The WHO pandemic treaty: where are we on our scepticism?

INTRODUCTION

The COVID-19 pandemic has revealed deep fault lines in global governance of health emergencies. In particular, the inadequacies of an existing mechanism—the international health regulations (IHRs)—in coordinating nation-states and ensuring equitable access to medical countermeasures (MCMs) during emergencies.1 The IHRs require states to put in place core capacities to detect as well as notify the WHO of a potential threat in their vicinity. However, when COVID-19 struck, the IHRs did not contain specific binding provision for equitable access to MCMs, and have been described as ‘a specialization that has largely retained a 19th century colonial framework of international cooperation for disease control’.2 Evidently, countries with the least economic and political bargaining power continue to suffer, as nationalism trumped over solidarity—and the global health community scrambled to deliver diagnostics, therapeutics and vaccines in an equitable manner that would prevent needless loss of lives.

As countries reel from the devastation, hard lessons are already spurring discussions on how best to transform pandemic prevention, preparedness and response, including a revision of the IHRs, a treaty on pandemics and more recently, the WHO has begun a ‘consultative process to design a platform for medical countermeasures during emergencies and interpandemic periods.

In this context, we explain how newer provisions of the pandemic treaty zero-draft text reflects concerns on equity; however, incentives the pandemic treaty could offer political leaders or pharmaceutical companies that would make them behave differently during another outbreak are still vague.

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SUMMARY BOX

⇒ The COVID-19 pandemic has revealed deep fault lines in global governance of health emergencies, in particular the inadequacies of an existing mechanism—the international health regulations (IHRs)—in ensuring equitable access to medical countermeasures during emergencies.
⇒ Hard lessons are already spurring discussions on how best to transform pandemic prevention, preparedness and response, including a revision of the IHRs, a treaty on pandemics and more recently, the WHO has begun a consultative process to design a platform for medical counter measures
draft text reflects concerns on equity; however, incentives the pandemic treaty could offer political leaders or pharmaceutical companies that would make them behave differently during another outbreak are still vague.
⇒ The COVID-19 pandemic revealed the need to boost production of biotechnology solutions where they are needed domestically in order to strengthen access and supply chains for all types of pandemic-related products during emergencies and interpandemic periods.
⇒ The WHO platforms for medical countermeasures must be organized around national and regional ownership that engender locally and regionally driven solutions, adaptable to local health needs and context to stop epidemics when and wherever they occur.

In our earlier analysis published in this journal, we shared our scepticism3 on the pandemic treaty, pandemic fund and the need to uphold equity and foster regional resilience. This commentary is a follow-up, and we expound further by discussing some of the substantive provisions for equitable access to MCMs embedded in the pandemic treaty zero-draft text and their key tensions. In this context, we explain how newer mechanisms such as the WHO platform for MCMs could complement ongoing reforms by fostering equitable participation in global health governance.
CHALLENGES FOR THE PANDEMIC TREATY ZERO DRAFT ON EQUITY

On 1 February 2023, the Intergovernmental Negotiating Body (INB), which is tasked with drafting and negotiation of the pandemic treaty, released a zero draft for WHO member states’ consideration. The final draft is expected to emerge from this document and will be presented to the 77th World Health Assembly by May 2024. Despite diverging views among members of the INB, substantive provision on the draft reflects key concerns on equitable access to countermeasures that could be legally binding.

For example, Article 7 of the zero draft states that ‘parties will take appropriate measures to support time-bound waivers of intellectual property rights’. Early commentaries on the zero-draft text have underscored the need for these promises to remain a priority, signifying a step in the right direction even if just for a few diseases. However, given the ongoing political tensions surrounding Intellectual Property (IP) waivers for COVID-19 at the World Trade Organisation and the secrecy that could veil the rest of the negotiations, there are possibilities that such provisions may be watered down and enforcement elusive.

Therefore, for many, the strongest commitment on equity, embedded in the draft is article 10, which states that the WHO will receive 20% of ‘pandemic-related products’. Half of this 20% would be provided to the WHO free of charge, and the remaining half would be provided at ‘affordable prices’. The proposal mirrors the pandemic influenza preparedness (PIP) model on equitable access, and also places the obligation on countries with manufacturing facilities to commit to securing such minimum supply to the WHO. Although the scope at this stage seems laudable and such an approach could enable affected countries to respond promptly, through procurement at the same time frame as self-procuring developed states, the PIP model as a viable procurement option for developing states also has its limitations. As such, for the treaty, implementation would depend on the extent of negotiations as well as other factors.

For starter, the COVID-19 pandemic offers many lessons on these vulnerabilities—that is, how fast international agreements and mechanisms for cooperation that are based on charity dissipate when countries are plagued by a shared biological threat. Interestingly, some countries have legislation that also prohibits the export of pandemic-related supplies in the event of public health emergencies, and we have seen the restriction on exporting MCMs from Asia, the USA and Europe. Moreover, for those countries with manufacturing capacity, who may sign on initially to securing supplies for the WHO, how long they would remain committed to equitable patience once the scramble begins is also unclear. Particularly, many governments are driven to appease their electorate, who will hold them accountable if they fail to deliver quickly enough. On top of that, the return of balance of power in politics in the international system and the fluid political nature of global health generate so many uncertainties because more often than not, global health aid is a tool for international diplomacy as much as for human health.

While there are calls for an independent body to monitor the alignment of countries’ commitments with their pandemic preparedness plans, such actions would benefit risk assessment activities including surveillance. However, as we queried in our earlier analysis, it is still vague what incentives the pandemic treaty could offer political leaders that would make them behave differently during another outbreak, and choose not to restrict export or hoard vaccines and instead prioritise populations who are at risk thousands of miles away. Or how pharmaceutical companies who have refused to share technologies and are well suited in protecting their shareholders’ dividends would balance their corporate social responsibility with profit generation when supplying the non-donated 10% stipulated in the zero-draft text.

Thus, contrary to what we may expect, without caution, certain types of solutions could deflect our attention from the deeper implications of the prevailing order that embodies logics which undermine health equity. In this case, as Krikorian and Torreele argue, ‘a dose of charity associated with the traditional market approach risks once again diverting us from the profound moral, political, and economic questioning of the way we finance, govern, and ensure the development and use of essential health tools’. Yet, if COVID-19 revealed anything globally, it is the need to boost production of biotechnology solutions where they are needed domestically in order to strengthen access and supply chains for all types of pandemic-related products during emergencies and interpandemic periods.

FOSTERING EQUITABLE PARTICIPATION IN GLOBAL HEALTH GOVERNANCE: THE WHO PLATFORM FOR MCMs

Thankfully, there are some encouraging signs of progress towards these goals, such as the WHO regional hub for mRNA COVID-19 vaccines in South Africa, with links to other low/middle-income countries (LMICs). Additionally, the WHO has embarked on a consultative process to design ‘a multidisease, multitool, end-to-end platform’ to coordinate the rapid development and equitable access for MCMs during the next pandemic. The platform is expected to converge the fragmented landscape on MCMs across a range of pathogens, learning on experiences from existing tools for equitable access such as the PIP framework and the Access to COVID-19 Tools-Accelerator (ACT-A), among others. In February, the WHO held a 2-day consultative high-level technical meeting in Johannesburg comprising various stakeholders to build a consensus for the prototype phase of the proposed platform, which was expected to be completed in April. This launch is expected to coincide with the United Nations General Assembly’s high-level meeting on pandemic prevention, preparedness and response in September 2023.
This is a worthy objective and such a platform could strengthen access to medicines during emergencies as well as routine supplies, particularly, diseases that disproportionately affect the continent, as demand for COVID-19-related products recedes. However, building on lessons from ACT-A, it will be crucial to take cognisance of the existing gaps in governance that exist in many international organisations, by ensuring the needs and interests of communities are well represented in order to ensure accountability to the people whose lives it determines. As such, the design and operationalisation of the WHO-proposed framework and its mechanism of governance must be organised around national and regional ownership that engender locally and regionally driven solutions, adaptable to local health needs and context, with inclusion of national and regional stakeholders in decision-making, in order to stop epidemics when and wherever they occur.

One way to do this is to consolidate regional efforts in Africa such as the Partnership for Africa Vaccine Manufacturing that aims to scale local vaccine manufacturing from 1% to 60% by 2040. In this regard, there are incentives to support this continental vision that are already gaining momentum, including the formation of a network of genomics centres and clinical trials community, a platform for pool procurement, centralised regulatory authority and a financing mechanism by regional development bank. The recent partnership between the Coalition for Epidemic Preparedness Innovation and Institut Pasteur de Dakar is also a step in the right direction.

Yet, patents, complexities of technology transfer, funding and sustainability issues remain key barriers to establishing a formidable, regionally led, end-to-end vaccine manufacturing ecosystem in Africa.

In addition to the equity arrangements embedded in the pandemic treaty, the WHO platform could foster technological transfer, strengthen research and development, help build out vulnerable supply chains for medical products, and improve the ability of local pharmaceutical industries to comply with international quality standards and development of human resources for health.

Finally, in the joint pursuit of equity, countries in Africa must continue to act collectively to strengthen regional institutional ties as shown in the wake of the COVID-19 pandemic. Equally crucial, processes that usher transitions in governance must also be fair, transparent and representative. Ultimately, leadership depends on its legitimacy. Internally, countries must also continue to address how local dynamics re-enforce global inequities, recognising how their policies, actions and inaction undermine research and development, supply chain and health system resilience.

For instance, “to establish a sustainable market, and in return for longer term health security as Alakija argues, African countries will initially have to pay more to cover higher local manufacturing costs”. Yet, there are disparities between countries procurement policies and local manufacturing in the continent. Hence, African countries should tailor a bottom-up policy environment and optimise resource allocation that is increasingly delivered by domestic financing to support health innovations. Although these conversations have begun, they were long overdue.

CONCLUSION

The COVID-19 pandemic has further exacerbated existing disparities within and between countries, and highlighted the limitations of the multilateral system when countries are faced by a shared biological threat. Top-down schemes, although well intended, only continue to perpetuate LMICs’ dependence on wealthy nations, which on its own threatens global health security. The road ahead to achieving equity is long, but as members of the Independent Panel for Pandemic Preparedness and Response assert, ‘the status quo is no longer an option’. These reforms provide a key moment for us to once again confront old battles—the prevailing ideologies, economic systems and trade regulations which leave access to medicine to the forces of the marketplace. It is imperative that their design, operation and governance foster a more equitable, transparent and sustainable system which takes into consideration the specific needs and capabilities of all countries—with equity, inclusivity and regional resilience at the core of pandemic preparedness and response. Otherwise, epidemics may continue to heighten inequality or increase mortality thereby prolonging suffering.

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