

SYMPOSIUM ON GLOBAL HEALTH AT A CROSSROADS PART I

TRADE-OFFS IN THE INTERNATIONAL LEGAL REGIME: THE CASE OF THE PANDEMIC AGREEMENT

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Introduction

COVID-19 starkly exposed the systemic frailties of global health governance, particularly concerning the functioning and utility of the International Health Regulations (IHR). Multiple independent reviews declared that the existing framework was designed to constrain rapid global action, and recommended concrete transformational reforms for the global health legal regime.¹ Most notably they recommended the negotiation of a new instrument to govern future pandemic prevention, preparedness, and response (PPPR). The appetite for a new instrument was cemented by a statement of support from twenty-six other world leaders and the director-general of World Health Organization (WHO).² From the start, there was a lack of clear unified vision for what a new treaty ought to achieve. This ideological rift generally fell along the North–South divide, something that continued throughout the negotiations of the treaty. Low- and middle-income countries (LMICs), suffering from the stark inequalities in vaccine access during the COVID-19 pandemic demanded embedding equitable distribution of life-saving health products into legally binding commitments. Meanwhile high-income countries (HICs) sought greater prevention and surveillance activities, determined to prevent spillover events from occurring and spreading in the first place.

The experiences of LMICs, where vaccine nationalism fundamentally determined pandemic outcomes, shaped the context for treaty negotiations. By mid-2021, 75 percent of COVID-19 vaccine doses had been administered in high- and upper-middle-income countries, while just 0.5 percent reached low-income countries.³ This gave rise to what the WHO director-general called a “catastrophic moral failure” of inequality. Consequently, there was significant erosion of trust between HICs and LMICs, and between institutions and publics that fundamentally

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¹ THE INDEPENDENT PANEL FOR PANDEMIC PREPAREDNESS AND RESPONSE, *COVID-19: MAKE IT THE LAST PANDEMIC* (2021); WHO, *WHO's Work in Health Emergencies: Strengthening Preparedness for Health Emergencies: Implementation of the International Health Regulations* (2005), WHO Doc. A75/9 Add. (2025); Jeffrey D. Sachs et al., *The Lancet Commission on Lesson for the Future from the COVID-19 Pandemic*, 400 THE LANCET 1224 (2022).

² WHO, *COVID-19 Shows Why United Action Is Needed for More Robust International Health Architecture* (Mar. 30, 2021).

³ Stephen Brown & Morgane Rosier, *COVID-19 Vaccine Apartheid and the Failure of Global Cooperation*, 25 BRIT. J. POL. & INT'L RELATIONS 535 (2023).

transformed the treaty's political landscape. For states, particularly LMICs, PPPR could no longer be treated as a technical cooperation problem; it became a question of justice, political credibility, and a push for reshaping the norms of cosmopolitan equity and solidarity in multilateralism.

The pandemic agreement also needs to be understood from a historical perspective, as an attempt to remedy long-standing weaknesses in global health multilateralism. Previous instruments such as the International Health Regulations and the Pandemic Influenza Preparedness Framework were heralded as milestones but ultimately revealed the limits of state implementation and compliance, and the difficulties of balancing sovereignty with collective security during an emergency. These precedents underscore that the pandemic agreement is part of a longer trajectory of contested multilateral efforts that have repeatedly faltered during crises.

Below, we highlight two issues negotiated as part of the Pandemic Agreement that clearly demonstrate these tensions which became deadlocked in a trade-off for negotiating parties: prevention and a "One Health" approach versus the Pathogen Access and Benefit Sharing (PABS) approach. Articles 4 ("pandemic prevention and surveillance") and 5 ("One Health approach for Pandemic Prevention, Preparedness and Response") embody the "prevention side" of the agreement. The European Union (EU), proposed more stringent provisions for these articles, but member states only agreed to much weaker forms at the very end of negotiations. Additionally, Article 12 addresses the creation of a PABS. It has proven very difficult to reach consensus, such that its negotiation continues, in a PABS annex to the main agreement. This essay addresses each of these issues in turn, analyzing the provisions' substantive content and why they have proven to be controversial and divisive. We conclude by cautioning the heralding of the adoption of the pandemic agreement as a success, because its ratification and implementation is subject to an international environment characterized by fragmentation and mistrust.

One Health

The One Health approach initially emerged in response to the H5N1 influenza outbreak and resulted in closer cooperation between WHO and the World Organization on Animal Health (WOAH). One Health has substantially evolved toward overcoming a purely human-centered approach and integrating human, animal, and plant health as well as environmental protection under its remit. At the institutional level a "Quadrupartite" of relevant international organizations was established,⁴ as well as the "One Health High-Level Expert Panel."

The IHR (2005) is mostly triggered when an outbreak appears in human populations, with insufficient emphasis being placed on upstream prevention of zoonotic spillovers (meaning they spread naturally between animals and humans). However, increasingly, emerging infectious diseases are zoonotic, driven by environmental degradation, habitat loss, climate change, and intensive farming. Additionally, unregulated use of antibiotics on healthy livestock fosters the rise of antimicrobial resistance (AMR). States widely agreed on the importance of "primary prevention" at the beginning of negotiations, given the catastrophic effects of a highly pathogenic and transmissible virus once it spreads from animals into human populations.

Considering the widespread agreement on the importance of real prevention, integrated planning, and surveillance, it may seem surprising that it proved so difficult to agree on the scope and content of the prevention component of the agreement. The Bureau of the Intergovernmental Negotiating Body (INB), which brings countries together to draft and negotiate a convention, agreement or other international instrument under the WHO Constitution to strengthen pandemic prevention, preparedness and response, introduced One Health from its first session in the initial outline of issues.⁵ One Health emphasizes

⁴ WHO, *QUADRIPARTITE CALL TO ACTION FOR ONE HEALTH FOR A SAFER WORLD* (2023).

⁵ WHO, *Draft Consolidated Outline Document of the Substantive Elements, as a Basis for Consideration and Discussion*, 6, WHO Doc. A/INB/1/8 (June 2, 2022).

intersectoral cooperation, integrated surveillance, whole-of-government approach and planning, as well as prevention of AMR. However, the leadership of the EU on prevention and One Health was progressively taken over by developing countries that were opposed to prescriptive and detailed obligations. These states saw integrated surveillance at the human, animal, and environmental levels as well as identification and management of zoonotic hotspots as particularly demanding and not counterbalanced by strong guarantees of technical and financial assistance. Developing countries also had serious concerns about the implications of stringent standards for food safety as possible obstacles in agricultural and food trade, which would fall within the scope of the WTO Agreement on Sanitary and Phytosanitary Measures.⁶ Finally, these countries raised the increased risk of marginalization and penalization of Indigenous and local communities because of a perceived threat arising from their wildlife consumption. Another predominant critique of One Health concerned the lack of equity and continuation of a colonial legacy that imposed demanding obligations on Global South countries for protection of the Global North. Over sixty NGOs supported these critiques by signing an open letter outlining similar objections.⁷

Additional challenges further complicated the negotiations. First, the other Quadripartite organizations—particularly the UN Food and Agriculture Organization—expressed their growing discomfort with WHO taking the lead in negotiating an issue that was inherently intersectoral. They lobbied to secure explicit recognition of their privileged roles and secured a seat at the negotiating table. This created frictions between the organizations and reportedly between line ministries in many countries, potentially resulting in the deletion of explicit references to the Quadripartite, with only passing references remaining to “other relevant intergovernmental organizations” in the treaty text.

A second significant obstacle emerged in the later stages of negotiation, when developing countries used prevention and One Health as a bargaining chip to secure favorable terms on the PABS. This can be explained by many developed countries placing them as their main priority in the negotiations, while the PABS system was arguably of equal importance to both groups. The artificial linkage between two fundamentally different issues produced controversial dynamics. For example, the EU insisted that if the details of the PABS system warranted a separate annex, then Articles 4 and 5 should receive similar parallel treatment even though that was probably unnecessary in operational terms.

The INB eventually split the topic into two articles. Article 4 provides that parties shall, in particular, address drivers of zoonotic diseases, identification and reduction of pandemic risks, coordinated multisectoral surveillance, control measures at the community level, surveillance, and prevention of vector-borne diseases. Article 4 also assigned to the Conference of the Parties the responsibility of adopting non-binding measures to encourage effective implementation and promoting cooperation as well as capacity-building and equitable access to health products, technology, and financing. The latter provision (paragraph 5 of Article 4) was the closest to injecting equity into the prevention aspects of the agreement. Article 5 reflects a significant recognition of One Health in a multilateral treaty for the first time. It focuses on the promotion of a One Health approach in general terms, including developing relevant national policies and promoting joint training across the human, animal, and environment sectors.⁸

⁶ [Agreement on the Application of Sanitary and Phytosanitary Measures](#), Apr. 15, 1994, 1867 UNTS 493.

⁷ [Reject “One Health Instrument” in the Pandemic Agreement](#), Civil Society Letter to Developing Country Ambassadors and Permanent Representatives of WTO and UN Missions in Geneva (May 21, 2024); Elaine Ruth Fletcher, *One Health Is a “One World” Agenda, Even as Negotiators Wrangle Over Inclusion in WHO Pandemic Accord*, HEALTH POL’Y WATCH (June 6, 2024).

⁸ WHO, [WHO Pandemic Agreement](#), WHO Doc. WHA78/1 (May 20, 2025) [hereinafter *Pandemic Agreement*].

Pathogen Access and Benefit Sharing (PABS)

Member states argued from the start that an agreement grounded in equity was to be the cornerstone of future global health security,⁹ with such ideals being echoed in WHO and independent reports. However, from the very start, the vision of equity was limited to accessing vaccines, therapeutics, and diagnostics in future health emergencies, with the Health Assembly resolution that launched the negotiations noting the need to address this gap.”¹⁰

The creation of an access and benefit system for pathogens (PABS) seeks to solve two public health problems. Firstly, to facilitate prompt and unimpeded access to pathogen samples (and associated genetic sequence data) for risk assessment and research and development on relevant medical countermeasures. Secondly, to improve access to medical countermeasures in LMICs.¹¹ In the proposal for PABS, countries agree to provide “PABS biological material” (as yet undefined) into a WHO managed system for risk assessment, and in turn this material can be transferred to third parties (e.g., the pharmaceutical industry) for research and development. In exchange for accessing pathogens and genetic sequence data, the pharmaceutical industry commits to benefit sharing by way of “legally binding contracts” with “participating manufacturers,” to provide a set percentage of “real time production of safe, quality and effective vaccines, therapeutics, and diagnostics” to WHO either in the form of donation, or at affordable prices, to distribute on the basis of “public health need,” during a future Pandemic Emergency.

Given the clear implications a PABS system has for HICs and for industry, consensus on it was difficult to achieve. In May 2025, after over three years of negotiations, even though member states adopted the Pandemic Agreement, the latter cannot be opened for signature and ratification until an Annex on PABS has been negotiated by a WHO Intergovernmental Working Group, which has set itself the ambitious target of reaching agreement on the annex by the Health Assembly in May 2026.

The divisions around PABS are extensive. As with One Health, these divisions largely fell along HIC versus LMIC lines. HICs sought two main concessions from PABS—firstly, to guarantee prompt and unhindered access to pandemic pathogen samples and associated genetic sequence data. This was intended to address their longstanding concern that countries exercising their sovereign rights over pathogen samples would slow down sharing in a future health emergency and slow down the development of novel countermeasures. Secondly, they adopted a protectionist stance when it came to industry, keen to minimize the extent to which industry would have meaningful benefit-sharing commitments under PABS, and ensuring there were no restrictions placed on intellectual property rights over PABS materials or products developed using those materials. On the other hand, LMICs sought to maximize benefit-sharing, restrict the extent to which intellectual property rights could be sought over PABS materials, have the system financed by industry, and ensure a robust track and trace mechanism that could identify any potential free-riding within the system.

The extent to which these issues can be meaningfully resolved remains to be seen, but the fact that the positioning of member states is so contrary to one another, and that very little movement has been made from these positions toward consensus over the last four years is deeply concerning, and does little to suggest that meaningful consensus on the details of PABS can be reached in the limited timeframe left.

⁹ World Health Assembly, *The World Together: Establishment of an Intergovernmental Negotiating Body to Strengthen Pandemic Prevention, Preparedness and Response* (2021); see Clare Wenham, Mark Eccleston-Turner & Maike Voss, *The Futility of the Pandemic Treaty: Caught Between Globalism and Statism*, 98 INT’L AFF. 837 (2022).

¹⁰ World Health Assembly, *supra* note 9.

¹¹ Abbie-Rose Hampton et al., *“Equity” in the Pandemic Treaty: The False Hope of “Access and Benefit-Sharing,”* 72 INT’L & COMP. L. Q. 909 (2023).

The issue has become more important in the negotiations (and more difficult to reach consensus on) because it has become the focal point for equity discussions in the treaty. Earlier drafts sought to have a more expansive view of equity, and more aspects of the treaty worked toward an equitable response in the future. As those issues have been removed or watered down by the negotiation process, PABS is all that is left for any semblance of equity to be attached to the agreement, and parties have become less willing to compromise.

Geopolitics and the Future of Multilateralism

The broader geopolitical environment complicates treaty negotiations. Firstly, the concurrent invasion of Ukraine and the war in Gaza produced significant challenges across the UN system, which inevitably fed into tensions in the INB negotiations. Secondly, political antagonism, such as that between United States and China over pandemic origins, transparency, and leadership have impeded consensus and fueled skepticism toward multilateralism in general. Notably, the United States' withdrawal from the WHO in 2020, and then again in January 2025, reintroduced volatility into multilateral governance conceptually, and financially. The withdrawal has triggered concern over funding gaps, disrupted emergency response capabilities, and risked a leadership vacuum. The broader political shift toward entrenched nationalism and protectionist politics in many states has also affected treaty dynamics, shaping how states view proposals that might constrain sovereignty.

This crisis of multilateralism undermines not only health cooperation but global governance more generally, causing states to hesitate before negotiating binding treaty obligations. The “golden age” of multilateral cooperation¹² has given way to fragmentation, as states increasingly prioritize flexible, interest-based alignments over universal frameworks. Such a trend is evident across trade, climate, and health cooperation. These shifts reflect frustrations with the perceived inefficiency of multilateralism but also broader systemic transformations in global order, including the diffusion of power and a growing skepticism toward universalism as a model for cooperation.¹³ The resulting landscape is characterized by an increasingly fragmented and pluralistic governance architecture, where regionalism and bilateralism supplement, and sometimes supplant, the UN system.¹⁴ During COVID-19, states often relied on regional mechanisms, such as the African Union's African Medical Supplies Platform, or bilateral partnerships, bypassing the WHO and UN efforts, once again demonstrating the limits of the UN system and a global multilateral order.

Conclusion

At a time of retrenching multilateralism, many see the adoption of the pandemic agreement as a success in the face of declining international cooperation. In this context, the pandemic agreement represents both an attempt to revitalize multilateralism and a test of whether global governance can adapt to fractured contemporary geopolitics. We caution that the pandemic agreement's ultimate effectiveness will depend on whether states are willing to commit to the trade-offs concerning One Health and PABS. The pandemic agreement thus occupies an ambivalent position: symbolically significant as an achievement of collective action, but structurally fragile within a broader international environment characterized by fragmentation and mistrust.

¹² Clare Wenham et al., *From Imperialism to the “Golden Age” to the Great Lockdown: The Politics of Global Health Governance*, 26 ANN. REV. POL. SCI. 431 (2023).

¹³ G. John Ikenberry, *The End of Liberal International Order?*, 94 INT'L AFF. 7 (2018).

¹⁴ Afifah Rahman-Shepherd et al., *Establishing the Value of Regional Cooperation and a Critical Role for Regional Organisations in Managing Future Health Emergencies*, 13 THE LANCET GLOB. HEALTH e585 (2025).