



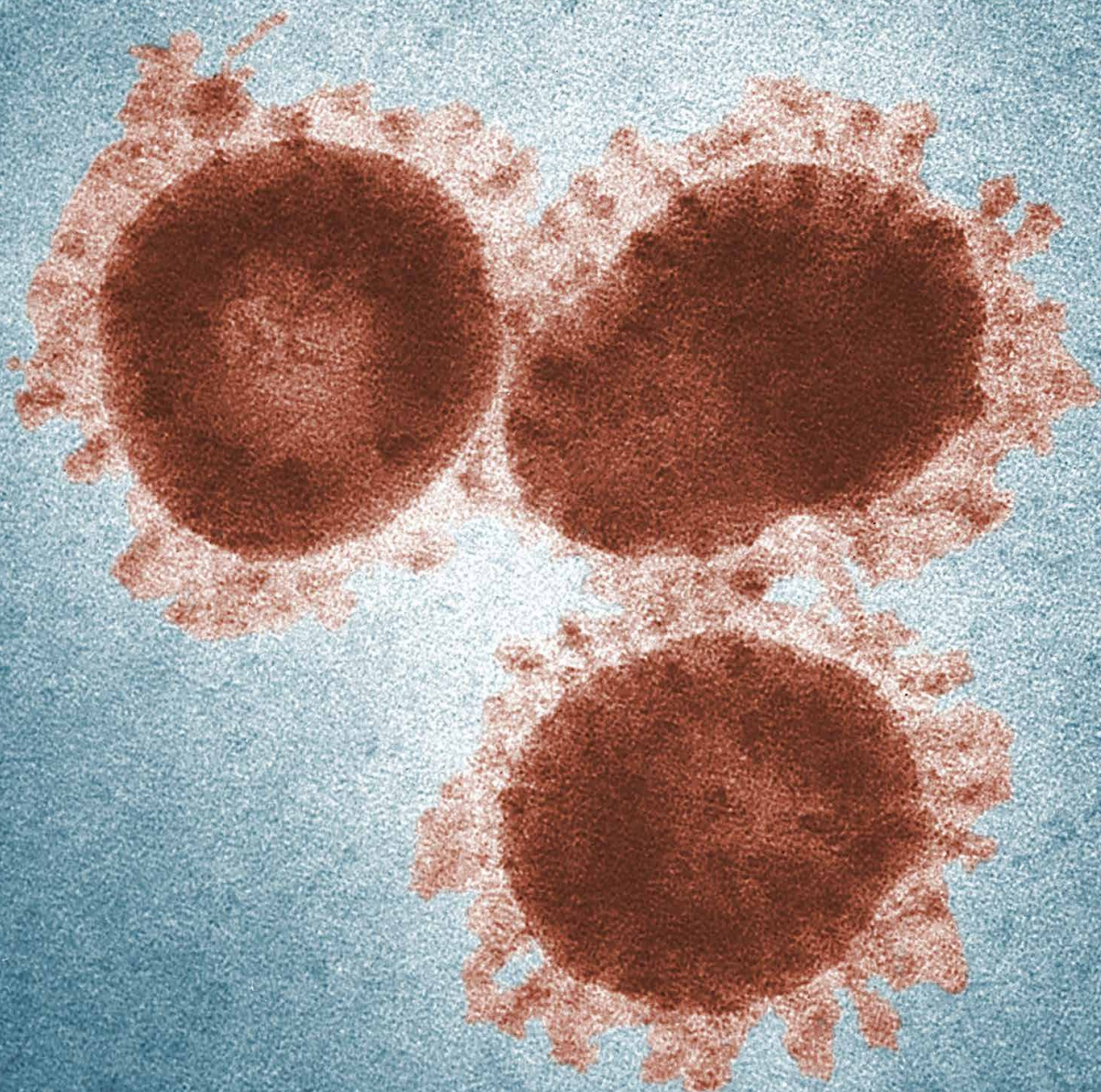
Health for All Now!  
People's Health Movement

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# Do we need a Pandemic Treaty now?

*A PHM Policy Brief*

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**M**any issues which need to be addressed to properly strengthen international health emergency preparedness and response are born out of our unjust neoliberal international society. The dominant perspective on global health security has meant a focus on the Global North ‘protecting’ itself from the Global South which is viewed as the ‘problem area’. This perspective is palpable in most health emergency preparedness and response initiatives, including today’s discussions around a Pandemic Treaty. Such issues demand the reimagining of global structures which take a human rights approach and has genuine equity and justice at their centre. There are valid questions regarding the adequacy of a new instrument, a Pandemic Treaty, at this point in time. This policy brief explores some of the questions raised by the proposal for a new Pandemic Treaty at the World Health Organization (WHO) and assesses the limitations of existing binding instruments, such as the International Health Regulations (IHR) of 2005.

This Policy Brief starts with a background to the Pandemic Treaty and the IHR and the context in which they emerged. This is followed by consideration of key issues: legal considerations of a Pandemic Treaty, fragmentation of health emergency preparedness and response, the need for sustainable and untied funding, and gaps in existing health emergency preparedness and response. The last section concludes with recommendations in view of the World Health Assembly Special Session on the Pandemic Treaty scheduled for 29 November to 1 December 2021. ■



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# BACKGROUND



Since the establishment of the WHO, global health security has been a key programme of work. [The International Health Regulations](#) were first implemented in 1969, following several revisions they were significantly amended with the revised Regulations adopted in 2005 and are intended to prevent, protect against, control and respond to the international spread of disease. Following the West Africa Ebola Outbreak, the [WHO Health Emergencies Programme](#) was created in 2016 in response to deficiencies of the global response to the outbreak. However, a key limitation of such health security approaches as recognized in the WHO's new [Health Systems for Health Security framework](#), is that the significant focus on the international spread of infectious diseases fails to sufficiently address the importance of strengthened health systems, which can then facilitate more effective health emergency preparedness and response.

A new legal instrument intended to strengthen pandemic preparedness and response [was recommended](#) in several reports assessing the pandemic response and had early vocal support from the [European Council](#) who first called for a Treaty in November 2020. In March 2021 these calls for a Treaty were echoed in [a joint letter](#) published by the WHO with 26 state leaders consisting of a mixed group of high-, middle- and low-income countries but with the notable lack of initial support from the United States, Russia and China. [Some initial questions](#) raised were the timing, given that the pandemic was and is still very much ongoing, with health systems and ministries focused on the COVID-19 response. Further, [the People's Health Movement raised](#) concerns regarding the potentially weak coordinating role of the WHO and the limited understanding of health emergency preparedness and response based upon the limited health security framing which favours countries with adequate resources.

## The Pandemic Treaty negotiations

- The [WHA74.7 Resolution](#) of May 2021, *Strengthening WHO preparedness for and response to health emergencies*, [WHA74\(16\)](#), decided upon the establishment of a Member State Working Group (referred to as WGPR) to discuss the 'benefits of developing a WHO convention, agreement or other international instrument on pandemic preparedness and response' and for the Secretariat to hold a special session of the WHA to discuss the WGPR's report.
- Prior to the special session the WGPR will have met on five occasions. Whilst these have been closed meetings, the meeting documents [have been published](#) by the Secretariat. This includes a [draft](#) of the WGPR report.
- The WHA74(16) Special Session is to be held on the 28<sup>th</sup> November – 1<sup>st</sup> December 2021. The [draft WGPR report](#) concludes "that there are benefits to developing a new instrument, while also acknowledging that the IHR (2005) currently remains the key legally binding instrument for pandemic preparedness". Therefore, a blended approach is to be expected which involves the negotiation of a Pandemic Treaty alongside the strengthening and potential amendments to the IHR.
- The draft WGPR report identified nine key issues which could be addressed by a Pandemic Treaty. Most welcome are the references to intellectual property in relation to issues of equity, the need for sustainable funding allowing the WHO to hold its leading and coordination role in global health, and reference to the importance of sample and benefit sharing.

[It was decided](#) at the 74th World Health Assembly in May 2021 for formal discussions to be held around the benefits of a potential Pandemic Treaty, with the outcomes to be reported at a special session of the World Health Assembly (WHASS) in November 2021 with [a second report expected](#) in early 2022 which will include potential IHR amendments.

## Key themes

### No Legal Gap Necessitating a Pandemic Treaty

In a discussion document ([A/WGPR/3/6](#)) for the third WGPR meeting, the Secretariat offered a risk, benefit and legal analysis of both the creation of a new legal instrument and amendments of the IHR. Within this document, the Secretariat states that there is existing precedent in amending the IHR. Whilst it is evident that the existing IHR

has been insufficient in ensuring effective pandemic preparedness and response it remains an important tool that can be amended to be made more adequate for the requirements at hand. The IHR are a binding instrument under Article 21(a) of the [WHO Constitution](#), which provides for the legally binding framework sought through a new Treaty. From a legal perspective, there is no obvious gap for which such a new Treaty is needed. Further, given the failures of effective global implementation of the IHR, there is no guarantee that a new legal instrument will have any better compliance, and the efficacy of international treaties can be exaggerated with [human rights treaties](#) being a useful example.

In addition, amending the IHR is a legally easier process than implementing a new Treaty. The pursuing of a pandemic Treaty under Article 19 requires a two-thirds vote

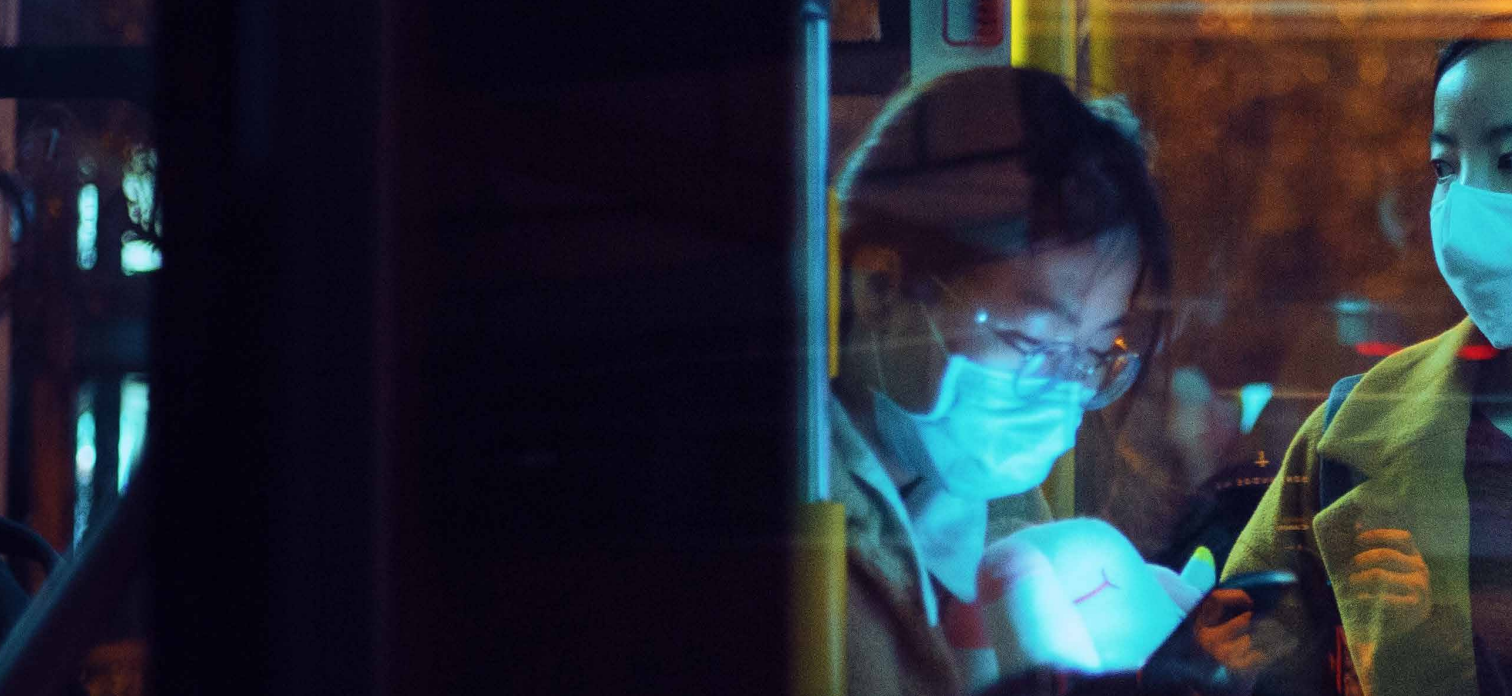
by Member states to be adopted (although adoption by consensus is possible). If the Treaty does go to vote and thus via an opt-in process, this might mean a Treaty is adopted without the support of one-third of Member States. Further, following adoption, the Treaty would come into force for each Member State only once it has been incorporated into its national institutional processes. Therefore, there is no certainty that a resultant Treaty would be implemented by all Member States and risks a fragmented approach (see a later section). In contrast, the IHR under Article 19, and any future amendments, are adopted through a simple majority (although adoption by consensus is possible) with any amendments automatically coming into force for all Member States within 24 months of adoption, with Member States having 18 months to provide notice of any rejection or reservations.

### **Further Fragmentation of Health Emergency Preparedness and Response**

As evident even pre-pandemic, and particularly in the COVID-19 response, the normative power of WHO and its central position within global health governance has been actively challenged and undermined. [An analysis](#) of the WHO's role in the international health emergency response demonstrated that the Organization "has been reduced to an institution to collect information on outbreak of diseases and analyse the event". Rather than holding a genuine leadership role, the WHO is instead dependent upon its partners to implement an effective emergency response. Yet, as evident during COVID-19, it is the WHO that is still held accountable for the international response.

The position of the WHO within global health governance has long been diluted by the increasing complexity of actors in this space. The [Access to COVID Tools Accelerator](#) and the [COVAX facility](#), are yet further examples of this, whereby philanthropic institutions in particular play a central role in the governance and decision-making, with minimal meaningful participation of the WHO. Yet, despite the inadequacies of such initiatives, and in particular of ACT-A and COVAX, in failing to prevent the current vaccine apartheid, support for such collaborative structures persist. For example, a European Commission paper on a potential Treaty featured support for flexible participation, which not only would allow regional entities such as the European Commission to participate but could further widen the backdoor for private influence. In the current context of widespread support for multistakeholderism there is a risk that such an approach will introduce fragmentation into a new instrument, whilst the IHR is led by WHO.

An additional layer of fragmentation within a pandemic Treaty pertains to the legal adaptation process under Article 19 as described above. This could result in a global landscape in which, unless objected to, all countries adopt the IHR and any future amendments, potentially fewer countries will have opted in for a new Treaty, with even fewer integrating the new Treaty into their national laws. In addition, the [WHO Secretariat](#) also pointed out that "a [new] framework convention could present obligations for parties to it that vary from obligations under the IHR". This would further increase the complexity and discordance in international health emergency preparedness and response.



### **Need for Sustainable and Unrestricted Funding**

A key factor in understanding and thus addressing the side-lining of the WHO and its insufficient health emergency response is its precarious financial situation. WHO's skewed funding that is minuscule and disproportionately made up of voluntary and earmarked contributions, undermines its autonomy and reduces its capacity as a leader in global health governance. This is a [well-established](#) and much-discussed concern. Yet, without it being appropriately addressed by the implementation of flexible and large enough funding, the WHO's ability to effectively function and provide leadership during emergency and non-emergency contexts alike will continue to suffer. In [2018-2019](#) just 2.3% of funding dedicated to the WHO was earmarked for Country Health Emergency Preparedness and the IHR versus 26.51% being spent on Polio eradication. It is of note that this was the prescribed focus of funding provided by the Bill and Melinda Gates Foundation, again highlighting the external influence of private actors on the WHO. Insufficient

and tied funding in global health is of course not limited to the WHO but also constrains national health system strengthening and the development of global public goods. The need for adequate and sustainable funding for health emergency preparedness also spans to state-level with insufficient investment [being cited](#) as a key challenge in the successful national implementation of the IHR.

### **Gaps in Existing Health Emergency Preparedness and Response**

COVID-19 has highlighted important gaps in emergency preparedness and response, which must be addressed by providing the WHO with the best binding instruments and adequate funding. In addition, there is a need for meaningful interventions in the interest of low-and-middle-income countries (LMICs).

Whilst the existing IHR does apply a [One Health approach](#), for instance by requiring the reporting of zoonotic spillover, it is insufficient and more needs to be done to prevent such transmission of animal-borne illness. There needs to be



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greater explicit recognition of the type of [interactions between](#) people and planet. Capital accumulation through increased productivity and consumption in the form of ecological extractivism plays a major role in climate breakdown and [increased risk](#) of zoonotic pandemics, yet is largely ignored. Existing health emergency preparedness and response initiatives are born out of the narrow global health framing which fails to sufficiently recognise the importance of non-communicable diseases and the need for strengthened national health systems. There needs to be an improved understanding of the importance of the linkages between [health security and health systems](#). In particular health systems must be public and equitable and apply a community primary health care services, with the greater inclusion of community initiatives, knowledge and practices and extended health surveillance. The importance of sample and benefit-sharing has been highlighted in the draft WGPR report, yet it is done so without reference to the [Nagoya Protocol](#) on Access and Benefit Sharing, nor the [Pandemic Influenza Preparedness Framework](#), provisions

must be made to ensure the extension of such agreements to the context of health emergency preparedness and response.

Inequitable access to COVID-19 vaccines is one of the biggest injustices of this pandemic. Yet, the dynamics observed today whereby booster vaccines are being administered in high-income countries whilst vaccine coverage in 50 countries at [below 10%](#) is unfortunately unsurprising. Rather, it is a reflection of the global neoliberal dynamics protecting and upholding the unjust global intellectual property system. The COVID-19 vaccine apartheid has been driven by unjust intellectual property restrictions which exist around COVID-19 medical technology and are being actively upheld by states such as the UK and Germany, thus facilitating pharmaceutical corporations to generate billions in profits despite the undue death and suffering caused. There needs to be a restructure of the current intellectual property system preventing corporate interests to be put above human rights, alongside increased local production capacity and benefit-sharing. Proposals and instruments to rebalance today's

vaccine apartheid exist, such as the COVID Technology Access Pool (C-TAP) and TRIPS waiver, but are being actively blocked by mostly high-income countries and private markets in favour of the deadly market-friendly status quo. Yet, a key issue highlighted by member states to be addressed by a Pandemic Treaty is equity. However, given the crossover between states blocking the TRIPS waiver whilst also actively supporting a Pandemic Treaty (most notably these include the United Kingdom, the European Union and Canada) casts doubt as to whether a treaty will permit the necessary structural changes to the intellectual property system in a way that meaningfully addresses equity concerns.

### **IHR amendments rooted in global justice**

Existing neoliberal global dynamics have created a structure in which it is often the interest of high-income countries and markets which dominate. As such, there is a strong need for any IHR amendments to be centralised in global justice and reflect adequately the needs of the world population. For example, the addition of commitments to equitable distribution of any medical technologies required for the prevention, detection and treatment of the disease in question must be incorporated into the IHR. This could take the format of the C-TAP or the TRIPS waiver and thus ensuring corporations cannot monopolise the production of medical technology. The scope of the IHR to prevent 'international spread of infectious disease' is a manifestation of the trade and state-focused health security framing, by widening the scope to epidemics and endemics this would facilitate stronger solidarity and justice for the prevention

and control of all serious disease outbreaks. The importance of international assistance and cooperation needs to be strengthened, in particular, the need for sample and benefit-sharing must be mandated with the principles of the PIP framework to be extended beyond just influenza.

### **Key messages**

- There is a lack of precise explanation and justification for a new legal instrument on pandemic emergency preparedness and response.
- It is unlikely that a Pandemic Treaty will produce the effect needed to facilitate effective health emergency preparedness and response, therefore targeted amendments must (also) be made to the IHR using a justice-centred approach. Such amendments must consciously and critically address the colonial and neoliberal influences on today's dominant understanding of health security.
- The leading and coordinating role of the WHO must be centralised and upheld with adequate, sustainable and flexible funding. The national-level implementation of the IHR, and with it health systems strengthening, must also be adequately funded.
- Given the prominent and devastating impacts of the COVID-19 vaccine apartheid, specific and obligatory commitments must be made to ensure equitable distribution of medical technology and flexible approaches to IP are key aspects of any future health emergency response. ■

## **FURTHER READINGS**

1. People's Health Movement - [\*Commentary of the WHO Special Session Two \(WHASS2\)\*](#)
2. Third World Network - [\*Proposal for a WHO Treaty on Pandemics Raises Concerns\*](#)
3. G2H2 - [\*The Politics of a WHO Pandemic Treaty in a Disenchanted World\*](#)

**@ People's Health Movement, 2021**

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