The Urgent Need for a Pandemic Accord

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The COVID-19 pandemic took the world by surprise. In early 2020, no one would have thought that in months to come, millions of people would be in 'lockdown', trillions of dollars would be lost to the global economy, and over 7 million people would die from the disease caused by the novel coronavirus. For many years before 2020, scientists and medical experts had been warning that the world was simply not ready for disease 'X'; such a pandemic was almost inevitable, however, coming as it did from a zoonotic virus for which no vaccines or drugs had been developed.

Although it has been declared that the Public Health Emergency of International Concern relating to COVID-19 is over, many countries, especially low-income ones, still have a substantial number of COVID-19 cases and are without access to the vaccines and drugs they need. There is the risk of becoming complacent again. There are hundreds of thousands of bird and animal viruses that could get transmitted to humans, and potentially onwards from human to human. A new infectious disease can almost certainly strike. The question is when.

While not all disease outbreaks can be prevented, they can be arrested so that they do not escalate into an epidemic or pandemic. Social inequalities

can be reduced, and health systems strengthened, to better protect populations against such outbreaks. The imperative is to understand what went wrong, and what it would take to make things right.

Critical Failures

To prevent history from repeating itself, the global community would do well to learn the lessons of COVID-19.

a. Countries were insufficiently prepared. Even those with strong healthcare systems geared to tackle pandemics had not tested them through, for instance, simulation exercises. Poorer countries did not have the resources to run a fully functioning public health system. In almost all countries, there was little understanding of the implications of a lockdown—for livelihoods and the economy, trade, and social services such as education.

b. Aside from public health experts, others had no understanding of how fast an outbreak can develop into a pandemic. Initially, governments took a 'wait and see' approach rather than precautionary action. February 2020 was a critical month when the opportunity to take control of the virus was lost.

c. Countries did not comply with the International Health Regulations (IHR) which have been in place since 2005, and often did not accept evidence-based advice from the World Health Organization (WHO).

d. The wide inequities between countries and population groups were exacerbated, and the consequences were dire in determining who had access to vaccines and drugs and who did not.

A New Pandemic Treaty and Amendments to the IHR

Early on in the pandemic, calls were made for action including developing a 'pandemic treaty' that would set out what countries need to do, and hold them to account. At a special session of the World Health Assembly (WHA)

in 2021, WHO's 194 member states agreed to negotiate a new 'Convention Accord or other International Instrument' on pandemic preparedness and response (PPR) (referred to as the WHO CA+ or the Pandemic Accord).[1] The work began with an Intergovernmental Negotiating Body (INB) being established with a final proposal to be delivered to the WHA in May 2024. In May 2022, it was also agreed that a Working Group on amendments to the IHR should be established (WGIHR).[2] Its report is due at the end of 2023. All member states are engaged in both negotiations.

From the beginning, the scope of the changes to the IHR has been contentious. The resolution of the WHA was to keep it to a small number of amendments, but some countries argued for a much wider scope. They sought, for example, for 'One Health'[a] prevention measures, and equity in access to drugs and vaccines. It has led to 300 amendments to the IHR being submitted to the WGIHR. Countries which might have preferred a more limited approach also jumped in when it was clear that the scope was to be broader. As a result, many proposed changes are similar to those suggested in the Pandemic Accord.

Ultimately, there has to be coherence and compatibility between the Accord and the IHR. It is likely that the Accord will have more of the overarching principles and wider issues, with the IHR defining the technical requirements to deliver them. There is a long way to go but the member states guiding the negotiations are meeting regularly to try to ensure coherence and avoid conflicting recommendations.

Guiding Principles

The following are the key principles that should be at the heart of the Pandemic Accord and the IHR:

a 'One Health' is a collaborative, multi-sectoral approach to health, which recognises the interconnection between people, animals, plants and their shared environment.

- **Solidarity.**

Preventing outbreaks from turning into pandemics is a collective responsibility and is in every country's self-interest. Unhelpful campaigning on social media and elsewhere has suggested that a new treaty could challenge the sovereignty of a country. That is not the case; countries will continue to take their own decisions. The Charter of the United Nations affirms the sovereignty of States Parties in addressing their own public health matters.[3] However, it also sets out the obligation to ensure that "activities within their own jurisdiction or control do not cause damage to their peoples, other States Parties, and areas beyond the limits of national jurisdiction".

- **Equity.**

Morality and national self-interest demand equitable access to all tools, including vaccines, diagnostics and treatments, and financing for these resources. Equity includes a change of attitude in governance. There needs to be equity in governance systems, for example, in financing for preparedness and response to pandemics. It should not be just controlled by donors.

Equity also means fairness in the assessment of what countries are capable of. There are significant differences in each country's ability to deliver preparedness and response. Poorer countries simply do not have the same level of resources as the developed ones.

- **Transparency.**

Transparency of data and genomic sequencing are vital to responding quickly and effectively to the pandemic, and required for the development of new drugs and vaccines. Transparency is what builds trust within and between countries.

- **Accountability.**

The new Accord must set out greater accountability requirements than were in place in the past. This is one of the key reasons for the Accord. Many

civil society organisations have been sceptical about whether a new treaty would make a difference, pointing out that compliance with the IHR is still lacking. That challenge must be met.

Accountability should be to the people of each country through parliamentary systems and civil society. It is also needed for mutual assurance between countries. When governments require extraordinary actions from their populations—for example, lockdowns and mask mandates—they need to be confident that other countries are also taking appropriate action.

Building Consensus

Early in 2023 the 'zero draft' of the Accord was made available and the real negotiations began. Taking into account all the discussions and proposed texts from member states, a revised draft—the 'first draft'—is to be produced in the summer of 2023. The negotiations are undoubtedly complex, but it is worth noting that a surprising amount seems to be commonly agreed upon.

The purpose of the Accord and its principles seem widely accepted, including the protection of the human rights of all people wherever and whoever they may be. There is particular concern that the needs of the most vulnerable people are taken into account in pandemics. There is commitment to the development of public health and healthcare systems and to protect staff, who are most at risk in epidemics and pandemics. There is a need to communicate well with the public and deal with misinformation. There is commitment to a 'whole-of-society' approach for all plans and actions, and recognition of the need for global coordination.

There appears to be conceptual agreement that preparedness plans should involve all of government, and that there should be regular simulation exercises. A 'Universal Health and Preparedness Review' is suggested as a mechanism for review of each country's preparedness. Both peer review of the plans as well as independent assessment are being discussed. Surprisingly, remarkably little is being said about public health response, presumably because so much of it falls within the IHR.

An area of work making encouraging process is prevention. This brings together human and animal health, now often described as 'one health'. Because zoonoses[b] are the greatest risk, actions to reduce transmission—such as closure of wet markets or banning of exotic animal trade—are being considered alongside work on the habitats of humans and animals. However, it seems unlikely that a fully considered plan will be ready for the Accord; a new protocol might be more appropriate. The Joint Plan of Action is being developed by WHO, the Food and Agriculture Organization, the World Organisation for Animal Health, and the United Nations Environment Programme,[4] making up the so-called 'quadripartite'.

Areas of Contention

The contentious issues are around equity, especially related to countries' access to vaccines, drugs, and other medical equipment. Member states might sign up to the principle, but there are great differences among them on how this should be achieved. Developing countries are pressing for a wider spread of manufacturing, particularly for vaccines, but not only for them. Success in getting mRNA vaccine manufacturing underway in South Africa is a good start, although manufacturing for the whole continent and globally will require both financial investment and technology transfer. The extent to which the pharmaceutical industry would be prepared to engage with technology transfer and the associated question of intellectual property rights is unclear.

Various models have been proposed to achieve access. When wealthier governments fund the research and development (R&D) of companies, for example, they could persuade industry players to earmark a percentage of vaccines for the poorer countries, or to sell these to them at cost. However, that would still leave the poorest countries at their mercy. Meanwhile, the pharmaceutical industry argues that without commercial pricing of new drugs and vaccines, there is no incentive for innovation.

b These are infectious diseases which can be transferred from animals to humans, or vice versa.

Such debates are not new. The World Trade Organization struggled to reach an agreement on a Trade Related Aspects of Intellectual Property Rights (TRIPS) waiver throughout the pandemic, with limited success.[5] This was despite an early agreement on TRIPS waivers for drugs in a public health emergency, reached many years ago in 2001 during the Doha Trade Round.[6]

It is difficult to see how there can be a breakthrough, but developing countries have made it clear they will not support a new Accord which does not deal with equity of access.

Crucial Gaps

The Pandemic Accord and the IHR will fail if two areas are not attended to: financing and accountability.

Financing: The G20 Independent High-Level Panel estimated that the annual financing need for future preparedness and response to pandemics was US$ 31 billion.[7] Even considering domestic and international financing, US$ 10 billion a year is required for PPR, which includes upgrading public health systems, R&D, and overall preparedness. If the amount seems high, it must be remembered that it is a tiny amount compared to the cost of a pandemic.

The G20 report and another from the World Bank and WHO[8] led to the establishing of the Pandemic Fund at the World Bank. However, the promised funding in the first year has been only US$ 1.6 billion, and there are concerns about how funds can be raised in the longer term. This is the moment for the G20 to deliberate on how the necessary financing can be found.

Accountability: For the Accord and the IHR to succeed, countries must deliver on the obligations they have committed to. External accountability mechanisms are also needed as safeguards to ensure that all parties are answerable for these obligations. The Panel, which this author chairs, firmly believes that there should be independent assessment of countries—their preparedness plans, response, and other matters which might be agreed upon in the Accord. WHO is a friend and supporter of countries,

which makes it difficult for it to challenge them in the public space. The Panel believes that the way forward is a small independent body for the Accord and perhaps the IHR, too. The Accord will be hosted by WHO but will have its own secretariat. An arms-length independent assessment body could be housed within the Accord's treaty structure. The International Atomic Energy Agency (IAEA) is one model being proposed, but because WHO already has much of the monitoring information, the independent assessment body need not be as large as the IAEA.

Assessments do not have to be about blaming and shaming. They need to be public but supportive, especially of countries that do not have the resources and are in need of financial and technical help. Pandemics create huge risks to individuals and nations. The public has a right to know what their governments and other governments are doing to protect them, and that includes ensuring countries across the world have the resources to deliver.

Dame Barbara Stocking, *Chair, Panel for a Global Public Health Convention, is responsible for opinions expressed in this article though they are informed by the Panel's discussions.*