Proposal for a WHO treaty on pandemics raises concerns

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Proposal for a WHO treaty on pandemics raises concerns

The move to launch negotiations on a global instrument on pandemic preparedness and response at the 74th session of the World Health Assembly (WHA) triggered concerns. The European Union-led earlier version of the draft decision circulated by the "Friends of the Pandemic Treaty" was subsequently pushed back and this resulted in a new text. The WHA in May 2021 ended up adopted a decision that proposes a special session of the Assembly to decide on the launch of such negotiations.

Operative Paragraph 1 (OP1) of the decision requires *"the Member States Working Group on Strengthening WHO Preparedness and Response to Health Emergencies 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".*

The earlier draft decision circulated by the Friend of the Pandemic Treaty sought to establish an Inter-Governmental Meeting to initiate negotiations. The decision that was adopted requests the Member States Working Group to assess the benefits of a WHO Convention or agreement or other international instrument on pandemic preparedness and response.

Further, OP 2 requests the WHO Director-General to convene a special WHA session in November 2021*,* with only that one agenda *"with a view towards the establishment of an intergovernmental process to draft and negotiate such convention, agreement or other international instrument on pandemic preparedness and response".* Thus, the Member States Working Group is expected to make a recommendation on the future course of action with regard to the proposed treaty.

The first meeting of the Working Group is required to "*consider the findings and recommendations of the Independent Panel for Pandemic Preparedness and Response (IPPPR), the IHR Review Committee* on the Functioning of the International Health Regulations 2005 during the COVID-19 Response *(IRC 2021) and the Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme (IOAC 2021) taking into account WHA Resolution 73.1 and the decision of the Executive Board (EB(148)12 2020) and to submit a report with proposed*

actions for WHO, Member States, and non-State actors, as appropriate for the consideration of 75th Session of WHA".

The bias towards a new pandemic instrument over the International Health Regulations (IHR), the existing legal instrument, is visible even from the title of the Decision text, which conspicuously excludes the IHR. The text requires Member States to specifically consider *"developing a WHO convention, agreement or other international instrument on pandemic preparedness and response".*

Following the adoption of WHA Resolution 73.1 in 2020, the WHO had initiated three committees/panels to study the functioning of the WHO and the international health response to COVID-19 viz. the IRC 2021, the IOAC 2021, and the IPPPR. Their recommendations, which are available in the public domain, also indicate a preference for a new international instrument on pandemic preparedness and response. However, before these findings and recommendations could be discussed by Member States, the WHA decision has pre-emptively proposed a solution, i.e. a new international instrument is to be drafted and adopted.

The informal negotiations on the earlier draft decision had started on 10 May 2021, ignoring the fact that developing countries and Least Developed Countries are battling new waves of COVID-19 cases. These countries are not in a position to effectively participate in the negotiations. The United States, Russia, and Brazil had tried to stall the EU-led proposal and negotiations, although they had expressed interest in the discussion at a later stage after examining the various committee reports. This led to the new decision text that then obtained the backing of the U.S. as well.

This Policy Brief critically analyses the option of a new pandemic treaty or other international legal instrument to enhance the pandemic preparedness and response. Part I provides an account of the origin of the idea of the pandemic treaty. Part II examines whether there is any legal vacuum which prevents the needed pandemic preparedness and response. Part III deals with the fragmentation of international health response and raises the concern that the new treaty will exacerbate fragmentation instead of consolidating the response. Part IV explains what to expect from the new treaty and the major process-related issues involved in the new pandemic treaty negotiations. This Policy Brief argues that instead of developing a new international instrument it is better to strengthen or amend the existing IHR.

Part I

Calls for a global pandemic treaty

The proposal for a new treaty on pandemics was first mooted by the President of the European Commission, Mr. Charles Michel, at the Paris Peace Forum in November 2020. Later, the statement of the Group of 7 leaders on 19 February 2021 called for exploring a "global health treaty" while the EU Council went further by voicing its commitment to work on an international treaty on pandemics within the WHO framework.

Although during the initial discussion, EC President Michel did not mention WHO, indicating the negotiations may be located outside the WHO, by February 2021 the EU had explicitly referenced the WHO, which means reliance on Article 19 of the WHO Constitution. On 30 March, EC President Michel and Dr. Tedros Ghebreyesus, the Director-General of WHO, proposed a new international treaty for pandemic preparedness and response at a joint press conference calling for a robust global health architecture.

According to Dr. Tedros, the new treaty would provide a framework for key issues such as:

- building resilience to pandemics and other global health emergencies, with robust national and global preparedness systems;
- ensuring timely and equitable access to pandemic countermeasures, including vaccines; supporting sustainable funding and capacity for prevention, detection, and responses to outbreaks; and
- promoting mutual trust.

According to the EU policy statement, the following are the priority areas:

- *better surveillance:* through increased laboratory capacities, global collaboration of the research centres, and increased funding for International Health Regulations capacity building;
- *better alert mechanisms*: through introducing more levels of alerts leading to Public Health Emergency of International Concern and Pandemic Declarations on a later stage;
- *better response*: through global co-ordination of the stockpiling of essential supplies, medicines and equipment, deployment of international medical teams on the ground, and globally co-ordinated research and innovation;

- *better implementation*: through robust country reporting mechanisms, joint-external evaluation and follow-ups.

In addition, there are references to goals such as equitable access, shared responsibility, accountability and transparency, without clear plans as to what could be the implementing provisions that can realize these goals. It is important to recall that even before the submission of the final reports of the review process set up under WHA73.1, the advocacy for a new treaty had already started. Later, the reports of IRC 2021, IOAC 2021 and IPPPR as well echoed this call for a new treaty. The proponents, without clearly articulating the need for a treaty such as whether there is a legal vacuum, or whether there was a breakdown of global coordination under the IHR (owing to certain other reasons), have pushed ahead with a highly visible political agenda.

Part II

Is there a legal vacuum on pandemic preparedness and response?

Neither the Friends of the Pandemic Treaty nor the committees and the panel mentioned above have clearly articulated what is the legal vacuum, if any, which slows down the international health response against the COVID-19 pandemic. A new treaty is usually proposed to address a lack of a legal mandate, if any. On the contrary, there exists a clear legal and constitutional mandate for the WHO to respond to pandemics, and to coordinate the actions of its Member States and relevant stakeholders, including other international organisations.

Article 2(g) of the WHO Constitution mandates the Organization *"to stimulate and advance work to eradicate epidemic, endemic and other disease"* as one of its important functions. The standard set by Article 1 of the WHO Constitution expands the scope of the stimulation and work that may be undertaken under Article 2. It encompasses all that can be done in furtherance of the objective of the WHO enshrined under Article 1, i.e. *"the attainment by all peoples of the highest possible level of health."*

Furthermore, all the above-mentioned priority areas listed by the WHO DG and the EU are well within the scope of the IHR 2005 – a specific set of regulations adopted under Article 21 of the WHO Constitution to prevent the international spread of disease, for action by the WHO and its Member States. IHR 2005 that replaced IHR 1969 was adopted through a WHA resolution in 2005, and came into force in 2007.

The IHR primarily creates an obligation on the WHO Member States to inform on *"all events which may constitute a public health emergency of international concern (PHEIC) within its territory".* The scope of authority accorded to WHO under the IHR is wide enough to enable the Organization to contact subnational entities, determine and declare PHEIC without state concurrence, make temporary or standing recommendations, review additional health measures taken unilaterally by states and also to settle disputes, if any, through multi-stage dispute settlement process. The IHR, most importantly, provides a mandate to the WHO DG to make an assessment of the reported event and take a decision on declaring it as PHIEC. The term used in the IHR is PHEIC and not pandemic.

The genesis and set-up of the IHR have over the years raised concerns among developing countries at the WHO because historically the substantial part of

international health law was aimed to protect the colonial powers from the infectious diseases from colonies, without undertaking any legal commitment to help the populations facing the infections in the South. But these regulations nevertheless are an existing legal tool that can be reformed, if needed, to better deal with pandemic preparedness and response.

One of the important shortcomings of IHR 2005 from a developing country perspective is the lack of clarity and detailing of legal obligations in the document. For example, provisions such as Article 44 obligates the WHO and other parties to offer assistance to affected countries. But it does not explain the nature and scope of assistance. There are no effective plans or pre-drawn schemes under which assistance will be provided. Similarly, there are provisions on technical and financial assistance as well in the IHR. But there is no guidance as to the nature of financial assistance or flow of technical knowledge from one Member State to another. As a result, the IHR in practice ends up as an instrument that creates a one-way obligation to inform about a potential PHEIC to the international community without any corresponding assurance on assistance.

The IRC 2021 believes that there are issues "that are not addressed by the IHR" and these can include in the new treaty for global preparedness and response (Recommendation 5 of Area of Work 3.10). Examples provided are for: (1) the rapid and timely sharing of pathogens, specimens and genome sequence information for surveillance and the public health response, including for the development of effective countermeasures; (2) equitable access globally to benefits arising from sharing the above; (3) rapid deployment of a WHO team for early investigation and response; (4) maintaining the global supply chain; and (5) prevention and management of zoonotic risks as part of a One Health approach.

This Policy Brief contends that Article 44 read with Articles 14, 46 and 57 of the IHR 2005 positively provides the legal mandate for the WHO and its Member States to take actions implementing almost all the above. However, the details of those obligations need to be set out.

For instance, Article 46 of IHR obligates the State Parties, subject to the national law and international guidelines, to *"facilitate the transport, entry, exit, processing and disposal of biological substances and diagnostic specimens, reagents and other diagnostic materials for verification and public health response purposes under these Regulations".* This Article read with 44 could be clarified to facilitate *"for the rapid and timely sharing of pathogens, specimens and genome sequence information for surveillance and the public health response, including for the development of effective countermeasures"* without compromising the norms for access and benefit sharing under the Convention on Biological Diversity and its Nagoya Protocol. In other words, an Annex to this Article can create a framework for accessing pathogens with corresponding obligations to share the benefits. A framework in line with the WHO's Pandemic Influenza Preparedness Framework for the sharing of influenza

viruses and access to vaccines and other benefits could be developed to give effect to Article 46. Similarly, the issue of global supply chain could be addressed through amending Annex 1 and /or Article 44.

A co-ordinated effort between the Food and Agricultural Organization (FAO) and the World Organization for Animal Health (OIE) to effectively prevent and manage zoonotic risks is very well within the ambit of Article 14 (1) of the IHR 2005 read with Articles 33, 70 and 72 of the WHO Constitution. While Article 14(1) is discretionary, Article 14(2) mandates WHO to coordinate, in cases where notification, verification and response to a manifestation of disease is primarily within the competence of other intergovernmental organizations or international bodies. It must be noted that an already existing agreement between the FAO and the WHO allows the two organizations to convene joint committees as well as joint missions on any question of common interest (see Article III and IV of the agreement). Similarly, Article 4 of the 2010 amended agreement between OIE and WHO provides for detailed means of collaboration between them under Article 4 of the agreement.

The obligations of the WHO and its Member States under IHR Article 44 is not merely to "co-ordinate" in these affairs but also to "assist", "co-operate", "facilitate" and "support" each other. It is important to note that while Member State obligations are qualified with the phrase "to the extent possible", **WHO's obligations under Article 44 also have such qualification**. Interestingly the subjectiveness of this clause "to the extent possible", which was introduced to demarcate the differentiated responsibilities of the low- and middle-income countries, has been used by the developed states to avoid specific obligations.

The Intergovernmental Working Group on Revision of the International Health Regulations in the *Review and Approval of Proposed Amendments to the International Health Regulations: Explanatory Notes* (2004) had highlighted this aspect of collaboration and assistance (Paragraph 15). The *Stellenbosch Consensus* of public international law scholars with its focus on global health also provides a systematic study of the application of Article 44, but fails to recognize the imperativeness of "assistance" by the WHO under the provision.

Apart from these provisions, IHR 2005 also has provisions for settling disputes or eliminating the inconsistencies in the interpretation or application of IHR amongst the State Parties, and between State Parties and the WHO. Article 56(5) has one of the unique models of dispute settlement clauses, enabling an international organisation to directly enter into contentious dispute with a State Party(s).

Article 43 further gives powers to WHO to independently review the actions or additional measures adopted by State Parties "which significantly interfere with international traffic" (refusal of entry or departure of international travellers, baggage, cargo, containers, conveyances, goods, and the like, or their delay, for more than 24 hours).

While Article 56 has not been invoked once, the IRC 2021, with regard to Article 43[1] states that *"WHO may ask countries to reconsider measures based on information received, but there is no obligation for WHO to do so, there is no clarity on what would constitute a justifiable measure, and there is no mechanism to empower WHO to hold countries to account for measures deemed unjustified"* (Paragraph 86).

The Committee was informed that WHO has not challenged any country that reported additional health measures, since these were understood in the context of containment and with the aim of protecting their own population from an unknown pathogen. Nevertheless, to imply that the WHO cannot act at all under Article 43 is an interpretation that renders the provision meaningless, which cannot be the intent of the State Parties.

Reasons for deficiencies in the implementation of the IHR

Various IHR review committees (IRC) instituted since 2009 have highlighted the challenges with respect to implementation of the IHR. Each committee has reiterated that inadequate staffing and financial resources constrain the work of the WHO Secretariat, Regional Offices and National Health Focal Points, thus compelling the IHR secretariat to select a few among their mandates and perform. The same has caused considerable deficiencies in achievement of national core capacities of the State Parties.

For instance, the 2016 IRC in its annual report stated as follows:

"The Regulations specified that all States Parties were to have core capacities in place by June 2012; however, by this date, only 42 (21%) of 193 States Parties declared that they had met their minimum core capacity requirements… States were allowed to request a two-year extension of the initial deadline to June 2014 and, in exceptional circumstances, a second two-year extension to June 2016. Although the number of countries with minimum core capacities rose to 65 by 18 November 2015, many countries clearly have a long way to go."

Further, the 2019 IRC annual report on implementation of the IHR suggests that State Parties are overall performing better in the detection capacities, such as surveillance and laboratory (above 65% globally), than in response capacities, such as emergency preparedness and response, for which the global average score was around 55%.

However, none of the IRCs have so far identified a "legal vacuum" as the reason for the deficient functioning of the IHR. At the most, what is reported is that there had been a lack of consensus on the interpretation of certain IHR provisions amongst

[1] IHR Article 43(4): After assessing information provided pursuant to paragraph 3 and 5 of this Article and other relevant information, WHO may request that the State Party concerned reconsider the application of the measures.

the actors both in the WHO and outside. For example, IRC 2021 presses the need for more clarity about the actions required after the determination of a PHEIC and the respective roles and responsibilities of State Parties and WHO.

While a simple interpretative text or commentary could solve this concern, there is no clarity as to how the proposed pandemic treaty will address the aforementioned structural issues of developing core capacities to respond to PHEIC, both for the State Parties and the WHO. If at all there exists certain issues which are not addressed or adequately addressed, they may be included in the IHR through an amendment. There is no legal bar against the inclusion of certain issues, which are currently not part of IHR.

Normative Value of IHR and Proposed Pandemic Treaty

As mentioned above the IHR is a legally binding instrument under Article 21 of the WHO Constitution that states: "*The Health Assembly shall have authority to adopt regulations concerning:*

(a) sanitary and quarantine requirements and other procedures designed to prevent the international spread of disease;
(b) nomenclatures with respect to diseases, causes of death and public health practices;
(c) standards with respect to diagnostic procedures for international use;
(d) standards with respect to the safety, purity and potency of biological, pharmaceutical and similar products moving in international commerce;
(e) advertising and labelling of biological, pharmaceutical and similar products moving in international commerce."

The proposed international instrument in the WHA 74 decision is to be adopted under Article 19 of the WHO Constitution that states: "*The Health Assembly shall have authority to adopt conventions or agreements with respect to any matter within the competence of the Organization. A two-thirds vote of the Health Assembly shall be required for the adoption of such conventions or agreements, which shall come into force for each Member when accepted by it in accordance with its constitutional processes."*

The legal effect of an instrument under Articles 19 and 21 is the same. Regulations under Article 21 can however move faster and bind more WHO Member States. An instrument under Article 19 needs to be adopted by two-thirds of the WHO members present and voting at the WHA, and it shall come into force only when accepted by the States in accordance with their respective constitutional processes. These conditions do not apply to an instrument under Article 21 and it can come into force for all WHO Member States, unless they opt out within a prescribed time.

The IRC 2021 also reiterates the legally binding nature of the existing regulations: *"Member States are automatically bound by the IHR unless they explicitly opt out of them within a specified time period. In the absence of a formal rejection or reservation, the rights and obligations imposed by the Regulations are legally binding on WHO and Member States, who do not necessarily need to sign or ratify them. Their legally binding nature is rooted in the WHO Constitution, which is itself an international treaty ratified by all Member States (paragraph 4)".*

Thus, when the normative value of both the instruments are equal, effectiveness of the regulations is greater and broader. This begs the question for the reasons for a treaty under Article 19 while Article 21 provides an explicit mandate to adopt regulations concerning "*sanitary and quarantine requirements* ***and other procedures*** *designed to prevent the international spread of disease".*

A Frequently Asked Question document dated 7th May 2021 by the Friends of a Pandemic Treaty states: "*In addition to the high-level political visibility and attention a treaty would provide, it would also provide for a sustained and long-term political engagement in a clearly defined process. Moreover, it would help support and develop a broad constituency of the stakeholders concerned, with defined tasks to shape and implement the treaty, and, where necessary, to develop details to support the objectives of the treaty".* Further, without any evidence it states that treaty helps to "*ensure durable public, private and government support at the global, regional, and local levels".*

There, the reasoning behind the treaty is not really the difference in the normative value of two instruments under Article 19 and 21 but is the political visibility. While it may be true that a treaty would provide visibility, on the other hand an instrument as proposed by the Friends of the Pandemic Treaty under Article 19 will lead to further fragmentation of international pandemic response and governance.

Part III

Fragmentation of health emergency response and norms

By adopting Article 2(a) of the WHO Constitution, the international community had established WHO as "the directing and coordinating authority" on international health work. By virtue of the other clauses of the same article, WHO is mandated to stimulate and advance work on epidemics and endemics, as well as to maintain effective collaboration with other international organisations, agencies and professional groups when deemed appropriate.

Further, Article 33 read with Article 72 allows for prompt and effective takeover of functions, resources and obligations from other international organisations or agencies, whose purpose and activities lie within the field of competence of the WHO, through specific agreements or arrangements.

On dealing with public health emergencies, the IHR through its Article 14(3) also clearly recognizes and advances the central role of WHO for public health purposes, especially when it comes to advice, support, or technical or other assistance. Article 57 mandates that IHR and other international legal instruments must be interpreted compatibly. Nevertheless, the WHO's response to health emergencies so far has been fragmented, both internally and externally, and it is important to understand why this is so.

The health emergency response of the international community is channelled through multiple institutional arrangements such as the Global Outbreak Alert and Response Network (GOARN), the UN Inter-agency Standing Committee (IASC) and its UN Crisis Management Team's Global Health Cluster Team (GHC), and the Global Preparedness Monitoring Board. WHO's role and responsibilities in emergency is captured in WHO's Health Emergency Response Framework.

Although referred to as a WHO-established body, GOARN is primarily an independent institution partnering with many public, quasi-public and private entities. In the steering committee of the GOARN, WHO is only one among 21 partnering institutions. A network primarily envisaged to focus on maintaining global public health security by ensuring coordinated mechanisms for outbreak alert and response, GOARN has built capacities to deploy those institutions that may have resources and expertise in the field.

The UNGA Resolution 46/182 of 1991 in paragraph 38 had set up the Inter-Agency Standing Committee (IASC) serviced by the Office of the United Nations

Disaster Relief Co-ordinators. The resolution also provides for collaboration among various international agencies, both intergovernmental and non-governmental organizations. The GHC is a team which is established under the aegis of IASC, to coordinate more than 900 partners under the health clusters. The WHO representative is a co-chair of the GHC's Strategic Advisory Group, and of the 10 members there are 2 from WHO. However, for responding to emergencies like COVID-19, WHO's role within the IASC remains that of a technical lead (Global Humanitarian Response Plan – on COVID-19). Its participation is also coordinated through health cluster partners.

The Global Preparedness Monitoring Board, although formally claimed to be co-convened by WHO and the World Bank, is actually an independent body comprising of "political leaders, heads of agencies and world-class experts". WHO remains as a facility used by the Board as a secretariat and has no direct role in its decision making or actions. The Board is tasked to *"(1) highlight critical gaps in preparedness, especially regarding the cooperation between key players, (2) identify potential mechanisms for addressing such gaps, (3) mobilize its influence with leaders and policy makers to increase preparedness activities and ownership at global, national and community levels".*

The above-mentioned networks and the peripheral role of WHO in these networks indicate a clear fragmentation of international health response to public health emergencies. It is extremely difficult to collect and manage information on an international health response from the internet, even for seasoned data miners, not to mention ground level agencies coordinating health responses. This is despite having separate offices for the Executive Director, WHO Health Emergencies Programme, assisted by the Assistant Director-General for Emergency Preparedness and Assistant Director-General for Emergency Response and International Health Regulations. The Health Emergencies Programme is overseeing the implementation of the Health Emergency Response Framework (ERF).

The ERF is the arrangement that spells out WHO's response to health emergencies, which includes emergencies that fall outside the scope of the IHR. Its standard operating procedures (SOP) clearly further fragments WHO's functioning internally. The purpose of the ERF is to provide *"WHO staff with essential guidance on how the Organization manages the assessment, grading and response to public health events and emergencies with health consequences, in support of Member States and affected communities."*

The ERF therefore provides SOP with various levels of alert and notification mechanisms. Further it provides for establishment of an Incident Management System within 24 hours of acute emergencies. The affected States will have incident managers with incident management teams, whereas WHO offices will have an Emergency Coordinator and an Incident Management Support Team. However, most of the response procedures have been managed through the partner coordination (ERF Chapter 5).

This means that WHO's role in the international health response is not one of giving direction. It has been reduced to an institution to collect information on outbreak of diseases and analyse the event. Once the outbreak information is passed on to the IHR Emergency Committee to determine the PHEIC status and also to UN Disaster Relief Co-ordinator, for the rest of the work, WHO is extremely dependent on its partners with no actual control over them or any legally enforceable commitments from them. The WHO is in effect at the mercy of the voluntariness of the very same networks which it claims to have established.

The arrangements basically rely on IHR's Articles 14 and 44(3) which use the phrase "international bodies" and Article 71 of the WHO's Constitution which allows the Organization to enter into arrangements with non-government entities. However, by excessively relying on the privatized modes of operation, WHO has not only allowed the Member States and intergovernmental organisations to shift their responsibilities to private actors, but allowed itself to move to the periphery of international health response during a health emergency.

The flagship co-ordination programme "Access to COVID-19 Tools Accelerator (ACT-A)" substantiates the above argument. ACT-A seeks to be a "ground-breaking global collaboration" bringing together selected governments, scientists, businesses, civil society, and philanthropists and organizations such as the Bill and Melinda Gates Foundation, the Coalition for Epidemic Preparedness Innovations / CEPI, Gavi, the Vaccine Alliance, FIND for diagnostics, The Global Fund, Unitaid, Wellcome Trust, the WHO, and the World Bank. However, there is no actual direct WHO Member State participation. The few governments involved are not seen either in the ACT-A website or its 'How it Works' document. Its complex partnership model actually dilutes the coordinating capacity of the WHO, as well as allows diffusion of accountability.

For example, one of the pillars of ACT-A is vaccines development, production, and equitable access. This is co-led by Gavi, CEPI and the WHO. However, the COVAX Coordinating Meeting, which is high-level body mentioned in *COVAX: Structure and Principles document*, is co-chaired by the board chairs of CEPI and Gavi and not by a WHO representative. The 5th decision making principle of the COVAX Coordinating Meeting states that *"No decision can be taken that would contradict a decision by the respective Boards of CEPI and Gavi; exceptions must be approved by the organisation's Board."* This establishes a hierarchical relationship, noting that both CEPI and Gavi are registered philanthropic organisations.

The workstream within COVAX is further fragmented and undertaken by many groups such as the Research and Development and Manufacturing Investment Committee (RDMIC), Technical Review Group, SWAT teams and Regulatory Advisory Group, Office of the COVAX Facility, Gavi Board, Market-Sensitive Decisions Committee. The WHO representatives have very minimal role to play in these bodies. WHO has a substantial participation only in the workstream policy and allocation.

In this context, the accountability statement of the ACT-A programme invites attention.

The 'How it Works' document of ACT-A states that: "*ACT-Accelerator is a collaborative and coordinated effort, not a new legal organization or decision-making entity… Formal governance for each of the Pillars (including transparency of administration, financial management, and accountability for resources raised and used) is provided by the existing Boards and governing bodies of each of the co-convening and lead organizations. The co-conveners of each Pillar are fully accountable for the development and oversight of the workplans and investment case for that area of work. Grant management and financial reporting to donors is managed by the receiving entity.*"

This clearly shows that the present arrangements shift the focus of the international community from the duty of Member States and the WHO to collaborate and assist under Article 44 of the IHR, to various voluntary and philanthropic mechanisms round the globe. Enough caution must be put against this trend, especially since the *IPPPR's Recommendation 5.iii* also advances a similar model of collaboration in the hope to ensure financial and regional capacities for future pandemics as well.

It is surprising that the Friends of the Pandemic Treaty and the committees fail to clarify and reinforce the obligations under Article 44 of IHR 2005, even after witnessing the deficiencies in the above model for the past few months. The recommendations, instead of stressing on the obligations under the IHR, actually move away from IHR 2005.

The FAQ circulated by the Friends of the Pandemic Treaty states that the new treaty is not a replacement of IHR: *"...with respect to the IHR, it is important to note that the treaty would not replace the IHR - on the contrary, the IHR would be a cornerstone of the treaty. The treaty would recognize the central role played by the IHR as the only international legal framework for preparedness and response to the international spread of disease at a technical level, and measures to further strengthen the IHR could be included in the treaty, without having to re-open the IHR themselves".* However, mere reference to IHR 2005 does not suffice in making IHR a cornerstone. There is no tangible plan in the agenda to bring Articles 14, 44 and 46 to life and into force.

Further, the model of the treaty advocated by the Friends and IPPPR is that of a 'Framework Convention' – a legal device prone to further fragmentation. As a framework convention, the newly proposed treaty can only provide broad norms. The detailed provisions and regulations required for the real action coordination will then need to be worked out through separate protocols. The treaty would therefore open up a regular, if not a permanent, negotiating forum. In other words, the treaty is not expected to bring any normative clarity at least in the short term, let alone institutional and operational coherence and coordination.

The background paper 16 to the IPPPR report also concludes that "*while treaty architecture and structure may not guarantee implementation, it is an important step in clarifying obligations and the responsibilities of states.*" A framework convention cannot do that efficiently. Generally speaking, a framework treaty creates its own organisational mechanism to administer the treaty. The decisions of the implementation or administration of the treaty is carried out by the Secretariat and the Conference of Parties. In this context, the IPPPR suggestion to have a Global Health Threats Council as the monitoring agency with **permanent representation of G20 members** is noteworthy. If the new treaty incorporates this Council, perhaps comprising individual heads of states then it would further undermine the decision-making abilities of the emergency committee and the DG under the IHR.

This will not only weaken the role of WHO in the already fragmented implementation of international health response but also will further fragment the norm setting process of the WHO. This double fragmentation bears the danger of deficit of accountability of actors. Of particular concern is the suggestion to have a structure of "permanent" G20 members representation would further undermine the rights and role of all WHO Member States.

IRC 2021's Recommendation and its Flawed Basis

The IRC 2021's recommendation to establish a global convention for pandemic preparedness and response is based on the example of the WHO Framework Convention on Tobacco Control (Paragraphs 4 and 117 of the IRC 2021 report), and the Friends of the Pandemic Treaty extensively relies on this recommendation to advance its proposed model. However, IRC's recommendations are based on three flawed assumptions.

Firstly, IRC 2021 ignores the fact that IHR itself provides a framework for health emergency response and assumes a Framework Convention can supplement IHR. What is needed for rectifying the deficiencies in the implementation of IHR are legal instruments in the nature of rules, clarifications, general commentaries of interpretation and prescriptive implementation guidelines. A framework convention, on the other hand, is a "parent" instrument under which many guidelines and regulatory protocols are later adopted and implemented. However, these guidelines or protocols are separate legal instruments to which the framework convention's Parties can choose to also become a Party or not.

Secondly, the IRC assumes that many areas of multi-sectoral cooperation needed for pandemic preparedness and response are outside the scope of the IHR (paragraph 117 of the IRC 2021 report). This is a flawed reading of the IHR as shown above in Part II. Furthermore, Article 57 of IHR 2005 actually converts the entire set of regulations into a *lex specialis* (law governing a specific subject matter), by requiring all other instruments and treaties to be interpreted consistently with the IHR during the period of a sustained PHEIC.

Thirdly, IRC hopes to build on Article 57(2) of the IHR, which allows Member States "having certain interests in common" to form special treaties or agreements to facilitate application of the IHR. It must be noted that Article 57 does not envisage a global convention to augment the performance of WHO under the IHR as cited by the IRC (Box 3 in the IRC 2021 report). Instead of supplementing the IHR, the new treaty could eventually create confusion as to the interpretation of the provisions of the IHR. Because of the proposed branding as a Convention and the requirements under Article 19, the new treaty will have a better face value than that of the IHR, although there is no guarantee that all the Member States would become a party to the Convention. Such a scenario cannot lead to coherent interpretation and application of the IHR provisions, and will further fragment the normative architecture as well.

Part IV

What to Expect from the New Treaty?

According to IRC 2021, the new framework convention may include provisions addressing rapid and timely sharing of pathogens, specimens and genome sequence information; global equitable access to benefits arising from development of effective counter measures; rapid deployment of a WHO team for early investigation and response; maintenance of the global supply chain; as well as the prevention and management of zoonotic risks.

The IOAC report (paragraph 22) also notes *"that such a treaty should support member states to comply with International Health Regulations (2005) provisions; build national, regional and global resilience for pandemic responses; mobilize financial resources collectively; and ensure universal access to diagnostics, treatments and vaccines for future pandemics based on the principles of solidarity, equity, accountability and transparency."*

The IPPPR believes that *"a framework convention would be an opportunity to address gaps in the international response, clarify responsibilities between States and international organizations, and establish and reinforce legal obligations and norms."* Additionally, it also states the possibility of including "*mechanisms for financing, research and development, technology transfer, and capacity building in the Convention"* (pages 46-47).

However, the proponents of a new treaty, especially the European Union, have not envisaged anything practical and pragmatic about the provisions relating to benefit sharing or equitable access to treatments and vaccines. The paradigm applicable to transfer of technology and knowledge are still articulated on the basis of voluntary licensing and patent pools. There is no compelling proposal made on forging better coordination, either to ensure development assistance or financing of the risk mitigation or the distribution of therapeutic instruments or vaccines.

The current pandemic has already wreaked economic and social havoc. There have been sharp declines in global trade and financial inflows experienced by developing countries during the past year as reported by the WTO, World Bank, and IMF. In South Asia alone, 60 percent of people are pushed into extreme poverty by COVID-19 according to World Bank estimates. The disbursement rates of the World Bank's and Team Europe's official development assistance are only about 50 percent. According to LDC Report 2020 of UNCTAD, least developing countries are

facing the worst economic crisis seen in the past 30 years as a result of COVID-19. At least 50 percent of the world's extremely poor live in these countries, and the current COVID-19 crisis is estimated to have pushed at least 32 million more people into poverty in 2020. Meanwhile, the vaccine manufacturers from developed countries are reported to be securing indemnity contracts from developing countries adding to the inequities of vaccine access.

However, none of these major concerns of developing and least developed countries may be effectively addressed through the new treaty proposal. The IPPPR report speaks of inequality when it states that *"inequality between and within countries have been exacerbated, and the impact has been severe on people who are already marginalized and disadvantaged."* Yet there is no mention of any social and economic measures which Member States or WHO could look at. The report, which speaks of about 115–125 million people being pushed into extreme poverty, and deaths of more than 17000 health workers, fails to mention concrete international measures which would increase the resources and capacities of Member States. The words "debt servicing" or "debt relief" do not even appear in the report.

In short, there is no promising legal innovation in the interest of developing and least developed countries in the treaty, that can ensure a meaningful collaboration and co-ordination based on the principles of solidarity, equity, accountability and transparency.

Global non-governmental organisations and international organizations such as the WTO, World Bank and IMF can also be expected to have great interest in the new treaty proposal, although WHO has no institutional agreement at the moment with them. Statements by the European Union highlight coordinating with non-state actors of scale and power. The IPPPR recommendation 3.iv has suggested that the IMF should routinely include a pandemic preparedness assessment, including an evaluation of the economic policy response plans.

It must be noted that many of the suggestions such as global co-ordination of sub-national entities, pre-PHEIC levels of alert and increased focus on detection capacities are primarily in favour of the developed world, and risks deepening the existing asymmetric relationship between developed, and developing and least developed countries. The proposals are part and parcel of a health securitization agenda. It is already argued above that many other reforms suggested can be addressed through IHR itself. Figure 1 below depicts this.

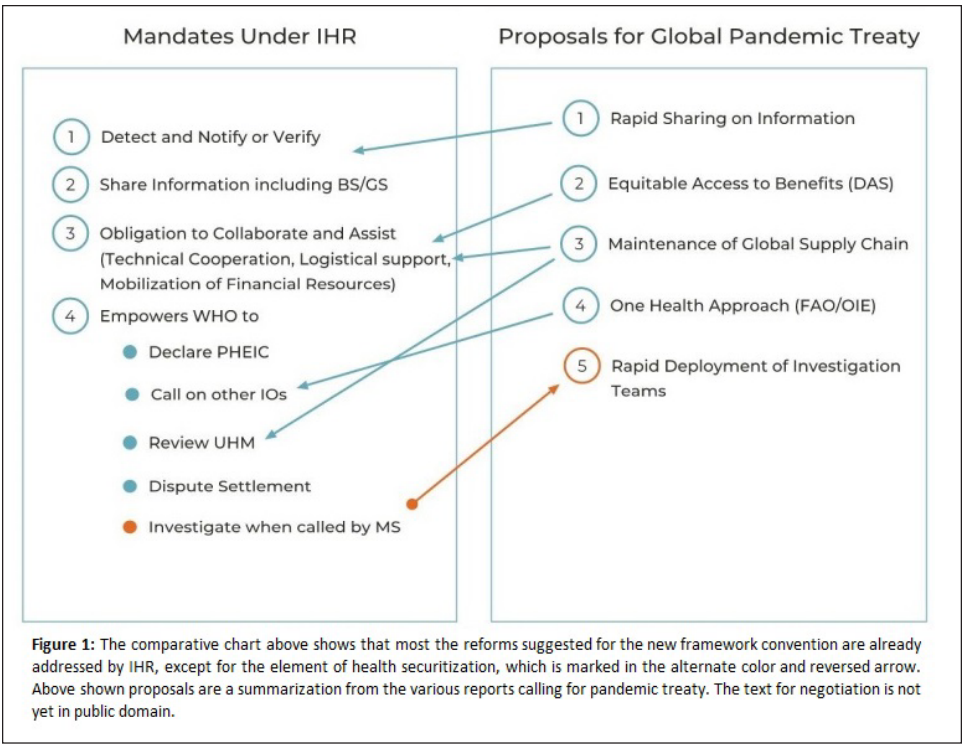

Figure 1: The comparative chart above shows that most the reforms suggested for the new framework convention are already addressed by IHR, except for the element of health securitization, which is marked in the alternate color and reversed arrow. Above shown proposals are a summarization from the various reports calling for pandemic treaty. The text for negotiation is not yet in public domain.

Proposed treaty is against basic principles of international law making

The call for a new treaty on pandemics is inextricably linked to the history of international health law, and the impoverishment of the developing states. As a consequence, the reawakened interest in international law making during the prolonging COVID-19 pandemic and its drastic impacts on human life and national economy, raises considerable alarm.

Seventeen months have passed since the COVID-19 outbreak in China, but the pandemic is far from over. As of 9 July 2021, there have been 185,291,530 confirmed cases of COVID-19, including 4,010,834 deaths, reported to WHO. Countries such as Brazil, India, Jordan, Nigeria, Pakistan, South Africa, Zimbabwe and more had reported oxygen shortages and deaths due to non-availability of medical oxygen for COVID-19 treatment. South-east Asia that had largely managed quite well in the early stage of the pandemic is now seeing surges in infections and deaths, with national health systems stretched to their limits.

According to the United Nations General Assembly Resolution 53/101, Principles and Guidelines for International Negotiations, paragraph 2(b), it is important to engage those States whose vital interests are directly affected by the matters in question.

Paragraph 2 is the practical embodiment of the Vienna Convention on the Law of Treaties norms of "free consent" and "good faith". There is a real risk that the current state of duress and dependency on developed states will force the developing countries to compromise further on their sovereign rights, if the pandemic treaty is negotiated during the COVID-19 crisis.

Requiring States to draft a treaty text and to negotiate the terms is not a practical idea, as many States are already short of human resources for implementing their own national policies and measures to contain the pandemic in their countries. This will lead to ineffective, unequal participation of developing and least developing countries in negotiations or drafting of the treaty.

Michael Wood, a Member of the International Law Commission, opines that before starting any treaty-making process, one should always ask two basic questions: *(1) Is a treaty really necessary to regulate the issue at hand, and (2) if so, what is the proper time to start negotiations?*

The answer to these questions will depend on many factors, especially the subject matter of the treaty and the socio-political context of its negotiations. On both counts, however, the proposal for the new pandemic treaty falls short. Proponents have not provided a satisfactory reason for why the treaty is necessary. It is also not proposed at the right time.

Reflecting the same concern IRC 2021 states: "*When the COVID-19 pandemic is over, the Committee recommends a more comprehensive assessment of progress on implementing previous Review Committees' recommendations, focusing on how recommendations have been implemented at the national and regional levels, as well as at WHO headquarters. At present, neither States Parties nor WHO have the time or the resources to undertake this work*".

Conclusion

A globally co-ordinated preparedness and response to pandemics is essential. But it is a very specific agenda and can be sufficiently dealt under IHR 2005. Although IHR has been historically biased against developing countries, it should be effectively rectified through certain amendments, by stressing upon the *obligation to assist* of the WHO and Member States. Drawing up clear concrete guidelines for better implementation or adoption of further annexures to IHR can help achieve the goal of a globally co-ordinated preparedness and response to public health emergencies, which requires international support. In this way, we can transform IHR from an instrument creating an obligation to inform about health emergencies into an effective legal instrument setting rights and obligations of parties during a health emergency, which requires international support.

As stated in many IHR review committees, the real issue behind the deficiencies in management of pandemics, is the lack of implementation of IHR due to resource constrains of WHO and the majority of its Member States. This cannot be resolved through a framework convention/treaty.

A new framework convention/treaty will also relax the existing legal norms established under the IHR. Further, there is no certainty as to which Member States will become party to the new convention and its separate protocols. Negotiations of a new framework convention/treaty pose a danger of reopening framework principles available under IHR, while also providing a way out for developed states to abdicate from their obligations under the present law.

Therefore, the call for a new treaty on pandemics is nothing but a delay tactic employed to downplay and suppress all calls for the improvement and advancement of the legal norms established under IHR. Instead of spending time and resources on a new pandemic framework convention/treaty the WHO Members States need to spend their scare resources on reforming IHR and ensuring its effective implementation.

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