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VIEWPOINT

Enforceable Commitments to Global Health Needed to Fulfill Rights

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The recent shifts in global health policy, particularly the United States' sudden retreat from key funding commitments and the Dutch government's decision to defund all projects related to women's rights, reflect a deeper crisis in global health governance.[1] These developments underscore the urgent need to reposition accountability not just as a discretionary moral obligation but as a fundamental legal principle deeply entrenched within international law and global health governance frameworks.[2] The right to health, codified in the International Covenant on Economic, Social and Cultural Rights and operationalized through instruments like the World Health Organization Constitution and the Sustainable Development Goals, imposes obligations on both national governments and international actors to uphold equitable, sustainable health policies. However, rising nationalistic tendencies now threaten to erode this framework, exacerbating vulnerabilities in low- and middle-income countries (LMICs) and undermining the principles of equity, global solidarity, and shared responsibility that are essential for a functional global health system.[3] Addressing this accountability gap requires a firm legal foundation, one that is already articulated in international human rights law.

General Comment 14 of the United Nations Committee on Economic, Social and Cultural Rights reinforces this imperative, emphasizing accountability as central to the realization of the right to health.[4] It underscores that health cannot be sustained solely through domestic efforts but requires collective global action, particularly for resource-constrained countries. At its core, General Comment 14 calls for the establishment of effective accountability mechanisms to ensure that states and other duty bearers uphold their obligations—not only within their borders but also in their extraterritorial engagements.[5]

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This principle is further reinforced by the extraterritorial obligations (ETO) framework, which affirms that states must not only refrain from actions that harm global health but also proactively ensure that their foreign policies, financial decisions, and trade agreements do not undermine health equity worldwide.[6] Yet despite this normative clarity, ETOs remain structurally weak, lacking binding compliance mechanisms, independent oversight, and legal consequences for non-adherence.[7] The absence of such enforcement structures has led to recurrent failures in global health governance, where donor states systematically disengage from financial commitments with impunity, despite the direct transnational consequences of these decisions.

This persistent accountability gap is not merely a technical or procedural deficiency—it represents a fundamental governance failure that threatens the realization of universal health coverage and the broader right to health. The World Health Organization estimates that over 400 million people globally still lack access to essential health services, a number set to rise unless global health financing structures prioritize long-term sustainability over short-term political considerations.[8] Yet rather than strengthening commitments to equity and preparedness, donor states continue to retreat from their obligations, prioritizing short-term domestic interests over long-term global health stability—even as ongoing public health emergencies of international concern such as Mpox, and disease outbreaks like Marburg in Rwanda and the Sudan virus in Uganda, demand sustained global cooperation.[9] This retreat from multilateralism reflects a broader shift toward nationalist approaches that dismantle long-standing commitments to the universal right to health.

The failures of the COVID-19 vaccine rollout illustrated the consequences of an accountability deficit in global health governance.[10] High-income countries monopolized vaccine supplies, while LMICs faced prolonged shortages, resulting in delayed immunization efforts and preventable mortality.[11] This vaccine inequity was a manifestation of a deeper structural failure, where global health policies continue to be dictated by donor-driven priorities rather than the principles of equity and justice. Without an accountability framework that enforces sustained commitments, global health governance risks becoming a further fragmented system where access to health is dictated by shifting political cycles rather than long-term obligations to universal health rights.

The consequences of this shift extend beyond financial constraints; they reinforce historical injustices, as the same nations that once dictated global health priorities through colonial public health models and structural adjustment programs have now abandoned their obligations under the pretext of national interest.[12] These obligations, however, are not discretionary; they constitute a duty of sustained engagement, recognized under international human rights law. Disregarding these obligations now does not simply create funding gaps—it represents a profound failure of accountability in global health governance that jeopardizes decades of progress in combating infectious diseases, improving maternal health, and advancing universal health coverage.

Another manifestation of this accountability crisis is the persistent inequity in global health research investments.[13] The epistemic injustice embedded in current research paradigms reflects a larger failure of accountability, where knowledge production remains disproportionately controlled by high-income institutions. This results in a system that marginalizes the priorities and expertise of LMIC researchers, reinforcing a model where research agendas, funding allocations, and intellectual property rights are dictated by donor-driven interests rather than responding to local health burdens and systemic inequities.[14] While some research areas, such as pandemic preparedness and malaria vaccine development, have received increased funding, others, including neglected tropical diseases, reproductive health, and decentralized community-driven research models, remain critically underfunded.[15] A truly accountable global health research agenda must dismantle extractive models that prioritize publication metrics over local impact and foster equitable partnerships

that empower LMIC-based researchers as central contributors rather than peripheral actors.[16]

Ensuring accountability in global health requires the institutionalization of binding governance mechanisms that guarantee sustained financial commitments, transparency in health financing, and participatory oversight. The successes of the US President's Emergency Plan for AIDS Relief and the Global Fund demonstrate that when long-term financial commitments are anchored in robust governance structures, they yield measurable public health gains.[17] However, the retreat from these commitments exposes the fragility of a global health system overly reliant on discretionary donor aid, undermining equity and shared responsibility.

Recognizing these vulnerabilities, the African Union Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria calls for predictable and diversified health financing to reduce reliance on external donors. It advocates for clear financial sustainability plans, stronger domestic resource allocation, and enhanced accountability from development partners. However, donor disengagement continues to undermine this vision, highlighting the limitations of voluntary commitments and reinforcing the need for binding commitments that ensure long-term health security beyond political cycles.

Make global health finance legally binding

To operationalize this vision, global health financing must transition from discretionary aid to a legally binding framework that is monitored, enforced, and insulated from political volatility. This requires:

- Institutionalizing binding financial commitments within multilateral legal instruments to prevent unilateral donor withdrawal.
- Embedding accountability mechanisms in treaty-based frameworks, including United Nations resolutions and financial compacts, to transform donor obligations from discretionary contributions into legal commitments.
- Establishing independent compliance mechanisms to track adherence, impose legal consequences for noncompliance, and strengthen enforcement pathways.
- Repositioning LMICs as co-governors of global health funding mechanisms to ensure that financial flows align with epidemiological priorities rather than externally imposed donor agendas.

Without these structural reforms, accountability will remain subject to political discretion rather than legal obligation. While initiatives such as the African Union Roadmap on Shared Responsibility and Global Solidarity lay an important foundation for sustainable health financing, their success depends on enforceable mechanisms that hold donor states accountable. If these measures remain voluntary, the right to health will remain a distant aspiration rather than an enforceable reality.

The future of global health cannot be dictated by shifting political cycles but must be anchored in an unwavering commitment to equity, solidarity, and justice.

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