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International WHO Initiatives in Pandemic Prevention: Critique and Prospects[1]

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Abstract

Despite lifting the COVID-19 pandemic status, the medical scientific community agrees that similar crises may recur in the future due to climate change, the rapid growth of the global population, and, consequently, the increased anthropogenic impact on the environment. Negative consequences of human economic activity include the destruction of ecosystems and expanded contact with wildlife, which increases the risk of mutations in existing pathogens and the spread of dangerous infectious diseases. Such processes can be classified as a new type of transnational threat and their timely prevention requires the consolidation of international efforts and the activation of global health diplomacy. Under the aegis of the World Health Organization (WHO), a number of legal and institutional mechanisms involving a wide range of participants have been developed to prevent pandemics and respond to related challenges. This article examines their functioning in the context of similar international cooperation programmes and draws conclusions regarding future development prospects. The work analyzes documents that form the regulatory framework of WHO's international pandemic prevention initiatives and presents various perspectives from domestic and English-language literature on the assessment of the organization's activities. The main focus is on the draft of the Pandemic Prevention, Preparedness, and Response Treaty, the WHO Pathogen Access and Benefit-Sharing System, the International Health Regulations, and the activities of COVAX. The author concludes that the results achieved by WHO do not meet its initial plans, and the reasons for the failures are systemic. They include countries' unwillingness to take on commitments that potentially limit state sovereignty, including accountability for breaches of agreements, as well as challenges with funding and limited transparency of international health organizations' activities overall. Practical recommendations are formulated regarding the formation of Russia's position on the future Pandemic Prevention, Preparedness, and Response Treaty.

Keywords: pandemic, Disease X, WHO, UN, Pandemic Prevention, Preparedness and Response Treaty, COVAX

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Introduction

The COVID-19 pandemic exposed the weaknesses of national healthcare systems, exacerbated political and economic contradictions between many countries, but at the same time proved the necessity of collective efforts to combat such challenges and expand global health diplomacy [Arsent'eva, 2022].

Traditionally, the primary initiatives concerning the normative regulation and institutionalization of international cooperation in the health sector come primarily from the WHO. Since its inception in 1948, bringing together 194 countries, it has aimed to achieve the highest possible level of health for humanity. In 2019, a large-scale reform of the WHO began, involving the introduction of digital technologies and innovations, the creation of new structures and work models to eliminate the duplication of functions of individual departments, the optimization of the regulatory framework, investment in staff training, and the attraction of new funding sources to reduce dependence on major donors. This process is still ongoing and is driven by the organization's current priorities – the Triple Billion targets announced in 2018 as part of WHO Director-General Dr. T.A. Ghebreyesus's modernization program. One of these goals is to ensure more effective protection in health emergencies, to achieve this, clear quantitative criteria were formulated. The results were initially expected to be summed up in 2023, but the pandemic caused delays, extending the deadlines by another two years. All in all, thirty-seven countries have received grants to strengthen their capacity to prevent and respond to infectious disease outbreaks. The coverage of the population with vaccines against measles, polio, cholera, meningitis, and yellow fever is gradually returning to pre-pandemic levels, and the number of countries using genomic sequencing methods for early detection and in-depth study of new pathogens is also increasing [WHO, 2024a].

The WHO has been warning about the possibility of a global epidemic since the Ebola fever wave. In 2016, to enhance operational capacity in case of a new disease outbreak, the Research and Development Blueprint for Action to Prevent Epidemics was adopted [WHO, 2016]. It emphasizes the need for urgent analysis of the situation on the ground immediately after receiving a notification of the detection of dangerous pathogens; evaluation and study of the emerging threat; and the formulation of recommendations and adoption of urgent response measures. Experts prepared a list of the most dangerous infections capable of causing a future pandemic. Initially, it included viruses of hemorrhagic fevers (Crimean-Congo, Marburg, Lassa, Rift Valley, Ebola), Nipah, Zika, and coronaviruses that provoke MERS and SARS respiratory syndromes. In 2018, an unknown variable – Disease X – was added to the list, which might spread widely, being caused by an unknown pathogen (virus, bacterium, fungus, parasite, or prion).

In this context, the theory of Kate Kelland, the author of the book "Disease X: 100 Days to End the Pandemic" [Kelland, 2023], is of interest. It took humanity 11 months to create a vaccine against SARS-CoV-2, and most likely, this time will not be sufficient in the future. The extremely high transmissibility of a probable new pathogen makes one think about the minimum possible time to find an effective way to combat it. Kelland's calculation is as follows: information about the pathogen must be quickly transmitted by local healthcare workers to the national health system, and then to the WHO. Within four days of this, the complete genetic sequence of the new virus is established and subsequently placed in open databases. Five days later, a complete quarantine is introduced in the country where the virus was discovered. Coordinated work on creating the corresponding vaccine based on pre-prepared prototypes provided by a specially founded organization for these purposes begins. Considering the testing process, 100 days should suffice to localize the epidemic and vaccinate the population.

Refraining from commenting on the optimism of Kelland's proposed program, it is worth noting its two key components: timely dissemination of information and collective vaccine creation based on existing developments – a quite logical prioritization in the uncertainty inherent in any crisis. The WHO's activities to prevent pandemics are built along these two lines. Therefore, the aim of this article

is to identify the strengths and weaknesses of the international initiatives of this organization aimed at forming a global pandemic prevention system, which, in turn, involves considering the features of their legal and institutional framework, identifying the most difficult issues to agree on at the intergovernmental level, as well as forecasting the practical application and potential for their operational compatibility.

The empirical methods used in this work are focused on analyzing documents that form the regulatory framework of the WHO's international initiatives in pandemic prevention, as well as domestic and English-language scientific literature. The limited number of relevant publications released since the beginning of the COVID-19 pandemic allowed, through deconstruction and apperception of different authors' views, to present a palette of the main critical remarks concerning the WHO's activities. Classic general logical methods of scientific cognition helped formulate the main conclusions.

Main Provisions of the Pandemic Prevention, Preparedness, and Response Treaty

After the official end of the COVID-19 pandemic, the WHO continues to stimulate global interest in Disease X. Public resonance around this topic has increased after its discussion at the Davos Economic Forum in January 2024. WHO Director-General Dr. T.A. Ghebreyesus emphasized that the organization's top priority and duty to future generations is the signing of *the Pandemic Prevention, Preparedness, and Response Treaty* (hereafter referred to as the *Treaty*) [WEF, 2024]. Work in this direction has been ongoing since December 2021, the drafting and coordination of the text is handled by the Intergovernmental Negotiating Body (INB) with the support of the WHO Secretariat and engagement of a wide range of non-state participants providing their suggestions during public hearings.

Initially, it was assumed that the conceptual draft of the *Treaty* would be adjusted until the approval of the final version at the 77th session of the World Health Assembly in May 2024. However, the delegates could not reach a common understanding and decided to hold voting next time after resolving all disagreements. The *Treaty* is intended to fill several gaps in international law which were identified during the COVID-19 pandemic – to create global mechanisms for ensuring preparedness and responding to health emergencies, including provision of stable and predictable funding, establishing control measures, building trust, and increasing transparency.

However, even the name of the final document remains uncertain – its draft version can still be called a treaty, accord, agreement, or even convention, depending on what the repeatedly revised text will finally represent. For example, the version from October 30, 2023, attempted to formulate the first legal definition of the term "pandemic" – "the global spread of a pathogen or its variant that infects human populations with limited or no immunity through sustained and high transmissibility from person to person, overwhelming health systems with severe morbidity and high mortality and causing social and economic disruptions, all of which requires effective national and global collaboration and coordination for its control" [WHO, 2023].

The definition turned out to be vague: it does not allow distinguishing between a pandemic and an epidemic. It is unclear what constitutes "overwhelming health systems" (there are no references to particular morbidity and mortality indicators as criteria) – this threshold will vary for different countries. In turn, declaring a pandemic entails the need for countries to comply with several international obligations, including imposing restrictive measures, and significantly increases the risk of WHO abusing its powers [Singer, Thompson and Bonsall, 2021]. As a result, in the version dated of March 13, 2024, the faulty definition was removed completely – a very controversial solution given that countering a pandemic requires a clear understanding of the term [WHO, 2024c].

The draft *Treaty* contains key recommendations primarily related to improving national health

systems and epidemiological surveillance in accordance with the UN's One Health concept (which includes three main components – the health of humans, animals, and ecosystems) and risk management strategies related to legal liability in the production, distribution, and use of new vaccines developed for pandemic pathogens. The necessity of cooperation in scientific research is declared, as well as international solidarity in creating effective measures and procedures for pandemic prevention, preparedness, and response, with a particular emphasis on helping developing countries.

For sustainable and geographically diversified production of pandemic-related (diagnostics, treatment, personal protection equipment, vaccines, etc.) and routine health products, *Treaty* parties commit to encouraging and facilitating the transfer of relevant state-funded technologies and know-how, primarily to developing countries. This process is expected to be carried out through licensing or within special international cooperation mechanisms with the WHO participation as a coordinator. According to Article 11 in its latest version, states should consider temporarily suspending intellectual property protection for the duration of the pandemic and, if necessary, may use the flexibility provisions of the WTO TRIPS Agreement. Previous versions of similar clauses were more imperative and also applied to commercial organizations.

The text states that after the *Treaty* comes into force, appropriate models and strategies will be developed to establish liability and no-fault compensation for harm to human health caused by vaccination. A similar program, the first of its kind, already exists within COVAX, which allocated funds for these purposes and thereby encouraged low- and middle-income countries to use vaccines developed in the shortest possible time.

The *Treaty* conditions involve the continuous existence of a multilateral cooperation format – the Secretariat and the Conference of the Parties, coordinating their actions with the World Health Assembly. It will be responsible for regularly reviewing the *Treaty's* implementation results and will be able to create bodies directly subordinate to it to solve the tasks set and to address experts for counselling.

To fund pandemic prevention, preparedness, and response measures, as well as to implement the International Health Regulations (2005), a Coordinating Financial Mechanism accountable to the Conference of the Parties is planned, fueled by mandatory and voluntary contributions from member countries, as well as charitable and public organizations.

Thus, the WHO is looking forward the *Treaty*, which, judging by its broad scope and described institutional structure, was initially conceived as a core of the entire future global system for pandemic prevention and response to any health emergencies, based on the logic that, along with weapons of mass destruction, they require special international control measures [WHO, 2022]. The *Treaty* does not provide fundamentally new, breakthrough tools; its main provisions are largely a revision of previously existing, often unconnected mechanisms, the review of which follows.

WHO System for Access to Pathogenic Microorganisms and Benefit-Sharing

A special attention should be given to the initiative outlined in the *Treaty* for the establishment of the *WHO Pathogen Access and Benefit-Sharing System (PABS)*. *Access and Benefit-Sharing (ABS)* is a conceptual framework describing the method and procedure for obtaining access to genetic resources (including human pathogens) and the distribution of benefits from their use, primarily vaccines and medicines.

The need for legal regulation of issues related to ABS arose long before the COVID-19 pandemic and began to be openly discussed against the backdrop of the avian influenza outbreak in 2005. Indonesia then began regularly providing its H5N1 samples to the *Global Influenza Surveillance and Response System* (GISRS, 1952). In 2007, its Minister of Health stated that by providing virus samples, developing countries become even more vulnerable as they do not receive new vaccines,

their scientists are not involved in the research, and this, in turn, contributes to global inequality. By deciding to stop providing virus samples to WHO due to a loss of trust in the organization, Jakarta put an end to the half-century-long practice of freely sharing such materials [Roos, 2008].

In response to criticism, in 2010, the *Nagoya Protocol on Access to Genetic Resources and the Fair and Equitable Sharing of Benefits Arising from their Utilization* (which came into force in 2014) was adopted as a supplement to the *1992 Convention on Biological Diversity*. Thus, ABS received its legal form. The main essence of the protocol boils down to the need for the "prior informed consent of the parties", one of which transfers genetic resources and associated traditional knowledge, and the other receives and agrees to use them on "mutually agreed terms". For these purposes, coordination centers and competent authorities are established in each country, as well as a mediation mechanism as the main instrument for implementing the protocol.

Within the scope of this article, another legal instrument is of interest, specifying the application of the Nagoya Protocol concerning viruses – in 2011, the WHO adopted the *Pandemic Influenza Preparedness Framework for the Sharing of Influenza Viruses and Access to Vaccines and Other Benefits (PIP)* [WHO, 2011], which implies signing of Standard Material Transfer Agreements within GISRS. Laboratories entering into these agreements should not seek intellectual property rights over the received biological material. The PIP mechanism applies to national influenza centers, other authorized laboratories, and WHO collaborating centers. The pharmaceutical industry is not included in this list.

Despite the desire to protect the interests of all parties involved in the transfer of genetic resources, the 2014 Nagoya Protocol is often criticized. Firstly, ABS in terms of benefit-sharing between the provider and user creates significant bureaucratic constraints – complying with all the prescribed rules takes a lot of time, which is very precious in the context of a potential pandemic. Moreover, many countries have developed relevant national legislation, which has significantly complicated international cooperation in this area.

Secondly, the protocol concerns genetic resource samples; therefore, the question arises whether it is applied to digital sequence information (DSI) on genetic resources. If not, as believed by the USA, EU, and Japan, for instance, its use does not entail benefit-sharing with providers, and the emerging global practice of publishing such materials in publicly accessible databases makes the ABS mechanism meaningless. This issue is being worked out at the expert level under the guidance of the Conference of the Parties to the Convention on Biological Diversity – debates here revolve around the problem of defining DSI and its scope, methods of tracking, control, and benefit-sharing from its use [UNEP, 2021].

The Director General of the International Federation of Pharmaceutical Manufacturers & Associations (IFPMA) believes that if China had decided to strictly comply with the provisions of the Nagoya Protocol, it would have had to start bilateral negotiations with each country individually to transfer data on SARS-COV-2, a process that would have stretched for many months. However, the WHO promptly confirmed the existence of the new coronavirus, and then information about its genetic sequence was published in the public domain almost immediately, in January 2020.

It is difficult to judge how timely the actions described above were, given the controversy over the virus's origin. The Wall Street Journal, covering the investigation conducted by the US House of Representatives, published an article based on materials from the federal Department of Health [Strobel, 2024]. According to its testimony, on December 28, 2019, Dr. Lili Ren from the Beijing Institute of Pathogen Biology uploaded SARS-CoV-2 DSI to GenBank. However, the US National Center for Biotechnology Information (NCBI), which oversees it, deleted all data since a clarifying counter-request was ignored. As a result, almost two weeks later, on January 11 and 12, respectively, China officially informed the WHO about the new virus and placed the DSI, obtained jointly with Australian colleagues, on another platform – first on virological.org (an unofficial forum), and then added it to other open databases.

American experts accuse their Chinese colleagues of refraining from detailed comments regarding the connection of the identified virus with pneumonia cases in Wuhan, as well as official

Beijing, which unjustifiably maintained a wait-and-see attitude and artificially restrained the spread of information about the epidemic. This created grounds for speculation regarding the origin of COVID-19 and the time of its detection. In the absence of other confirmed facts, the only explanation for the actions of the Chinese authorities is their desire to gain time to take appropriate measures to contain the crisis and demonstrate the country's readiness to respond to emergencies as quickly as possible.

As for the WHO's position, it did not clarify the confusion that arose – the report on the virus's origin prepared in March 2021 [WHO, 2021] was written by a group of researchers, half of whom were the WHO staff and the other half was appointed by the Chinese government. They provided empirical data (the Chinese authorities denied the WHO access to raw patient data) for joint analysis with the foreign co-authors, resulting in no conclusive findings about the virus's mutation and the circumstances of its transmission from animals to humans. Nevertheless, the version of a laboratory leak of SARS-CoV-2 was deemed «extremely unlikely», the conclusion was later criticized by the scientific community due to the lack of incontrovertible evidence and the political significance of such an important issue, even considering the hypothesis of an artificial virus origin [Hernandez, Corman, 2021].

In other words, the ABS mechanism does not guarantee that in the event of the detection of a dangerous pathogen, information about it will become available to other countries straight away due to political and administrative complications. It is possible to solve the problem only if the use of DSI is subject to the same legal rules and procedures as genetic resources, and this presents the innovation of the *Treaty*. Declaring the absence of any contradictions with the Convention on Biological Diversity and the Nagoya Protocol, it elegantly evades terminology issues and outlines two similar scenarios for state transmission of sequence data of pathogens with pandemic potential: for biological materials, including genetic resources, and for DSI.

The WHO plans to become the coordinator of the currently forming global network of laboratories, biorepositories, and data banks. When signing the relevant documents, it will be sufficient to transfer information and materials to just one element of this network for further distribution worldwide retaining the PABS labelling with the source of origin indicated at all stages of use, up to the manufacturing of the final product or publication of a scientific article. The first step was taken back in 2021 when the WHO launched the BioHub program. Its first facility was a center in Spiez, Switzerland, which will eventually integrate laboratory networks of program-participating countries, providing access to biological materials and DSI (this issue is still being worked out), including to pharmaceutical companies. Another significant initiative was the launch of the new coronavirus network CoViNet in March 2024, which brought together 21 countries. Their joint work will form the basis for the conclusions of WHO Technical Advisory Groups on virus evolution and vaccine composition [WHO, 2024d].

However, the *Treaty* does not specify the recommended time frame within which data on the genomic sequence of pathogenic microorganisms with pandemic potential must be transferred, nor does it prohibit their placement in publicly accessible databases (for example, GenBank, GISAID [Covington, 2023]. The absence of such requirements represents a way to bypass the future PABS system, significantly reducing its effectiveness – a situation referred to as a "benefit-sharing loophole" [Hampton, 2023].

In light of the difficulties described above, the best option seems to be the rejection of a "package" approach, where access to pathogens and data on their genetic sequences in the context of a potential pandemic and the urgent search for suitable vaccines is directly tied to the fair distribution of countermeasures. These should be treated as two separate issues to eliminate bargaining between states, lengthy negotiation processes, and bureaucracy.

Access to Pandemic Countermeasures

When discussing the sharing of benefits arising from utilization of pathogens, pandemic countermeasures are primarily implied – diagnostics, personal protective equipment, medications, and vaccines. A notable tool developed under the WHO's aegis in this area is the Access to COVID-19 Tools (ACT) Accelerator, launched in April 2020. This initiative brings together governments, private businesses, NGOs, charitable foundations, and research centers.

The COVAX mechanism was introduced within the ACT. Its purpose was twofold: first, to select the most promising vaccines (including Pfizer-BioNTech, Moderna, Sinopharm BBIBP-CorV, AstraZeneca, AstraZeneca-SKBio, and Johnson & Johnson); and second, to ensure adequate production volumes to establish optimal pricing and subsequent sales to low-income countries (covering vaccine expenses for 20% of their population), as well as other countries without bilateral agreements with pharmaceutical companies.

COVAX ceased operations in December 2023, reporting the achievement of its goals. However, in the early stages of the pandemic, when urgent measures were needed to create a sustainable global immunity, overcoming "vaccine nationalism" was not successful. Manufacturers were reluctant to fulfill their obligations to the WHO, as many had already signed bilateral contracts with countries. This undermined the concept of COVAX, which aimed to have deliveries to the Global South covered by the price differences [Médecins Sans Frontières, 2021]. The leadership of COVAX, responsible for vaccine procurement from manufacturers – *the Global Alliance for Vaccines and Immunization* (GAVI) – faced criticism. Organizationally, GAVI represents a public-private global partnership (PPP), a form of collaboration between governments and businesses to address socially significant issues on mutually beneficial terms. The main sponsors include the United Kingdom, the Bill and Melinda Gates Foundation, the United States, and Norway. The primary problem was that PPPs typically do not pressure their partners –pharmaceutical companies – and do not encourage them to bypass existing market mechanisms, ignoring commercial profit, for the sake of public good.

Ultimately, while COVAX's overall supply volume was met, the planned timelines were missed, which was critical in the early pandemic stages. For example, GAVI's official documentation shows that the target for vaccine deliveries consistently dropped throughout 2021, from 2 billion doses to 1.4 billion, yet even this figure was not reached – only 910 million doses were delivered [de Bengy Puyvallée, Storeng, 2022].

COVAX's failure can be attributed to several key reasons: "vaccine nationalism" [Zhou, 2022] by developed countries (accounting for 15% of the world's population but having purchased 60% of the available vaccine pool bilaterally by January 2021), limited financial participation of high-income countries in COVAX, lack of transparency in deals with pharmaceutical companies, export restrictions by some states, insufficient vaccine production facilities in the global south, low levels of technological cooperation, and over-reliance on AstraZeneca [Pushkaran, Chattu, and Narayanan, 2023].

The legal framework of COVAX also had shortcomings: firstly, its existence did not preclude bilateral agreements outside the alliance; secondly, participation did not involve situational changes regarding intellectual property rights (limiting production volumes and increasing prices: for instance, South Africa paid €5.25 per dose in January 2021, while the EU – just €2.16); thirdly, COVAX's operation was supposed to be self-sustaining through price differences in purchases and deliveries but ended up fully dependent on voluntary contributions from high-income countries .

It is worth noting that the COVAX proportional distribution scheme also does not stand up to criticism. The slogan "no country should vaccinate more than 20% of its population until all countries reach 20%" was ineffective because this percentage was insufficient to achieve national herd immunity. High-income countries did not adhere to this target from the very beginning. Moreover, COVAX intended to supply vaccines based on equality, not equity. The first vaccine shipment went to Ghana, where the COVID-19 situation was significantly better than, for example, in Chile [Kalaitzidis, 2021]. However, even formal equality could not be attained – COVAX did not limit the possibility of targeted donation of vaccines in any way, as a result, the geopolitical aspect, "vaccine diplomacy" inevitably came to the fore – in total, about 42% of doses were distributed according to

the wishes of donor countries [Pushkaran, Chattu, and Narayanan, 2023]. Moreover, pharmaceutical companies themselves created additional difficulties for a number of legal reasons prohibiting governments purchasing vaccines from transferring or reselling them to third countries and organizations. In each case, the process of agreeing on the terms of supply took a long time and was a trade secret [Reuters, 2021].

Thus, COVAX failed to address "vaccine inequality" promptly particularly affecting African countries [Wei, Kamande, and Lang'at, 2023]. By early 2024, 51.8% of the continent's population was vaccinated instead of the target 70%, which the WHO had aimed to achieve by mid-2022, with COVAX delivering only 62.7% of all vaccines. The remainder came through other channels, such as the African Vaccine Acquisition Trust (AVAT) and bilateral agreements [Africa CDC, n.d.].

A similar mistake is evident in the draft text of the *Treaty*, which requires the WHO to make agreements under PABS with manufacturers of diagnostic, therapeutic tools, and vaccines to provide 10% of their products for free and 10% at non-commercial prices for distribution through a specially organized *Global Supply and Logistics Network (the Network)* during a public health emergency of international concern. This provision in Article 12 lacks guarantees, does not specify if the agreement details will be publicly available, outlines no principles for distribution to end-users, and offers no sanctions or incentives to influence governmental and private companies.

International Health Regulations

In parallel with the preparation of the Pandemic Prevention *Treaty*, there was active discussion about the International Health Regulations (IHR) of 2005. These regulations serve as a unified structural and functional framework for activities aimed at ensuring "sanitary and epidemiological well-being of the population in the event of a public health emergency of international concern". The regulations include a list that is open to new infectious diseases and an algorithm for verifying emergencies for proactive, rapid, and flexible responses to potential threats. The effectiveness of the IHR is ensured by their mandatory nature [Popova et al., 2017].

The ongoing risk of future pandemics has sparked debates about the need to revise certain points of the IHR to adapt them to contemporary realities. The WHO members initially did not plan extensive negotiations on the entire document to avoid serious disagreements between states [Butchard, Balogun, 2023].

As a result, at the 77th World Health Assembly in May 2024, several amendments were adopted [WHO, 2024b]. The main point introduced the new concept of a "pandemic emergency", which the WHO Director-General has the right to declare; other changes involve appointing or establishing a national coordinator and/or national authority to monitor compliance with the regulations within the jurisdictions of member states, as well as convening a committee to facilitate the implementation of the IHR for experience exchange and mutual learning. In other words, the new edition introduces additional bureaucratic procedures and is limited to recommendations.

Criticism of the Pandemic Prevention Treaty

The Pandemic Prevention *Treaty*, in the current development and negotiation stage, is facing criticism. The most controversial issue is the uncertainty regarding its legal binding nature. Russian legal scholars E.V. Safronova and N.S. Petrishcheva consider the resulting text as determination of the "contours of a global system for managing national healthcare systems". In their view, the existing project limits the state sovereignty of countries by delegating some powers to transnational elites [Safronova, Petrishcheva, 2023]. Specifically, the authors are most concerned about the points related to the obligations to give developing countries access to technologies and innovations, to promote the development of research capacity, to introduce international standards for training qualified personnel, to provide access to genetic resources, to conduct international simulation exercises and inspections,

to strengthen the role of the WHO as a coordinating body, etc. Researchers accuse the WHO of attempting to establish a ban on independent expert opinions, as the draft *Treaty* defines a new concept of "infodemic" – false or misleading information during a disease outbreak that undermines public health measures. However, in the last two editions of the treaty, the drafters, facing difficulties in choosing a legally acceptable wording, removed this point and abandoned the idea of a universal mechanism for collegial assessment of national, regional, and global capacities and gaps in pandemic prevention and preparedness due to concerns from countries that it might infringe on state sovereignty.

The British Parliament also expressed similar concerns, questioning the need for a new treaty when the IHR already exists and whether the collegial body created under it would turn into an institute of supranational control. However, during the House of Commons debates in April 2023, Anne-Marie Trevelyan, then Minister of International Trade, assured on behalf of the government that the text did not threaten national sovereignty – London would retain control over all health-related decisions, including vaccination [UK Parliament, 2023].

An interesting opinion comes from A. Phelan, an expert in international health law from the Johns Hopkins Center for Health Security. She believes that recognizing the different capacities of countries in pandemic prevention alongside the principle of equity, meaning all have "unhindered, equal, and timely access to safe, effective, quality, and affordable products and services", as well as technologies, relevant information, and social support measures, the *Treaty* drafters abandoned the idea of including a point on "common but differentiated responsibilities" of states, removing it even from the preamble, though it had been highlighted separately in the "zero draft" of the Treaty with several options. This approach to solving global problems was first formulated within international environmental law and means that countries should act proportionally to their capabilities. High-income countries indicated their reluctance to include it, citing incompatibility with universal obligations for pandemic preparedness and response.

Lawrence Gostin, director of the WHO Collaborating Center on National and Global Health Law at Georgetown University, points out other weaknesses of the *Treaty* – countries avoid taking on international obligations, primarily financial ones [Balakrishnan, 2023]. The UN attempts to update the topic of pandemic prevention (examples include the *UN General Assembly High-Level Meeting on Pandemic Prevention, Preparedness, and Response, the Global Preparedness Monitoring Board* (GPMB) created jointly by the WHO and the World Bank Group, the *Global Health Threats Council*, and initiatives by the G-7 and G-20) [Anderson, 2023]. Nevertheless, the issue of sustainable funding sources and volumes for pandemic prevention, preparedness, and response remains a significant problem. Gostin acknowledges that few of his colleagues are optimistic about the future of projects like *the Pandemic Fund* created by the World Bank, the WHO, and partners at the G-20 summit in Indonesia in 2022. The target amount of necessary funds was set at $31.1 billion, but by January 2024, only $2 billion had been raised [World Bank Group, 2023]. Similar problems may arise with the material support for implementing the provisions of the *Treaty* under consideration.

Concerns are also raised by provisions implying restrictions on intellectual property rights, alongside a point calling on states to facilitate fair distribution of pandemic countermeasures among developing countries by transferring 20% of such produced means to the WHO, as well as technologies and know-how for timely scaling up their production. Analysts from the think tank at the Ministry of Health and Family Welfare of India question how supply chains will be organized, how the list of countries in need of assistance will be formed, etc. [Gandhi, Dumka, and Kotwal, 2023].

American researchers Brett Schaefer and Steven Groves believe that the United States should oppose voting for the treaty draft [Schaefer, Groves, 2024]. Reviewing the document's text, they focus on political aspects – criticizing China and calling for a clause on the need for a comprehensive investigation into the origin of COVID-19. They are dissatisfied that the initial draft's provisions obliging governments to provide immediate access (within their jurisdiction or control) to international expert teams to sites where dangerous pathogens are detected for threat assessment and rapid response deployment; ensure full and timely disclosure of genomic data; and explain steps related to neglecting trade and movement restrictions. Additionally, Schaefer and Groves focus on points declaring the need

to assist developing countries (which, according to the UN, includes China, the world's second-largest economy) in strengthening pandemic countermeasures capacity – analysts argue that assistance should be voluntary and that it is more logical to distinguish countries based on their income levels, as the World Bank does. Given the overall "weakness" of the document and the lack of certainty on many points, they recommend that the U.S. Congress not ratify the Pandemic *Treaty* even if it is signed. On the other hand, such a step carries reputational risks, so their colleagues urge the government not to miss the opportunity to strengthen American influence in the developing world to maintain global leadership [Imparato, Nagar, 2023].

Conclusions

The Pandemic Prevention *Treaty* could become a significant milestone in global governance akin to the Paris Agreement, depending on its final content, the presence of strict norms ensuring fair resource distribution, and the implementation of the "One Health" approach to zoonotic disease prevention. However, the draft is largely declarative, with numerous vague formulations and reservations ("within the means and resources available", "in accordance with its capabilities", "on mutually agreed terms", etc.), reflecting countries' reluctance to commit to clearly defined procedures and standards.

The text does not mandate countries to implement any restrictive measures in the event of a pandemic (such as those related to international travel and trade). Given the general nature of the recommendations for governments, it raises the question of why it should be formalized as a separate treaty rather than as an addendum to the International Health Regulations (IHR). The IHR mainly focus on early detection and notification of cases that potentially pose a public health emergency of international concern. In contrast, the *Treaty* is aimed not only at containment but also at preventing such situations, which requires robust accountability mechanisms capable of significantly enhancing the role of the WHO.

Plans include creating a Conference of the Parties, a Secretariat, a WHO Global Supply Chain and Logistics Network, and a Coordinating Financial Mechanism to fund their activities and implement the *Treaty* provisions. The rules of procedure for their operation will be agreed upon separately, with no guarantees that future subordinate bodies and expert advisory groups will not emerge, further increasing the bureaucratic burden on the WHO and leading to additional expenses beyond mandatory membership fees, the size of which is also yet to be determined.

Against the backdrop of financial uncertainty, disagreements over the Pandemic Access and Benefit Sharing (PABS) system, and the failures of the COVAX initiative, conflicts are intensifying between high- and low-income countries, particularly between Africa on one side and the US and Europe on the other. For the former, priorities include supporting their national pharmaceutical industries and gaining full access to scientific data (i.e., pathogen samples and genomic sequencing), perceived by the latter as a key leverage in vaccine distribution and technology transfer for local production, implying the relinquishment of intellectual property rights. The atmosphere of mutual distrust narrows the possibilities for compromise on key provisions, and with each round of discussion, the *Treaty* is gradually being diluted. Additionally, the political will of governments to conclude any agreement potentially limiting sovereignty diminishes over time as other events push health issues off the global agenda.

The Russian Federation, after severing relations with many Western countries, reacts cautiously to the WHO activities. State Duma Deputy Speaker Pyotr Tolstoy mentioned that leaving this organization is "on the agenda" for several reasons: it supported anti-Russian sanctions, closed its Moscow Office for the Prevention and Control of Noncommunicable Diseases (which was largely funded by Russia), supports the concept of the "third gender" and does not consider transsexualism a deviation, therefore the country has to use the previous version of the international classification of diseases, etc. The WHO's decision to suspend the approval process for the Sputnik V vaccine due to the military operation in Ukraine is also seen as purely political.

Nevertheless, Russian Health Minister Mikhail Murashko emphasizes the importance of cooperation in epidemic and pandemic prevention, considering withdrawal from the organization premature. The medical community supports his view: however, surveys indicate that more than half of respondents do not believe that leaving would negatively impact the country. Those in favor of remaining highlighted the importance of the organization's informational and educational role, providing opportunities for professional knowledge acquisition and the development of medical science in general [RBC, 2022].

The *Treaty*, in its current form, will not fundamentally change anything for Russia. However, a demonstrative refusal to sign it could be seen as a desire to distance itself from global medical diplomacy and collective efforts to aid developing countries, leading to reputational losses on the world stage. Furthermore, the actual implementation of the document, involving the creation of specialized bodies to monitor compliance with its provisions and fulfill financial obligations, will not be formalized before 2026. This gives Russia time to foresee the likelihood of its national interests being compromised and to withdraw from the *Treaty* according to its stipulated procedures.

The WHO has often been criticized for lacking sustainable results. Despite successes in combating smallpox, polio, malaria, and tobacco smoking, it has shown inadequacy in responding to the spread of new viruses, such as swine flu, Ebola, and COVID-19, primarily due to insufficient funding: member state contributions constitute less than 20%, with the rest coming from various donations, including from private companies, determining the organization's priorities as well as dependence on key donors. In other words, the WHO is decentralized due to weakly interacting regional offices, not entirely autonomous, and limited in both its authority and resources. States are reluctant to delegate decision-making on issues directly affecting national healthcare systems to the WHO, reducing its role to that of a coordinator.

On the other hand, after the pandemic, it strives to improve its image and create the necessary conditions to strengthen sanitary and epidemiological security. The WHO actively promotes the agenda of preventing the next "Disease X", representing a global threat requiring collective decisions, openness to expanding international cooperation, monitoring, and control by the organization – at the level of academic research, production of vital resources (vaccines, medicines, diagnostics, etc.), and establishing logistics chains for their supply. This implies greater responsibility for both states and businesses and, consequently, increased government allocations, which, as practice shows, countries of the Global North are not ready for, preferring not to limit competition in the pharmaceutical market and not to bind themselves with specific obligations. The Global South lacks leverage to ensure the *Treaty's* practical content rather than declarative provisions. Therefore, the WHO initiatives are weaker than national sovereignty, making it impossible for the organization to realize its significant evolutionary potential at this historical stage.

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