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### **The Proposed Pandemic Treaty and the Challenge of the South for a Robust Diplomacy**

*By Obijiofor Aginam*

The motivation for a pandemic treaty is infallible because of the ‘globalization of public health’ in a rapidly evolving interdependence of nations, societies, and peoples. Notwithstanding the lofty purposes of the proposed pandemic treaty as a tool for effective cooperation by member-states of the WHO to address emerging and re-emerging disease pandemics in an inter-dependent world, the proposal nonetheless raises some structural and procedural conundrums for the Global South. The negotiation of a pandemic treaty should, as a matter of necessity, take into account the asymmetries of World Health Organization member-states and the interests of the Global South.

#### **Overview of the Issues**

As COVID-19 ravages the world with over 160 million confirmed cases and 3 million deaths globally,<sup>1</sup> every country, from the highly industrialized to the Low- and Middle-income Countries, is now grappling with the health, social, and economic costs of the pandemic. In all regions, countries have implemented strict lockdowns, travel restrictions, and public health practices ranging from hand washing to masking in public places, contact tracing, and physical and social distancing since the World Health Organization (WHO) declared COVID-19 a pandemic that constitutes a “public health emergency of international concern” over a year ago. With the record production and approval of vaccines with scientifically proven efficacy against the virus, vaccine hesitancy, vaccine nationalism and protectionism have impeded the roll-out of vaccines in many countries. In a widely published commentary on 31 March 2021, twenty-five heads of government and international agencies issued a joint call for a global pandemic treaty.<sup>2</sup> As

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<sup>1</sup> World Health Organization, “Numbers at a glance”. Available from <https://www.who.int/emergencies/diseases/novel-coronavirus-2019>.

<sup>2</sup> The commentary has been signed by J. V. **Bainimarama**, Prime Minister of Fiji; Prayut **Chan-o-cha**, Prime Minister of Thailand; António Luís Santos da **Costa**, Prime Minister of Portugal; Mario **Draghi**, Prime Minister of Italy; Klaus **Iohannis**, President of Romania; Boris **Johnson**, Prime Minister of the United Kingdom; Paul **Kagame**, President of Rwanda; Uhuru **Kenyatta**, President of Kenya; Emmanuel **Macron**, President of France; Angela **Merkel**, Chancellor of Germany; Charles **Michel**, President of the European Council; Kyriakos **Mitsotakis**, Prime Minister of Greece; **Moon** Jae-in, President of the Republic of Korea; Sebastián **Piñera**, President of Chile; Andrej **Plenković**, Prime Minister of Croatia; Carlos Alvarado **Quesada**, President of Costa Rica; Edi **Rama**, Prime Minister of Albania; Cyril **Ramaphosa**, President of South Africa; Keith **Rowley**, Prime Minister of Trinidad and Tobago; Mark **Rutte**, Prime Minister of the Netherlands; Kais **Saied**, President of Tunisia; Macky **Sall**, President of Senegal;

observed by these leaders, “there will be other pandemics and other major health emergencies. No single government or multilateral agency can address this threat alone. ... The question is not if, but when. Together, we must be better prepared to predict, prevent, detect, assess and effectively respond to pandemics in a highly coordinated fashion. The COVID-19 pandemic has been a stark and painful reminder that nobody is safe until everyone is safe.”

### **The ‘Globalization of Public Health’**

The motivation for a pandemic treaty is infallible because of the ‘globalization of public health’ in a rapidly evolving interdependence of nations, societies, and peoples. From an infectious disease perspective, it is now almost universally accepted that pathogenic microbes do not carry national passports neither do they respect the geo-political boundaries of sovereign nation-states. As the past Director-General of the World Health Organization, Gro Harlem Brundtland, observed, “in an interconnected world, bacteria and viruses travel almost as fast as e-mail and financial flows”. With globalization, “a single microbial sea washes all of humankind. There are no health sanctuaries. The separation between domestic and international health problems is no longer useful.” The observation by the world leaders that “the question is not if, but when” the next pandemic will emerge strongly re-echoes the crisis of emerging and re-emerging infectious diseases first defined by WHO in the late 1990s as newly emerging diseases or the re-appearance of a known disease after a significant decline “whose incidence in humans has increased in the past two decades”. As William McNeill provocatively argued in *Plagues and Peoples*, “infectious diseases which antedated the emergence of humankind, will last as long as humanity itself and will surely remain as one of the fundamental determinants of human history”. From an enlightened self-interest perspective, and globalization of public health paradigm, the ‘norm entrepreneurs’ for a pandemic treaty are right to state that “the COVID-19 pandemic has been a stark and painful reminder that nobody is safe until everyone is safe”.

### **Three Conundrums for the Global South**

Notwithstanding the lofty purposes of the proposed pandemic treaty as a tool for effective cooperation by member-states of the WHO to address emerging and re-emerging disease pandemics in an inter-dependent world, the proposal nonetheless raises some structural and procedural conundrums for the Global South. First is the **capacity conundrum**, a perennial and structural impediment in an asymmetrical international system. If there is one hard lesson from the negotiation of multilateral treaties and regulatory frameworks in the 1990s including health related agreements under the auspices of the World Trade Organization (WTO) like the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS), Agreement on the Application of Sanitary and Phyto-Sanitary Measures (SPS), General Agreement on Trade in Services (GATS), Agreement on Technical Barriers to Trade (TBT), and treaties on climate change, disarmament and arms control, migration, and many others, it is the fact that most of the Global South lacked the capacity to effectively negotiate these treaties as equal partners with the industrialized countries of the Global North. **Capacity conundrum** is manifest both in the diminutive size of delegates of developing and least-developed countries in treaty negotiating forums, and the relative lack of expertise and technical knowledge by these delegates vis-a-vis those of the industrialized countries.

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Pedro **Sánchez**, Prime Minister of Spain; Erna **Solberg**, Prime Minister of Norway; Aleksandar **Vučić**, President of Serbia; Joko **Widodo**, President of Indonesia; Volodymyr **Zelensky**, President of Ukraine; **Dr Tedros** Adhanom Ghebreyesus, Director-General of the World Health Organization.

Second is the ***policy disconnect conundrum***, the paradigm that health being “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” should be at the core of sustainable development. To achieve this, states must pursue a carefully planned strategy of coherence between health and other sectors to ensure that trade, economic and investment objectives and policies do not undermine public health. This was apparent in the Uruguay Round of Trade negotiations leading to the establishment of the WTO in 1995 where most of the Global South woefully failed to pursue coherence between their trade policies and health objectives. It took six years of sustained activism by the Global South supported by civil society alliances, from 1995 to 2001, to achieve the Doha Declaration on TRIPS and Public Health.<sup>3</sup> If the proposed pandemic treaty, as expected, includes intellectual property rights (patent) protection for vaccines, and the vexed issue of Research and Development to incentivize the private sector, how prepared is the Global South to negotiate these issues with industrialized countries whose positions are mostly influenced by corporate lobby.

Third is the ***international regulatory and governance misalignment conundrum***, a practice where regulatory frameworks operate in silos within the autonomy of respective treaties signed and ratified by individual states. The implication of this is that, under the auspices of the WHO, the Global South will negotiate a pandemic treaty that is either misaligned or completely non-aligned with their positions under pre-existing treaties like the *Nagoya Protocol on Access to Genetic Resources and the Fair and Equitable Sharing of Benefits Arising from their Utilization to the Convention on Biological Diversity*.<sup>4</sup> The Nagoya Protocol provides for access and benefit sharing of genetic resources including the genetic sequence information of pathogens. To align the proposed pandemic treaty with existing treaties like The Nagoya Protocol and related treaty regimes on human rights, the sharing of pathogenic samples, and benefit-sharing of scientific and biomedical inventions and innovations resulting from such samples should serve all of humanity to ensure the “attainment by ***all peoples*** of the highest possible level of health”.

## **Overview of the Legal Powers of WHO**

The idea of a pandemic treaty is not entirely new in global health governance. Pursuant to the relevant provisions of its Constitution (Articles 19-22), WHO has the authority to negotiate treaties, conventions, and regulations on global health matters. WHO has negotiated a treaty only once since its establishment in 1948 – the Framework Convention on Tobacco Control (FCTC) (adopted under Article 19 of its Constitution and came into force in 2005). On infectious diseases, pursuant to its legal powers under Articles 21 and 22, the World Health Assembly (WHO’s highest policy making organ) adopted the current International Health Regulations (IHR 2005) in 2005. The purpose and scope of the IHR “are to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade”. While seeking to maintain a delicate balance between international control of disease, and minimal interference with trade and travel, the IHR 2005 makes detailed provisions for the maintenance of core disease surveillance capacities in the ports of entry (seaports and airports) of WHO member states and the establishment of The Emergency Committee on whose advice and recommendation the WHO Director General would make a determination whether an “event constitutes a public health emergency of international concern”.

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<sup>3</sup> World Trade Organization, *Declaration on the TRIPS agreement and public health*, Adopted on 14 November 2001. Available from [https://www.wto.org/english/thewto\\_e/minist\\_e/min01\\_e/mindecl\\_trips\\_e.htm](https://www.wto.org/english/thewto_e/minist_e/min01_e/mindecl_trips_e.htm).

<sup>4</sup> See <https://www.cbd.int/abs/>.

WHO is an inter-governmental organization of 194 diverse member-states. The negotiation of a pandemic treaty should, as a matter of necessity, take into account the asymmetries of its member-states and the interests of the Global South. Often, most of the Global South is marginalized in multilateral negotiations. As with most global crises, especially pandemics in recorded history, COVID-19 has shattered the bonds of our shared humanity. To reconstruct these bonds, the legal and regulatory mechanisms, diplomatic and political processes deployed for the negotiation of a pandemic treaty should strive to build trust in the relations of nations and peoples, and strive to deliver the dividends of good health to vulnerable populations in the Global South. These challenges are compelling factors to assess the legal and political mechanisms and processes that anchor the pandemic treaty negotiations by WHO member-states. To be legitimate, the negotiations should be guided by the principles enunciated in the WHO Constitution, most importantly the principle that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of **every** human being without distinction of race, religion, political belief, economic or social condition”, and the objective of WHO – “the attainment by **all peoples** of the highest possible level of health”.

### **Building the Capacity of the South**

Based on lessons from the negotiation of trade-related health treaties in the 1990s where the voices and strategic interests of the Global South were relegated to the peripheries, a pandemic treaty in an interdependent and globalized world should be anchored on the pillars of “enlightened self-interest”. The fundamental purpose of the treaty must match the expectations of the vulnerable constituents of the global village: those that are often and easily left behind during pandemics and related crisis. To address the three conundrums highlighted in this Opinion, pro-Global South think tanks and epistemic institutions led by the Geneva-based South Centre should urgently put in place measures aimed at (i) building the capacities of Low- and Middle-Income member-states of WHO towards understanding the complex issues to be negotiated as part of the pandemic treaty; (ii) developing the necessary policy coherence between health and other sectors including boosting the capacity of Ministries of Health to become effective in health and trade diplomacy; (iii) guiding and supporting the delegations from the Global South throughout the negotiations in Geneva; (iv) building a comparative advantage from existing treaties that are promotive and supportive of the interests of the Global South; and (v) devising measures to counter corporate and commercial interests in the negotiations especially with respect to benefit-sharing arrangements related to biomedical innovations from shared pathogens.

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