Africa and the Democratic Republic of the Congo were the most prominent health emergencies that states, international organizations, and non-governmental actors confronted. In the first decade of this century, the international community mounted extraordinary efforts against infectious diseases inflicting a terrible toll on Africans, including HIV/AIDS and malaria.

How times have changed. The COVID-19 pandemic has created health and political crises that threaten to alter Africa's place in global health. The pandemic has ravaged affluent and well-resourced countries, causing illness, death, economic damage, and social disruption on a scale not experienced in these countries for decades. These consequences triggered controversies about how governments prepared for, and responded to, the pandemic. What is happening in Africa does not register in countries that this pandemic has badly mauled.

But, for African countries, it is potentially worse. In another unprecedented feature of this pandemic, China and the United States have turned it into another geopolitical battleground in their competition for power and influence in international relations.[3] The balance-of-power politics between the Chinese and U.S. governments have made WHO so vulnerable that its ability to help nations, especially low-income countries, during and after the pandemic might be jeopardized. The United States and other countries are upset with how WHO interactions with China appeared too deferential to, and praiseful of, the Chinese government and are demanding changes to the organization, with little, if any, regard for the interests of African countries.

In short, changes in the distribution of power might be shifting Africa's place in global health. Before the COVID-19 pandemic, Africa was, for at least 20 years, a priority in the global health activities undertaken in a hegemonic system—an international system dominated by one power, the United States, rather than characterized by competition among two or more rival countries. The Sino-American rivalry has shaped responses to the COVID-19 pandemic, underscoring that the balance of power has returned and displaced the hegemonic system. This change threatens to move Africa's place in global health to the periphery of the new balance-of-power system.

Of course, the return of geopolitics has implications for African countries beyond global health. However, with a pandemic highlighting how the distribution of power has changed, an examination of global health is warranted. This chapter focuses on one aspect of the potential impact on global health of the geopolitical turn in international relations—the international law associated with protecting and promoting health from pathogenic and other threats. The COVID-19 pandemic is not over, but it has already damaged the international law that featured in global health in the hegemonic system. This damage matters for more than just Africa, but the consequences for African countries should inform conversations about what comes after

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[3] 'Is China Winning?' The Economist (2020), p. 7.

the pandemic. For Africa, the pandemic's impact on the international law relevant to global health promises to be complicated rather than catastrophic.

Much of the global health effort focused on Africa in the first two decades of this century, including significant increases in international health assistance, did not directly arise from, or depend on, international law. However, various areas of international law factored into how states, international institutions, and non-governmental organizations (NGOs) addressed health problems in African nations. Analyzing how the return of geopolitics affects this web of international legal regimes provides insights into the future of international law in the health diplomacy that African countries will conduct.

2 Africa, Global Health, and International Law in the Hegemonic System

2.1 Global Health and the Hegemonic System in the Post-Cold War Period

International health cooperation began in the latter half of the nineteenth century with a series of conferences addressing the cross-border spread of infectious diseases.[4] These conferences involved treaty negotiations, reflected emerging scientific research and public health strategies, and laid the groundwork for the establishment of international health organizations.[5] WHO's creation after World War II expanded intergovernmental efforts on health. These efforts produced remarkable achievements, especially WHO's successful eradication of smallpox.

However, in the history of health cooperation, nothing compares to the astonishing activities undertaken after the Cold War. High-income countries devoted more political attention and economic assistance to global health than they had ever done. The highlight of this phenomenon is the President's Emergency Plan for AIDS Relief (PEPFAR) launched by the United States in 2003, which 'represents the largest commitment by any nation to address a single disease in history.'[6] WHO member states radically revised the main international agreement on infectious diseases, the International Health Regulations, and adopted the first treaty in history on tobacco control. Philanthropic foundations, especially the Gates Foundation, catalyzed innovative activities. Countries collaborated with intergovernmental bodies and NGOs on ground-breaking initiatives, such as the Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund) and the Global Alliance for

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[4]Howard-Jones (1975).

[5]Goodman (1971) and Fidler (1999).

[6]President's Emergency Plan for AIDS Relief (2018). The U.S. government also started the President's Malaria Initiative in 2005 'to reduce malaria-related mortality by 50 percent across 15 high-burden countries in sub-Saharan Africa.' President's Malaria Initiative (2020).

Vaccines and Immunization. NGOs brought international human rights to bear on health problems, such as access to antiretroviral treatments for HIV/AIDS, on a scale and with an impact not seen before.

No one factor explains why global health was transformed after the Cold War. However, the collapse of the balance of power and the emergence of a hegemonic system created an unprecedented context for many policy areas. This change in the distribution of power opened political space for new interests, ideas, participants, institutions, movements, and approaches addressing all sorts of problems. With the constraints of balance-of-power politics gone, the first decade of this new period witnessed a burst of initiatives that produced new international law on, among other things, environmental protection, chemical weapons, trade, and war crimes.[7]

The health community took advantage of the new political space. Interest in revitalizing WHO increased in the 1990s. The desire to strengthen WHO informed the appointment of Gro Harlem Brundtland, former Norwegian prime minister and global leader associated with the cause of sustainable development,[8] as director-general in 1998. Efforts began on revising international law on infectious diseases, rejuvenating international human rights law in global health, and crafting a new treaty to bolster the fight against tobacco consumption.[9]

For global health and other policy areas, the hegemonic system proved more open to change, including for the development of international law, than the Cold War's balance of power. Conceptually, balance-of-power politics drive major powers to view issues, initiatives, and ideas in terms of how they might affect the distribution of power. This 'zero sum' perspective forces the great powers to attempt to control developments to hurt competitor states or prevent change that might benefit rivals.

In a system that has a preponderant power rather than a balance of power, the hegemonic state can pursue its interests and ideas with less resistance. However, because the hegemon faces no pressure from rivals, it can be more agnostic about novel issues, emerging initiatives, and new ideas.[10] The post-Cold War hegemonic system exhibited these features. The United States used its power to advance its agenda, including the spread of democracy and economic globalization. But the United States turned a blind eye to many political strategies and developments that it did not prioritize or support. Thus, the hegemonic system proved tolerant of policy innovation and change across international relations.

Global health reflected these features of the hegemonic system. The United States elevated global health in its national security and foreign policy, which translated into U.S. support for making WHO more effective and revising international law in

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[7]See, e.g., UN Framework Convention on Climate Change (1992), Chemical Weapons Convention (1992), World Trade Organization (1994), Rome Statute on the International Criminal Court (1998).

[8]World Commission on Environment and Development (1987).

[9]International Health Regulations (2005), Committee on Economic, Social and Cultural Rights (2000), WHO Framework Convention on Tobacco Control (2003).

[10]Mearsheimer (2019).

light of the threat from emerging infectious diseases. In contrast, the human right to health enjoyed a renaissance, despite the lack of U.S. commitment to it. Indeed, the right to health was central to a global movement to ensure access to antiretroviral therapies for HIV/AIDS that confronted U.S. use of international trade law to protect the intellectual property rights of pharmaceutical companies. This movement was critical to high-income countries increasing their health assistance in the battle against HIV/AIDS, including PEPFAR and the Global Fund.

2.2 Africa as a Global Health Priority in the Hegemonic System

In the global health politics facilitated by the hegemonic system, Africa was a priority. Much of the increase in health assistance from high-income countries and foundations went to help African countries, including efforts against HIV/AIDS and malaria. For example, the United States 'is the largest funder and implementer of global health programmes worldwide,' amounting to $11 billion in 2019, and 'most of U.S. global health funding designated for specific country and regional efforts is allocated to Africa.'[11] More generally, sub-Saharan Africa received more development assistance for health 'than any other region in 2017 (the most recent year for which data is available).'[12] The scale of the health assistance funding and the programs supported was beyond anything ever seen in international health cooperation. The assistance contributed to progress against targeted diseases across Africa, which underscored the importance in global health of achieving more equitable access to pharmaceutical products and economic resources.

This provision of resources to combat diseases in Africa had 'spill over' effects. Low-income countries, led by Indonesia, challenged how WHO shared influenza virus samples provided by such countries with pharmaceutical companies in high-income countries. Low-income countries complained that the virus-sharing system did not ensure that benefits from research and development on the viruses would flow back to them. Using the Convention on Biological Diversity, low-income countries claimed sovereignty over influenza virus samples and insisted that the virus-sharing system include benefit-sharing.[13] African countries supported this demand for more equitable access to pharmaceutical and economic resources. WHO-sponsored negotiations produced the Pandemic Influenza Preparedness Framework (PIP Framework), another unprecedented development in global health governance.[14]

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[11]Kaiser Family Foundation (2019).

[12]Institute for Health Metrics and Evaluation (2018), p. 13.

[13]Convention on Biological Diversity (1992).

[14]World Health Organization (2011).

However, being a global health priority in a hegemonic system generated concerns for African governments and leaders. The scale of the disease threats affecting African countries highlighted problems with health care systems, public health capabilities, and continental health cooperation. The scale of donor funding deepened the dependence of African nations on high-income countries, multilateral organizations, and NGOs and raised questions whether African states could develop capacity to manage health threats without remaining dependent on aid for decades. These questions became more acute when international health assistance began to plateau and decline after the Great Recession.

The dependence was also not helping African countries address demands arising from other changes in global health. The revision of the International Health Regulations in 2005 (IHR (2005)) included unprecedented obligations for countries to develop and maintain basic surveillance and response capacities.[15] The IHR (2005) were designed to achieve 'global health security,' an objective that made Africa's participation in the revised regulations important. However, the IHR (2005) came with no funding to help low-income countries comply with the obligations on national public health capacities. This problem informed criticism in Africa and elsewhere about efforts to 'securitize' health, a phenomenon that critics associated with the desire of high-income countries to protect themselves against the spread of infectious disease.

2.3   The Tale of Two Ebola Outbreaks

2.3.1   Ebola in West Africa

The post-Cold War developments in global health that featured or affected Africa converged in the Ebola outbreak in Guinea, Liberia, and Sierra Leone in 2014. This outbreak was a disaster for global health and its focus on Africa. WHO's response was so bad that the UN Secretary-General created the UN Mission for Ebola Emergency Response. The crisis in West Africa, and the outbreak's threat to other African countries, demonstrated that the aid spent on HIV/AIDS and other health challenges had not sufficiently improved health care and public health capabilities in many African nations. The outbreak saw countries impose travel measures that violated the IHR (2005) and revealed that compliance with the IHR (2005)'s obligations on surveillance and response capacities in Africa and around the world was inadequate.

The response also resulted in Ebola virus samples from West Africa being distributed around the world with little attention paid to the sharing of benefits from research and development on the samples. This outcome highlighted that the virus-and-benefit sharing achieved by the PIP Framework did not apply to

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[15]International Health Regulations (2005), art. 5 and annex 1.

non-influenza pathogens. The need for high-income countries, especially the United States, to expend more political and economic capital on another African health crisis underscored the dependence of African nations. The deployment of French, British, and American military forces in the emergency response effort reinforced the framing of health as a matter of national and international security.

The West African Ebola outbreak provoked efforts to assess what went wrong, implement reforms, and chart a new course for global health and its commitment to Africa. The United States helped the African Union (AU) create the Africa Centres for Disease Control and Prevention (Africa CDC) to support health initiatives of AU member states and strengthen the capacity of their health institutions.[16] For its part, WHO improved its emergency preparedness and response capabilities so that it could better help countries manage disease events. WHO also supported initiatives designed to improve implementation of the IHR (2005), including through joint external evaluations, in which 44 African nations participated.[17] In 2017, WHO member states appointed Dr. Tedros Ghebreyesus, an Ethiopian, as the first African director-general of the organization.

2.3.2 Ebola in the Democratic Republic of the Congo

The first test for these efforts came with the DRC's Ebola outbreak in 2018. As noted above, WHO mounted an impressive response in difficult circumstances, including the first widespread use of Ebola vaccines developed after the 2014 outbreak in West Africa. Director-General Tedros won plaudits for his leadership. Unlike what happened in West Africa, WHO's performance in the DRC produced no calls for WHO reform. The DRC's outbreak also provided the Africa CDC with an opportunity to support African efforts against an African disease crisis. The Africa CDC deployed the African Volunteer Health Corps to provide assistance to the DRC and neighboring countries.[18] Despite the challenges of controlling Ebola in the DRC, the effort succeeded by the end of 2019 in bringing the outbreak to verge of elimination in 2020. The United States was the largest donor to the response effort, but it did not exhibit the global health leadership it had so frequently done in the post-Cold War period.

In terms of international law, the response to the DRC's Ebola outbreak involved a controversy about the timing of Director-General Tedros' July 2019 declaration of a public health emergency of international concern under the IHR (2005).[19] Despite the outbreak getting more dangerous, the emergency committee, which advises the director-general on whether to declare a public health emergency, repeatedly recommended against a declaration—advice Director-General Tedros accepted.

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[16]African Union (2020).

[17]World Health Organization (2020d).

[18]Tadesse (2019).

[19]Fidler (2019).

International lawyers and global health experts criticized the reasons given for not exercising the declaration power. Leaving aside the legal and health arguments, the emergency committee expressed skepticism about (1) the benefits a declaration would provide for the response effort; and (2) the effectiveness of the IHR (2005)'s rules against trade and travel restrictions that the committee feared would follow a declaration.

This skepticism connects to concerns that reviews of the Ebola outbreak in West Africa raised about the IHR (2005), especially the provisions on declaring a public health emergency of international concern and managing travel and trade restrictions. Although various reviews made recommendations focused on these aspects of the IHR (2005), WHO member states did not amend the regulations after the West African crisis. In the DRC outbreak, the emergency committee's resistance to declaring a public health emergency, and its lack of confidence in the rules on trade and travel measures, indicated that health leaders no longer perceived that these once-ground-breaking aspects of the IHR (2005) were productive for global health purposes.

WHO's success in supporting the DRC with scientific, medical, and public health capabilities, combined with the skepticism in the emergency committee's deliberations about the IHR (2005), suggested that, under Director-General Tedros, WHO would exhibit leadership more through deploying its functional capabilities than by exercising specific, controversial authorities under the IHR (2005). If so, the Ebola outbreaks in Africa informed an important shift in global health governance as the second decade of the century approached its end.

Although the two Ebola outbreaks kept Africa as a global health priority, the distribution of power in international relations was changing during the 2010s. The United States remained the strongest power, but Chinese and Russian efforts to challenge the United States gained prominence and achieved momentum. An article in 2014 entitled 'The Return of Geopolitics' captured the ongoing transition from a hegemonic to a balance-of-power system.[20] This transition continued, leading U.S. experts to declare as a new decade began that great-power competition would characterize international relations for the foreseeable future.[21]

This change in the international system did not affect global health in the 2010s. Neither China nor Russia challenged U.S. leadership in global health, and the return of balance-of-power politics did not derail U.S.-supported efforts, such as PEPFAR and the Global Fund. The Ebola outbreaks in Africa, and the controversies these outbreaks created, also did not attract geopolitical interest. Thus, during this decade, how the re-emergence of the balance of power would affect global health, and Africa's place within it, remained unclear.

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[20]Mead (2014).

[21]Colby and Mitchell (2020).

3 The COVID-19 Pandemic: Global Health, Africa, and International Law in a Balance-of-Power System

3.1 *The Geopolitical Features of the COVID-19 Pandemic*

The COVID-19 pandemic provides the first opportunity to assess how global health might fare in an international system dominated by the balance of power. The results, so far, are ugly. From the pandemic's early days, the United States and China framed the outbreak, and their responses, in geopolitical terms. As news about a dangerous disease event in China spread, U.S. commentary blamed China's leaders and political system for the outbreak and identified how the United States could take advantage of China's travails. For China, the political implications of the outbreak were so serious that its response had to reflect its great-power status, perspective on sovereignty, and global ambitions. Thus, China's narratives about the government's handling of the outbreak reflected its political requirements and geopolitical calculations more than events on the ground or its obligations under international law.

When the pandemic turned the tables on the United States and China, these patterns continued. As the United States struggled with COVID-19, American leaders, politicians, and pundits blamed China for the illness and death that the United States and other countries were suffering and accused China of violating the IHR (2005). As China controlled the coronavirus outbreak, it maneuvered to exploit the pandemic to expand its global influence and seize the mantle of the world's leading power. Critics of the U.S. response to the pandemic accused President Trump of relinquishing global leadership to China.

The manner in which China and the United States have approached the pandemic reflects how the balance of power distorts rival powers' perceptions of political developments, policy challenges, and international law. Great-power competition shrinks the space available for political cooperation, policy innovation, and international law, unlike what the hegemonic system fostered after the Cold War.

The distorting effect of geopolitics can also be seen in how the U.S. government has criticized WHO and its director-general, frozen U.S. funding for the organization, and decreased other forms of support for it because, according to President Trump, WHO has been 'China-centric' in responding to the pandemic.[22] The U.S. government has not anchored its measures against WHO in international law, including the WHO Constitution or the international law on the responsibility of international organizations.[23] These moves recall when, during the Cold War, the United States withheld funding from WHO because the Reagan administration

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[22]Shear and McNeil (2020) (reporting on President Trump's criticisms of WHO and the freeze on U.S. funding for the organization). WHO rejects the criticisms made by the Trump administration about how the organization responded to the pandemic. See, e.g., Lovelace (2020).

[23]International Law Commission (2011).

argued that the organization was working against U.S. interests by pushing for universal access to primary health care, an objective the Soviet Union supported.[24]

3.2 From Priority to Periphery: The Return of Geopolitics, Global Health, and Africa

The geopolitical features of the COVID-19 pandemic are widely acknowledged, but less attention has been paid to the implications of the return of balance-of-power politics for Africa and global health. As noted above, global health was prominent in the hegemonic system, with Africa a priority in global health. With the COVID-19 pandemic, the balance of power has turned global health into a venue for Sino-American competition. China and the United States have each damaged health cooperation by insisting that WHO's actions support its respective national interests. This spat between great powers threatens to marginalize African countries in the new international politics of global health.

Indicators of marginalization are appearing. The withdrawal of U.S. support for WHO, criticism of WHO's interactions with China from other high-income countries and entities (including Australia, Japan, and Taiwan),[25] and geopolitical squabbling over WHO reforms could weaken the organization. A weakened WHO would create the most problems for low-income countries, which depend more on the organization for outbreak assistance and other health purposes than do China, the United States, and countries with more capable health systems.

The more WHO becomes a battleground for balance-of-power politics, the more countries around the world, including those in Africa, will confront pressure to support China or the United States on global health issues. The U.S. government's criticisms of Director-General Tedros and U.S. moves against WHO already motivated African leaders to declare their support for Tedros.[26] Chinese attempts to counter U.S. actions against WHO, such as pledging more support for the organization,[27] will reinforce U.S. perceptions that WHO is beholden to Beijing and produce U.S. displeasure with African countries for backing a leader and organization reliant on China.

The potential souring of U.S. diplomatic relations with African countries over WHO will not, in all likelihood, remain confined to global health. Well before the COVID-19 pandemic, U.S. policymakers were concerned about inroads that China was making in Africa. The geopolitics of the COVID-19 pandemic could merge with these long-standing American worries about China's ambitions in Africa. This

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[24]Thomas (2020).

[25]Hernández (2020).

[26]Winning (2020).

[27]Shih (2020).

dynamic could mean that balance-of-power calculations alter U.S. perceptions of its global health efforts in Africa.

Does China expect, U.S. diplomats might ask, African countries to support its positions on the pandemic and at WHO because of Chinese investment and other activities in Africa? Why, U.S. politicians might wonder, should the United States continue expensive health programs in Africa when African governments favor China? What strategic benefits, China hawks in the United States might enquire, have PEPFAR and other U.S.-backed initiatives produced for the United States when African leaders side with China on a range of issues, including global health?

These questions highlight how the return of geopolitics, as manifested in the COVID-19 pandemic, could undermine the U.S. political calculations that helped make Africa a priority in global health for the better part of two decades. If the United States changes its outlook on Africa and global health for geopolitical reasons, then African countries will confront continued dependence in the health context while being marginalized in global health politics. Turning to China for help would accelerate the marginalization because it would harden the shift in U.S. policy, require African countries to accept conditions that come with Chinese assistance, and subject health aid for Africans to the geopolitical calculations of a different great power.

3.3 At the Geopolitical Periphery: International Law, Global Health, and Africa

As seen in the Cold War, balance-of-power politics affect international law, including through geopolitical incentives to ignore international law, use international law as a weapon against rival states, and maneuver for advantage in the development of international law. Responses to the COVID-19 pandemic exhibit these features of international law operating within a balance-of-power system. This reality creates questions about the future role of international law in global health and highlights the marginalization of Africa in global health.

In taking action against WHO, the U.S. government has provoked questions about whether its actions violate international law, including U.S. obligations under the WHO Constitution to pay its assessed contributions. Whether the U.S. government withholds monies appropriated for its assessed contribution remains to be seen.[28] As of 31 March 2020, the United States owed WHO nearly USD 100 million in current and past-due assessed contributions.[29] So far, the administration has not provided an international legal argument that justifies withholding assessed contributions over pandemic-related issues. However, the United States faces few consequences if it withholds assessed contributions for WHO to

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[28]Borger (2020a).
[29]World Health Organization (2020b).

advance its geopolitical interests *vis-à-vis* China. African countries would have no leverage if the United States chose to ignore its obligations on assessed contributions for geopolitical reasons, but the consequences of a weakened WHO for those countries could be considerable.

The U.S. government has frozen large sums of money intended for WHO that constitute voluntary contributions to the organization. The United States has no obligation under international law to make such contributions. The scale of U.S. voluntary contributions reflects the strategy that the United States used to maintain control over the increased resources it committed to global health in the post-Cold War period. The additional funds made more global health activities possible, including efforts in Africa, but the voluntary nature of the contributions made those activities dependent on the interests of the donor government. The U.S. reaction to WHO's dealings with China during the pandemic indicates that U.S. interests have changed, exposing dependency and vulnerability in global health, including in Africa, to U.S. power.

Criticism of WHO's interactions with the Chinese government also critiques China's behavior, including allegations that it was not transparent about the outbreak in Wuhan. These allegations raise questions about whether China's actions were inconsistent with the WHO Constitution's principle that the health of all peoples is dependent on the full cooperation of states.[30] In addition, concerns about China's transparency informed arguments that China violated the IHR (2005)'s provisions on notification and information sharing.[31] China has rejected claims that it violated international law, and its power serves as a disincentive for most countries, including those in Africa, to dwell on the issue.

The only serious push for Chinese accountability has come from the United States. President Trump asserted that China should pay compensation because it failed to share information and control the outbreak in its territory.[32] U.S. legal experts have argued that, under the international law on state responsibility, China owes compensation for violating the IHR (2005). The legal case that China committed an internationally wrongful act and must pay compensation to other countries for the damage the pandemic has caused under the international law on state responsibility is difficult to make,[33] and no country, including the United States, will pursue such a case in law.[34] Instead, U.S. demands for compensation will ignore international law in favor of unilateral actions against China.[35] Retaliation would

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[30]World Health Organization Constitution (1946), preamble.

[31]International Health Regulations (2005), arts. 6 and 7.

[32]Stein et al. (2020).

[33]Fidler (2020).

[34]Legal cases brought in the United States by individuals or state governments against China for damages associated with the pandemic are not based on international law. Rather, these cases argue that exceptions in the U.S. Foreign Sovereignty Immunity Act permit the lawsuits by removing China's sovereign immunity before U.S. federal courts for commercial or tort law claims against the Chinese government. For discussion, see Keitner (2020a, b).

[35]Stein et al. (2020).

serve U.S. geopolitical interests, but it could force other countries to declare their support for one side or the other. This squabble underscores how balance-of-power politics affects global health and international law in ways not seen in the hegemonic system.

The geopolitical reactions to the pandemic have included calls for WHO reform from countries concerned about WHO's interactions with China. Australia proposed giving WHO the power to enter countries to investigate disease outbreaks,[36] and U.S. officials have presented G7 health ministers with reform ideas.[37] Although presented as WHO reforms, these ideas flow primarily from Australian and American concerns about China's behavior. WHO reforms that essentially target China will force member states, including those in Africa, to 'pick sides' in a confrontation between the United States and China. African governments will have their own positions on reforms, but China and the United States will interpret support or opposition through the lens of the balance of power.

The same dynamic would arise if WHO member states decide to amend the IHR (2005) after the pandemic. Ideas for revising the regulations existed before COVID-19, such as supplementing the director-general's power to declare a public health emergency of international concern with authority to issue non-emergency alerts. The pandemic has increased interest in re-visiting the IHR (2005), and the United States has proposed giving the director-general authority to issue alerts before declaring a public health emergency and subjecting WHO member state compliance with the IHR (2005) to regular review. Opening the IHR (2005) to revision will turn all eyes towards how the United States and China perceive amendments. In addition, starting the process to amend the IHR (2005) means that state parties can propose revisions for any provision. The tabling of such proposals could also produce geopolitical maneuvering in the amendment process that affects all WHO member states and that contributes to producing amended regulations that are weaker than the existing agreement.

The return of the balance of power also has implications for the role of international human rights law in global health.[38] In the hegemonic system, international human rights law enjoyed increased prominence in global health. The movement for access to antiretroviral treatments for HIV/AIDS elevated the right to health, and, in another unprecedented feature of the IHR (2005), WHO member states included human rights provisions in the revised regulations. However, the COVID-19 pandemic contains features that suggest international human rights law is entering troubled waters.

First, China's efforts to use the pandemic to increase its global influence connects to pre-pandemic worries that China's rise to great-power status was creating threats to international human rights law, especially protections for civil and political rights.

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[36]Needham (2020).

[37]Borger (2020b).

[38]On health and human rights, see Gostin (2014), chapter 8 (Health and Human Rights: Human Dignity, Global Justice, and Personal Security).

Much of the criticism about China's response to the Wuhan outbreak focused on the Chinese government's repressive acts, particularly its censorship and persecution of individuals attempting to share information at odds with official positions.[39] Human rights advocates also associated China's increased geopolitical sway with the spread of authoritarianism, and the pandemic has provided incentives for authoritarian leaders and governments to claim more power at the expense of individual rights. These human rights fears about the rise of China and authoritarianism apply to Africa as well because of China's increased presence there and indications of increased authoritarian behavior by African governments.[40]

Second, the utility of digital technologies, such as COVID-19 'track and trace' applications for smartphones, to help governments address the pandemic has created human rights concerns about the right to privacy in the face of expanded government surveillance. These concerns have analogues in earlier global health activities, such as worries about privacy in connection with HIV/AIDS testing. However, the rush to develop, adopt, and use smartphone applications against COVID-19 around the world, including within Africa,[41] has broader human rights implications, especially in a context where China's rise and the spread of authoritarianism already has human rights organizations nervous.

Countries, international organizations, and NGOs are grappling with these pandemic-related human rights issues. Looking ahead, debates about human rights, including in global health, are likely to reflect the geopolitical fault line between the United States and China, much as the superpower rivalry marked human rights discourse during the Cold War. The presence of this fault line changes the human rights context for global health from the open, flexible environment that existed under the hegemonic system. What impact this change has on African deliberations on human rights and global health remains to be seen, but those deliberations will take place in the shadow of balance-of-power calculations about international human rights law.

Geopolitics is also affecting international law in the context of the development of drugs and vaccines for COVID-19. The United States has accused China of not sharing coronavirus samples collected during the Wuhan outbreak and, thus, undermining vaccine development efforts. This accusation recalls arguments made in the controversy about sharing influenza viruses emerged in the mid-2000s. That controversy involved competing claims about how international law regulated virus sharing needed to promote public health.

For influenza viruses, countries crafted the PIP Framework in 2011. For non-influenza pathogens, the Nagoya Protocol to the Convention on Biological Diversity entered into force in 2014, which reinforced sovereignty over pathogenic material but did not contain obligations to share such material with WHO or other

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[39]See, e.g., Wolfowitz and Frost (2020) and Palmer (2020).

[40]Freedom House (2020), pp. 24–27.

[41]Harrisberg (2020).

countries.[42] China, but not the United States, is a party to the Convention on Biological Diversity and the Nagoya Protocol. U.S. concerns about the Nagoya Protocol's impact on global health pre-date the COVID-19 pandemic, but the United States, even during the hegemonic system, failed to dissuade most countries, including many African states, from ratifying the Nagoya Protocol. Given support for the protocol, the prospects for the United States using the pandemic to change international law on sharing pathogenic material are not good.

The efforts to develop vaccines and drugs for COVID-19 have raised another issue that implicates international law and global health—the challenge of providing equitable access to vaccines and drugs produced to combat the pandemic. As happened during the H1N1 influenza pandemic in 2009, calls for equitable access to COVID-19 vaccines and drugs have been made, and WHO stresses the need for such access. However, as in 2009, there is no international legal framework for equitable access to pharmaceutical products. This situation leaves low-income countries, especially those without capacities to manufacture vaccines or drugs, vulnerable to how states exercise their sovereignty and use their economic resources when vaccine or drug supplies are insufficient to meet demand. With COVID-19, the lack of international law on equitable access will not, by itself, agitate the Sino-American rivalry. However, geopolitics could affect equitable access if, for example, China develops a vaccine first and pursues an equitable-access strategy that prioritizes supplying low-income countries, including in Africa, over high-income countries.

4   Conclusion

The COVID-19 pandemic is not over. Much remains uncertain about the pandemic's course, including how COVID-19 will affect Africa over the coming months. Much also remains unclear about how the Sino-American competition for power and influence will continue to affect pandemic response efforts and influence post-pandemic activities. The pandemic did not cause the change in the distribution of power that ended the hegemonic system and brought geopolitics back to world affairs. However, this change has affected how China and the United States have behaved during this crisis, and the change is likely to inform how these two countries handle global health issues that come after the pandemic.

Thus, the return of balance-of-power politics has far-reaching implications for global health, Africa's place in global health, and the international law relevant to this policy area. Global cooperation and international law on health will be more politically contested, and geopolitics will shift Africa towards the periphery of global health policy. These changes will transform the context in which African

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[42]Nagoya Protocol (2010).

governments conduct health diplomacy through the remainder of the COVID-19 pandemic and beyond.

This transformed context will not always feature the dramatic geopolitical machinations seen between the United States and China in the current pandemic, but *realpolitik* will reshape global health in ways that are hard to predict but are necessary to anticipate. Looking back at international cooperation and international law on health during the Cold War might have limited value. African nations emerged from those decades unprepared for many threats the global health community addressed in the post-Cold War period. Similarly, international law was not prominent in international health activities during the Cold War. The return of the balance of power is stimulating political and legal conversations in other policy areas, including trade and climate change, that are focused on adapting to this change. These conversations might provide better insights on how African countries can adjust health diplomacy to protect and advance their interests in this latest 'new world order.'

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