

G2H2 REPORT

THE POLITICS OF A WHO PANDEMIC TREATY IN A DISENCHANTED WORLD

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The politics of a WHO pandemic treaty in a disenchanted world **Conference version of the G2H2 report, November 2021**

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The politics of a WHO pandemic treaty in a disenchanting world

Why a G2H2 report on the pandemic treaty

As an independent platform of civil society organizations committed to advancing the right to health, the Geneva Global Health Hub (G2H2) has engaged on the idea of a pandemic treaty soon after it was presented at the World Health Organization (WHO) in 2021. We started the process through a public webinar analysing the scope of the pandemic treaty in May 2021¹.

The announcement that some Member States were eager to enact new binding instruments for global health came as a surprise, as most health policy arrangements are grounded on soft norms, and the WHO has used its constitutional normative power adopting binding agreements only twice in its seven decades of history. The development sounded all the more unexpected since those very influential Member States spearheading the idea of a binding treaty for pandemic preparedness and response have staunchly opposed in the past treaty-making processes that were ruminated at length at the WHO. The most recent case is the forefront rejection of the treaty on needs-driven research and development (R&D) to be negotiated at the WHO, recommended by a vast number of independent experts and by a resolution of the WHO (WHA61.21)², by the WHO Consultative Expert Working Group (CEWG)³ and subsequently by the UN High Level Panel on Access to Medicines⁴.

The emergency scenario generated by SARS-CoV-2 seems to have now helped heal the treaty fatigue symptoms that several Member States had acknowledged as the source of their reluctance to binding norm-setting - particularly after the painstaking negotiations on the Framework Convention on Tobacco Control (FCTC)⁵. Their proclaimed intention is to build a more robust global health architecture that will protect new generations⁶ from other pandemics and potential health emergencies projected for the future, which no single government or multilateral agency can tackle alone. But the WHO is already equipped with a binding instrument aimed to address health emergencies, the International Health Regulations that was revised in 2005, and grossly overlooked during the harshest phases of the viral evolution in 2020. This begs the question: why?

As civil society organizations anchored in the human rights obligations developed around the right to health, we have always advocated for binding regimes in global health, as a reasonable alternative to soft-law arrangements and voluntary approaches. This is the

¹ <https://g2h2.org/posts/may2021/>

² https://apps.who.int/gb/ebwha/pdf_files/WHA61-REC1/A61_Rec1-part2-en.pdf

³ https://apps.who.int/gb/CEWG/pdf_files/A65_24-en.pdf.

⁴ <http://www.unsgaccessmeds.org/final-report>

⁵ https://www.who.int/fctc/text_download/en/

⁶ <https://www.who.int/news/item/30-03-2021-global-leaders-unite-in-urgent-call-for-international-pandemic-treaty>

reason why in the past we have supported the academic and civil society drive in support of the R&D treaty at the WHO, and we have actively engaged in conversation with several constituencies to promote the idea of a Binding Framework for Global Health⁷.

Through this research, G2H2 plans to dive into the pandemic treaty discourse by interacting with the plentiful literature produced on the subject. We have also decided to bring on board actors that so far - with a few exceptions - have been consistently neglected in the formal WHO negotiations, namely experts and civil society entities from the global South, and those who have directly been at the forefront of the response to the pandemic in different countries. In doing so, G2H2 opens the pandemic treaty discussion to a broader mapping of reality, one that cannot be limited to the WHO and the health sector alone, in a state of global affairs worsened by the pandemic. COVID-19 has only displayed the systemic interconnected dimension of the crisis that needs to be closely considered when thinking about pandemic scenarios, if we are earnestly planning to prepare and respond to future emergencies. G2H2 feels it is necessary to expand the policy dialogue and the perspectives on the pandemic treaty and share its preliminary effort at addressing the complexity of this arena through a bottom-up qualitative research activity.

One of the main purposes of this research is to contextualize the treaty proposal and explore viable global governance mechanisms that are adequate in safeguarding the right to health in the context of preventing and tackling health emergencies, based on the principles of international law and multilateral cooperation. It represents an independent civil society attempt to shed light on some of the thorniest and unresolved issues whose relevance cannot be ignored, in the management of the current and future pandemics, and which require to be injected in the discussion through various expertise of representatives from all over the world, in the lead up to the special session of the World Health Assembly (WHA), and beyond. This research is in no way exhaustive, and it is in many ways an open living document to be updated and revised with the evolution of the WHO negotiating process as it unfolds.

Research questions and methodological approach

G2H2 selected three research questions for this study based on a participatory process that involved its members at different stages, and internal Steering Committee debate in June and July:

1. Is a new international pandemic treaty required to overcome legal constraints and address public health needs for pandemic preparedness and response?
2. What are the (geo)political factors behind the call for a pandemic treaty and who are the actors driving this agenda?
3. What other policy approaches and mechanisms could be envisaged to prevent future health emergencies and effectively govern international pandemic preparedness and response?

⁷ Gostin L., Friedman E. A., "Towards a Framework Convention on Global Health: A Transformative Agenda for Health Justice", in *Yale Journal of Health Policy, Law, Ethics* (2013), available at <https://digitalcommons.law.yale.edu/yjhple/vol13/iss1/1/>.

The study derives its normative basis from the human-rights based approach to health and policy-making in guiding its analysis and recommendations⁸. It builds on the Kingdon's three-streams model, which explains why policy issues emerge on the international agenda, and what is the imputable role of entrepreneurs and policy-windows in this dynamic⁹. At a secondary level, in the context of the ongoing COVID-19 crisis, this research project advocates for the need to place the right to health and the increasing multiplicity of health determinants at the centre of the international agenda. The global governance for public health must be transformed in a way that recognizes that COVID-19 is not simply a viral infection, but a complex synergistic epidemic with clinical and structural vulnerabilities entrenched by poor health, precarity, unemployment, deprivation and marginalization¹⁰. Moreover, planetary concerns related to biodiversity loss, climate change and other threats as drivers of zoonotic diseases have potently made their way through the global health governance malaise. The current growth model falls short on equity and poverty reduction grounds and the international community needs to recognize its limits and responsibilities¹¹, while opening a more sovereign economic space for countries and societies, based on the need for decolonizing the development agenda^{12 13 14}. The pandemic has clearly pointed to the formidable wall of health discrimination and inequality that envelopes the culture of health institutions and healthcare settings, across the scalar levels of local and global action¹⁵.

The research-team, consisting of Remco van de Pas & Priti Patnaik, carried on the research from August to mid-October 2021. Nicoletta Dentico oversaw the conceptualization, writing and structure of the report. The research was conducted through:

- A preliminary online consultation with G2H2 members, to share the conceptual framing of the research and possible alliances therein - both in terms of experts to interview and specific cases to examine in the context of the current pandemic.
- A scoping literature review of academic journals, policy documents and online media. This was done via a selective, iterative technique that focused on the

⁸ London, L. (2008). What is a human-rights based approach to health and does it matter?. *Health and human rights*, 65-80.

⁹ Kingdon, J. W., & Stano, E. (1984). *Agendas, alternatives, and public policies* (Vol. 45, pp. 165-169). Boston: Little, Brown.

¹⁰ Mendenhall, E. (2020), Why social policies make coronavirus worse. *Think Global Health*, 27th March 2020, <https://www.thinkglobalhealth.org/article/why-social-policies-make-coronavirus-worse#:~:text=COVID%2D19%20is%20a%20syndemic.&text=A%20syndemic%20emphasizes%20the%20fact,broader%20factors%20like%20social%20inequality> and also Mendehall, E. and Gravlee, C.C. (2021), How COVID, Inequality and Politics Make a Vicious Syndemic, *Scientific American*, 26th August 2021, <https://www.scientificamerican.com/article/how-covid-inequality-and-politics-make-a-vicious-syndemic1/>.

¹¹ Rodrick, D. (2021), The Metamorphosis of Growth Policy, The Project Syndicate, 11th October 2021, <https://www.project-syndicate.org/commentary/new-growth-policies-for-developing-countries-by-dani-rodrik-2021-10>.

¹² Raworth, K. (2017). *Doughnut economics: seven ways to think like a 21st-century economist*. Chelsea Green Publishing.

¹³ Tinbergen, J. (1976). *Reshaping the international order*. *Futures: the journal of policy, planning and futures studies*.

¹⁴ Fanon, F. (1967). *The Wretched of the Earth* [1961], trans. Constance Farrington.

¹⁵ [Cousins, T., Pentecost M., Alvergne A., et al. \(2021\). The changing climates of global health. *BMJ Global Health*, 2 March 2021.](#)

pandemic treaty and governance of international outbreaks in recent history (since 2000). The chosen approach also allowed looking laterally into political and diplomatic developments in other sectors and policy-areas, such as in security, economic, trade, ecological and food domains.

- Semi-structured interviews with a selected group of participants including international policymakers, health diplomats, civil society actors, academic representatives and public health professionals. This group included participants from all WHO regions, except for the Western Pacific region. The intent was to reach out to the widest possible geographical representation, so as to ensure a proper account of perspectives coming from high-income, middle-income and low-income countries for diversity in analyzes and positions. Most interviewees are directly involved in, or closely monitoring the developments on pandemic governance and treaty proposal.

As many as 35 interviewees were approached and 23 participated in the study. The interviews were guided by a semi-structured format based on the three research questions. They lasted between 30 minutes and 2 hours. Data was collected via online, telephone or in-person interviews. The anonymity of participants was guaranteed. Data collection, storage and transcription was done in a secure manner.

The findings of the study were categorised along the main themes identified. This combines and triangulates the findings from the literature review as well as the interviews with participants and G2H2 consultations. Given the multiplicity and complexity of the issues related to pandemic governance, the findings did not cover all themes addressed by the participants but focused on the priority issues that emerged. The findings consist of clustered assessments by the researchers and do not necessarily represent an individual opinion or position by a research participant.

The COVID-19 pandemic and the creeks of global governance

COVID-19 has kept the world in a pandemic grip since early 2020 and has clearly shown the malaise of global health governance at the intersection of global crises that have converged in 2020: the mounting inequalities, the doom of climate change and the structural pathogenesis of globalization¹⁶. The world was not and is still not effectively able to prepare for, predict, prevent, respond to and recover from a multi-country outbreak or pandemic. As the WHO Independent Panel for Pandemic Preparedness and Response (IPPPR) has recalled in its outspoken report *Make it the Last Pandemic*¹⁷, the planetary expansion of the new coronavirus should never have occurred in the first place. Not only did SARS-CoV-2 appeared invisible and unknown in a world that had ignored repeated warnings from multiple scientific circles and most of the recommendations from multilateral commissions and organizations, but the international community supposedly had all the

¹⁶ Sell S. and Williams O., "Health under capitalism: a global political economy of structural pathogenesis", Review of International Political Economy, <https://www.tandfonline.com/doi/abs/10.1080/09692290.2019.1659842>.

¹⁷ COVID-19: *Make it the Last Pandemic*, Report of the Independent Panel for Pandemic Preparedness and Response, May 2021, <https://theindependentpanel.org/>

technical knowledge and tools to confine the viral evolution and make SARS-CoV-2 a geographically controlled epidemic. It simply did not do it. The WHO Director-General declared the outbreak a Public Health Emergency of International Concern (PHEIC) on 30 January, when there were already 98 cases in 18 countries outside China¹⁸. But his declaration was not followed by immediate emergency responses in most countries, despite the mounting evidence that a highly contagious new pathogen was spreading around the planet. “For a strikingly large number of countries, it was not until March 2020, after COVID-19 was characterized as a ‘pandemic’, and when they had already seen widespread cases locally and/or reports of growing transmission elsewhere in the world, and/or their hospitals were beginning to fill with desperately ill patients, that concerted government action was finally taken”¹⁹. While disputes are ongoing over the origins and timeline of the outbreak, the world counts roughly 252 million COVID-19 cases and 5.1 million deaths²⁰ as of mid-November 2021, although the real death toll is expected to possibly be three times higher²¹. All continents by now have gone through recurring waves of the pandemic, yet differences in mortality, prevalence, detection and response capacity remain stark. As with most infectious diseases, the trajectory and impact of COVID-19 vary widely across affected countries and communities²², easily transforming the disease into a pandemic of inequalities and inequities²³. Those with insufficient or no social protection were dramatically exposed to the virus, often because of pre-existing health conditions that made them more vulnerable to it. More frequently, it was the nature of their work and their living conditions, or the risk of losing their daily *hand-to-mouth* income, that dragged people into the contagion.

The virus of an asphyxiating globalization

The COVID-19 pandemic did not come to break globalization. It came to reveal what was already broken. Quite ferociously, it came to demonstrate the interconnection between humankind, animals and other living beings, and the environment. Deforestation and the ever-increasing destruction of natural habitats and displacement of living species, wildlife trading and trafficking²⁴, resource-intensive lifestyles and conditions, unsustainable food

¹⁸ WHO Director-General’s statement on IHR Emergency Committee on Novel Coronavirus (2019-nCoV), Geneva, 30 January 2020, [https://www.who.int/director-general/speeches/detail/who-director-general-sstatement-on-ihr-emergency-committee-on-novel-coronavirus-\(2019-ncov\)](https://www.who.int/director-general/speeches/detail/who-director-general-sstatement-on-ihr-emergency-committee-on-novel-coronavirus-(2019-ncov)).

¹⁹ *COVID-19: Make it the Last Pandemic*, May 2021, p. 28, https://theindependentpanel.org/wp-content/uploads/2021/05/COVID-19-Make-it-the-Last-Pandemic_final.pdf

²⁰ <https://covid19.who.int/>

²¹ <https://www.economist.com/graphic-detail/coronavirus-excess-deaths-estimates>

²² Van Damme, W., Dahake, R., Delamou, A., Ingelbeen, B., Wouters, E., Vanham, G., ... & Assefa, Y. (2020). The COVID-19 pandemic: diverse contexts; different epidemics—how and why?. *BMJ Global Health*, 5(7), e003098.

²³ N. Maani, A.M. Abdalla, S. Galea, Avoiding a legacy of unequal non-communicable disease burden after the COVID-19 pandemic, *Lancet Diabetes & Endocrinology*, 2021; 9(3):133–135, [https://www.thelancet.com/journals/landia/article/PIIS2213-8587\(21\)00026-7/fulltext](https://www.thelancet.com/journals/landia/article/PIIS2213-8587(21)00026-7/fulltext).

²⁴ While the connection between the trafficking of wild animal species and public health is not yet sufficiently analyzed by the global health community, the WHO evidence shows that 75% of emerging diseases have a wildlife link and scientific evidence proves that at least 19 pandemics have been attributed to the wildlife trade, causing an estimated 1.4 billion cases of disease in past 100 years, and 87 million deaths. In the USA, there are currently 70,000+ cases of reptile-associated salmonellosis annually from pets, and 6,000+ cases in the UK. Cfr. Brown C. et al.

production and consumption systems, are right at the origin of the subsequent emergence of zoonoses since the beginning of the new millennium²⁵, particularly viruses like influenza and other pathogens²⁶. The declining biodiversity, linked to industrial agriculture and intensive livestock breeding, is a major driver of spillovers of infectious diseases – the devastation of forests for palm oil plantations enabled the conditions for the spreading of Ebola and Nipah viruses²⁷. In other words COVID-19, a manifestation of the *Anthropocene*, imposes a new sense of purpose to health policymaking in the current and future responses to the pandemic, whereby “we need to recognize that we are moving beyond the point of saturation”, as the scientist Johan Rockstrom rightly points out²⁸. This is also an opportunity for the international community that believes in public health and the role of multilateral institutions, to re-imagine itself and project innovative ways to engage beyond classical models. “Climate change is a health crisis” has recently declared the WHO Director General opening the WHO conference on Health and Climate Change in Glasgow: failure to address pandemics and climate change as complex interrelated issues is likely to lead to false preparedness and response strategies within any future treaty²⁹.

COVID-19 has also revealed the structural inequalities within and among countries, and between genders, and further deepened them. In 2020, the adoption of lockdown measures prevented millions of people in precarious circumstances from earning their daily income in the informal economy to feed their families, and the impossibility for many of them to be able to confine themselves led to legitimized widespread use of arbitrary violence in the streets. Meanwhile, at home, alarming trends around the world signaled a gross increase of domestic violence on women and a sharp regression in the exercise of women’s human rights. The body politics of COVID-19 imposed an unbearable burden on women, globally, in their capacity as “shock absorbers”³⁰ in the recurrent and ongoing

“Emerging zoonoses and pathogens of public health significance – an overview”, in *Rev. sci.tech.Off.int.Epiz2004*, 23(2), 435-442, (<https://pubmed.ncbi.nlm.nih.gov/15702711/>) and also Rosen G.E. and Smith K., “Summarizing the Evidence on the International Trade of Illegal Wildlife”, *Nature Public Health Emergency Collection*, 2010; 7(1): 24–32 ([10.1007/s10393-010-0317-y](https://doi.org/10.1007/s10393-010-0317-y)). More recently, linked to COVID-19, Warwick C., “Wildlife-pet markets in a one-health context”, *International Journal of One Health*, 1st February 2021, <https://www.onehealthjournal.org/Vol.7/No.1/7.pdf>.

²⁵ In 2012 there was as a MERS coronavirus outbreak in Saudi Arabia and Jordan. Other virus species leaps have occurred with swine flu (H1N1) in 2009, bird flu in 2013 and 2017 (H7N9), as well as other pathogens such as Zika and Ebola, Dentico N., “The COVID_19 Crisis in Health Systems and Prospects for Recovery: The View from Italy”, *Health Policy Watch*, 27th March 2020, <https://healthpolicy-watch.org/the-covid-19-crisis-in-health-systems-prospects-for-recovery-the-view-from-italy/>.

²⁶ Wallace R., (2016). *Big farms make big flu: dispatches on influenza, agribusiness, and the nature of science*. NYU Press.

²⁷ Khetan, A. K. (2020). Covid-19: why declining biodiversity puts us at greater risk for emerging infectious diseases, and what we can do. *Journal of General Internal Medicine*, 35(9), 2746-2747.

²⁸ Rockstrom J. Safeguarding a Climate – Towards a Sustainable Future. Kapuscinski Development Lectures. 6 Oct. 2021. <https://kapuscinskilectures.eu/lectures/safeguarding-a-climate-towards-a-sustainable-future/>

²⁹ Carlson, C. J., Albery, G. F., & Phelan, A. (2021). Preparing international cooperation on pandemic prevention for the Anthropocene. *BMJ Global Health*, 6(3), e004254.

³⁰ Reyes E., “Body Politics in the COVID-19 Era from a Feminist Lens”, in *The World Needs Healthy Commons*, Development, Volume 63, numbers 2-4, December 2020, p.262-269, <https://doi.org/10.1057/s41301-020-00266-w>.

scenario of austerity measures and reduction of social spending. The effects of the crisis on working mothers are likely to be persistent.³¹

The health emergency in most countries has also dramatically hampered public health service provisions and health programs in many settings: the number of HIV-positive people diagnosed and treated, as well people treated for drug-resistant TB, dropped between 10- 20%³². The very likelihood of dying from COVID-19 has proven to be significantly higher across poorer wealth quintiles, and higher still for black or indigenous communities; for example, in Brazil the death-toll among Afro-descendants has been 40% more exorbitant than among White Brazilians.³³

The World Bank has calculated that the number of people living in extreme poverty has increased by 97 million due to COVID-19, reaching a staggering 732 million in 2020. While high and middle-income countries are slowly recovering from the pandemic, the World Bank highlights that the impact of COVID-19 on poverty is projected to be worsening³⁴ in the least developed economies. The number of people who did not have access to adequate food to eat has risen steeply during the COVID-19 pandemic, reaching 2.37 billion people³⁵, almost a third of humankind. Of course, this food insecurity cannot be merely attributed to the pandemic, yet COVID-19 has exacerbated pre-existing hunger determinants³⁶, and it is tragic that its long-term ripple effects on socio-economic wellbeing in lower-income countries will remain relatively neglected³⁷.

At the same time the pandemic period has served the richest in our societies very well³⁸. With governments bailing-out their worsening economies, the stock market has boomed driving up billionaire wealth, even while the real economy has faced the deepest recession in a century. The world's 10 richest billionaires have collectively seen their wealth increase by \$540bn in 2020³⁹, while US billionaire wealth surging by 70%, or \$ 2.1 trillion during the pandemic⁴⁰.

³¹ Alon, T., Doepke, M., Olmstead-Rumsey, J., & Tertilt, M. (2020). The impact of COVID-19 on gender equality (No. w26947). National Bureau of economic research.

³² <https://www.theglobalfund.org/en/news/2021-09-08-global-fund-results-report-reveals-covid-19-devastating-impact-on-hiv-tb-and-malaria-programs/>

³³ Imperial College COVID-19 Response Team. (2020). Report 22: Equity in response to the COVID-19 pandemic: an assessment of the direct and indirect impacts on disadvantaged and vulnerable populations in low- and lower middle-income countries. <https://www.imperial.ac.uk/media/imperial-college/medicine/mrc-gida/2020-05-12-COVID19-Report-22.pdf>

³⁴ https://www.globalpolicy.org/sites/default/files/download/Spotlight_2021_web_gesamt_c.pdf

³⁵ [https://www.fao.org/state-of-food-security-nutrition#:~:text=Nearly%20one%20in%20three%20people%20in%20the%20world%20\(2.37%20billion,people%20in%20just%20one%20year.](https://www.fao.org/state-of-food-security-nutrition#:~:text=Nearly%20one%20in%20three%20people%20in%20the%20world%20(2.37%20billion,people%20in%20just%20one%20year.)

³⁶ <https://www.fao.org/3/cb4474en/cb4474en.pdf>

³⁷ Van Damme, W., Dahake, R., Delamou, A., Ingelbeen, et al., (2020). The COVID-19 pandemic: diverse contexts; different epidemics—how and why?. *BMJ Global Health*, 5(7), e003098.

³⁸ Berkhout, E., Galasso, N., Lawson, M., Rivero Morales, P. A., Taneja, A., & Vázquez Pimentel, D. A. (2021). The Inequality Virus: Bringing together a world torn apart by coronavirus through a fair, just and sustainable economy. <https://oxfamlibrary.openrepository.com/bitstream/handle/10546/621149/bp-the-inequality-virus-250121-en.pdf>

³⁹ Oxfam America, *Pandemic Profiteers Exposed*, Oxfam Media Briefing, 22 July 2020, <https://www.oxfamamerica.org/explore/research-publications/pandemic-profits-exposed/>.

⁴⁰ <https://inequality.org/great-divide/updates-billionaire-pandemic/>.

The inevitable COVID-19 vaccines drive has created a bonanza for some pharmaceutical companies and further enhanced the financialization of Big Pharma⁴¹. In the small group of the mRNA COVID-19 vaccine producers and intellectual property holders, Moderna alone welcomes 5 of the newly emerging 8 vaccine billionaires who pocket tax free profits from publicly funded vaccines⁴², while Pfizer and its German partner BioNTech have predicted more than U\$72 billion in sales for the year 2021 alone⁴³. Pfizer, in particular, legally funnels the billions it receives from governments' purchase of its vaccine through tax havens in the Netherlands and elsewhere⁴⁴.

The Covid-19 pandemic has exacerbated beyond any imagination the negative externalities of the unbridled tide of globalization and the ineluctable tensions present in today's world economy and global governance. Resorting to the valuable analysis of the political-economist Dani Rodrick, who has deeply surveyed the larger rights and wrongs of globalization, we can indeed assert that the COVID-19 pandemic has made even more cogent his 'Globalization Paradox' (Rodrick's model derives from the 2008 financial crisis) described in a key political trilemma: "we cannot have hyper-globalization, democracy, and national self-determination all at one. We can have at most two out of three"⁴⁵. We cannot simultaneously pursue democracy, national self-determination, and economic globalization. When the social arrangements of democracies inevitably clash with the international demands of globalization, national priorities take precedence. The problem is that the pandemic has in no way reversed the problematic tensions and tendencies that were visible before the crisis, and in fact:

The crisis seems to have thrown the dominant characteristics of each country's politics into sharper relief. Countries have in effect become exaggerated versions of themselves. This suggests that the crisis may turn out to be less of a watershed in global politics and economics than many have argued. Rather than putting the world on a significantly different trajectory, it is likely to intensify and entrench already-existing trends⁴⁶.

It is impossible for G2H2 to conceptualize the WHO pandemic treaty proposal outside of this 'globalization paradox' gridlock which relies on old models of capitalist growth. These are and remain the primary causes of the COVID-19 crisis, and the constraints are nowhere more visible than in the domains of healthcare. One would imagine that, after two years of the SARS-CoV-2, research agendas that are focussed on the structural challenges of the health (in)security and the health (in)equality linkages should have gained new meaning. But multilateral institutions and the global health community remain unwilling to make this cognitive leap and continue to prefer the comfort zone of global security mechanisms that prolong the vertical economic management of health through disease-

⁴¹ Fernandez R. and Klinge T.J., *The financialization of Big Pharma: private gains we can ill afford*, SOMO and KU Leuven, April 2020, <https://www.somo.nl/wp-content/uploads/2020/04/Rapport-The-financialisation-of-Big-Pharma-def.pdf>.

⁴² <https://www.somo.nl/modernas-free-ride/>.

⁴³ <https://www.theguardian.com/world/2021/aug/11/covid-19-vaccines-the-contracts-prices-and-profits> .

⁴⁴ <https://www.ftm.eu/articles/pfizer-avoids-taxes-via-the-netherlands>

⁴⁵ Rodrik, D. (2011). *The globalization paradox: why global markets, states, and democracy can't coexist*. Oxford University Press.

⁴⁶ Rodrick D., (2020), "Will COVID-19 Remake the World?", in Project Syndicate, 6 April 2020, <https://www.hks.harvard.edu/centers/mrcbg/programs/growthpolicy/will-covid-19-remake-world>.

control and the primacy of biomedical approaches that continue to guarantee the interference of giant corporate actors and the privatization of the health agenda, away from more cumbersome systemic approaches⁴⁷.

Genesis of a pandemic treaty proposal

Closing the 74th World Health Assembly (WHA) on 31st May 2021, Dr Tedros Adhanom Ghebreyesus, the WHO Director General, concluded the session with a strong message:

One day – hopefully soon – the pandemic will be behind us, but we still have to face the same vulnerabilities that allowed a small outbreak to become a global pandemic [...] That's why the one recommendation that I believe will do the most to strengthen both WHO and global health security is the recommendation for a treaty on pandemic preparedness and response [...] This is an idea whose time has come [...] that creates an overarching framework for connecting the political, financial and technical mechanisms needed for strengthening global health security⁴⁸

Light on details, the proposal of a new pandemic treaty supposedly seeks to avoid the notion of secrecy and health nationalism that have hampered the containment of the SARS-CoV-2 contagion. In fact, the initiative derives from a European demarche directed at enhancing the European Union (EU) geopolitical clout ensuing France and Germany's leadership towards supporting the WHO⁴⁹ against US President Trump's hazardous blame-game and ultimately departure from the organization.

The EU has invested heavily in lobbying for this project. The idea of an international pandemic treaty was first proposed by European Council President Charles Michel at the Paris Peace Forum in November 2020, "to establish stronger international commitment to preventing these crises [...] If we want a fairer world, a more robust world, a world better able to withstand shocks – as more shocks (like climate change) will certainly come – we must be better prepared."⁵⁰

President Michel spearheaded the proposal again at the Special Session of the UN General Assembly in response to the coronavirus disease (COVID-19) pandemic held on 3-4 December 2020: "The objective is to do better in all areas where we recognise it is in our interest to strengthen cooperation", the areas being: risk monitoring; better financing and coordination of research; a more efficient system of alerts and information sharing; improving access to healthcare⁵¹.

⁴⁷ Schrecker, T. (2019). Globalization and Health: Political Grand Challenges, *Review of International Political Economy*, July: 26-47, <https://www.tandfonline.com/doi/abs/10.1080/09692290.2019.1607768>.

⁴⁸ <https://www.who.int/director-general/speeches/detail/director-general-s-closing-remarks-at-the-world-health-assembly---31-may-2021>

⁴⁹ <https://www.france24.com/en/20200625-germany-and-france-shore-up-support-for-who-seek-global-answer-to-covid-19> and <https://healthpolicy-watch.news/germany-france-push-for-more-power-funding-for-who/>.

⁵⁰ <https://www.consilium.europa.eu/en/press/press-releases/2020/11/12/intervention-du-president-charles-michel-au-forum-de-paris-sur-la-paix/>.

⁵¹ <https://www.consilium.europa.eu/en/press/press-releases/2020/12/03/press-release-by-president-charles-michel-on-an-international-treaty-on-pandemics/>

Only a few weeks later the pandemic treaty was fielded in Geneva at the 148th session of the WHO Executive Board in January 2021, championed among a handful of reforms that Germany and France had floated to the WHO Member States in August 2020, with a specific view on WHO's work in health emergencies⁵². The European Council president's push received an enthusiastic welcome from the WHO Director General - "I think a pandemic treaty is the best thing that we can do that can bring the political commitment of Member States", Dr Tedros acclaimed at the Executive Board's meeting: possibly, in his relentless quest for international cooperation for managing the pandemic crisis or alternatively, and just as likely, using the treaty idea as the golden opportunity to seal his prospective re-election in 2022. Ever since the COVID-19 pandemic has started, governments have continued to flout WHO's guidance; one of the reasons, according to accredited experts, is WHO's feeble legal mandate in responding to a pandemic scenario.⁵³ But is this, really, the vulnerability that allowed the local outbreak to become a global health crisis? And are we sure that we need to protect the entire world population from health threats through the one centralized global surveillance system that the EU website has dedicated to the pandemic treaty features as the scenario for the future?⁵⁴

In the longstanding quest for setting up a governance mechanism capable of dealing with health emergencies – in 1851, a group of mostly European nations gathered in Paris to craft a common framework for harmonizing responses to the international spread of diseases. Back then, pandemics provoked by cholera and the plague spread recurrently through several countries, and the most common measures were quarantines of incoming travelers and ships⁵⁵. We need to consider that an instrument of international law that endows the WHO with the normative framework for emergency coordination and countries' response exists already, and has existed for some time: the International Health Regulations (IHR)⁵⁶ adopted by the World Health Assembly (WHA) in 1969.

⁵² <https://www.reuters.com/article/us-health-coronavirus-who-reform-exclusi-idUSKCN25F1TT>

⁵³ S. L. Vijav, WHO's Legal Mandate Is Weak In Responding to COVID-19 Emergency; But Changes Are Up To Member States, *Health Policy Watch*, 23 April 2020, <https://healthpolicy-watch.news/whos-legal-mandate-is-weak-in-responding-to-covid-19-emergency-but-changes-are-up-to-member-states/>

⁵⁴ <https://www.consilium.europa.eu/en/policies/coronavirus/pandemic-treaty/>

⁵⁵ At the end of the XIX century, the main aim was not full coordination of how to deal with outbreaks altogether. The main goal was "to harmonize measures taken by states against international trade and travel. Disparities between the measures adopted by states were disrupting commercial activities". As the main global mode of transportation was by sea, the Paris conference in 1851 was focused on measures restricting maritime transportation, particularly at the moment of arriving into foreign ports. "The project was unsuccessful. At the diplomatic level, several states were simply unwilling to cave in to their police powers to confront outbreaks. What remained was the understanding that agreements would become necessary. Indeed, some very specific conventions on the spread of some infectious diseases were agreed in the following decades", from Von Bogdandy A. and Villareal P.A. (2020), *International Law on Pandemic Response: A First Stocktaking in Light of the Coronavirus Crisis*. Max Planck Institute for Comparative Public Law and International Law, MPIL Research Paper Series, No 2020-07, p. 3.

⁵⁶ <https://www.who.int/publications/i/item/9789241580410>

The WHO International Health Regulations (IHR)

The WHO has been often contested by scholar and legal analysts for its rather restrained initiative in shaping new binding norms under its Constitution⁵⁷. Its main instruments, adopted under Article 21 of the WHO Constitution (something that is somewhat contentious in the current debate) are the International Sanitary Regulations, the International Health Regulations (IHR), and the Nomenclature Regulations. The outbreak of the Severe Acute Respiratory Syndrome (SARS) in 2002 gave impetus to the new negotiating efforts aimed at revising the IHR, since the 1969 version of the IHR was deemed to be inadequate for the globalized scenarios of the 21st Century. In 2005, the 58th WHA unanimously agreed on the revision of the IHR with the task to “prevent, protect against, control, and provide a public health response to the international spread of disease”. The legal instrument was then adapted to the exponential increase in international travel and trade, and the potentially revamped emergence of international disease threats and other health risks. Under IHR, Member States are required to develop, strengthen and maintain core public health capacities for surveillance and response by using existing national resources to control diseases that cross borders. The IHR has established an early warning system and helps guide countries to detect, assess and respond to health threats and inform other countries quickly. WHO is required to be notified of health events and ensure coordination. Under the IHR, countries are required to notify and report events and other information through their National IHR Focal Points (NFP) to a regional WHO IHR Contact Point. The IHR acts as an assessment tool to help Member States assess the severity of a health event, and provides a framework for consulting with WHO. This enables WHO to ensure appropriate technical collaboration for effective prevention of such emergencies or containment of outbreaks and, under certain defined circumstances, inform other Member States of the public health risks where action is necessary on their part.

Since entering into force in June 2007, the IHR 2005 has been the core tool to regulate disease outbreaks with an international dimension. It is a detailed and encompassing legal instrument with 66 Articles, 9 Annexes and 2 Appendixes covering all WHO Member States (194) plus Liechtenstein and the Holy See. The treaty’s approach has been innovative in many ways⁵⁸: “It was meant to usher an era of rules-based disease surveillance and response, where state sovereignty gives in to shared goals of the international community. Its obligations and protocols reflect a condensed understanding of best practices developed through many decades of diplomatic negotiations, expert input, and also on-the-ground-operations in health campaigns”.⁵⁹

⁵⁷ Aginam O. (2014), “Mission (Im)possible? Thw WHO as a ‘Norm Entrepreneur in Global Health Governance”, Freeman M., Hawkes S. and Bennet B. (eds), *Law and Global Health: Current Issues*, 2014, 559-562. Also, Gostin L, Sridhar D. and Hougendobler D. (2015), “The normative authority of the World Health Organization”, *129 Public Health*, 2015, 855 and 858. Finally, Toebes B. (2018), “Global Health Law: Defining the Field”, in Burci G-L . and Toebes B. (eds), *Research Book on Global Health Law*, 2018, E. Elgar, p. 11.

⁵⁸ Fidler D (2005), From International Sanitary Conventions to Global Health Security: The New International Health Regulations, *Chinese Journal of International Law*, Volume 4, Issue 2, November 2005, pp. 325-392, <https://doi.org/10.1093/chinesejil/jmi029>

⁵⁹ Von Bogdandy A. and Villarreal P.A. (2020), International Law on Pandemic Response: A First Stocktaking in Light of the Coronavirus Crisis, *MPIL Research Paper Series*, No 2020-07, Max Planck Institute for Comparative Public Law and International Law, March 2020, https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3561650

The IHR reflects a range of good practices that were developed and have sustained for decades, if not centuries, and remain a milestone against which Member States' compliance and responses can and must be measured. It is hardly recalled these days that the IHR still distills the international consensus on how health emergencies and pandemics should be dealt with.

It is undeniable that while information sharing by Member States and the WHO Secretariat is the foundation of international disease surveillance and response, the COVID-19 pandemic has revealed the *not-so-hard* political culture around the implementation of the IHR hard law provisions. The iterated violations of legal obligations have reflected critical deficits that need to be recognized in the existing framework, including the binary conditions for the declaration of a Public Emergency of International Concern (PHEIC), the failure in pursuing capacity building in countries, the weak system of accountability and financial support to health sectors, the lack of a process for independent verification and compliance evaluation, along with ambiguities in relation to travel restrictions. Hence, the IHR has ended up being the easy scapegoat of policymakers and global experts⁶⁰ in light of its apparent limitations in the middle of the harshest phases of the COVID-19 pandemic in 2020. Even the WHO seems to have somewhat neglected the tool in the early phase of the emergency⁶¹. The reality is that IHR does have implementation mechanisms developed by the IHR Monitoring and Evaluation Framework, with mandatory components, that need to be enforced to achieve a robust integration of IHR's object and purpose⁶², including WHO's own obligations under the IHR⁶³.

Beating the treaty drums

In March 2021, the EU, the WHO and 25 heads of states and governments signed a call to the international community to begin the negotiation process to sign a treaty on pandemics. The call, which was published in several newspapers around the world, has formed the basis for the creation of the "Friends of the Treaty", a group of countries asking to engage in building "a more robust international health architecture" focused on pandemic preparedness and response, the rationale being that "at a time when COVID-19

⁶⁰ Para 111 of the Review Committee Report on the International Health Regulations (RCR-IHR) states that "the IHR has no teeth", i.e. there are no enforcement mechanisms. Likewise, the Global Preparedness Monitoring Board 2020 report claims that the "IHR lack of enforcement mechanisms has made it difficult for WHO to ensure compliance", Cfr. <https://www.gpmb.org/annual-reports/annual-report-2020>, p.45.

⁶¹ Villareal P.A. (2020), "COVID-19 Symposium: "Can They Really Do That?" States' Obligations Under the International Health Regulations in Light of COVID-19", Part II, in *Opinio Juris*, 31 March 2020, <http://opiniojuris.org/2020/03/31/covid-19-symposium-can-they-really-do-that-states-obligations-under-the-international-health-regulations-in-light-of-covid-19-part-ii/>.

⁶² Behrendt, S. and Mueller, A. (2021), Why the rush? A call for critical reflection on the legal and human rights implications of a potential new international treaty on pandemics. *EJIL: Talk! The European Journal of International Law*, 29th July 2021, https://www.ejiltalk.org/why-the-rush-a-call-for-critical-reflection-on-the-legal-and-human-rights-implications-of-a-potential-new-international-treaty-on-pandemics/?utm_source=mailpoet&utm_medium=email&utm_campaign=ejil-talk-newsletter-post-title_2

⁶³ Von Bogdandy A. and Villarreal P.A. (2020), *op. cit.*, p. 8 and p. 20.

has exploited our weaknesses and divisions, we must seize this opportunity and come together as a global community”⁶⁴. The call refers to the need for improving alert systems, data-sharing, research, and local, regional and global production and distribution of medical and public health counter measures. The focus is on enhancing the “sharing of information”, “sharing of pathogens” and “sharing of technologies”, as highlighted by the WHO Director General Dr Tedros Adhanom Ghebreyesus when presenting the call at the WHO with European Council President Charles Michel.⁶⁵ Moreover, it reads that the international pandemic treaty “would make it possible to integrate the One Health approach in the international health architecture, thereby connecting the health of humans, animals and the planet”.⁶⁶ Finally, it does recognize the reality of the International Health Regulations (IHR) and mentions that “existing global health instruments, especially the International Health Regulations, would underpin such a treaty”.

With such a high-profile international call and with such an institutional push, the pandemic treaty proposal easily landed into the agenda of the 74th World Health Assembly in May 2021. The topic attracted substantive interest prior to the assembly, mostly deriving from the numerous Member States that had raised concerns on the proposal in the lead up to the governing body session. With Chile heading the discussion⁶⁷, hesitance was variously expressed at WHA74 on getting engrossed in discussions about a treaty to avoid a future pandemic *right in the middle of the COVID-19 crisis*. “Only once COVID has been defeated will it be appropriate for us to consider fundamental changes to the way WHO works and new treaties or conventions. We must understand why the instruments we have are not working. Is the problem with the instruments themselves? Or the way they are being used? Only a multi-faceted analysis involving all states could allow us to draw conclusions on that and to develop a future health architecture,” the Russian representative insisted during the WHA debate⁶⁸. But Russia was not, and is not, the only key geopolitical player unsympathetic to this proposal. The US, China, India and Brazil have demonstrated a scanty appetite to the idea, and continue to have reservations on the deliberative process at the WHO.

The discussion has eventually led to establishing ‘a Member States Working Group on Strengthening WHO Preparedness and Response to Health Emergencies’ (WGPR) tasked with the comprehensive mandate of looking at addressing future health emergencies⁶⁹. At the same time, the WGPR is tasked to formulate an in-depth assessment regarding the benefits of developing a new WHO convention or agreement in this arena, which sets the grounds for convening a special session of the World Health Assembly (WHASS) in

⁶⁴ <https://www.who.int/news-room/commentaries/detail/op-ed---covid-19-shows-why-united-action-is-needed-for-more-robust-international-health-architecture>.

⁶⁵ <https://www.who.int/news/item/30-03-2021-global-leaders-unite-in-urgent-call-for-international-pandemic-treaty>

⁶⁶ Ibidem

⁶⁷ <https://minrel.gob.cl/news/who-will-hold-a-special-session-to-analyze-the-international-pandemic>.

⁶⁸ Dentico N. (2021). The WHO pandemic treaty: responding to needs or playing COVID-19 geopolitics?. Briefing paper, Global Policy Forum, October 2021, p. 6.

https://www.globalpolicy.org/sites/default/files/download/Spotlight_Briefing-Nicoletta_Dentico.pdf

⁶⁹ https://apps.who.int/gb/ebwha/pdf_files/WHA74/A74_R7-en.pdf.

November 2021, to pass under review and deliberate on a WGPR report⁷⁰ regarding the reasons and the implications of a pandemic treaty⁷¹.

The Working Group⁷² has held four meetings in the second half of 2021⁷³. In addition, it has been supplemented with deep dives on specific issues in inter-sessional meetings. Its report⁷⁴, published on November 12th, recommends that countries establish an inter-governmental negotiation body tasked with developing “a WHO convention, agreement or other international instrument on pandemic preparedness and response” through a government-driven process to develop a zero draft, setting the negotiation modalities and timelines. In addition, the report asks Member States to further develop proposals to revise and strengthen the IHR. Even as there is a sense of momentum around a new instrument, the lack of clarity on what the work ahead will actually be generates different and diverging perspectives on the directions that Member States will be taking. Discussions reflect contentious policy choices for countries battling the pandemic, and delegations feel under pressure, respondents from the global South noted. Some Member States respondents to this study indicated that, as deliberations happened during the WHA74 on the resolution on pandemic preparedness, the discussions in the working group were pushed in a particular direction: “There is an insistence on the need on making big reforms in the system right now, in the middle of a pandemic”. But countries need more time; some of them are frustrated with the process, respondents stressed.

“Amending the IHRs and negotiating a treaty? Not many countries can play different tables at the same time, especially if they are closely connected to each other, in terms of the financial and human resources”, one delegate from the global South responded in the interview. And another one highlighted that “This process is very complicated for small delegations, given the amount of work entailed within and between ministries in capital”.

“The temptation to put everything in a single negotiating framework is a tactical move” one legal expert interviewed commented. Decisions will be determined in the coming months: after the WHASS in November 2021, at the Executive Board in January 2022. Finally, the 75th World Health Assembly in May 2022 could see the formal launch of the negotiating process.

⁷⁰ The resolutions underpinning the WGPR include: WHA74.7 that established the working group; and the related decision WHA74.16, asking the working group to “to prioritize the assessment of the benefits of developing a WHO convention, agreement or other international instrument on pandemic preparedness and response and to provide a report to be considered at the special session of the Health Assembly.”

⁷¹ [https://apps.who.int/gb/ebwha/pdf_files/WHA74/A74\(16\)-en.pdf](https://apps.who.int/gb/ebwha/pdf_files/WHA74/A74(16)-en.pdf)

⁷² The Working Group is chaired by Indonesia and the United States of America. The Vice-Chairs include Botswana, France, Iraq and Singapore.

⁷³ <https://apps.who.int/gb/wgpr/>

⁷⁴ Draft report of the Member States Working Group on Strengthening WHO Preparedness and Response to Health Emergencies to the special session of the World Health Assembly
https://apps.who.int/gb/wgpr/pdf_files/wgpr5/A_WGPR5_2-en.pdf

Public health needs and pandemic governance gaps: Is a new treaty the solution?

The landscape of global health governance has been exposed to a radical and unrestrained transfiguration in the last two decades. The emergence of private actors, and their incorporation into what was a publicly dominated health governance system, are manifestations of a phenomenon that has revolutionized the health governance architecture into a splintered arena of wealthy influential entities claiming a role in global health. In a matter of few years, health institutions have virtually lost their lines of authority and responsibility, both politically and legally, in a structural metamorphosis that has – among other things – weakened the state’s ability to govern globalization and protect the global ecosystem⁷⁵. The makings of this transformation in a few decades are driven by the ideology of ‘new public management’, the theory that has modeled major traditional institutions on the perceived virtues and values of the private sector. Eventually, these have remained underfunded, often contested, and compelled to adapt to the new reality of overlapping and competing mandates. Such is the sad case for the WHO.

The COVID-19 crisis has exacerbated this governance complexity in unpredictable ways. It has penetrated the equivocal relationship between economics and science, fueling skepticism against medical solutions. It has come to sweep the world at a time of dramatic decline of substantive democracy and impulsive rise of national-populist leaderships, with potential long-term risks of the reshaping of state power.⁷⁶ The virus endures with its variants in the flare-up of big-powers’ rivalry and breaks through the broken threads of multilateralism.⁷⁷ Meanwhile, the empty seats of the new COVID-19 online diplomacy have imposed additional problems to the multilateral machinery, further stretching power imbalances in decision-making processes, albeit under the presumption of an extended participation capacity.⁷⁸

In this context, which is largely one of disenchantment and distrust, we need to situate the pandemic treaty discussion. Its proponents deliberately invoke a multilateralism-saving discourse to cast their nets to new supporters of the proposal. But their slogans are not fully convincing. Too many questions about the health crisis (and beyond) triggered more by the multilateral failure than by the virus, creep unanswered in the WHO rooms. We do not know yet how the outbreak originated. We do not know why some regions have had less devastating epidemics than others. But in this vacuum, and in the midst of the crisis still, the WHO machinery has started to roll up the pandemic treaty process and anchor it

⁷⁵ Gleckman, H. (2018). *Multistakeholder Governance and Democracy: A Global Challenge*. Routledge, 2018, p. 28-51.

⁷⁶ <https://www.voanews.com/covid-and-democracy>

⁷⁷ C.F. Pereira Da Silva Gama, *Broken Threads: Reshaping Multilateralism with COVID-19 Under Way*, *E-International Relations*, 10 May 2021, <https://www.e-ir.info/2021/05/10/broken-threads-reshaping-multilateralism-with-covid-19-under-way/>

⁷⁸ Since the beginning of the pandemic, G2H2 members have been directly confronted with such dynamics in WHO governing bodies’ meetings, including the 74th WHA. The current adoption of resolutions appears somewhat deprived of substantive Member States’ negotiating interaction. The governing bodies’ meetings, more often than not, have resulted in ceremonial deliberations, or statements concerning what individual Member States have done to handle the health crisis at home, and challenges ahead.

to a formal negotiation process. The gaps in the pandemic governance regimes have been reviewed in four major mandated international instances; 1. the Report of the Review Committee on the Functioning of the International Health Regulations (RCR-IHR) during the COVID-19 response ⁷⁹; 2. The Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme⁸⁰; The WHO Independent Panel for Pandemic Preparedness and Response (WHO IPPPR) ⁸¹; 4. The Global Preparedness Monitoring Board.⁸²

The major gaps that the WHO Secretariat has diagnosed in the current governance system, based on such reports, are as follows:

- The global health architecture and governance for pandemic preparedness and response;
- The difference between the actual and perceived levels of preparedness by States;
- The IHR as useful but lacking proper implementation and enforcement mechanisms to ensure compliance;
- The financing of the preparedness and response (a public good) at the national, regional and global levels being suboptimal;
- The inequitable access to countermeasures like vaccines;
- The 'One Health' approach and the need for strengthening surveillance and preparedness at the human-animal-environment interface;
- The risk assessment, alert and rapid response, including the determination of a PHEIC.

The four formal reports include 131 recommendations. The WHO Secretariat has selectively provided the WGPR with an overview of these recommendations and some preliminary findings^{83 84}, where it is possible to identify multiple levels of convergence and divergence. All four reports recommend, in one way or another, a new WHO international legal agreement ('a treaty'), lending these reports' recommendations to becoming a main argument in the hands of the treaty proponents to pursue this pathway. The RCR-IHR specifies (p. 16) that a global convention on pandemics should support the *implementation* of the IHR. The IPPPR report, in mid-May 2021 invited to adopt the new treaty within the next 6 months as a *complementary* instrument to the IHR (p. 47), using the powers under Article 19 of the WHO Constitution. As pinpointed by international law experts, all reports "contain remarkably little analyses of the far-reaching and multi-faceted detrimental effects that the WHO's and different States' response to the emergence of the SARS-CoV-2 virus has had and continues to have on people's health and lives

⁷⁹ <https://www.who.int/publications/m/item/a74-9-who-s-work-in-health-emergencies>

⁸⁰ <https://www.who.int/publications/m/item/a74-16-independent-oversight-and-advisory-committee-for-the-who-health-emergencies-programme>

⁸¹ https://theindependentpanel.org/wp-content/uploads/2021/05/COVID-19-Make-it-the-Last-Pandemic_final.pdf

⁸² https://www.gpmb.org/#tab=tab_1

⁸³ https://apps.who.int/gb/wgpr/pdf_files/wgpr2/A_WGPR2_3-en.pdf

⁸⁴ https://apps.who.int/gb/wgpr/pdf_files/wgpr3/A_WGPR3_5-en.pdf

around the world”⁸⁵. Neither do these reports “engage in detail with the many *legal* questions that these responses raise, among them questions about the potential violations of the IHR as well as of numerous human rights, including in particular the human right to highest attainable standard of health (right to health) as referenced in the preamble of the 1948 WHO Constitution. Nor do the reports examine in detail why the current international treaty on pandemics is insufficient to address outbreaks of infectious diseases in the future”⁸⁶.

Yet, the political pressure in Geneva and in several capitals is mounting, and it has taken centre stage in the global health policy arena outside of the WHO too. Several scholars and civil society representatives have made their nuanced cases for an international treaty⁸⁷, inspired by the reports’ recommendations or rather pushed by the aspiration of “regulating issues that are currently not” or by the good interactions with delegations that seem open to inputs in terms of equity considerations. The development of a competent dialogue around the need for binding arrangements in global health is one of the positive outcomes of the pandemic treaty proposal, whatever the position on this issue, and this should ideally set an opportunity for the international community that believes in public health and in the role of public institutions to re-imagine itself, beyond the classical disease models, on the new set of organizing principles that stem from the COVID-19 conjuncture.

The need for a new instrument has been outlined by the EU delegation during the WGPR sessions^{88 89}, further specified in a statement⁹⁰ at the WGPR in October⁹⁰. The EU argument is that while the amendment to the IHR is a welcome process, it would not lead to the ‘game-changing’ requirements for creating the conditions for increased international solidarity and preparing the world for future threats. A new treaty instead is needed to address the new focus areas that the COVID-19 experience has brought to the fore, namely the procedures for rapid risk assessment, alert and response; the need for securing health emergency workforce and global assistance to outbreak areas; possibly, the global financial mechanism for health emergency preparedness and response. The EU has already

⁸⁵ Behrendt, S. and Mueller, A. (2021), Why the rush? A call for critical reflection on the legal and human rights implications of a potential new international treaty on pandemics. EJIL: Talk! The European Journal of International Law, 29th July 2021, https://www.ejiltalk.org/why-the-rush-a-call-for-critical-reflection-on-the-legal-and-human-rights-implications-of-a-potential-new-international-treaty-on-pandemics/?utm_source=mailpoet&utm_medium=email&utm_campaign=ejil-talk-newsletter-post-title_2.

⁸⁶ *ibidem*

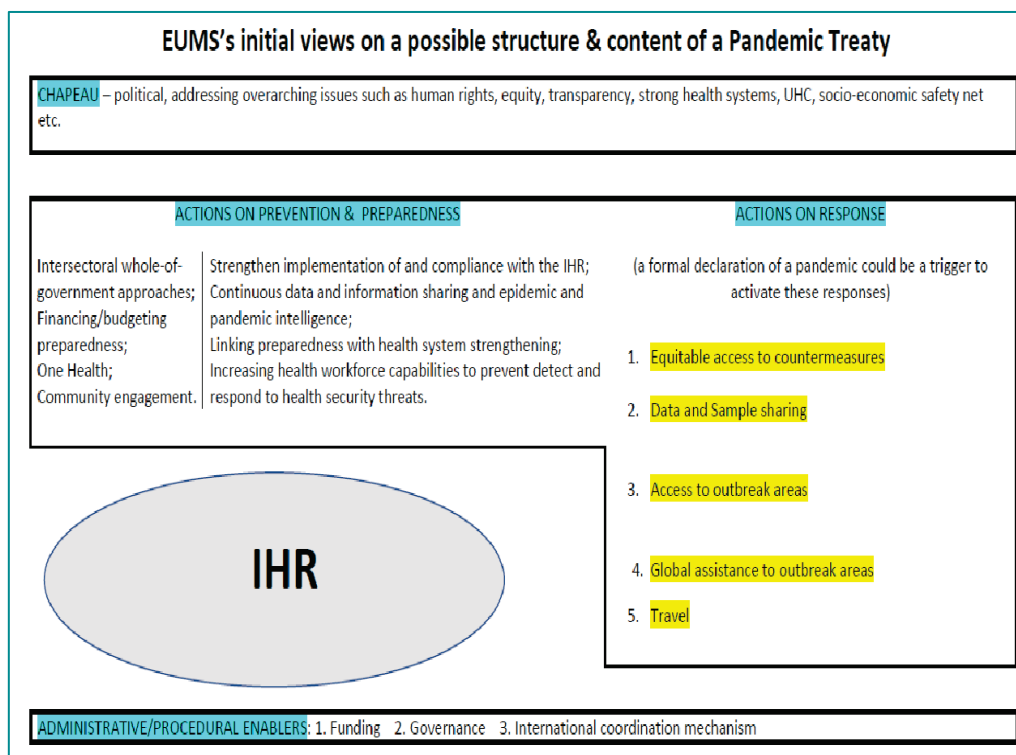
⁸⁷ Nikogosian, H. and Kickbush, I. (2021). The case for an international pandemic treaty. The BMJ, 25th February 2021, doi: <https://doi.org/10.1136/bmj.n527>. A similar call has been made by the Pandemic Mitigation Project. <https://pandemicmitigationproject.com/>

⁸⁸ https://eeas.europa.eu/sites/default/files/com_reflection_paper_on_pandemic_agreement.pdf

⁸⁹ https://eeas.europa.eu/sites/default/files/eu_member_states_initial_views_on_structure_content_of_a_pandemic_treaty_31_august_2021_0.pdf

⁹⁰ https://eeas.europa.eu/delegations/un-geneva/105113/3rd-working-group-strengthening-who-preparedness-and-response-health-emergencies-eu-statement_en

structured its initial proposal of the possible elements and content of a treaty in a visual representation⁹¹ :



The intent is promoting the new instrument’s alignment with the IHR and other relevant legal frameworks, and injecting the WHO with more agency and greater capacity in preventing outbreaks and better managing them in a globalized world. The EU recognizes the significant work ahead, given the contentious nature of the response measures that ought to be enacted when a pandemic is declared, and the fact that funding, governance and international coordination are not clarified in the proposal yet. Financing any new norms for governing future health emergencies will be key for the success of the new rules.

According to the WHO Secretariat, “The WHO Constitution expressly provides the World Health Assembly with three types of possible instrument: (a) The Health Assembly may adopt conventions or agreements, per Article 19; (b) The Health Assembly may adopt regulations, per Article 21; (c) The Health Assembly may make recommendations, per Article 23.” These instruments are not exclusive. The WHA may address a health subject (for example, pandemic preparedness and response) through one or more instruments under one or more of the instrument models, or a combination thereof. The Secretariat analysis, however, suggests that “a new instrument could provide authoritative structure and cohesion to the global governance of pandemic preparedness.” It also makes some reference on the equity aspects of a potential treaty, one of the most contentious elements for the future negotiations. “A treaty could include ensuring economic and social protection and advancing respect for human rights, providing for equitable access to healthcare services and medical countermeasures, including vaccines, and ensuring equitable

⁹¹ *Ibidem*

representation and participation". In the past, it adds, "such *soft law* framing has resulted in terms that skew towards the *aspirational*, rather than *operational*."

But how have the G2H2 research respondents reacted to this presumed *need for a pandemic treaty*?

Despite the dynamism of so many initiatives and the production of so many streams of policy making, delegates interviewed for the research appeared overall less interested in prodding the idea of a new instrument than in addressing some of the perceived reasons for the COVID-19 failure. Whether there is a new parallel instrument to the IHR or not - this is a recurrent argument from the interviewees - "nothing has ever stopped Member States from investing in domestic preparedness and response measures, and from engaging in international collaboration".

Respondents from the global South have highlighted that the implementation of the IHR provisions has retrospectively proven to be a major hurdle, including the prolonged negligence in supporting the core capacities of poorer states (Art. 44 of the IHR) in fulfilling their public health functions⁹². Failure of several governments to abide by the IHR obligations in the context of COVID-19 needs to be reckoned as the unfortunate legacy of such neglect. Yet, "IHR has weaknesses that could be amended", insists one delegate from Africa, "what failed is the actual use of the IHR".

"The IHR have been used for half a century now, a time during which the world has witnessed other pandemics, including influenza and HIV/AIDS" argued one health official from the global South, adding: "COVID-19 has happened at a particular time, at the peak of economic globalization. What are we trying to resolve with a new treaty? We need to interrogate ourselves on the failure of IHR and its implementation, not delving into the creation of a different instrument altogether. What is actually needed is immediate concrete action in dealing with the current pandemic and related inequities, including access to countermeasures like vaccines". Legal experts interviewed for this research have noted that the IHR provides for the inclusion of equitable access to countermeasures. As discussions in the Working Group progressed, the treaty option gained traction than only strengthening the IHR.

Respondents from the EU seem convincingly aligned with the treaty idea "as the line to follow" because "everything is better than what we have now" and "this is a political momentum to reposition the WHO in the multilateral field" (quoting comments from three different delegates). The idea of amending the IHR is a governance-weakening path for some, but others express concern at the lack of clarity, or substance, in the treaty proposal, more so because "everybody is at risk when it comes to a pandemic, so the idea of a hierarchy and difference of needs between North and South is a false image".

One of the persons interviewed appears convinced of his claim that 170 countries already support the treaty, and another has expressed confidence that "China will not block the treaty". But in reality feelings are mixed. Officials from the Global South do acknowledge

⁹² Habibi, R., Burci, G. L., de Campos, T. C., Chirwa, D., Cinà, M., Dagrón, S., ... & Hoffman, S. J. (2020). Do not violate the International Health Regulations during the COVID-19 outbreak. *The Lancet*, 395(10225), 664-666.

the need for reflecting on future mechanisms against pandemics, yet remain convinced that this is not the best moment to engage because the COVID-19 response requires, right now still, the utmost level of Member States' attention, energy and concentration. Moreover, some of them reckon, any serious pandemic reflection will require - after such a long systemic crisis - a deep analysis on how societies have to organize and transform their economies and above all their health systems vis-à-vis future health risks. This largely requires prioritizing the needs of the global South, where public health systems often do not even exist, and where healthcare is almost exclusively in the hands of a private healthcare industry which is largely unfit for health emergency events like COVID-19⁹³.

As the WHO IPPPR has recalled, the pandemic's tsunami-like effect has indicated that health systems were overall not prepared for a health emergency, this being the case also for universal public health systems in high-income countries, overwhelmed by the aggressive spread of the virus notwithstanding their health welfare infrastructures. That is why, according to several experts interviewed, developing strong and resilient public health systems should be a high priority on the WHO agenda and for the international health community – a consideration made already in the aftermath of the Ebola crisis between 2014 and 2016⁹⁴ that has remained pretty much unattended. COVID-19 imposes a reflection on why health systems strengthening remains somewhat secondary to other health policy goals. As an example: despite the understanding that health workforce development and decent employment represent essential conditions for health security and the implementation of the health-related SDG agenda, international investments in this area have dwindled over the last 5 years⁹⁵. Health professionals and academic involved in the research note that the limited financing of public health core functions - both at the domestic and international level - is largely due to the fact that public health has not been a political priority. With the exception of some Asian countries, confronted with epidemics in the past and endowed with a strong sense of public responsibility in health, very few governments have taken ownership in the last decade for investing in strengthening domestic and global health systems. Many of them, it should be added, were prevented from doing so by several constraints, including financial constraints associated with debt service payment, often a strangling factor in health policy-making⁹⁶.

It is a tragedy in many ways – this is *our* observation - that so far the mass market failures in health during the pandemic should have “neither generated any significant shift in the multilateral governance of health and health systems, nor a retreat from private health and the partnership model that has largely defined and framed engagement with and

⁹³ Williams, O. D. (2020). COVID-19 and Private Health: Market and Governance Failure. *Development* 63, 181-190, 17th November 2020, <https://doi.org/10.1057/s41301-020-00273-x>.

⁹⁴ Kluge, H., Martín-Moreno, J. M., Emiroglu, N., Rodier, G., Kelley, E., Vujnovic, M., & Permanand, G. (2018). Strengthening global health security by embedding the International Health Regulations requirements into national health systems. *BMJ global health*, 3(Suppl 1), e000656.

⁹⁵ World Health Organization. (2021). Working for health: a review of the relevance and effectiveness of the five-year action plan for health employment and inclusive economic growth (2017-2021) and ILO-OECD-WHO Working for Health programme. <https://www.who.int/publications/i/item/9789240023703>

⁹⁶ https://www.eurodad.org/covid19_debt4 and also https://www.eurodad.org/covid19_debt_faq

promotion of private health in the last two decades⁹⁷. The multilateral approach is ideologically oriented to the private sector in the COVID crisis, albeit being tinged with statements of ‘the lessons learned’ and the ‘need for change’ in areas such as investment in public health systems and financing for equitable access, it will definitely be a testing ground for any pandemic treaty negotiations. The multilateral path dependency and political as well as financial support of the private players, both of which are so evident in global health and wider global governance, will need to be harshly confronted in the hypothesis of a pandemic treaty.

An intricacy of political triggers

As mentioned earlier, treaty making at the WHO has occurred only twice in over 70 years of history. The first trigger to mobilize the international community was a global health security concern which resulted in the establishment of International Sanitary Regulations (1951), the ancestor of the International Health Regulations (IHR). More recently, the Framework Convention on Tobacco Control (FCTC)⁹⁸ marks the first and only international public health treaty negotiated and concluded under the aegis of the WHO, with the intent of tackling the smoking and tobacco pandemic.

This is considered a landmark event for international law, opening “a new legal dimension in international health cooperation”⁹⁹. The FCTC, like most treaty exercises pursued at the UN in recent decades, is an “evidence-based convention, building up on the millions of pages of research produced to provide the public-health evidence of the problem and opening up the books of the major tobacco corporations”¹⁰⁰. The negotiation was preceded by years of masterful evidence collection by academic experts and civil society organizations who exposed the industry’s role in this arena, and prepared for the complex implications of any anti-tobacco route anchored in the WHO. The WHO DG Gro Harlem Brundtland’s fortunate determination to embark on a treaty pathway then came after accumulating this wealth of evidence, including through the Expert Committee findings.

This research-based, bottom-up process featured by the primary role of international civil society organizations and the voices of groups from the global South was then a key feature of the FCTC, although that account is somewhat lost in today’s conversation. The same approach has characterized other significant attempts at breakthrough normative exercises at the WHO. The most obvious allusion is to the Research and Development (R&D) Treaty, which had been initially suggested by a resolution of the WHO

⁹⁷ Williams, O.D. (2020), op cit.

⁹⁸ https://www.who.int/fctc/text_download/en/.

⁹⁹ Nikogosian, H. (2021), A Guide to Pandemic Treaty: Things You Must Know To Help You Make a Decision on a Pandemic Treaty. The Graduate Institute, Geneva, 2021, p. 9.

<https://www.graduateinstitute.ch/sites/internet/files/2021-09/guide-pandemic-treaty.pdf>.

¹⁰⁰ Intervention of Michél Legendre, Director of the Tobacco Campaign at Corporate Accountability, at the G2H2 webinar “The pandemic treaty proposal: seeking accountability after the disaster?”, held on 10th May 2021, <https://g2h2.org/posts/may2021/>.

(WHA61.21)¹⁰¹, then by a WHO Consultative Expert Working Group (CEWG)¹⁰² and finally by the UN High Level Panel on Access to Medicines¹⁰³. Unfortunately, it was boycotted (and diplomatically killed) by a bare handful of European Member States now proposing the pandemic treaty, and by the US delegation, asserting that the exercise would be outside of the WHO mandate. The same societal effort of competence and engagement led to the result of the 1997 Anti-Personnel Landmines Convention¹⁰⁴, to the creation of the International Criminal Court in 1998¹⁰⁵ and later to the 2015 Framework Convention on Climate Change¹⁰⁶.

Unlike the pandemic treaty now being discussed at the WHO. In essence: the missing societal breadth for change that usually drives treaty-making, together with the lack of solid evidence about the cogency of a second health emergency instrument, beyond the rhetoric of saving multilateralism, represents the constitutive weakness of the current initiative at the WHO. The dynamic of the proposal is top-down and over-solutionistic. Moreover it is enshrined in a hasty, somewhat hyper-personalized, logic of immunity¹⁰⁷. The question of political support will likely be addressed through the EU's powerful geopolitical interplay at motivating Member States to be part of the treaty and furthering it over and garnering appropriate narratives to this end¹⁰⁸. But this is not a game played in the rooms of the WHO alone.

Europe's new geopolitical assertion on the global health arena

While the pandemic treaty's chronicles account that Chile was the first proponent of an international pandemic treaty at WHA73, and Chile itself claims this primacy, the EU's leadership in bringing the proposal forward in all possible international circles cannot be questioned. The pandemic treaty idea has stemmed at a time of geopolitical crisis of public reasoning, with the fight against the pandemic morphing into a competition of political regimes. The rift between the US and China has considerably influenced cooperation on pandemic response and broader governance. This has included the announced US withdrawal from the WHO, the timing and mandate of the WHO mission to China on the origins of the COVID-19 outbreak, and the new fire over the old debate concerning Taiwan's observer status at the WHO. After the shock of Brexit, suspended in the uncertainties of the US presidential elections, the EU and some of its member states, notably Germany and France, have made it a priority to commit to saving multilateralism

¹⁰¹ https://apps.who.int/gb/ebwha/pdf_files/WHA61-REC1/A61_Rec1-part2-en.pdf

¹⁰² https://apps.who.int/gb/CEWG/pdf_files/A65_24-en.pdf.

¹⁰³ <http://www.unsgaccessmeds.org/final-report>

¹⁰⁴ <https://www.un.org/disarmament/anti-personnel-landmines-convention/>

¹⁰⁵ https://en.wikipedia.org/wiki/International_Criminal_Court

¹⁰⁶ https://unfccc.int/sites/default/files/resource/parisagreement_publication.pdf

¹⁰⁷ Dentico, N. (2021). The Breathing Catastrophe: COVID-19 and Global Health Governance. *Development*, 13th July 2021, <https://link.springer.com/article/10.1057/s41301-021-00296-y>.

¹⁰⁸ McInerney, T.F. (2021). Factors Contributing to Treaty Effectiveness: Implications For A Possible Pandemic Treaty. Global Health Centre Policy Brief. Graduate Institute, Geneva, 2021, p. 6. <https://www.graduateinstitute.ch/sites/internet/files/2021-10/PolicyBrief2.pdf>

and leveraging a form of 'strategic autonomy' as an influential player in the global scene¹⁰⁹.

The pandemic has also been particularly disruptive in Europe, well beyond Italy's first viral tsunami¹¹⁰. It has inflicted several blows. In March 2020, the EU decision to suspend the intransigent rules of the Stability and Growth Pact (SGP), to allow countries the needed financial margins to tackle the pandemic, marked a point of no-return. This translated into then reaching some commonality in vaccine distribution and economic aid through the Next Generation EU Recovery Plan. COVID has clearly immunized the European institutions from their old defensive positions on finance and health. The European Commission's decision to negotiate the purchase of COVID-19 vaccines on behalf of all its members was a breakthrough move, one that has dispatched Europe's serious contractual weaknesses in its interaction with vaccine producers. However it has sharpened European citizens' quest for bolder integration, particularly on health security and health policies, towards building a union resilience¹¹¹. To this end, the European Commission communicated a plan for a more integrated European Health Union in November 2020¹¹². Amongst others, it will create an EU Health emergency preparedness and response authority (HERA)¹¹³.

While scholars have noted how the trend of 'Europeanizing' public and global health matters could render the EU more vulnerable to political influences beyond the health domain¹¹⁴, the EU diplomatic initiative distils from what we could represent as a renewed sense of communal identity after the early 2020 trauma in the wake of COVID-19's unexpected arrival. There are good reasons to suppose that this is the drive behind the European Commission's lead in ushering the launch of the Access to COVID-19 Tool Accelerator (ACT-A) on 24th April 2020 at the WHO in Geneva, with the Bill and Melinda Gates Foundation (the mastermind of the project's design)¹¹⁵, President Emmanuel Macron from France and President Cyril Ramaphosa from South Africa, among several other leaders and heads of state. The event was clearly meant to send a sign of concrete international cooperation in the midst of the US administration's escalating attacks against the WHO.

The treaty proposal is likely influenced by the cold winds blowing in those months of unprecedented operational challenges for the organization, and the entire world. Its narrative is made up of mobilizing concepts such as "global solidarity", "fairness", "trust", "equity", "transparency", but G2H2 research respondents contend that the rush in this European pandemic leadership is problematic, since it "has precluded a thorough analysis

¹⁰⁹ Helwig, N. (2020). Covid-19 Calls for European Strategic Autonomy. *FIIA Comment*, 13.

¹¹⁰ Dentico, N. (2020). The COVID-19 Crisis in Health Systems & Prospects for Recovery : The View from Italy. Health Policy Watch, 27th March 2020, <https://healthpolicy-watch.news/the-covid-19-crisis-in-health-systems-prospects-for-recovery-the-view-from-italy/>.

¹¹¹ /files/communication-european-health-union-resilience_en.pdf

¹¹² https://ec.europa.eu/info/sites/default/files/communication-european-health-union-resilience_en.pdf

¹¹³ https://ec.europa.eu/info/law/better-regulation/have-your-say/initiatives/12870-European-Health-Emergency-Preparedness-and-Response-Authority-HERA_en.

¹¹⁴ Brooks, E., & Geyer, R. (2020). The development of EU health policy and the Covid-19 pandemic: trends and implications. *Journal of European Integration*, 42(8), 1057-1076.

¹¹⁵ Zaitchik, A. (2021). How Gates Impeded Global Access to COVID Vaccines. *The New Republic*, 1 April 2021, <https://newrepublic.com/article/162000/bill-gates-impeded-global-access-covid-vaccines>.

of the root causes in the global pandemic governance failure and of the structural challenges that have emerged - beyond public health needs". As interviewee scholars suggest, "this political activism, while showing that the EU can step into the leadership vacuum left by the Trump administration, and that states in the global North are doing something, could actually end up being a distraction from the current failures of global health governance, and bring the focus on geopolitical interests rather than strengthening the WHO". With the expanding array of expectations being squeezed into the treaty, there are considerable doubts that "the actual needs, including the current response to the epidemic, will really ever be met by the treaty proposal". Non-EU respondents suggest that the global governance failure must be addressed "with a different, not health-sector alone, strategy".

Now, the EU and WHO have moved to fashion the "Friends of the Treaty" group¹¹⁶ even before setting the scene for a diplomatic negotiation, highlighting the intrinsically geopolitical nature of the proposal and of the need to get it sealed institutionally at the WHO. The rush is presumably due to the potential competition with the plethora of similar proposals stemming from other fora – the Global Health Threats Council and Fund to be located at the UN in New York, as per the recommendations of the WHO IPPPR, or the International Pandemic Financing Facility contained in the report of the G20 High Level Independent Panel on Financing the Global Commons for Pandemic Preparedness and Response¹¹⁷.

Two observations must be made in this regard. The EU born idea only later received the support of other member states in the context of the UK-chaired G7¹¹⁸. The Italy-led G20 has not endorsed the notion of the treaty, with the Italian presidency much too busy in negotiating its own proposed Global Health and Finance Board¹¹⁹, in line with the Health and Financing Board idea from the IMF¹²⁰; the Board has in the end been weakened into a G20 Joint Finance-Health Taskforce¹²¹. Secondly, only a few countries from the global South have openly supported the treaty as *friends*: Indonesia, Thailand, South Korea

¹¹⁶ The full list of countries and entities that signed the treaty proposal are the following; Albania, Chile, Costa Rica, Croatia, Fiji, France, Germany, Greece, Indonesia, Italy, Kenya, Republic of Korea, The Netherlands, Norway, Portugal, Romania, Rwanda, Senegal, Serbia, South Africa, Spain, Thailand, Trinidad and Tobago, Tunisia, Ukraine, the United Kingdom.

¹¹⁷ <https://pandemic-financing.org/report/foreword/>.

¹¹⁸ <https://www.g7uk.org/g7-leaders-to-agree-landmark-global-health-declaration/>.

¹¹⁹ <https://home.treasury.gov/news/press-releases/jy0435>

¹²⁰ <https://impakter.com/future-global-health-financing-real-change/>

¹²¹ <https://www.politico.eu/article/g20-countries-launch-taskforce-financial-firepower-health-crises/>. The proposals of the Global Health and Finance Board and of the Joint Finance-Health Taskforce have both been spearheaded by the WHO Pan-European Commission on Health and Sustainable Development chaired by former Italian Prime Minister Mario Monti. In [a report](#) published in September, the WHO said the board's role could be to ensure "preparedness and responsiveness to health crises, including through the release of necessary resources." The initiative was inspired by the success of the [Financial Stability Board](#) set up after the 2008 global financial crisis. The civil society organizations gathered in the C20 have consistently criticized the notion of a Global Health Board at the G20, for the implications that this apex entity may produce on the mandate and authority of the WHO, from which it paradoxically emanates. The second reason of concern was the idea of a new health entity placed at the G20, where only a small number of (powerful) countries are represented – a worrisome precedent. Neither the features and mandate of the Global Health and Finance Board or of the Joint Finance-Health Taskforce, and the relation with the WHO herein, are detailed in the G20 proposals.

(Asia), Tunisia, Senegal, Rwanda, South-Africa (Africa), and Chile (Latin-America). While the EU has claimed global legitimacy for the proposal, the population of the countries and EU represented by the treaty endorsement virtually consists of less than 15% of the world population¹²². It is evident that Europe has ambitious and sophisticated political grounds to continue pushing for this route, as part of a global battle that may also dialogue with the increasing OECD role in the post-pandemic scenario, especially in terms of tax treaty rules¹²³.

A number of participants in this research from the Global South and based in Geneva have noted that several Latin-American, African and Asian countries have doubts on the policy drivers and values of the European initiative, including whether it would benefit their societies in the case of new health emergencies. Several political leaders from non-EU countries have come to support the treaty proposal, but health diplomats interviewed have lamented the limited involvement of the Geneva delegations. European leaders and delegates have lobbied directly their capitals bypassing the Geneva missions altogether, a fact that has caused some degree of confusion. One African diplomat affirmed of having learnt about his country's support to the treaty from a press release.

A winning agenda for the WHO Director General

Since the very preliminary conversations around the idea of a pandemic treaty Dr Tedros, the WHO DG, has been a fervent preacher of the European initiative. His keenness to conquer and assert the WHO governance space for this diplomatic route has some explanations. It came one exact year after the beginning of the outbreak and still in the midst of an institutional and personal COVID-19 related legitimacy crisis. Quite a few respondents in this research observed that it is rather unusual for a Director General of a UN organisation to single handedly jump on board the development of a treaty advanced by a bare handful of countries, however influential those may be: "the proposal should have been adequately discussed and mandated by the EB or the WHA at least, before the DG put all the institutional weight behind the idea, while Member States are still pretty unaware of it". Dr Tedros expressed his full-fledged enthusiasm for a treaty when announcing it for the first time at the WHO EB148 in January 2021.

This precedent was set by Gro Harlem Brundtland, who made it very clear that the fight against the tobacco industry would be one of her priorities, only a few months after being elected WHO DG in 1998. As a seasoned politician she took the initiative of seeding the path towards the binding instrument in the house and setting the organization in motion for Member States to gradually support the idea of an international convention in this arena. The scientific evidence against tobacco and the vector of the tobacco pandemic – the tobacco industry's practices – had been developed by the research community since 1993¹²⁴ and societal mobilization had led the way to the tobacco convention's proposal

¹²² <https://www.worldometers.info/world-population/population-by-country/>

¹²³ <https://www.oecd-forum.org/posts/towards-increasing-certainty-in-uncertain-times-revising-tax-treaty-guidance>.

¹²⁴ The idea of a binding instrument to safeguard public health and strongly regulate the tobacco industry started to come about after the publication of a few first scientific articles on the lethal effects of tobacco, and the industry's

actually becoming a formal WHO DG-driven process aimed at engaging Member States into negotiation.

The COVID-19 emergency requires exceptional measures and rapid proposals. But the treaty proposal has been deprived of any arguments and real evidence at the EB148 and at the WHA74. Respondents from the global South have commented that by placing himself at the forefront of the Friends of the Treaty’s proposal, “Dr Tedros raises questions about his allegiance to interests by all other Member States. The WHO DG should support *the joint efforts by all of 194 Member States*” (our emphasis). The sentiment in Geneva is that some African countries have become early endorsers of the treaty in the wake of repeated persuasion attempts by the WHO DG. As one Geneva diplomat from Africa noted, “there is a vivid perception that in March 2021 the treaty was being pushed hard by Dr Tedros, partly because European Member States constantly evoked the WHO prerogative to propose treaties”. The diplomat added: “It seems that some developed countries are trying to bulldoze everything; they argue that there is an urgent need for a treaty, but don't explain where this need comes from.” “If the treaty is something that the Secretariat is going to draft and submit to our consideration, it is going to be very complicated.

It somewhat subverts the logic of multilateralism, and the leadership of Member States”, is the concerned comment of another delegate from Latin America. Several respondents from the global South remarked that Dr Tedros’ active involvement in the treaty process could be related to his securing the European financial support for the organization, under considerable budget pressures during the pandemic, but also to his seeking political support for re-election in 2022 – indeed, he is the sole candidate in the race for WHO Chief election, with “the Berlin nod”¹²⁵.

“Dr Tedros’ overzealous support has put the WHO Secretariat (the legal team) in a rather awkward situation”, according to one legal expert interviewed for the research, “as they now need to recommend the development of a treaty while a proper analysis of (expressed) needs and pathways by the Member States is still missing”. Other respondents were concerned that these reversed policy steps explain partly the rather complicated procedural process of the WGPR where a proposal (agreeing to commence treaty negotiations) is currently being discussed together with a parallel track (the IHR revision);

aggressive role against science in this field (tobaccotactics.org/wiki/influencing-science-funding-scientists). The notion was hatched for the first time in July 1993 thanks to the academic initiative promoted by Ruth Roemer and Milton I. Roemer (UCLA) and Allyn L. Taylor (Whittier University): “For quite some time, Taylor had supported the notion that the WHO should urgently rediscover its all too long neglected constitutional function to promote the development and implementation of *new* international law in the domain of public health”. Ruth Roemer proposed to apply this approach to tobacco control, since the WHO already had a policy on tobacco. The idea landed with the WHO tobacco officials and in 1994 at the 9th World Tobacco Conference in Paris, which produced a resolution asking the WHO to “immediately kickstart one initiative aimed to prepare the route for an international convention of tobacco control, to be adopted by the United Nations”. MacKay, J. (2003), The Making of a convention on tobacco control. *Bulletin of the World Health Organization*, vol. 81, n. 8, 2003, p. 551, In this regard, see also Diethelm, P. and McKee, M. (2006). *Lifting the Smokescreen: Tobacco industry strategy to defeat smoke free policies and legislations*. European Respiratory Society and Institut National du Cancer, 2006. https://www.researchgate.net/publication/237123646_Lifting_the_Smokescreen_Tobacco_industry_strategy_to_defeat_smoke_free_policies_and_legislation.

¹²⁵ <https://www.france24.com/en/live-news/20210922-tedros-seen-uncontested-for-who-top-job-after-berlin-nod>.

“delegates still need to agree, before the 75th WHA, on content-specific recommendations, *and* this goes on while the pandemic is still ongoing and requires direct policy action in countries”.

The equity & access trigger for countries of the global South

In these initial stages, the proponents of the treaty have clearly managed to drum up support for the idea. There has been a steady groundswell of support for a new legal instrument of a binding nature, particularly from African countries who see this process as a way to ensure commitments on equity.¹²⁶ “The EU has deep pockets and played their game well,” one developing country diplomat concluded during the interview for this research, “meticulously firing on all cylinders to make the treaty happen”.

For low and middle income countries supporting the treaty outright, or for those inclined to consider it a new effective instrument for pandemics, access to COVID-19 countermeasures is a key driver for engaging in these discussions, in a landscape of ongoing vaccine apartheid. Governments need to demonstrate they are doing whatever possible to cherish multilateral health cooperation and overcome the global health inequity that COVID-19 has entrenched further and that has left many health-care workers to die in the global South without protections¹²⁷, among heavily affected populations.

The EU is willing to discuss equity in the context of a new treaty and the US has circulated a non-paper on the review of the IHR to the WGPR whereby it puts forward its suggestions to “Improve Equity in the Global Health Security Preparedness and Response”. In this paper, the US lays out several elements, in relation to: R&D, rapid access to products, strengthening regulatory systems, expanding manufacturing capacity, improving purchasing and procurement, improving liability protection and compensation¹²⁸. The paper espouses equity in an inspiringly touted agenda, but this promise for the future collides with the enduring inequitable vaccine distribution: “a catastrophic moral failure” to use Dr Tedros’s unequivocal words¹²⁹. This is a phenomenon that grows more grotesque every day still, even as the report is being written.

¹²⁶ [Round One to the EU & Friends: "Treaty" Option Gains Support](https://genevahealthfiles.substack.com/p/round-one-to-the-eu-and-friends-treaty), Geneva Health Files, November 5 <https://genevahealthfiles.substack.com/p/round-one-to-the-eu-and-friends-treaty>

¹²⁷ <https://microbiologycommunity.nature.com/posts/10-images-illustrate-the-global-vaccine-inequity>

¹²⁸ United States Non-paper on Areas for Further Discussion to Improve Equity in the Global Health Security Preparedness and Response, WGPR. However, the US inputs appear highly problematic, firstly because the equity discourse is uniquely placed in the mere biomedical perimeter. But even in this context, TWN analysts rigorously explain why, in the name of equity, the US inputs are skewed to “reinforce and maintain the status quo of its dominance in the global pharmaceutical industry pushing for voluntary licences and stringent regulatory harmonization standards likely to act as barriers for generic pharmaceuticals and access to medical tools. See Ramakrishnan, N. and Gopakumar, K.M. (2021), WHO: US ‘non-paper’ on equity reinforces its pharmaceutical industry dominance, *Third World Network Info Service on Health Issues*, October 18, 2021. <https://wp.twnnews.net/sendpress/email/?sid=NTYyODE&eid=MzkyNA>

¹²⁹ <https://news.un.org/en/story/2021/03/1087992>

Most respondents believe that the broad principles that undergird this new treaty must address the WTO TRIPS agreement. For this to happen, some delegates from the global South conjure that a new wider UN-treaty would be able to build in cogent exceptions to the strong Intellectual Property provisions contained in the TRIPS Agreement in the event of a health emergency – a sort of alternative to the time-limited waiver. “The treaty could include provisions expanding governments’ capacities to protect public health during health emergencies”, is the comment of an African delegate, “poorer countries should be able to use compulsory licensing approaches easily, without being threatened by rich countries. Simply referring to TRIPS flexibilities is not useful in such a treaty”. Another African delegate hinted that “whether hosted at the WHO or at the UN General Assembly, a treaty should prescribe obligations to support mechanisms like the COVID-19 Technology Access Pool (C-TAP)”¹³⁰ However, the International Federation of Pharmaceutical Manufacturers Association (IFPMA), does in no way encourage the WHO C-TAP mechanism.

There are a lot of additional expectations in relation to what policymaking and civil society respondents refer to as the access to medicines ‘unfinished agenda’. In their opinion, this pathway could reopen old difficult conversations that ought to be integrated in the context of the emergency negotiation, aimed at devising binding terms on access to medical products. This projection may sound overtly optimistic. The political momentum for the access to medicines agenda at the WHO has been painstakingly engineered through a series of unwavering initiatives, including the negotiation of a WHO Global Strategy on Public Health, Innovation and Intellectual Property (GSPoA)¹³¹, which was progressively neutralized and dismantled into a toothless WHO mapping and bureaucratic exercise by a few very influential Member States, among them the European Union.

Information as power: The Pathogen-Sharing Imperative

One of the most pressing concerns for the global South delegates in these treaty discussions implicate issues of sovereignty and capacity building, namely the access to pathogen-sharing benefits governed by the Nagoya Protocol (Convention on Biological Diversity)¹³². Many countries have adopted the hard law regime of the Nagoya Protocol¹³³. The supporters of the treaty allegedly intend to go further than existing access and benefit-sharing norms, suggesting that Nagoya was not designed for public health with its

¹³⁰ <https://www.who.int/publications/m/item/c-tap-a-concept-paper>. The C-TAP mechanism which is supposed to pool the voluntary licences of pharmaceutical companies for the advancing the research and development of new COVI-19 related medical remedies has remained largely empty. Companies have not shared their knowledge.

¹³¹ https://www.who.int/phi/publications/Global_Strategy_Plan_Action.pdf

¹³² *The Nagoya Protocol on Access to Genetic Resources and the Fair and Equitable Sharing of Benefits Arising from their Utilization (ABS) to the Convention on Biological Diversity* is a supplementary agreement to the Convention on Biological Diversity. It provides a transparent legal framework for the effective implementation of one of the three objectives of the CBD: the fair and equitable sharing of benefits arising out of the utilization of genetic resources. The Nagoya Protocol was adopted in 2010 and entered into force in 2014. Its objective is the fair and equitable sharing of benefits arising from the utilization of genetic resources, thereby contributing to the conservation and sustainable use of biodiversity. <https://www.cbd.int/abs/about/#objective>

¹³³ <https://www.cbd.int/abs/doc/protocol/nagoya-protocol-en.pdf>

“bilateral, transactional nature”¹³⁴. Health requires multilateral solutions and the treaty could place measures contained in the Nagoya Protocol into a pandemic context, including covering genetic sequencing data in addition to pathogens. “If Nagoya provisions cannot be adapted to address public health, a new treaty can design new provisions” a global health law scholar told us. However, carving out exceptions in a new treaty where Nagoya rules will not apply, as can be interpreted from the EU statement. It might harm the interests of developing countries, diplomats from the global South cautioned: “countries will instantly lose the leverage and the gains they have made in decades. While carve outs are possible, a WHO treaty cannot cancel the obligations of another treaty”, it was pointed out. Respondents from developing countries highlight that there was no problem with sharing of genetic information during COVID-19, so the needs to include provisions on pathogen sharing was questioned.

“A carve out could essentially means that countries can free-ride: if a country is not a party to Nagoya, and a new treaty does not oblige access to benefits, in effect that country will be able to use information on pathogens without being obliged to share benefits”, one legal expert respondent explained his concern that an ill-devised treaty may take away the sovereignty developing countries now have. The fight for access to genomic information has been rampant during COVID-19; the pandemic provides a unique opportunity to access information for medical products development without adequately addressing questions on benefits, this is the fear from respondents’ different positions. Although the pandemic provides a chance to improve existing rules on benefits sharing, it is not clear whether developing countries with limited capacity (including negotiating capacity) will be able to steer these crucial conversations in a way that would secure their interests and concerns.

“Sharing information on pathogens requires resources to collect, classify and collaborate in terms of personnel and laboratory capacities. A surveillance system has to be built on trust”, one African diplomat explains, suggesting the need for a legal structure that governs the roles and responsibilities of private actors. For pharmaceutical companies, grabbing business from pathogens is an obvious temptation, instead equitable access to data, resources and products – in essence, global common goods – must be ensured. “If we are to have a decentralized structure on sharing information on pathogens, it is important to have strong legal systems at national and international levels that will enable actors to interact with each other whether it is university-university or company to company” he elaborates. Finally, as explained by the civil society actors interviewed, the issue of access to countermeasures developed on the basis of sharing data on genetic sequences from the South will be critical to treaty discussions – indeed, one of the few bargaining terrains. Unconditional sharing, as suggested by the EU current position, will be for them a disincentive to join a treaty.

¹³⁴ https://eeas.europa.eu/delegations/un-geneva/105113/3rd-working-group-strengthening-who-preparedness-and-response-health-emergencies-eu-statement_en

Europe's road to immuno-politics, after COVID-19

As the world approaches the third year of the pandemic, it is perhaps a capricious coincidence of history, or rather a telling sign of the times, that the special session of the WHA on the pandemic treaty and the 12th Ministerial Conference of the World Trade Organization (WTO) are occurring in parallel. On the same days, and in the same venue.

The European Union is advocating for hard law at the WHO with another 25 countries, convinced that the current state of things is not acceptable and that the painful lessons learnt from COVID-19 need to be implemented through an international binding agreement, to prepare for future threats and save multilateralism. At the WTO, two thirds of its 164 Member States – mainly developing countries – are equally convinced that the current state of knowledge monopolies is not acceptable in the face of the recurring waves of devastation and death caused by the pandemic, and for this reason they support the adoption of a conditional temporary waiver of Trade-Related Intellectual Property Rights (TRIPS Waiver). The waiver is a hard-law provision enshrined in the 1994 Marrakesh Agreement¹³⁵, whose implementation was proposed by South Africa and India on 2nd October 2020. It aims to enable the freedom to operate and reduce legal uncertainty for manufacturers, with the goal of expanding and diversifying production and supply of COVID-19 medical products for the prevention, containment, and treatment of the COVID-19 pandemic¹³⁶. For over one year now, sustained European efforts - led by Germany and including Switzerland, the UK and Norway – have blocked progress on this negotiation. Text based discussions, which have been going on for ages, appear to be leading nowhere. The EU talks the negotiation talk, but stubbornly refuses to walk the waiver walk, having pretty much imposed the same position on the G20 countries¹³⁷. The opponents of the TRIPS waiver have been working with the WTO DG on a 'the third way' approach that avoids the suspensions of IP rights, encourages or subsidizes tech-transfers of medical knowledge to low and middle income countries, and incentives voluntary licences, while easing tariffs and trade of goods and services.

As the international community toys with the idea of a pandemic treaty, the rapid enabling of an expanded and more affordable production of and access to COVID-19 medical tools is urgently required in the South. Tangible progress on global vaccination would foster the necessary trust for international cooperation. Instead, COVID-19 vaccine distribution continues to mirror a tale of global injustice, with systemic hoarding from a bare handful of high-income countries¹³⁸ – 7.66 billion doses have been administered globally, but only 5 percent of people in low-income countries have received at least one dose (as of 20 November 2021)¹³⁹. Much of the variations in infection and death trends is due to this

¹³⁵ WTO Marrakesh Agreement from 1994 https://www.wto.org/english/docs_e/legal_e/04-wto_e.htm

¹³⁶ Contrary to the claim that the South lacks manufacturing capacity, vaccines have long been made in over eighty developing countries. Although novel, mRNA manufacture involves less steps, fewer ingredients and structural capacity than traditional vaccines. MSF has identified many capable producers in the South. See in this regard <https://msfaccess.org/sharing-mrna-vaccine-technologies-save-lives> and also <https://www.nytimes.com/interactive/2021/10/22/science/developing-country-covid-vaccines.html>.

¹³⁷ <https://www.ituc-csi.org/g20-trade-ministers-fail-on-trips?lang=en>.

¹³⁸ <https://www.nytimes.com/interactive/2021/03/31/world/global-vaccine-supply-inequity.html>

¹³⁹ <https://ourworldindata.org/covid-vaccinations>

forced condition of unequal access to not only vaccines, but also diagnostic tests, protective equipment, devices, oxygen and other equipment. For their part, while continuing to preach the *leave no one behind* or the *no one is safe until everyone is safe* mantras in international circles, high-income countries continue to hoard vaccines as they roll out plans to give their citizens a COVID-19 booster in a bid to help increase their societies' protection against the virus, surging again in Europe (as we write)¹⁴⁰.

Development of COVID-19 vaccines and other therapeutics have been accelerated by considerable government financing¹⁴¹; six major vaccine developers received over US\$12 billion in public funding¹⁴². Revenues from their IP monopolies will exceed tens of billions¹⁴³. But throughout 2021, supply shortages have disrupted vaccine supplies. IP monopolies block competition, making it hard to quickly increase supplies. To give one example of the IP protection's negative externalities, against the cheerleaders of intellectual property monopolies, only four companies produce the plastic bioreactor bags needed to make vaccines under time pressure and on a global scale¹⁴⁴.

But the EU, while pushing immunity as the new organizing principle, will not listen. Speaking at the World Health Summit in Berlin on the treaty proposal, the European Council adviser Simona Gourguivea said adamantly that "it is just a fairy tale that if you lift a patent, something will happen [...] we are trying to build a 'third way approach' as also mentioned by WTO DG Ngozi"¹⁴⁵. Charles Michel has anticipated that the treaty could set the scene for the operationalization of the third way, so as "to move quickly and in a more coordinated way to ensure that medical equipment is available"¹⁴⁶.

One academic scholar said that "the treaty proposal is about equipping smaller players with new capacities, to mitigate power disparities", while other European respondents insisted that the European treaty proposal aims to increase international solidarity and address the "major failures of the global response to the current pandemic, that are still there". One European delegate insisted that the EU and other countries (the so called Ottawa Group) do want to remove the obstacles to the scaling up of pharmaceutical production, but their preference is for the use of voluntary licensing mechanisms¹⁴⁷, coordinated technology transfers and measures to ease export restrictions and tariffs' barriers that might have limited the flow of COVID-19 vaccines and protective equipment: "funds would be made available via public-private initiatives such as COVAX and ACT-A, even giving them a

¹⁴⁰ <https://www.bbc.com/news/world-europe-59358074>

¹⁴¹ <https://www.businesswire.com/news/home/20210110005098/en/Governments-Spent-at-Least-%E2%82%AC93bn-on-COVID-19-Vaccines-and-Therapeutics-During-the-Last-11-Months>

¹⁴² <https://www.msf.org/governments-must-demand-all-coronavirus-covid-19-vaccine-deals-are-made-public>

¹⁴³ <https://www.theguardian.com/business/2021/mar/06/from-pfizer-to-moderna-whos-making-billions-from-covid-vaccines>

¹⁴⁴ <https://mattstoller.substack.com/p/why-are-there-shortages-of-plastic>.

¹⁴⁵ World Health Summit10 (2021), A New Pandemic Treaty: The "Bretton Woods" Moment for Global Health?, 25th October 2021,

https://www.youtube.com/watch?v=sj9FdTicCd0&list=PLsrCyC4w5AZ8F0xsD3_rzLcfxHbOBRX4W&index=29

¹⁴⁶ <https://www.consilium.europa.eu/en/policies/coronavirus/pandemic-treaty/>.

¹⁴⁷ All licensing requires case-by-case, patentholder-by-patentholder, country-by-country negotiations. But licensing is only limited to patents, without requiring sharing 'industrial secrets' needed to make complex biochemical compounds.

permanent status. Discussions have gone on for a year now”, explained one delegate. “The COVAX facility and ACT-A, which might become permanent financial mechanisms under a treaty, have been a failure because they have no binding mechanisms to ensure access”, said another.

One African health diplomat remarked that “greed and nationalism remain *the* problem”, while a prominent global health official from the same continent elaborated on the urgency to see “strategies headed to strengthen regional approaches to the pandemic, rather than only focus on multilateral agreements: there are 57 developing nations saying they need the waiver to help themselves. Countries do want to help themselves, help their people”. For their part, respondents from civil society organizations agree that the treaty proposal is in the end “a political distraction from the TRIPS waiver dialogue, a tactical bypass and political bargain by the EU”. One CSO representative judged that “there is considerable contradiction in the position of the EU, especially when it comes to upholding values such as human rights, equity and democratic, participatory policy making”.

But is the contradiction a real one? Not necessarily. The EU third way approach negotiated at the WTO - focusing on a narrow but complex band of technical fixes to the current set of global trade agreements to increment manufacturing, while upholding the IP monopoly – virtually converges with the binding instrument drive at the WHO. With the excuse of pandemic surveillance and response, the two tracks are mutually functional to the new logic of immunity that moves health securitization forward under the pressure of a biomedical community, as powerful as ever.

When COVID-19’s unprecedented viral wave began to mount in 2020 the international community, steered by a few influential private and public players, decided to entrust the global management of the crisis to the public-private partnerships (PPP) that have dominated the global health arena for two decades. This decision, disgraceful as it may look, marks a point of no-return because PPPs, incorporating wealthy governments and philanthropic foundations, as well as a significant number of pharmaceutical companies, staunchly believe in the miracles of IP for their innovation^{148 149}.

Hailed as ground-breaking collaborations in the fight against COVID-19, the Access to COVID-19 Tools Accelerator (ACT-A), and its most outstanding and funded pillar COVAX, have been designed as a prototype architecture for dealing with global health emergencies, which now combines the remit and operationality of several PPPs. The new creature is a hyper-PPP of some sort, or better a “super PPP”, as it has been defined¹⁵⁰. This COVID-related creation signals a new phase of iteration of the PPP model, “the first example of an ‘alliance’ of major established PPPs intended to benefit not just developing countries, but the entire world [...] drawing on their established ‘comparative advantage’¹⁵¹. The goal of this evolved PPP model, even more firmly grounded on the impenetrable jurisdiction of foundations of private law, is to scale up a hybrid (public & private) arrangement, initially designed for developing countries and specific problems, to global scale challenges. The

¹⁴⁸ https://www.researchgate.net/publication/338871115_Finding_equipoise_CEPI_revises_its_equitable_access_policy

¹⁴⁹ <https://www.gavi.org/vaccineswork/intellectual-property-and-covid-19-vaccines>

¹⁵⁰ Storeng, K.T. et al. (2021), op cit.

¹⁵¹ Ibidem

complex structure has granted the corporate players – not only big pharma, but also the financial sector – considerable power, making the public representation elusive in many ways, which reinforces power asymmetries. These have now been fully examined¹⁵² and globally displayed with COVAX¹⁵³. But the EU and the G20 only focus on ACT-A and reiterate support to all its pillars¹⁵⁴

Based on this research's findings, our plausible hypothesis is that one of the remits of the pandemic treaty may be to seal the establishment of entities like COVAX inside the WHO institution, with the WHO Member States' blessing. On the one hand, the treaty proponents have always interpreted this initiative as a strategy to ascribe responsibilities to other stakeholders beyond governments, in a whole-of-society approach that mainly winks at the private sector, "the safety of the world's people cannot rely solely on the goodwill of governments", said the WHO Director General, Tedros Adhanom Ghebreyesus when closing the 74th WHA. On the other, curiously, a few powerful non-state actors traditionally opposed to binding arrangements have now expressed keen interest in developing a pandemic treaty. These include the Bill and Melinda Gates Foundation (BMGF) and the International Federation of Pharmaceutical Manufacturers Association (IFPMA): "the discussions around a possible International Pandemic Treaty need to take into account the important role played by the innovative biopharmaceutical industry and its supply chain in fighting the virus" we read in the IFPMA statement:

It will be important to acknowledge the critical role played by the incentive system in developing tests, therapeutics, and vaccines to contain and defeat the coronavirus.

We hope that the discussions on an International Pandemic Treaty will address enablers for future pandemic preparedness – the importance of incentives for future innovation, the immediate and unrestricted access to pathogens, and the importance of the free flow of goods and workforce during the pandemic – in addition to continuing the multi stakeholder approach undertaken in ACT-A and COVAX¹⁵⁵.

The EU strategy is sophisticated, but it risks to produce a number of serious wounds to the current fragile setting of intergovernmental action both at the WTO and WHO. At the WTO, because the European Commission's resistance without concessions to what the vast majority of WTO Member States have demanded for months now, with support of global expert and institutional consensus¹⁵⁶, may disrupt the negotiations in other sectors and prospectively the functioning of the very trade organization. At the WHO, because the forced rush to the pandemic treaty may lead to fragmentation and uncertainty in the governance of health emergencies and contribute to the agency's unhealthy fragility if the health security corporate sector, in its various configurations, were allowed to come on

¹⁵² Gleckman, H. (2021). COVAX, a global multistakeholder group that poses political and health risks to developing countries and multilateralism. TNI LongReads, 1st April 2021, <https://longreads.tni.org/covax>.

¹⁵³ <https://msf.org.au/article/media-coverage/covax-how-plan-vaccinate-world-has-failed>.

¹⁵⁴ <https://www.g20.org/wp-content/uploads/2021/10/G20-ROME-LEADERS-DECLARATION.pdf>.

¹⁵⁵ https://www.ifpma.org/wp-content/uploads/2021/03/IFPMA_Statement_International_Pandemic_Treaty_30March2021.pdf.

¹⁵⁶ The IP Waiver proposal has gained support from international organizations like WHO, UNESCO and UNAIDS, from over 700 Members of Parliament in Europe, from important scientific and academic entities worldwide, and from experts and Nobel Laureates like Joseph Stiglitz. Pope Francis has repeatedly appealed to implement the waiver and unblock the discussion at the WTO, to start a new scenario to save lives.

board in the new negotiating route towards future pandemic preparedness and response. The potential legitimization of the corporate capture's participation in the negotiation for a new instrument sets a precedent doomed to erode, not strengthen, the constitutional function of the WHO.

Discussion

1. Advancing the IHRs: an alternative to the new pandemic treaty pathway?

The substance and implementation of the International Health Regulations have rightly come under scrutiny during the COVID-19 pandemic and it is absolutely necessary to assess their gaps, their restricted scope and conservative limitations, including the lack of effective provisions that address the zoonotic aspects of health emergencies. The IHRs do not address preparedness matters of public health emergencies, either. However, many treaty proposals discussed at WGPR overlap with the IHRs remit in the field of core capacities, early notifications, information sharing, powers of WHO, travel and trade measures issues. The message that the IHRs are intrinsically weak and ineffective - a narrative frame used quite aggressively by treaty proponents - bears the dangerous consequence of weakening the political commitment behind the IHRs implementation even more. Amendments to the IHRs can be made, including proposing and complementing new regulations (ART.57) but the development of core capacities in countries' health systems is the problem and if we want to prepare for pandemics the international financial commitment must go to health systems strengthening. This is even more of a priority after COVID-19: capacities have been overstretched. The IHRs can provide the reference for this capacitation, they embody a collective wisdom and were crafted in a collaborative process, something that WHO Member States should not hurriedly dismiss. The idea of complementing the IHR provisions, with the aim to strengthen the grounding of the WHO and state response to pandemics is a viable option, abiding to the principles of full respect of the human dignity and human rights, respect for the WHO Constitution and the UN Charter, protection of all people from the spread of disease and respect for the sovereign autonomy of Member States (Art.3). Scholars reckon that updating the IHR and making them more relevant to address the existing governance and compliance requirements should be possible, under the existing institutional structures of the WHO. Rather than renegotiating the IHR altogether, a review conference approach could be applied, as for the Biological Weapons Convention, where biannual meetings are used to re-establish procedures and norms associated with the initial treaty¹⁵⁷. Another approach could be a "universal periodic review" mechanism including peer-reviews, reports by special rapporteurs, experts, and civil society¹⁵⁸.

¹⁵⁷ Rebecca Katz, 'Pandemic Policy Can Learn from Arms Control', *Nature* 575:7782, 2019.

¹⁵⁸ Wenham, C., Eccleston-Turner M. and Voss, M (2021). The Risks Associated with a Pandemic Treaty: Between Global Health Security and Cosmopolitanism. SSRN Papers, 21st October 2021, https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3950227.

2. International cooperation is a Member States' obligation, not an option

The right to health places obligations on States and ensures an essential ground for shaping measures aimed at preparing for and responding to pandemics, but COVID-19 describes, among other things, a human rights crisis¹⁵⁹. Since the SARS-CoV-2 outbreak, the world has discovered that many governments, including in the high-income countries, have neglected disease prevention and preparedness for health emergencies in their public health systems. Denying the very existence of the virus, others have withheld rights-based preparedness and responses to COVID-19, disproportionately impacting marginalized populations. Overall, the pandemic response globally does not kindle any serious confidence in the global health community's capacity to ignite changes that are consistent with Member States' human rights obligations. The UN Committee on Economic, Social and Cultural Rights has emphasized that international cooperation and assistance is a global duty, and "the fact that the current crisis is a pandemic reinforces this obligation of States"¹⁶⁰, which of course is not only limited to ensure universal equitable access to vaccines wherever needed. This duty to cooperate is the foundation of any health emergency preparedness and response, and the forms of this obligation will have to be strengthened further, whatever the future negotiating scenario at the WHO.

3. A different order of priority in international treaty-making

The biomedical rationale of the pandemic treaty, in the cosmopolitan narrative of its proponents, needs to be challenged against the cogency of two crucial treaty-making processes that are moving in parallel at the United Nations Human Rights Council in Geneva: the Binding Treaty on Transnational Corporations and Human Rights, in its seventh year of negotiation¹⁶¹ and the new draft Convention on the Right to Development¹⁶² released – with symbolic coincidence – in January 2020 by the UN Office of the High Commissioner for Human Rights. Both diplomatic routes, started well before COVID-19, have gained incredible relevance after two years of health emergency, since they address structural knots of the globalized economy that produce emergencies on people and planet. The pandemic response has to do with putting an end to the free-riding operations of transnational corporations which carry out their extractive operations in many parts of the world with no legal liability – a mechanism that has resulted in severe human rights violations, devastation of the environment, and complete impunity in the

¹⁵⁹ https://www.un.org/victimsofterrorism/sites/www.un.org.victimsofterrorism/files/un_-_human_rights_and_covid_april_2020.pdf

¹⁶⁰ Statement on universal and equitable access to vaccines for the coronavirus disease (COVID-19) : statement by the Committee on Economic, Social and Cultural Rights. 2020
<https://digitallibrary.un.org/search?f1=author&as=1&sf=title&so=a&rm=&m1=p&p1=UN.+Committee+on+Economic+%2C+Social+and+Cultural+Rights&ln=en>

¹⁶¹ <https://www.ohchr.org/en/hrbodies/hrc/wgtranscorp/pages/igwgontnc.aspx>. The UN process enables States to discuss concrete provisions to regulate transnational corporations and other business enterprises with regard to human rights in international law, and to provide access to justice and effective remedy to affected people, ensuring that global loopholes perpetuating corporate impunities are closed.

¹⁶² https://www.ohchr.org/Documents/Issues/Development/Session21/3_A_HRC_WG.2_21_2_AdvanceEditedVersion.pdf

global South¹⁶³. On the other hand, the COVID-19 syndemic is a crisis of globalization's development model. The Western development myth, imposed as a universal assumption for human progress, had already brandished its irredeemable limitations well before COVID-19. But its pervasiveness has severely eroded the capacity for most countries to pursue autonomous trade and economic avenues in a globalized scene. The 1986 Declaration on the Right to Development¹⁶⁴ affirms that 'States have the primary responsibility for the creation of national and international conditions favourable to the realization of the right to development', and the right to health is an extremely reliable indicator of that responsibility. Now that the climate crisis and the COVID-19 health crisis compel a new sense of urgency on rethinking the modes of the globalized economy to prevent future spillovers and limit pandemics, Member States from high-income countries should seriously concentrate on these two diplomatic processes, to fill the flagrant gaps of international law, if they want to address the importance of One Health as a continuum across human, animal, plant, and planetary health, beyond the restricted surveillance approach.

4. Untangle the economic and financial knots to prepare for pandemics

A global study published in April 2021 by the Initiative for Policy Dialogue at Columbia University signals an emerging austerity shock that most governments are imposing budget cuts, precisely at a time when their citizens and economies are in greater need of public support¹⁶⁵. Analysis of IMF fiscal projections shows that budget cuts are expected in 154 countries this year, and in 159 countries in 2022. This means that 6.6 billion people - 85% of the global population - will be living under austerity conditions by next year, a trend expected to continue at least until 2025. The high levels of expenditures needed to cope with the pandemic have left governments with growing fiscal deficits and debt, but instead of exploring the appropriate financing options to provide direly-needed support for socio-economic recovery through fiscal justice many governments - advised by the IMF, the G20 and other institutions - indulge in austerity schemes. It is impossible *not* to position the pandemic treaty negotiation in this reductionist financial and fiscal scenario, which disrupts societies *and* economies, making health and development cooperation among states an impossible mission. What space exists for the expansion of the right to health and the provision of public universal health services during the current emergency, even before the future ones come, if this is the perimeter in which governments are allowed to operate? And how can the health pandemic be separated from the socio-economic pandemics that the variants of fiscal policies promise to prolong?

Every year, countries are losing a total of \$483 billion in tax to global tax abuse committed by multinational corporations and wealthy individuals - enough to fully vaccinate the global

¹⁶³ Achieving a treaty that regulates the role of translational corporations in the field of human rights would be a game-changer in terms of claiming the accountability of pharmaceutical companies in imposing high prices for vaccines and medicines that have been publicly funded and in their refusal to share knowledge - among other things - in the context of the pandemic crisis. See in this regard <https://www.kit.nl/vaccine-scarcity-is-not-necessary-if-drug-companies-share-their-knowledge/>.

¹⁶⁴ <https://www.ohchr.org/en/professionalinterest/pages/righttodevelopment.aspx>

¹⁶⁵ <https://policydialogue.org/files/publications/papers/Global-Austerity-Alert-Ortiz-Cummins-2021-final.pdf>

population against Covid-19 more than three times over ¹⁶⁶. Every year, multinational corporations are shifting US\$1.19 trillion worth of profit into tax havens, causing governments around the world to lose US\$312 billion annually in direct tax revenue¹⁶⁷. It is the OECD countries, not the palm-fringed islands, that enable most of the tax abuse. The urgency for the UN to step in to negotiate profound modifications to the international tax rules is growing.

There is also a constant overlap between fragile or non-existent public healthcare systems and debt in low-and-middle income countries. 64 countries spend more on external debt payments than on public healthcare. Debt is a virus. Recent IMF figures explain how its viral burden has grown from 35% to 65% in the last decade¹⁶⁸, and is bound to soar soon by another 10%, bringing half of Africa on the brink of bankruptcy. Cancelling all external debt payments due in 2020 alone by the 76 lowest income countries would *liberate* US\$ 40 billion, US\$ 300 billion if cancellation included 2021. Releasing such gigantic amounts would be in itself a global common that would enable investments in pandemic preparedness and response. Debt cancellation has a relevance of its own, when talking about pandemic preparedness and response, as creditor countries have accumulated a meaningful ecological debt towards impoverished nations. Their neoliberal industrial policies and TNCs' plundering have abundantly contributed to shaping the 'Age of pandemics' in which we live, where "pathogens of zoonotic origin, and the challenges posed by antimicrobial resistance, present a continued and growing risk"¹⁶⁹. Developing countries are now paying the consequences of what they have not created. Linked with zoonotic events of the past, creditors' ecological debt is directly related to the predictions of new spillovers, as deforestation increases globally¹⁷⁰ and global ice loss is catching up to worst-case scenario predictions¹⁷¹.

Tackling illicit financial flows is also indispensable. Funds illegally earned, transferred, and/or utilized across borders produce a gigantic loss of resources that governments need to fund public initiatives and strategic investments. The 2021 report of the High Level Panel on International Financial Accountability, Transparency and Integrity for Achieving the 2030 Agenda¹⁷² calls for strong measures to curb illicit financial flows, which could feed public budgets' capacity to respond to health crises, including pandemic prevention and surveillance. The WHO Council on the Economics of Health for All recently provided key recommendations in this arena to governments and multilateral organisations (including the WB and IMF) ¹⁷³saying that Member States need to focus on the malignant diseases of

¹⁶⁶ <https://taxjustice.net/2021/11/16/losses-to-oecd-tax-havens-could-vaccinate-global-population-three-times-over-study-reveals/>.

¹⁶⁷ https://taxjustice.net/wp-content/uploads/2021/11/State_of_Tax_Justice_Report_2021_ENGLISH.pdf

¹⁶⁸ <https://www.imf.org/external/pubs/ft/fandd/2020/09/debt-pandemic-reinhart-rogooff-bulow-trebesch.htm>.

¹⁶⁹ BMJ2021; 375:n2879, signed by 32 Ministers of Health. The world must act now to be prepared for future health emergencies, 23 November 2021, <https://doi.org/10.1136/bmj.n2879>.

¹⁷⁰ <https://www.un.org/en/desa/global-forest-goals-report-2021>

¹⁷¹ <https://www.theguardian.com/environment/2021/jan/25/global-ice-loss-accelerating-at-record-rate-study-finds>.

¹⁷² [https://uploads-](https://uploads-ssl.webflow.com/5e0bd9edab846816e263d633/602e91032a209d0601ed4a2c_FACTI_Panel_Report.pdf)

[ssl.webflow.com/5e0bd9edab846816e263d633/602e91032a209d0601ed4a2c_FACTI_Panel_Report.pdf](https://uploads-ssl.webflow.com/5e0bd9edab846816e263d633/602e91032a209d0601ed4a2c_FACTI_Panel_Report.pdf)

¹⁷³ https://cdn.who.int/media/docs/default-source/council-on-the-economics-of-health-for-all/who_councilh4a_councilbrieffinal-no2.pdf?sfvrsn=bd61dcfe_5&download=true

the financial system to respond to health needs. Not even the proposed creation of a sustainable finance mechanism¹⁷⁴ for a UD\$10 billion global pandemic preparedness facility and a US\$100 billion emergency fund – linked to either the new Global Health Threats Council, global financial institutions like the World Bank, or both – will reliably serve the purpose unless and until such structural financial impediments are removed.

Conclusions

Whatever the route of the pandemic treaty, whatever the strategies for pandemic preparedness and response, it will not be possible for negotiators to sideline how deeply unjust the international order is, and to avoid positioning themselves vis á vis this conjuncture. In 2020, with the establishment of the ACT-Accelerator, the international community completely entrusted the organizational setup and the operational management of the first viral pandemic in human history to public and private partnerships, based on Western forms of knowledge and authority. In 2021, the pandemic treaty conceptualization may purposely build on the joint effort by the WHO and these super multistakeholder alliances to set novel criteria for shaping international law through the inclusion and involvement of corporate actors, in their metamorphic disguise. This is probably the scenario that scholars have in mind when advocating that “everybody should be in from the very beginning”.¹⁷⁵ And this is what the proponents of the pandemic treaty have in mind when they claim that “What is missing in multilateral cooperation is a single forum that brings together all relevant organizations and actors under one umbrella [...] with a mandate linked to health threats”¹⁷⁶.

The construction of the immunity paradigm after COVID-19 embraces many dimensions. We have to ask ourselves, with Abram De Swaan, “What kind of catastrophe does it take before countries will adopt the policies and cooperation that would have been feasible and beneficial all along?”¹⁷⁷

¹⁷⁴ Fletcher, E.R. (2021), Independent Panel Co-Chairs Blast Slow Pace of Pandemic Reforms – Call for UN Summit After Next Week’s Special World Health Assembly, Health Policy Watch, 22nd November 2021, <https://healthpolicy-watch.news/91844-2/>.

¹⁷⁵ C.F. Pereira Da Silva Gama, Broken Threads: Reshaping Multilateralism with COVID-19 Under Way, p. 5.

¹⁷⁶ BMJ2021; 375:n2879, signed by 32 Ministers of Health. The world must act now to be prepared for future health emergencies, 23 November 2021, <https://doi.org/10.1136/bmj.n2879>.

¹⁷⁷ Van de Pas, R., & Ooms, G. (2021). Giving hope a sporting chance: COVID-19 as a beneficial epidemic?. *BMJ global health*, 6(4), e005784.