G2H2 GENEVA GLOBAL HEALTH HUB

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
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EXECUTIVE SUMMARY

In early 2021, the announcement that some Member States were eager to kick off negotiations for a new binding instrument for global health at the WHO came as a surprise. Most health policy arrangements are grounded on soft norms, and the WHO has used its constitutional normative power adopting binding agreements only twice in over seventy years of history. This development appeared more unexpected as the Member States promoting the idea of a treaty for pandemic preparedness and response have in the past staunchly opposed hard norm setting at the WHO.

Through its bottom-up qualitative research involving 23 respondents, the Geneva Global Health Hub (G2H2) has dived into the unfolding arena of the WHO pandemic treaty to inject in the public dialogue around the proposal the insights from experts and civil society actors, including those who have been at the forefront of the pandemic response in countries, as well as WHO delegates in Geneva and in capitals. The G2H2 research has opened the pandemic treaty discussion to a broader mapping of reality and its current failures, in the presence of legal frameworks (the WHO International Health Regulations, IHR 2005) that should have obliged countries to cooperate and share information for contrasting SARS-CoV-2's aggressive viral evolution. Failure to do so projects a scenario that cannot be limited to the WHO and the health sector alone, as we enter the third year of the COVID-19 and the world has not yet immunized itself from its dysfunctional power structures and economic ideologies.

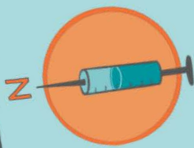
G2H2 analytical framework draws from Dani Rodrick's globalization paradox. We look at the pandemic treaty idea through the lens of the asphyxiation of capitalism's new unbridled pandemic tides, and the intractable tensions that persist in today's neoliberal economy. The global governance of the current landscape furthers itself from true multilateralism and manifests itself through enhanced concessions to multistakeholderism in the UN system. COVID-19, while exacerbating the world's deep structural inequalities, has brought to light the interconnected nature of the current health and environment crises and imposes now a new sense of purpose to policymaking in public health, beyond the individual-level biological causes or risk factors and the disproportionate emphasis on technological solutions. A pandemic is not a fact of life, a natural phenomenon. It represents instead the by-product of a systemic governance failure that can be avoided through a significant change of direction and a policy paradigm shift pursued in good faith through international cooperation. This shift is hard to see still, beyond diplomatic rhetoric exercises. The persistent widening global vaccine apartheid and the resolute opposition by those very countries that propose the WHO pandemic treaty, to suspending intellectual property rights at the WTO, so to enhance access to scientific knowledge and decentralized capacities of production and

provision of COVID-19 countermeasures, menace the international trust needed in treaty negotiations, advance the dominant privileges of the pandemic profiteers and pose threats to multilateralism.

The report traces the genesis of the pandemic treaty proposal and its diplomatic evolution within the WHO, and identifies its different geopolitical drivers in a rapidly changing landscape. Does the world really need a new pandemic treaty? What's the evidence behind the energetic push to negotiating one? And what are the trade-offs? G2H2 respondents' analyses assembled in the research imagine different ways the conundrum of health needs, politics and limits might play out in the coming years, beyond the official narratives around the pandemic treaty. The issue of preparing and responding to future pandemics impinges, once again, on the need for countries' capacities to use resources for universal public health systems with trained personnel, and for their freedom to determine the nature of the development they want to see, including through a reshaping of globalization. The G2H2 research is a tool. It has been written to stimulate conversations and upgrade the global health justice agenda after the shocks provoked by COVID.

LIST OF ABBREVIATIONS

ACT-A	Access to COVID-19 Tool Accelerator
BMGF	Bill and Melinda Gates Foundation
CBD	Convention on Biological Diversity
CEWG	Consultative Expert Working Group
CRtD	Convention on the Right to Development
CSO	Civil Society Organization
C-TAP	COVID-19 Technology Access Pool
EB	Executive Board
EC	European Commission
EU	European Union
EUMS	European Union Member State
FCCC	Framework Convention on Climate Chance
FTCT	Framework Convention on Tobacco Control
HERA	Health Emergency Preparedness and Response Authority
HLPAM	(UN) High Level Panel on Access to Medicines
GPMB	Global Preparedness Monitoring Board
GSPoA	Global Strategy and Plan of Action, Public Health, Innovation and IP
ICC	International Criminal Court
IFPMA	International Federation of Pharmaceutical Manufacturers' Association
IMF	International Monetary Fund
IOAC	Independent Oversight and Advisory Committe
IP	Intellectual Property
IHR	International Health Regulations
IPPPR	Independent Panel for Pandemic Preparedness and Response
MS	Member State
NFP	National Focal Point
OHCHR	Office of the High Commissioner for Human Rights
PHEIC	Public Health Emergency of International Concern
R&D	Research and Development
RRC-IHR	Report of the Review Committee on the Functioning of the International Health Regulation
SDG	Sustainable Development Goal
SGP	Stability and Growth Pact
TNC	Transnational Corporation
TRIPS	Trade-related Aspects of Intellectual Property Rights
UNHRC	United Nations Human Rights Council
WB	World Bank
WHA	World Health Assembly
WHO	World Health Organization
WHOC	World Health Organization Constitution
WHO DG	World Health Organization Director General
WGPR	Working Group on WHO Preparedness and Response to Health Emergencies
WTO	World Trade Organization



PANDEMIC
TREATY

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 2021[1].

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 prominent 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 scholars and by a WHO consensus in resolution (WHA61.21)[2].

The emergency scenario generated by SARS-CoV-2 seems to have now helped heal the treaty fatigue syndrome 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)[3]. Their proclaimed intention is to build a more robust global health architecture that will protect new generations[4] 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 reason why in the past we have supported the academic and civil society

1 https://g2h2.org/posts/may2021/

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

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

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

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 Health[5].

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 in the management of the current and future pandemics, and such that require to be injected in the discussion right from the start, 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 revised with the evolution of the WHO negotiating process.

5 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/.

RESEARCH QUESTIONS AND METHODOLOGICAL APPROACH

Based on a participatory process that involved its members at different stages, G2H2 selected three research questions for this study:

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 which are the actors driving this agenda?
3. What other policy approaches could be envisaged to prevent future health emergencies and effectively govern pandemic preparedness and response?

The study derives its normative basis from the human-rights based approach to health and policy-making in guiding its analysis and recommendations[6]. 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 dynamic[7]. 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 marginalization[8]. 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

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

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

8 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/.

reduction grounds and the international community needs to recognize its limits and responsibilities[9], while opening a more sovereign economic space for countries and societies, based on the need for decolonizing the development agenda[10 11 12]. 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 action[13].

The research-team, consisting of Remco van de Pas & Priti Patnaik, carried on the research from August to mid-October 2021. Nicoletta Dentico led the conceptualization, structure and writing 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 pandemic treaty and governance of international outbreaks in recent history (since 2000). This approach 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 participants including international policymakers, health diplomats, civil society actors, scholars and public health professionals. The research comprised respondents from all WHO regions, except for the Western Pacific. Reaching out to the widest possible geographical representation was G2H2 intent, to ensure a wide range of perspectives coming from high-income, middle-income and low-income countries, for the sake of analytical diversity and variety of positions. Most interviewees are directly involved in, or closely monitoring the developments on pandemic governance and the treaty proposal.

35 interviewees were approached and 23 participated in the study. 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 online, by telephone or in-person interviews. Participants were guaranteed anonymity in accordance with Chatham Rules. Data collection, storage and transcription were done in a secure manner.

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9 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.

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

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

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

13 Cousins, T., Pentecost M., Alvergne A., et al. (2021). The changing climates of global health. BMJ Global Health, 2 March 2021.

Table 1: Overview and breakdown of research participants profile

CATEGORY	GEOGRAPHIC BACKGROUND	NUMBER
(Health) diplomat	Europe	4
(Health) diplomat	Africa	3
(Health) diplomat	Americas	2
(Health) diplomat	Asia	1
Global Health official	Africa	2
Global Health official	Europe	1
Academic	Europe	3
Academic	Americas	3
Academic	Africa	1
Academic	Australia	1
Civil society	America	1
Civil society	Asia	1

The study findings were categorised along the main themes identified. This combines and triangulates with the findings from literature review as well as the G2H2 consultations and analyses from panelists in G2H2 webinars. Given the multiplicity and complexity related to pandemic governance issues, the findings did not cover all themes addressed by the participants but focused on the priorities emerging at the time of the interviews. 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 FAILURE 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 globalization[14].

The world was not and is still not effectively able to prevent, predict, prepare for, 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*[15], the planetary expansion of the new coronavirus should never have occurred in the first place. SARS-CoV-2 appeared unexpected 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 had all the 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 China[16]. 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"[17]. While disputes are ongoing over

14 Sell, S. and Williams. O., (2019), 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.

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

16 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)/.

17 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

the origins and timeline of the outbreak, the world counts roughly 252 million COVID-19 cases and 5.1 million deaths[18] as of mid-November 2021, although the real death toll is expected to possibly be three time higher[19]. 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 communities[20], easily transforming the disease into a pandemic of inequities[21]. 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.

18 https://covid19.who.int/

19 https://www.economist.com/graphic-detail/coronavirus-excess-deaths-estimates

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

21 Maani, N., Abdalla, A.M., Galea, S. (2021). 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.

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 and other living species and the environment. Deforestation and the ever-increasing destruction of natural habitats and displacement of living species, wildlife trading and trafficking[22], resource-intensive lifestyles and conditions, unsustainable food production and consumption systems, are right at the origin of the subsequent emergence of zoonoses since the beginning of the new millennium[23], particularly viruses like influenza and other pathogens[24].

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 viruses[25]. COVID-19, a symptomatic manifestation of the Anthropocene, imposes now a new sense of purpose to health policymaking in the current and future responses to the pandemic: "we need to recognize that we are moving beyond the point of saturation", as the scientist Johan Rocktrom rightly points out[26]. The crisis marks an opportunity, for the international community that believes in public health and the role of multilateral institutions, to re-imagine itself and project new ways to engage beyond classical models. "Climate change is a health crisis" has declared

22 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. "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). 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.

23 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/.

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

25 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.

26 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/

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 treaty[27].

COVID-19 has also revealed the deep 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 that fed their families. 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 signalled 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 have imposed an unbearable burden on women globally, as their capacity as "shock absorbers" [28] has played a key role in the ongoing scenario of austerity measures and recurrent reduction of social spending. The effects on working mothers are likely to be persistent[29].

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%[30]. 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[31].

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 worsening[32] 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 people[33], almost a third of humankind. Of course, this food insecurity cannot be merely attributed to the pandemic, yet COVID-19 has exacerbat-

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

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

29 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.

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

31 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

32 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

33 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.

ed pre-existing hunger determinants[34], and it is tragic that its long-term ripple effects on socio-economic wellbeing in lower-income countries will remain relatively neglected[35].

At the same time COVID-19 has served the richest in our societies very well[36]. 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 USD$ 540 billion in 2020[37], while US billionaire wealth surging by 70%, or USD $ 2.1 trillion during the pandemic[38]. The inevitable COVID-19 vaccines drive has created a bonanza for some pharmaceutical companies and further enhanced the financialization of Big Pharma[39]. In the small group of the mRNA 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 vaccines[40], while Pfizer and its German partner BioNTech have predicted more than USD $72 billion in sales for the year 2021 alone[41]. Pfizer and Moderna legally funnel the billions received from governments' purchase of their vaccines through tax havens in the Netherlands and elsewhere[42 43].

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 invaluable analysis of the political-economist Dani Rodrick, who has deeply surveyed the larger rights and wrongs of globalization, it is indeed reasonable to assert that the pandemic has made his 'Globalization Paradox' even more cogent. Deriving his analytical model from the 2008 financial crisis, Rodrick describes this paradox 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"[44]. 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

34 https://www.fao.org/3/cb4474en/cb4474en.pdf

35 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.

36 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://oxfamilibrary.openrepository.com/bitstream/handle/10546/621149/bp-the-inequality-virus-250121-en.pdf

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

38 https://inequality.org/great-divide/updates-billionaire-pandemic/.

39 Fernandez, R. and Klinge, T.J., (2020). 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.

40 https://www.somo.nl/modernas-free-ride/.

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

42 https://www.ftm.eu/articles/pfizer-avoids-taxes-via-the-netherlands

43 https://www.somo.nl/modernas-free-ride/.

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

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 trends*[45]*.*

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 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. They continue to prefer legitimizing existing relations of power and naturalizing global health security according to beliefs that provide an avenue for the global elites to discipline and control the non-elite countries and people. Through the dominance of technological solutions, they prolong the vertical management of health though disease-control and the primacy of biomedical approaches, thereby allowing the interference of giant corporate actors and new phases in the privatization of the health agenda, away from more cumbersome but indispensable systemic approaches[46].

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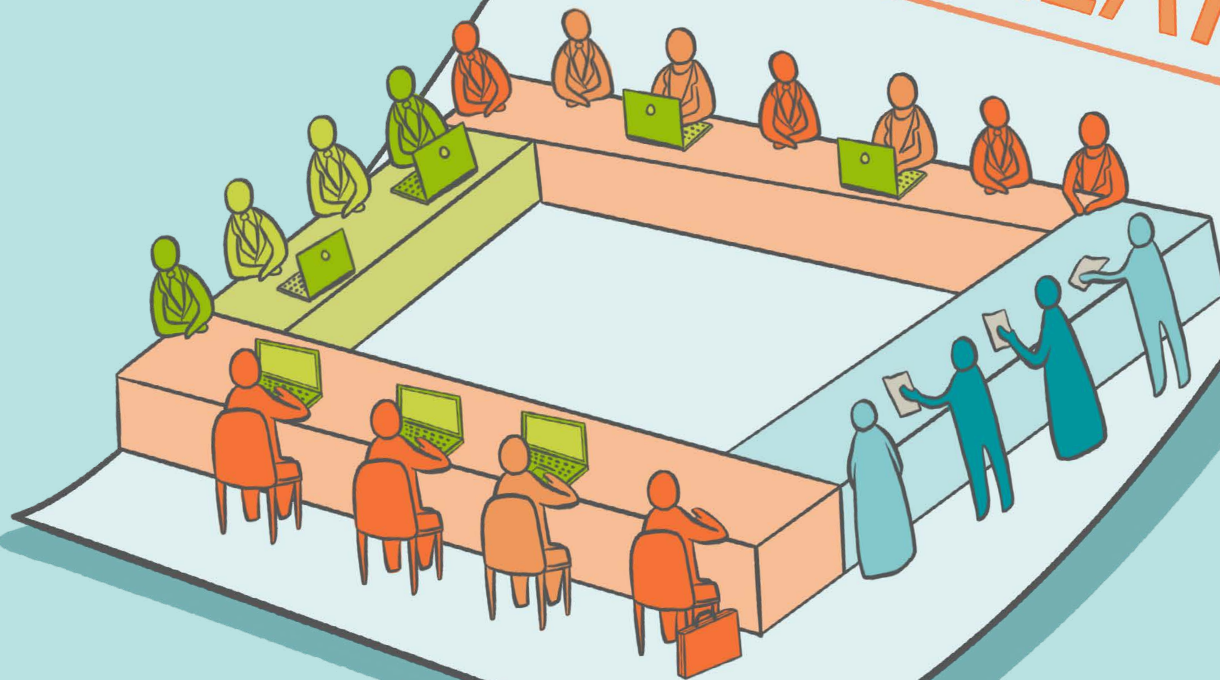
45 Rodrick, D., (2020), "Will COVID-19 Remake the World?", in Project Syndicate, 6 April 2020, https://www.hks.harvard.edu/centers/mrcbg/programs/growthpolicy/will-covid-19-remake-world.

46 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.


PANDEMIC
TREATY

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 security[47]*.*

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 WHO[48] 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[49]. President Michel spearheaded

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

48 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/.

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

the proposal again at the Special Session of the UN General Assembly in response to the coronavirus disease (COVID-19) pandemic 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 healthcare[50].

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 emergencies[51]. 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[52]. 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 features as the scenario for the future?[53]

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

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

52 Vijav, S. L., (2020). 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/

53 https://www.consilium.europa.eu/en/policies/coronavirus/pandemic-treaty/

In the longstanding quest for setting up a governance mechanism capable of dealing with health emergencies[54] we need to recall 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)[55] adopted by the World Health Assembly (WHA) in 1969.

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 Constitution[56]. 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.

54 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 ships. 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 arrival 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.

55 https://www.who.int/publications/i/item/9789241580410

56 Aginam O. (2014), "Mission (Im)possible? The WHO as a 'Norm Enterpreneur 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.

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 IHR approach has been innovative in many ways[57]: "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"[58].

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 distils the international consensus on how health emergencies and pandemics should be dealt with.

57 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

58 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

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 experts[59] 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 emergency[60] . 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 purpose[61], including WHO's own obligations under the IHR[62].

59 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.

60 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/

61 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

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

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, 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 has exploited our weaknesses and divisions, we must seize this opportunity and come together as a global community"[63].

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[64]. The international pandemic treaty, the call recites, "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"[65]. Finally, it does recognize that "existing global health instruments, especially the IHR, 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 in the lead up to the governing body session. With Chile heading the discussion[66], 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?

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

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

65 Ibidem

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

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 debate[67]. But Russia was not, and is not, the only key geopolitical player unsympathetic to this proposal. The US, China, India and Brazil have raised concerns and expressed 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 emergencies[68]. At the same time, the WGPR has been asked 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 November 2021, to pass under review and deliberate on a WGPR report[69] regarding the reasons and the implications of a pandemic treaty[70].

The Working Group[71] held four meetings in the second half of 2021[72]. In addition, it has been supplemented with deep dives on specific issues in inter-sessional meetings. Its report[73], published on November 12th, recommends that countries establish an inter-governmental negotiation body for developing "a WHO convention, agreement or other international instrument on pandemic preparedness and response" through a government-driven process aimed to formulate a zero draft, set 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 the work ahead generates different and diverging perspectives among Member States, with contentious policy choices for countries battling the pandemic. In addition, delegations feel under pressure, as research respondents from the global South have conveyed. Some Member States respondents indicated that, following deliberations at the WHA74 on the resolution on pandemic preparedness, the discussions in

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

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

69 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."

70 https://apps.who.int/gb/ebwha/pdf_files/WHA74/A74(16)-en.pdf

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

72 https://apps.who.int/gb/wgpr/

73 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

74 The World Together: Establishment of an intergovernmental negotiating body to strengthen pandemic prevention, preparedness and response. https://apps.who.int/gb/ebwha/pdf_files/WHASSA2/SSA2(5)-en.pdf

the working group were overall pushed in one particular direction: "There is an insistence on the need for making big reforms in the system right now, in the middle of a pandemic. But countries need more time". Some delegates are frustrated with the process, respondents stressed.

As a matter of fact, in December 2021 WHO Member States adopted a decision to establish an Intergovernmental Negotiating Body (INB) to draft and negotiate a WHO convention, agreement or other international instrument on pandemic prevention, preparedness and response[74]. Some of them are pushing for a zero draft of a treaty by August 2022. The WGPPR for its part will continue looking at the possibility of reforming the IHR.

"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 capitals". Negotiations for new rules to govern future health emergencies will be shaped in the coming months and years: "The temptation to put everything in a single negotiating framework is a tactical move" one legal expert interviewed commented. The Inter-governmental body will have to report on the outcome of its efforts at the World Health Assembly in 2024.

74 The World Together: Establishment of an intergovernmental negotiating body to strengthen pandemic prevention, preparedness and response. https://apps.who.int/gb/ebwha/pdf_files/WHASSA2/SSA2(5)-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 used to be a publicly dominated health governance system, are manifestations of a phenomenon that has revolutionized the health architecture into a hustling unordered arena of wealthy influential entities claiming their role in global health.

The 'new public management' theory, at the heart of this transformation, has modelled the very traditional institutions on the perceived virtues and values of the private sector. In a matter of few years, 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 ecosystem[75]. 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, fuelling scepticism against medical solutions. It has come to sweep the world at a time of dramatic decline of substantive democracy and of impulsive rise of national-populist leaderships, with potential long-term risks for the reshaping of state power[76]. The virus endures with its variants in the flare-up of big-powers' rivalry and shuffles the broken threads of multilateralism[77]. Meanwhile, the empty seats in the rooms 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].

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

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

77 Pereira Da Silva Gama, C.F., (2021). Broken Threads: Reshaping Multilateralism with COVID-!) 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.

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, linger in the WHO rooms. The gaps in the pandemic governance 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 Programme[80]; The WHO Independent Panel for Pandemic Preparedness and Response (WHO IPPPR) [81]; 4. The Global Preparedness Monitoring Board[82].

This is what the WHO Secretariat has diagnosed as missing in the current governance system, based on such reports:

- The lack of a global health architecture 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 is less than suboptimal;
- The inequitable access to countermeasures ;
- The 'One Health' approach and the need for 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].

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

In one way or another, all four reports suggest a new WHO international legal agreement ('a treaty'), lending a main argument to the treaty proponents. Advocating for a global convention on pandemics, the RCR-IHR specifies (p.16) that it should support the implementation of the IHR. In May 2021, the IPPPR report invited to adopt the new treaty within 6 months as a complementary instrument to the IHR (p. 47), using the powers under Article 19 of the WHO Constitution. International law experts highlight that 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 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 WHO Constitution. Nor do these reports examine why the IHR are insufficient to address outbreaks of infectious diseases in the future"[86].

Yet, the mounting political pressure in Geneva and in several capitals has taken centre stage in the global health policy arena. Several scholars and civil society representatives have made their nuanced cases for an international treaty[87], inspired by the reports' recommendations or rather pushed by the aspiration of "regulating issues that are currently not" or by the interactions with delegations that seem open to inputs in terms of equity considerations. The development of a competent dialogue around the need for binding rules in global health is one of the positive outcomes of the pandemic treaty proposal, whatever the position on the issue, for the international community that believes in public health. The EU argument for a new instrument — outlined by the EU delegation during the WGPR sessions[88] [89], further specified in a statement in October[90] — 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

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

future threats. A treaty is needed to focus on the new areas that the COVID-19 experience has brought to the fore: 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 possible elements and content of a treaty are preliminarily illustrated in a visual representation[91]:

EUM's initial views on a possible structure & content of a Pandemic Treaty

CHAPEAU — political, addressing overarching issues such as human rights, equity, transparency, strong health systems, UHC, socio-economic safety net, etc.

ACTIONS ON PREVENTION & PREPAREDNESS

Intersectoral whole-of-government approaches; Financing/budgeting preparedness; One Health; Community engagement.

Strengthen implementation of and compliance with the IHR; Continuous data and information sharing and epedemic and pandemic intelligence; Linking preparedness with health system strengthening; Increasing health workforce capabilities to prevent, detect, and respond to health security threats.

ACTIONS ON RESPONSE

A formal declaration of a pandemic could be a trigger to activate these responses

1. Equitable access to countermeasures
2. Data and sample sharing
3. Access to outbreak areas
4. Global assistance to outbreak areas
5. Travel

ADMINISTRATIVE/PROCEDURAL ENABLERS: 1. Funding 2. Governance 3. International coordination mechanism

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 and the fact that funding, governance and international coordination are not clarified in the proposal yet. Financing binding 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 instruments: (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 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

91 Ibidem

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 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) in fulfilling their public health functions[92]. 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 another 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.

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" (comments from three different delegates). "The idea of amending the IHR is a insufficient 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".

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

One of the persons interviewed appears convinced of the claim that 170 countries already support the treaty, and another has expressed confidence that "China will not block the treaty". But in fact feelings are mixed. Officials from the global South do acknowledge the need for considering 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 hardly 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-19 [93].

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 2016 [94] 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 years[95]. 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 a few 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-making[96].

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.

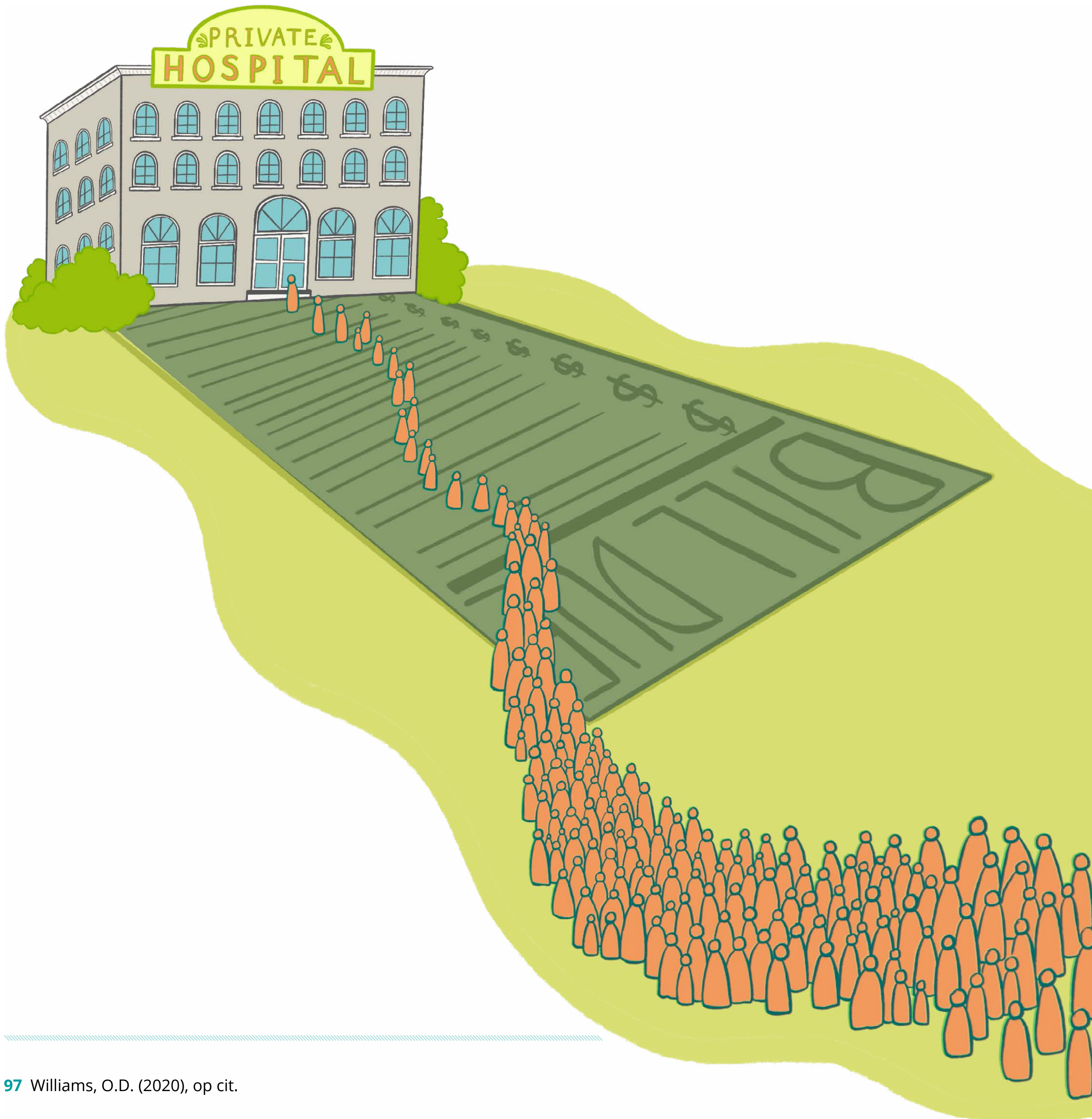
94 Kluge, H., Martín-Moreno, J. M., Emiroglu, N., Rodier, G., Kelley, E., Vujnovic, M., & Permanand, G. (2018). Strengthening global health security by embedding the International Health Regulations requirements into national health systems. BMJ global health, 3(Suppl 1), e000656.

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

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 promotion of private health in the last two decades"[97].

The multilateral approach remains ideologically oriented to leveraging 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. The multilateral path dependency on private players will need to be harshly confronted in the hypothesis of a pandemic treaty.



97 Williams, O.D. (2020), op cit.

AN INTRICACY OF POLITICAL TRIGGERS

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 Bruntland's fortunate determination to embark on a treaty pathway was based on this wealth of evidence.

This research-based, bottom-up process featured by the primary role of international civil society organizations and the voices of communities from the global South was then a key feature of the FCTC, even if this 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 contentious case is the Research and Development (R&D) Treaty, which had been originally proposed in a WHO resolution (WHA61.21)[101], then retrieved by a WHO Consultative Expert Working Group (CEWG)[102] and finally by the UN High Level Panel on Access to Medicines[103]. Notwithstanding its broad consensus, the idea was boycotted (and diplomatically killed) by a

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/.

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

bare handful of European Member States — those which now propose the pandemic treaty — and by the US delegation asserting that the negotiation would be outside of the WHO mandate. Mapping other processes, the same societal effort of competence and engagement led to the 1997 Anti-Personnel Landmines Convention[104], to the creation of the International Criminal Court in 1998 [105] and later to the 2015 Framework Convention on Climate Change[106]. Very different is the genesis of the pandemic treaty now being discussed at the WHO. In essence: the missing societal breadth that usually drives treaty-making, together with the lack of solid evidence about the cogency for a new health emergency instrument, represent so far the weakness of the current initiative. Beyond the rhetoric of saving multilateralism, the proposal's dynamic is top-down and enshrined in a hasty logic of immunity[107]. The EU powerful geopolitical interplay will obviously address the question of political support, garnering appropriate narratives to this end[108]. But this is not a game played in the rooms of the WHO alone.

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

EUROPE'S NEW GEOPOLITICAL ASSERTION ON THE GLOBAL HEALTH ARENA

While the pandemic treaty's chronicles account that Chile was the first proponent of a 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 in 2020, 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 and leveraging a form of 'strategic autonomy' as an influential player in the global scene[109].

The pandemic has also been particularly disruptive in Europe, well beyond Italy's first viral tsunami[110]. It has inflicted several blows. In March 2020, the EU decision to suspend the intransigent rules of the Stability and Growth Pact (SGP), as 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 resilience[111]. To this end, the European Commission communicated a plan for a more integrated European Health

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

Union in November 2020 [112]. 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 domain[114], the EU diplomatic initiative distils from what we could represent as a renewed sense of communal identity. 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 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" group[116] 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

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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.

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.

similar proposals stemming from other fora — for example 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 in the report of the G20 High Level Independent Panel on Financing the Global Commons for Pandemic Preparedness and Response[117].

The EU born idea received the support of other key member states only later in the context of the UK-chaired G7 [118]. The G20 did not endorse the treaty proposal, with the Italian presidency much too busy in negotiating its own proposed Global Health and Finance Board[119], aligned with the Health and Financing Board idea from the IMF[120] (the G20 Board got finally reduced into a G20 Joint Finance-Health Taskforce[121]). It must be said that initially only a few countries from the global Sout openly supported the treaty as friends: Indonesia, Thailand, South Korea (Asia), Tunisia, Senegal, Rwanda, South-Africa (Africa), and Chile (Latin-America). But the complexion of support to the treaty changed in a matter of months; Europe's ambitious political grounds to continue pushing for this route[122] achieved the result of more than 100 countries supporting the decision of a special session of the World Health Assembly dedicated to the pandemic treaty discussion.

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.

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.

122 https://ecfr.eu/special/power-atlas/health/

A WINNING AGENDA FOR THE WHO DIRECTOR GENERAL

Since the very initial conversations on the idea of a pandemic treaty Dr Tedros has been a fervent preacher of this 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 amid an institutional and personal COVID-19 related legitimacy crisis.

Quite a few respondents in this research observed that it is unusual for a Director General of a UN organisation to single-handedly jump on the development of a treaty supported by a 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. In fact, this precedent has been set by Gro Harlem Bruntland, 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 towards the binding instrument in the WHO, setting the organization in motion for Member States to gradually support the idea of an international convention in this arena. But 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 1993 [123]. The COVID-19 emergency now requires exceptional measures and rapid proposals. Respondents from the global South have commented that by placing

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

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 more so because the treaty proposal looks deprived of convincing evidence, in the face of reality. The WHO DG should support the joint efforts by all of 194 Member States".

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. One African diplomat noted that "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." Similar feelings loom in other diplomatic areas: "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 one 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"[124].

"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); "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".

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

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[125]. "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, access to COVID-19 countermeasures is a key driver for engaging in these discussions, in a landscape of ongoing vaccine apartheid. While many health-care workers are left to die in the global South without protections[126], governments need to demonstrate they are doing all they can in the spirit of multilateral health cooperation to overcome the global health inequity that COVID-19 has entrenched further. 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 compensation[127].

The paper espouses equity in an inspiringly touted agenda, but this promise collides with the enduring inequitable vaccine distribution: "a catastrophic moral failure" to use Dr Tedros's words[128], and a grotesque

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

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

127 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 in 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

representation of enduring global failure, as the report is being written.

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)"[129].

Additional expectations are raised, linked to what policymaking and civil society respondents define 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[130].

128 https://news.un.org/en/story/2021/03/1087992

129 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.

130 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) 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)[131]. Many countries have adopted the hard law regime of the Nagoya Protocol[132]. 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 "bilateral, transactional nature" [133].

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, 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 mean 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

131 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

132 https://www.cbd.int/abs/doc/protocol/nagoya-protocol-en.pdf

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

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 Latin American diplomat explains, suggesting the need for a legal structure that governs the roles and responsibilities of private actors. For pharmaceutical companies, monetising information 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" a global health law scholar from the south said. 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.

EUROPE'S ROAD TO IMMUNO-POLITICS IN THE NEW PANDEMIC ERA

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) were scheduled to overlap. The emergence of the Omicron, a new variant of SARS-CoV-2 upended the plans for the Ministerial which had to be postponed just days before it was scheduled to begin. Trade negotiators from the North and the South were unable to travel to Geneva.

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 Agreement[134], 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 pandemic[135]. 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 have failed to get support from WTO members citing lack of consensus on the waiver proposal. The EU talks the negotiation talk, in its own terms, but stubbornly refuses to walk the

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

135 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.

waiver walk, having somewhat imposed the same position on G20 countries[136]. The opponents of the TRIPS waiver have been inclined towards the WTO DG's 'the third way' approach: this avoids the suspensions of IP rights, but encourages voluntary licensing to manufacture drugs 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 countries[137] — 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)[138]. Much of the variations in infection and death trends is due to this 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)[139].

Development of COVID-19 vaccines and other therapeutics have been accelerated by considerable government financing[140]; six major vaccine developers received over USD$12 billion in public funding[141]. Revenues from their IP monopolies will exceed tens of billions[142]. 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, only four companies produce the plastic bioreactor bags needed to make vaccines under time pressure and on a global scale[143].

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"[144]. 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"[145].

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

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

138 https://ourworldindata.org/covid-vaccinations.

139 https://www.bbc.com/news/world-europe-59358074.

140 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

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

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

143 https://mattstoller.substack.com/p/why-are-there-shortages-of-plastic.

144 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

145 https://www.consilium.europa.eu/en/policies/coronavirus/pandemic-treaty/.

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 mechanisms[146], 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 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 policy official 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 pushed 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, more powerful than ever before.

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[147] [148].

146 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.

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

148 https://www.gavi.org/vaccineswork/intellectual-property-and-covid-19-vaccines

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 defined[149]. 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"[150]. 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 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 examined[151] and globally displayed with COVAX[152]. But the EU and the G20 only focus on ACT-A and reiterate support to all its pillars[153], making all possible efforts to make them appear efficient solutions.

Based on this research's findings and the emerging proposals from rich countries in the context of the treaty discussions, there is a concerted effort to institutionalise mechanisms such as the ACT Accelerator and the COVAX Facility. This directly impinges on WHO Member States' ability to exercise oversight, since these mechanisms are outside of the purview of WHO governing bodies.

It is a plausible working hypothesis that one of the pandemic treaty's remits may be the permanent establishment of entities like ACT-A and COVAX inside the WHO operational framework. 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 when closing the 74th WHA. On the other, a few powerful non-state actors traditionally opposed to binding arrangements have curiously 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). IFPMA believes that the discussions around a possible pandemic treaty "need to take into account the important role played by the innovative biopharmaceutical industry and its supply chain in fighting the virus".

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

150 Ibidem

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

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

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

Also, as 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 COVAX*[154].

The EU strategy (supported by the UK and Switzerland) is sophisticated, but it risks to inflict a number of serious wounds to the current fragile setting of intergovernmental action, both at the WTO and WHO. At the WTO, the European Commission's hazardous resistance to what the majority of WTO Member States have demanded for months now, without concessions despite pro-waiver support by global experts, Nobel laureates and the broad institutional consensus[155], risks to jeopardize negotiations in other trade sectors and prospectively the functioning of the very trade organization. At the WHO, the forced rush to the pandemic treaty, once the initial euphoria for the "historic moment"[156] has decanted, 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 board in the new negotiating route towards future pandemic preparedness and response. The potential legitimation 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.

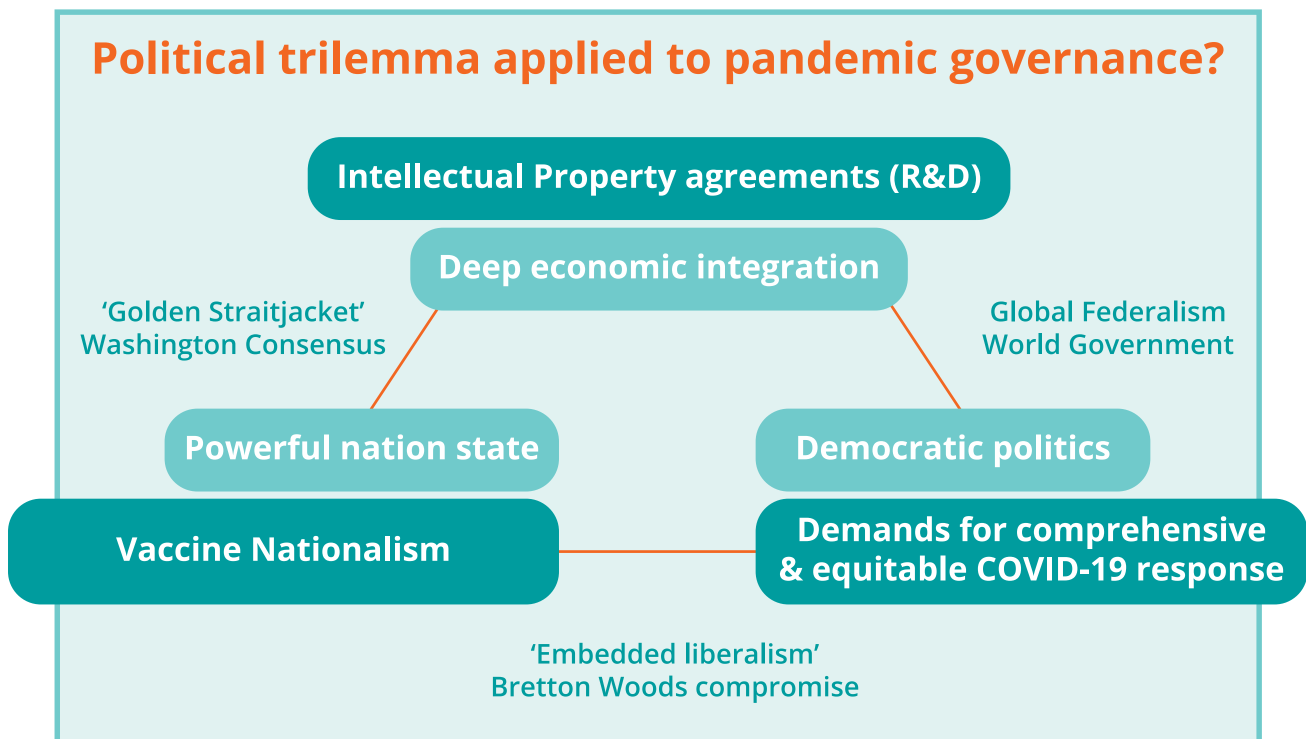
154 https://www.ifpma.org/wp-content/uploads/2021/03/IFPMA_Statement_International_Pandemic_Treaty_30March2021.pdf.

155 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.

156 https://www.consilium.europa.eu/en/policies/coronavirus/pandemic-treaty/

DISCUSSION: THE POLITICAL TRILEMMA OF THE PANDEMIC TREATY

The treaty proposal has an aspiration: "bring countries together, to dispel the temptations of isolationism and nationalism". The commitment to a treaty should be guided by "solidarity, fairness, transparency, inclusiveness and equity"[157]. Looking at these principles through the lenses of Rodrik's political trilemma seems promising; countries proclaim that they are willing to cooperate and share some form of sovereignty to prepare for and respond to pandemic risks. By sharing their responsibility in an inclusive and rights-based manner with multiple concerned actors, and with several financing options available, it should be possible to respond in a democratic legitimate way to the existential risks of globalization.



Source: Rodrik, The Globalization Paradox, 2011

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

But can and will this trilemma realistically be resolved in this manner? Can developing countries truly cherish the confidence that richer nations will take the responsibility to share what is needed to enable access to global public goods? The chronicles of two years in the current pandemic, with wealthier countries' insistence on vaccine nationalism and continued reluctance (particularly, but not exclusively the EU) to adopt a measure of international law such as the temporary suspension of monopoly intellectual property regimes, does mitigate expectations considerably. Most of our research participants have expressed this mood of disenchantment, or rather preventive scepticism, towards the treaty idea and how it is politically framed. The enterprising push for the pandemic treaty, for quite a few of them, is regarded as a distraction from the failure of global governance in managing COVID-19: "at least on the surface it appears that states in the global North are doing something".

This analysis is confirmed by other reports and studies, not easily seduced by the cosmopolitan ideals enumerated in the pandemic governance instrument[158]. Meaningful evidence exists that the explicit political quest for democratic cooperation on responding to public health threats by those very governments that implicitly advance the hegemony of neoliberal values in its tendency to depoliticize causes of ill health and solutions to health inequalities is a hardwired challenge. No indication exists that this pandemic treaty would project a different scenario, or mark an exception, as of now. For the pandemic treaty to gain political legitimacy it would be relevant to urge political leaders to regain control of globalization in response to COVID-19 by regulating the production and financial markets and reshaping the international trade system, to go beyond the global value chains[159]. Globalization was about to start, when the UN had in mind the establishment of a New International Economic Order in 1974 [160], the ground for the solidary and cooperation expressed in WHO's Alma Ata Declaration on Primary Health Care (1978)[161]. After decades of trade liberalization and free riding capitals markets, the only way to prevent the failure of pandemics is to address the deadly vitality of today's globalized capitalism.

1 ADVANCING THE IHRS: AN ALTERNATIVE TO THE NEW PANDEMIC TREATY PATHWAY?

The substance and implementation of the IHRs 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

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

159 https://rodrik.typepad.com/dani_rodriks_weblog/2007/06/the-inescapable.html

160 https://digitallibrary.un.org/record/218450

161 https://www.who.int/publications/i/item/declaration-of-alma-ata

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 treaty[162]. Another approach could be a "universal periodic review" mechanism including peer-reviews, reports by special rapporteurs, experts, and civil society[163].

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. COVID-19 indicates, among other things, a human rights crisis[164]. 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'[165] , 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

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

163 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.

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

165 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/h?f1=author&as=1&sf=title&so=a&rm=&m1=p&p1=UN.+Committee+on+Economic%2C+Social+and+Cultural+Rights&ln=en

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 negotiation[166] and the new draft Convention on the Right to Development[167] 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 externalities 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 global South[168]. 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 Development[169] 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, and environmental health, beyond the restricted surveillance approach.

166 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.

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

168 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/.

169 https://www.ohchr.org/en/professionalinterest/pages/righttodevelopment.aspx

4 UNTANGLE THE ECONOMIC AND FINANCIAL KNOTS TO AVOID FUTURE 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 support[170]. 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 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 socioeconomic pandemics that the variants of fiscal policies promise to prolong?

Every year, countries are losing a total of USD $483 billion in tax to global tax abuse committed by multinational corporations and wealthy individuals — enough to fully vaccinate the global population against Covid-19 more than three times over[171]. Every year, multinational corporations are shifting US$1.19 trillion worth of profit into tax havens, causing governments around the world to lose USD $312 billion annually in direct tax revenue[172]. 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 decade[173], 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 USD $40 billion, USD $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.

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

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

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

173 https://www.imf.org/external/pubs/ft/fandd/2020/09/debt-pandemic-reinhart-rogoff-bulow-trebesch.htm.

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"[174]. 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 disease spillovers, as deforestation increases globally[175] and global ice loss is catching up to worst-case scenario predictions[176].

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 Agenda[177] 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 has provided important recommendations in this arena to governments and multilateral organisations (including the WB and IMF)[178] directing Member States' focus on the malignant diseases of the financial system to respond to health needs. Not even the proposed creation of a sustainable finance mechanism[179] for a USD $10 billion global pandemic preparedness facility and a USD $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.

174 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.n287.

175 https://www.un.org/en/desa/global-forest-goals-report-2021

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

177 https://uploads-ssl.webflow.com/5e0bd9edab846816e263d633/602e91032a209d0601ed4a2c_FACTI_Panel_Report.pdf.

178 https://cdn.who.int/media/docs/default-source/council-on-the-economics-of-health-for-all/who_councileh4a_councilbrieffinal-no2.pdf?sfvrsn=bd61dcfe_5&download=true

179 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/.

CONCLUSIONS

Since its inception, COVID-19 has shown our false certainties and the inability of the international community to work together. Despite being inter-connected, the extreme fragmentation of global health governance has made overcoming common threats an almost unsurmountable challenge. On the other hand, economic growth is no longer productive. It has become instead a cancerous proliferation disrupting the social organism and causing ecological catastrophes. 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, worsened by COVID-19.

In 2020, with the establishment of the ACT-Accelerator, the international community made the consequential decision to entrust the overall organizational setup and the operational management of the first viral pandemic in human history to public and private partnerships, de facto private foundations based on Western forms of knowledge and authority. This marks a new step towards the privatization of global health rights. In 2021, the concern of many civil society organizations is that the pandemic treaty conceptualization may purposely build on the WHO joining efforts with these hyper multistakeholder entities to open the path for shaping international law through the inclusion and involvement of corporate actors, in their metamorphic disguise (corporate and philanthropic). This is probably the scenario that some scholars have in mind when advocating that "everybody should be in from the very beginning"[180]. And this is what the proponents of the pandemic treaty have in mind probably 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"[181].

Earth's ferocious counter-attack in the form of an invisible pathogen, the produce of what Cameroonian philosopher Achille Mbembe calls the longstanding practice of necropolitics[182] in a world consumed by the desire of apartheid, and the Korean philosopher Byung-Chul Han defines the death drive of capitalism[183], provides the cogent opening for a paradigmatic change. The maquillage of the current system will not serve the purpose. Let's not waste this global health crisis in reductionism.

180 Pereira Da Silva Gama C.F. (2021). op. cit. p.5.

181 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.

182 Mbembe, A., (2019). Necropolitics. October 2019. Duke University Press.

183 Byung-Chul, H., (2021), Capitalism and the death drive. August 2021. Wiley.

ABOUT G2H2

The Geneva Global Health Hub (G2H2) is a membership-based association created in Geneva in 2016 to provide a space and enable civil society to meet, share knowledge and create initiatives to advocate for more democratic global health governance.

The Geneva Global Health Hub is a civil society project. The values that guide and drive our work are belief in democracy with equity in diversity; dignity; accountability and transparency; and ethics and justice. Join us, engage, and help us building a strong civil society space in Geneva for more democratic global health.

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