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The Global Pandemic Agreement: Insights and Recommendations

CENTER FOR GLOBAL HEALTH SECURITY & DIPLOMACY

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Executive Summary

Following the detection of Covid-19, the international community failed in combating and limiting the spread of the deadly virus. Partially due to the lack of resources for pandemic-related products, finances, and international cooperation, this failure resulted in drastic loss of life and a breakdown in global health security. Undeniably, the drastic effects of Covid-19 called for a Global Health Agreement. This paper is an independent evaluation conducted by Center for Global Health Security experts of the Articles of the Agreement. The first half of this paper assesses the effectiveness and feasibility of the proposed articles and goes on to identify possible gaps in implementation. The latter half makes novel recommendations that would augment effectiveness of the Agreement and ensure the WHO Member States adopt the Agreement.

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Historical Background of the World Health Organization

Now yearly celebrated, the foundation of the WHO is a United Nations specialized agency focused on promoting international health and safety, connecting nations to promote international health, researching causes and cures for diseases.[1] Following World War II and the enactment of the United Nations, Diplomats in San Francisco, 1945, discussed the creation of the WHO as a United Nations specialized agency.[2] On February 15, 1946, the Economic and Social Council of the United Nations instructed the Secretary General to convene the conference.[3] Thus, the WHO Constitution was adopted under article 57 of the United Nations Charter. Finally, on April 7, 1948, the WHO entered into force. Their primary focus is to act as the directing and coordinating authority on international health work.[4]

Some of the WHO's successful eradication and successful declines of diseases include Smallpox, which was fully eradicated in 1980, and Polio, whereas vaccinations have aided in the significant decline in cases. The Polio virus only remains in Pakistan and Afghanistan. Several other diseases still remain relevant today, such as severe acute respiratory syndrome (SARS), a viral respiratory disease that first emerged in China in 2003 and quickly spread to surrounding countries. This was the first severe easily transmissible airborne virus to emerge in the 21st century, successfully combated by the WHO and the Global Outbreak Alert and Response Network (GOARN). In 2020, the WHO declared the global outbreak of Coronavirus, a respiratory and enteric virus, first emerged in China, that spread to 229 countries and territories and resulted in 14.9 million excess deaths worldwide.[5]

It is fundamental when discussing how the WHO combats viral diseases, it's recognized they are not combating alone. The WHO relies on donations and partnerships to facilitate and provide nationwide vaccination drives. As Covid-19 spread to nearly every country in the world, there was not a vaccine readily available, which made the virus spread rapidly without a proper defense mechanism.

1 Shaalaa.com. (n.d.).

2 Gostin, L. O. (2023, April 17).

3 Ibid.

4 Ibid.

5 "14.9 Million Excess Deaths Associated with the COVID-19 Pandemic in 2020 and 2021."

Prior to the creation of the vaccine, the WHO government bodies, and front-line workers worked tirelessly to implement procedures including mask wearing, curfews, and isolation, to prevent the virus from spreading further. To their avail, once the vaccine was created and distributed, the spread of the virus slowly came under control.

However, not every country had the means or privilege to obtain the vaccine as quickly as others, resulting in increasing loss of life. Many of those were from developing countries without financial support. Recently, the WHO and European Union (EU) joined forces to support eight South East Asian countries combating Covid-19 and prepare for future pandemics.[6] The EU donated twenty million euros to this program, and the WHO will use the funds to support Cambodia, Indonesia, Lao People's Democratic Republic, Malaysia, Myanmar, the Philippines, Thailand, and Viet Nam.[7] Following the outbreak of Covid-19, it was clear to Member States of the WHO that a treaty of sorts was required to achieve global health through global health diplomacy. They decided the treaty will focus on pandemic prevention, preparedness, and response.[8]

Background on the Global Pandemic Agreement

In December 2021, the World Health Assembly (WHA) established in accordance with Rule 41 of its Rules of Procedure ("The Rules" or "Rules"), an Intergovernmental Negotiating Body ("INB") open to all Member States and associates.[8] The structure of the INB is as follows, "it will operate as a subdivision of the WHA, consider and make recommendations to the WHA on matters specifically assigned to it by the WHA."[9]The INB was established in order to draft and negotiate an accord or international instrument that appealed to Member States of the WHO. The INB represents all regions of the world with its goal to strengthen pandemic prevention, preparedness, and response.[10]

6 World Health Organization. (n.d.-c).
7 Ibid.
8 World Health Organization. "Proposed Method of Work - World Health Organization."
9 Ibid.
10 Ibid.

The WHO Member States agreed to proceed with further developing the accord, with the latest negotiating text published in October 2023; Proposal for negotiating text of the WHO Pandemic Agreement (the "Agreement"). The Agreement falls under Article 19 of the WHO's Constitution. Article 19 gives the 194 Member States of the WHO the authority to adopt conventions or agreements on any matter within the WHO's capability. The Agreement was "driven by the need to ensure communities, governments, and all sectors of society- within countries and globally- are better prepared and protected, in order to prevent and respond to future pandemics."[11]

In accordance with relevant Rules and resolutions of the WHA, the INB may decide to involve the participation of relevant stakeholders including NGOs, CSOs, other experts, and expert bodies. If the INB decides to allow relevant stakeholders to engage, they may attend open sessions of the INB but will not take part in any decision-making and any inputs provided by them will be subject to calls to order by the Secretariat.[12] The Agreement has a target to be finalized by May 2024, with the eligibility of coming into force once it is ratified by two-thirds of WHO Member States.

The objective of the Agreement is as follows under Article 2, "the WHO Pandemic Agreement, guided by equity, the right to health and the principles and approaches set forth herein, is to prevent, prepare for and respond to pandemics, with the aim of comprehensively and effectively addressing the systemic gaps and challenges that exist in these areas, at national, regional and international levels."[13] The Agreement was originally proposed by the European Union, as the treaty's biggest supporter, developing countries in Africa are equally supportive in hopes for access to a regular distribution of vaccines. This Agreement represents a new era of international commitment to health and safety as well as a mutual understanding between international communities.

11 World Health Organization. (n.d.-e). Pandemic prevention, preparedness and response accord.

12 World Health Organization. "Proposed Method of Work - World Health Organization."

13 World Health Organization. (n.d.-e). Pandemic prevention, preparedness and response accord.

While the Agreement is still in its early stages, its expected support through global coordination will build a stronger, reliable WHO. The Agreement could also lead to the development of related initiatives and or become a model document for countries around the world that want to further develop their own health systems.

Analysis of Provisions in the Agreement

During the initial meetings of the INB, in December 2022, the Conceptual Zero Draft WHO CA+ was proposed. Several meetings took place in 2023 where Member States negotiated and proposed changes to the Articles within the draft. Much of the Zero Draft WHO CA+ was adopted, which is featured on the preliminary text of the Agreement. As of recent negotiations which took place on November 6-10, 2023, there has been a major development on the text of the agreement as well as written statements by relevant stakeholders. The Agreement calls on the rights to global health security through the principles of equity, equality, and the effectiveness of refined and new measures of pandemic prevention, preparedness, and response. There are currently 36 Articles within the Agreement as well as preambles, an introduction to the use of terms, and general principles and approaches. If ratified, the world could observe a new era of global health diplomacy through the means of deliberated international collaboration.

According to Articles within the Agreement, the Member States are proposing to be more transparent in publicizing scientific data, establish subsidiary bodies and a panel of experts to provide scientific advice, program training for healthcare workers, mobilization of skilled and trained multidisciplinary global public health emergency workforce deployable to Member States, new health policies, and faster and equal distribution of vaccines. The Agreement, legally binding under international law, has been drafted under the potential to enhance a stronger response and resilience to the emergence and threatening reemergence of pathogens. However, there are many barriers that risk the ratification of the agreement.

WHO Framework Convention on Tobacco Control

Comparable to the WHO Framework Convention on Tobacco Control (FCTC), the pandemic response Agreement is "evidence based that reaffirms the right of all people to the highest standard of health".[14] The FCTC is the first treaty negotiated under the WHO and one of few that remains binding between Member States. This treaty represents a revolution in the world of smoking and global health security. The WHO FCTC had 168 Signatories, including the European Community, making it one of the most widely welcomed treaties in the history of the United Nations. This raises the following questions, what about the FCTC was so appealing to receive this reaction by Member States, and what aspects of the implementation of the FCTC can the pandemic response Agreement adopt to encourage ratification.

Similarly, the WHO FCTC was a necessary response to the globalization of the tobacco epidemic. In response to the demands of public health, the WHO FCTC focuses on price and tax measures to reduce the demand for tobacco, protection from exposure to tobacco smoke in public spaces, regulation of the contents of tobacco products, packing and labeling of tobacco products, educational awareness, and more. The provisions within the framework called for essential support in which Member States were in full agreement.

In the first working group sessions of the treaty making process, there was a strong element of hope for a treaty that would lead to significant changes in the way Member States responded to global health. The WHO created a framework of steps to follow when drafting an international agreement, a framework they still apply to contemporary drafting sessions. The steps were as follows, to include clear, precise rules, include rules that are easy to verify, aid developing states, require Member States to submit national reports and establish international review mechanisms, and to provide for a regular meeting of Member States.[15] The steps of the treaty-making process in 1999, were followed precisely in the agreement making process of 2023.

14 1. 6 May 2009, "Who Framework Convention on Tobacco Control," PAHO/WHO | Pan American Health Organization, accessed February 10, 2024, https://www.paho.org/en/documents/who-framework-convention-tobacco-control#:~:text=The%20WHO%20Framework%20Convention%20on,the%20highest%20standard%20of%20health.

15 Treaties make a difference, August 16, 1998.

On May 24, 1999, the Health Assembly adopted a resolution which allowed them to embark on the preparation of a draft text of a framework convention on tobacco control. The well incorporated procedure that allowed them to do so was divided into two stages. The first was a working group on the framework itself, and the second was an intergovernmental negotiating body to draft and negotiate the framework. While this process worked well in drafting the pandemic response Agreement, there has been a dramatic shift in global health, political alliances, and the global economy since the ratification of the WHO FCTC that has not been taken into consideration. The global economy, political affiliations, and the status of global health including antimicrobial resistance compliance, should be fundamentally considered when undertaking a treaty drafting process with 194 Member States.[16]

The barriers to implementing the FCTC included lack of health-care system infrastructure, low political priority, and lack of funding. These barriers are also present in the drafting of the pandemic response Agreement, amongst others, but unlike the FCTC, they reduce the likelihood of the ratification of the Agreement tenfold. During the widespread of Covid-19, contemporary society wondered how the United Nations and the WHO would respond. The onus fell on international leaders and organizations to create a response that prevented future threats to national security. A key problem the WHO is facing is compelling Member States to ratify the Agreement. The circumstances surrounding the potential prevention of ratification include the language of the Agreement, the lack of discourse of relevant events such as a war or conflict breaking out during a global pandemic, provisions that ensure the prevention of zoonotic spillovers, surveillance in ecosystems, AMR compliance, realistic financial support, amongst other factors.

16 Shelley DR;Kyriakos C;McNeill A;Murray R;Nilan K;Sherman SE;Raw M;, "Challenges to Implementing the WHO Framework Convention on Tobacco Control Guidelines on Tobacco Cessation Treatment: A Qualitative Analysis," Addiction (Abingdon, England), accessed February 10, 2024, https://pubmed.ncbi.nlm.nih.gov/31777107/#:~:text=Conclusion%3A%20Important%20barriers%20to%20implementing,priority%20and%20lack%20of%20funding.

The remainder of this paper will highlight key recommendations that provide remedies to the potential dissolvement of the Agreement such as how to overcome the same barriers the WHO faced during the drafting of the FCTC and insight to why the ratification of this Agreement will be advantageous to the Member States and global health security for generations to come.

Evaluation and Recommendations

Surveillance and AMR Compliance

As noted in the Agreement under Chapter II, Article 4, Pandemic prevention and public health surveillance, cooperation between State Parties in bilateral, regional, and multilateral settings is key in strengthening surveillance capacities. In order to succeed, there are various measures that need to be taken to meet the refined benefits surveillance in multiple sectors will bring. First, it is impertinent that surveillance be conducted across all relevant sectors including human, animal, and plant. In order to truly act on pandemic prevention, the global community must tackle potential catastrophic events at the source.

Integrated surveillance and AMR compliance are key to the success of global health and national security. Integrated surveillance is considerably important within the Arctic as permafrost continues to thaw and bacterial, fungal, and viral pathogens release. Not only is melting permafrost dangerous to our ecosystems, but the threat of exposing infectious diseases and unknown bacteria is a threat to national security.

Given the rise of AMR compliance, continuous advancement in medical technology, the best the world has seen to date, will be inefficient when people develop immunity to antibiotics. "AMR has emerged as one of the principal public health problems of the 21st century that threatens the effective prevention and treatment of an ever-increasing range of infections caused by bacteria, parasites, viruses, and fungi no longer susceptible to the common medicines used to treat them."[17] The WHO has addressed this issue and in 2001, created a Global Strategy for Containment of AMR which provided materials on how to reduce the spread of AMR microorganisms. In April 2014, WHO was the first to publish a global report on the surveillance of AMR with the help of national and international surveillance networks.[18] Antimicrobial resistance kills around 1.27 million people worldwide.[19] AMR compliance will be challenging if a medication dedicated to the eradication of a pandemic was resisted by the majority of the human race.

We recommend AMR be introduced first and foremost as a definition in the preambles of the Agreement and acknowledged within the Agreement as a global threat to the success of the several objectives. We further recommend a clause be introduced in relation to States Parties best efforts on mitigating AMR compliance for the purpose of pandemic prevention, preparedness, and response.

Second, we recommend surveillance across the animal, and plant sectors as well as human and we encourage the WHO and State Parties to include this specific language in the draft text of the Agreement. The longer the global community fails to acknowledge the relevance and importance of surveillance in the animal and plant sector the higher the risk that humans face of viruses deriving from animal or plant origin that in turn lead to human transmission. In addition, collaboration with local organizations that play a key role already in surveillance across these sectors would prove beneficial and efficient in saving reduced costs.

17 Francesca Prestinaci, Patrizio Pezzotti, and Annalisa Pantosti, "Antimicrobial Resistance: A Global Multifaceted Phenomenon," Pathogens and global health, 2015, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4768623/.

18 Ibid.

19 "National Estimates for Antibiotic Resistance," Centers for Disease Control and Prevention, December 13, 2021, https://www.cdc.gov/drugresistance/national-estimates.html.

In addition, collaboration with local organizations that play a key role already in surveillance across these sectors would prove beneficial and efficient in cost saving. For example, the Wildlife Conservation Society (WCS) is already working with approximately 60 countries with more than 125 years of scientific research relating to pathogens and collaborative surveillance. However, it is important to note if the WHO decides to pursue these collaborations that the rules of transparency apply just the same for the purpose of collaborative surveillance where relevant scientific data and research will be shared and made accessible across States Parties.

Lastly, surveillance can reaffirm the need of pandemic prevention and response through strengthening compliance technology as noted under Article 4 subsection 3, where States Parties shall cooperate in safely handling samples containing pathogens and the use of related digital goods. Biosecurity threats remain at large. Implemented by the Russian Federation, the deployment of mobile labs, epidemiologists, and the transportation of inactivated samples have proven to be very successful with no spillover since its implementation. The Russian Federation created six different mobile labs including inflatable labs, mini vans, with respect to quarantine control. The mobile labs were deployed with a simulation of resolving accidents with pathogenic biological agents. The distribution of mobile labs was tested in bilateral and multilateral formats.[20]

The tasks for the epidemiologists involved organizing emergency response measures, planning activities to stop further spread of infectious diseases, and more. The lab specialists were assigned with testing of unknown samples, preparation of mobile labs for employment, and more. The teams, which consisted of over 100 specialists from around the world, successfully identified pathogens in all the samples. The mobile labs are relevant today and are working on being expanded.[21]

20 Delegation of Russian Federation, Presentation at Biological Weapons Convention, December 12, 2023.
21 Ibid.

Rights of Health and Care Workers

Article 7 focuses on health and care workforce. During the COVID-19 pandemic, health and care workers became the most important and dependable people on earth. Their health, safety, and recovery are absolutely essential to combat the exposure and progression control of pathogens. The Article addresses gender and youth disparities and inequalities and contains goals to establish and maintain effective workforce planning systems and strengthen education and training. What is unique yet questionable about subsection 3 is the mobilization of skilled and trained multidisciplinary global health emergencies that is deployable to support Parties upon request based on public health needs.

The language of deployable insinuates these healthcare workers will be treated somewhat like soldiers and it is not clear if healthcare workers will be mobilized at once, or if their primary residence will be on a training base like Army Primary Reserves. It is also unclear what employment and protection rights the healthcare workers are to have, especially if traveling to foreign countries. These rights need to be explicitly addressed to protect the rights of all persons.

We recommend the Agreement include more appropriate language with respect to deployment as well, including emphasis on the employment rights and safety for health and care workers on foreign land. In the event of a conflict during a global pandemic, the rights and safety of health and care workers are of utmost importance. This must be addressed in the Agreement and should be acknowledged in bilateral and multilateral settings.

Finances

Recognizing the second most important condition of the Agreement, first and foremost being global health, as financing. Financing is critical to the success of ratification of the Agreement. Article 20 focuses on financing, declaring a sustainable funding mechanism shall be established by the Conference of the Parties no later than December 31, 2026. A capacity development fund that shall be resources, inter alia, through the following:

- "Annual monetary contributions from Parties to the WHO Pandemic Agreement;
- Monetary contributions from recipients pursuant to Article 12 herein; and
- luntary monetary contributions from Parties to the WHO Pandemic Agreement
- Voluntary monetary contributions from all relevant sectors that benefit from international work to strengthen pandemic prevention, preparedness and response; and
- Donations from philanthropic organizations and foundations and other voluntary monetary contributions."[22]

The breakdown and use of recognized mechanisms such as the World Bank Pandemic Fund, NGOs, CSOs, and relevant stakeholders, are not established and must be negotiated accordingly otherwise urgency will be followed by a sudden collapse. The Government of the United Kingdom has already spent $3.21 billion pounds on COVID-19 measures so far with the cost expected to rise.[23] The government of the United States of America have spent $4.6 trillion in response to COVID-19.[24] We recommend States Parties identify who will be contributing finances accounting for pandemic prevention, preparedness, and response, manufacturing and delivering pandemic-related products, etc., prior to 2026. We further recommend once a list has been established, a treasurer or small council be created within each individual organization disclosing funds ensuring transparency on all pandemic-related products manufacturing and distribution.

22 Proposal for negotiating text of The who pandemic agreement, October 30, 2023, 23.

23 UK biological security strategy - GOV.UK.

24 Office, U.S. Government Accountability.

Lastly, there should be a safeguard introduced to subsection (b) under Article 10 with respect to the access of pharmaceuticals and pandemic-related products distributed by third-party organizations. Developing countries and marginalized communities must be reassured they will not be affected by the upscaling of pharmaceuticals and pandemic-related products derived from political commitment and personal financial gain.

Withdrawal of State Parties

Article 27, which addresses withdrawal of Parties, states any time after two years from the date in which the Pandemic Agreement has entered into force for a Party, they may withdraw from the Agreement via written notice.[23] There have been some reservations regarding this clause, while every Party should have the autonomy to withdraw, there are no independent consequences or encouragements to remain if withdrawal is considered. As previously noted, financial support is very significant to ratification.

Instead, if a large financial contributor withdraws, this may create a sequence of unfortunate events which in turn would lead to the dismantlement of the Agreement. We recommend a clause be put into place for larger financially committed States Parties to deter the appeal of withdrawal.

25 Proposal for negotiating text of The who pandemic agreement, October 30, 2023, 27–28.

Key Recommendations

- **Include objectives in relation to States Parties best efforts on mitigating AMR compliance and surveillance across the animal, and plant sectors as well as human;**

- **Under Article 7, include more appropriate language with respect to deployment as well, include emphasis on the employment rights and safety for health and care workers on foreign land;**

- **States Parties identify who will be contributing finances accounting for pandemic prevention, preparedness, and response, manufacturing and delivering pandemic-related products, etc., prior to 2026 and a treasurer or small council be created within each individual organization disclosing funds ensuring transparency on all pandemic-related products manufacturing and distribution;**

- **Under Article 27 or where States Parties deem fit, a clause be put into place for larger financially committed States Parties to deplete the appeal of withdrawal.**

Conclusion

The World Health Organization has taken great lengths to respond to the repercussions following COVID-19. Their response can only be noted as efficient, valuable, and transformative. Despite the overwhelming concerns by States Parties, NGOs, CSOs, relevant stakeholders and citizens around the world, the WHO took all their concerns and decided to move forward with a once in a lifetime Agreement, which if ratified, could transform international health approaches and global diplomacy. The WHO has prioritized developing countries addressing socioeconomic differences, the importance of health and care workers, the relevance of transparency and advancement of scientific research, and more.

Overall, their response and continued efforts with negotiations have made significant progress. While we believe amendments are still required on the Agreement and our recommendations will be favorable, the future of pandemic preparedness, prevention, and response, is bright.

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