BMJ Global Health

Is the proposed global treaty an answer for public health emergencies?

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To cite: Juneja Gandhi T, Dumka N, Kotwal A. Is the proposed global treaty an answer for public health emergencies? *BMJ Glob Health* 2023;**8**:e012759. doi:10.1136/bmjgh-2023-012759

Handling editor Seye Abimbola

Received 6 May 2023
Accepted 13 July 2023

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INTRODUCTION

Health equity is when everyone can attain their full potential for health and well-being.[1] 'The World Together', the Intergovernmental Negotiating Body (INB) was formed in December 2021 to draft and negotiate a WHO's global accord, an international legal agreement to strengthen pandemic prevention, preparedness and response.[2] INB presented the zero draft for consideration of the Member States on 1 February 2023 on its website.[3 4] Following the principles of inclusiveness, transparency, efficiency, equity, cooperation and solidarity; and based on the premise that the world wants and needs a global treaty to prevent the insufficiencies or gaps that existed in the COVID-19 pandemic management and response[5 6] discussions are ongoing among the Member States of WHO (194 countries) on the draft pandemic accord. Governments are also discussing the proposed amendments to the International Health Regulations (IHR, 2005) considering the challenges posed by the COVID-19 pandemic under the guidance of the Working Group on Amendments to the IHR (WGIHR).[7]

A final draft of the 'Global Accord' and the revised IHR—2005 with more than 300 amendments will be produced for consideration at the 77th World Health Assembly (WHA) scheduled in May 2024—as decided by the governments at a special session of the World Health Assembly in late 2021. Various amendments in IHR are being discussed in the meetings guided by the WGIHR to strengthen the regulations further and make the world safer from public health emergencies while ensuring greater equity in the global response to emergencies. These regulations, which will be legally binding on 196 countries, provide an overarching legal framework that defines countries' rights and obligations in tackling public health emergencies that have the potential to cross borders.[8] The proposed IHR amendments along with the global pandemic accord are being touted to provide a comprehensive, complementary and synergistic set of global health agreements on pandemic prevention, preparedness and response.[9]

It is critical to understand and assess the need and use of a 'Global Accord' for pandemic response planning, which is legally binding; thus, a few points should be clearly understood. First, international instruments such as conventions, framework agreements and treaties are all binding legal agreements made between countries.[9] Second, the WHO Secretariat's role is to support countries, including its 194 Member States, as they agree on the new international accord; it is not involved in determining the contents of the accord. Additionally, WHO's Member States requested the WHO Director-General in December 2021 to convene INB meetings and support its work. Another notable point is that

SUMMARY BOX

⇒ WHO global health accord or WHO convention, agreement or other international instrument on pandemic prevention, preparedness and response ('WHO CA+')—is purported to be a positive step towards a more equitable and robust response planning for future public health emergencies for a unified response.
⇒ Presented by Intergovernmental Negotiating Body, the zero draft of the accord is being negotiated among countries currently for consideration of final draft at the 77th World Health Assembly scheduled in May 2024.
⇒ The draft global accord has several gaps and serious questions still to be deliberated on to make it acceptable to countries and population across the world.
⇒ The global accord must address all issues like governance, regulatory, operational, information sharing, enforceability, quality and monitoring.
⇒ This commentary highlights what does this accord mean for low-income and middle-income countries especially when the world faced challenges in implementing International Health Regulations 2005 during COVID-19.

the WHO has involved many relevant stakeholders in the process of developing the new accord—United Nations system bodies, and non-State actors in official relations with the WHO; WHO is also seeking complementary inputs through public hearings with stakeholders such as—public policy scientific, medical and academic institutions, international organisations; private sector; civil society; philanthropic organisations; and other entities with relevant knowledge, expertise or experience.[9]

However, it is to be noted that WHO has remained unsuccessful to mount and mediate a global response to COVID-19 pandemic; it has remained ineffective to recognise and send help to low-income countries (LICs) through a coordinated global response.[10 11] We, as a global community, have not yet understood the origins of the COVID-19 pandemic despite the formation of multiple teams to undertake the task and this allows people to question the role of WHO Secretariat. Distrust and dissatisfaction on the role of WHO and the global pandemic management approaches have percolated across the globe, not only in the scientific community but also among the common man.[12 13]

BACKGROUND: GLOBAL ACCORD OR PANDEMIC TREATY

As per WHO, the proposed global accord is based on the principles of equity, cooperation and solidarity to develop a unified response to public health emergencies. Outlining the strengths, the accord zero draft assures the equal distribution of 'pandemic-related products', especially priority populations identified in national health plans, through accessing 20% of such products with WHO.[4 14] The draft also states that half of this 20% should be provided free of cost to WHO, while the remaining half should be provided at 'affordable prices'. Acknowledging the extensive hoarding of supplies—vaccines, diagnostic devices, personal protective equipment and essential medicines during the COVID-19 pandemic by affluent nations, this step appears to be appropriate.[14]

The treaty is being billed as a definitive opportunity to strengthen global health and take an integrated whole-of-environment approach. Some of the global accord's positive initiatives include pre-emptive capacity building of Human Resource for Health (HRH); outlining expectations from nations to commit at least 5% of their annual healthcare budget to improve their pandemic preparedness and response systems; commitment to pandemic product distribution and temporary patent alleviation; sharing of technology and manufacturing practices by time-bound waivers of intellectual property to enable its rapid scale-up.[14] There is also a request for nations to allocate a proportion of their gross domestic product (GDP) for international cooperation on pandemic prevention, response and recovery. The amount is not yet specified but it is expected to be according to a country's ability to pay, to avoid further inequality.[14]

However, there are many expectations as well as speculations surrounding the global treaty under preparation. It is a common understanding that a global cooperative agreement on future pandemic preparedness should be prepared by all the countries together, keeping up with the principles of solidarity, equity and cooperation. There are many unresolved issues and assumptions surrounding the document; one of the most important and grave concerns is an unethical and unexpected lack of transparency in the accord's discussion proceedings and arguments presented by the member countries.[15 16] The speculations surrounding the pandemic treaty include that this would give WHO 'a limitless mandate' and/or 'full control' to decide status and measures of pandemic control and response. WHO would accord unwavering restrictions and punishments on using WHO-prohibited medicines and diagnostics (even though proven effective in local contexts), impose lockdowns, over-rule national public health laws, travel restrictions, and censorship—thus, restricting countries and people's autonomy.[15 16] To be precise, it would give an unlimited power to WHO when the document is passed as an International Law, or as a 'rules-based order'—a new term devised to evade any local, regional or national laws.

CHALLENGES/ UNADDRESSED ISSUES IN THE GLOBAL ACCORD/PANDEMIC TREATY

The mandate of global pandemic treaty is wide-ranging and over-ambitious, covering cross-cutting issues such as universal health coverage, antibiotic resistance, patents and intellectual property laws on medicines, cooperation on disease surveillance, one health or human–animal–environment interactions that contribute to pandemic risk. We realise that on one hand, it will be helpful to have such an all-encompassing document, however, on the other hand, all these mandates may have an impact on countries' Public Health or Disaster Management Act/s. Thus, either the document should be in coherence or broad enough to cover different aspects on countries' own public health act/s or resolutions.

In the context of sharing 20% pandemic-related products with WHO, the supply chain mechanisms should be deliberated further, including who should be providing these products, will there be any rotation policy among countries, more by developed nations rather than low-income and middle-income countries (LMICs)? Furthermore, where will these supplies be stored, how will these be distributed in case of established needs by countries; how the need will be established and verified, how the supplies be circulated to prevent expiry and wastage, etc?—are only a few of the questions that should be answered in the accord and the procedures. Moreover, rights for each country still need to be deliberated on, including for the countries which are given resource assistance. The countries' needs should be prioritised rather than imposing WHO's own requirements and recommendations.

Regarding the commitment of at least 5% of their annual healthcare budget for pandemic preparedness

and response systems, it may be done voluntarily as this percentage might be unaffordable for some nations and still insufficient to cover all requirements. In the context of HRH, the document should also mandate renewing promises to not recruit HRH from WHO red list countries, as such recruitment makes talent retention and health system strengthening extremely challenging in these countries. Additionally, it should also be clarified that no HRH will be placed in any country by WHO without explicit permission of that country.

Another pertinent question is about information sharing among countries, which was greatly compromised in the case of the COVID-19 pandemic. The document should carefully outline the process of assessment of a possible threat, along with information sharing mechanisms and social media usage among countries—how the information regarding a possible threat will be shared, investigated and confirmed by countries without creating scare and fear among the population at large. The draft document should also categorically highlight measures that will be taken in case a country fails to do so. This should be followed by a process outline of instituting quarantine mechanisms at various levels, along with trade and travel in this globalised world. Rather than thinking about short-term stop-gap solutions, overall, the draft should look at a long-term, sustainable and unbiased mechanism for predicting, preventing and managing public health emergencies.

The most critical issue is how the promises made in the pandemic treaty will be kept and assured by all the countries; what will be the repercussions if a country or countries do not abide by the same. For instance, if a country does not notify a potential threat; if countries keep on engaging in risky activities related to the human–animal–environment interface; if a country carries on engaging in trade and travel activities while a threat is being investigated inside the country, etc. Important pointers that come to mind are the advantages for a country to abide by the global accord—incentives, or perks assured for the country; consequences for inaction; disincentives for non-participating countries; the regulatory bodies to monitor and evaluate worldwide responses to the global accord, without impacting the autonomy of any member state—should be elaborated in the document and/or in the proceedings. At the same time, the disincentives should not be too large to be handled by an LIC/LMIC.

Another important question is—how the implementation by all the countries will be assured in light of difficult implementation of IHR 2005 during the COVID-19 pandemic and poor commitments towards other treaties such as on biodiversity and climate change?[5] The gaps in implementation and non-compliance to IHR 2005[6 17 18] and the fact that nobody has been held accountable for the same, makes us rethink how a new treaty will generate the commitment that the IHR was unable to? Furthermore, countries' capacity and ability to respond, people's autonomy, unjustified travel and trade restrictions—will also affect implementation of any treaty per se and make the implementation extremely challenging. It also has the threat of being misused to place trade and other sanctions on countries.

WHO CA+ mentions constitution of a 'Governing Body' and 'Consultative Body'. The Governing Body will promote the effective implementation of WHO CA+.[4] The Governing Body will have a Conference of the Parties (COP) as the supreme policy setting organ. The Consultative Body will provide advice and technical inputs for the decision-making processes of the COP, without participating in the decision-making.[4] Director-General of WHO will serve as a Secretariat for the WHO CA+. The Parties will implement a universal peer review mechanism to assess national, regional and global preparedness capacities and gaps through a 'whole-of-government' and 'whole-of-society' approach.[4]

The members of these institutions created under WHO CA+ will have to be defined, their selection criteria, eligibility, etc; ensuring their representativeness, unbiasedness and trustworthiness will be critical to ensure a well-functioning system. This universal peer-review process, that is, countries reviewing each other's implementation of the accord—makes it vulnerable to political manoeuvring, lobbying and autocracy by stronger and wealthier countries and quid pro quo arrangements.[14] Some of the papers have recommended the constitution of an independent body that will be responsible for monitoring the alignment of countries' commitments to pandemic preparedness with their actions.[14 19] But again—who will be the members of such an independent body—is a pertinent question. Will these efforts make the countries accountable and compliant towards a new treaty for pandemic management?[5 20] Why is there still a need for such a global accord when IHR 2005 is already in place and is being amended (with more than 300 amendments)? What led to significant gaps in COVID-19 response[13] with most of the countries failing to comply with IHR 2005?[12 21] Will this pandemic treaty help to bridge the gap between global north and global south?[22]—are some of the questions that come to mind when the need for one more legal document is being emphasised by the global community.

It has also been recommended that pandemic governance must be done at the level of the UN General Assembly (UNGA), as countries are represented by their heads of state in the UNGA.[23] The insufficiency of the legally binding instrument is also reflected by country's autonomy, dissent, disapproval and biased decisions towards issues that have global repercussions, for example, use/misuse of veto powers invested with five countries. This would also help in placing the public health agenda in a broader context of international law, security, trade and human rights, and will enhance compliance similar to human rights and the control of chemical and nuclear weapons[23] or will it really?

Exploring the importance and relevance of such an accord is critical for a dynamic country like India which has managed the COVID-19 pandemic far better than even some of

the developed countries. Despite challenges like huge population, high population density (especially in urban areas), vulnerable population, extensive labour migration, threats from neighbouring countries, limited manufacturing capacity in the initial stages of the COVID-19 pandemic, limited health system capacity and service provision to begin with, India has been successful in managing the COVID-19 pandemic owing to its able leadership, efficient use of resources, innovative approaches and involvement of the scientific community. Some of the novel initiatives include Make in India, successful vaccine research, distribution and implementation of world's largest vaccination programme; leverating technology including IT innovations such as CoWIN, Arogya Setu; Vaccine Maitri. The country is further expanding and strengthening its healthcare infrastructure and services—with increased allocation of resources through Emergency COVID-19 Response Package (ECRP-I and II), Pradhan Mantri-Ayushman Bharat Health Infrastructure Mission and Fifteenth Finance Commission tied health grants in addition to enhanced allocation to NHM including Ayushman Bharat- Health and Wellness Centres and Ayushman Bharat Pradhan Mantri Jan Arogya Yojana, other schemes like Pradhan Mantri Swasthya Suraksha Yojana and improving public–private partnerships. The success of India's 'whole of government' and 'whole of society' approach was evident to the entire international community.

How is the global accord expected to benefit India? The country should actively participate and critically evaluate the provisions of a new pandemic treaty looking at the ways it will help the country and citizens and also at the provisions which may constrain our response and actions for our own citizens in future—keeping in mind the limited resources, especially at the time of emergencies, when achieving self-sufficiency is critical. We need to discuss whether we require an additional accord for handling public health emergencies, when strengthening and improving on the existing treaties or IHR would be more beneficial for the world as a whole.[13]

CONCLUSION

COVID-19 was indeed a wake-up call for the global health community to push for a cohesive response to public health emergencies. Overall, although the draft global accord is being hyped to be a positive step towards a more equitable and robust response planning for future public health emergencies, there are several gaps and serious questions still to be deliberated on. The document should point towards an accountability matrix which is acceptable to the participating countries and at the same time ensuring that decisions are not left to a few countries. Additionally, the learnings and best practices from COVID-19 should be carried along for future and the suggestions from all stakeholders should be considered in a positive manner. Countries and their residents should be able to see an incentive in signing and going ahead with this global accord rather than taking it as just another treaty being forced on or being signed as is. It will be much better if the existing IHR 2005 could be improved on and strengthened rather than coming up with another accord to be signed by the countries. Amendments in IHR will be easier for countries to adopt rather than going ahead with the signing of new regulations through a cumbersome ratification process. Moreover, in this way, countries (Member States) can opt out of any amendments they do not agree with, making the commitments less controversial to the global population.

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Contributors TJG, AK and ND are involved in the conception and design of article. These three authors are equally involved in the evidence acquisition, analysis, interpretation and drafting of the work.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient consent for publication Not applicable.

Ethics approval Not applicable.

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement All data relevant to the study are included in the article.

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