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The pandemic agreement on the home straight?

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The "Geneva Telegram" deals with events in Geneva's multilateral organizations on a current topic, this time the 12th meeting of the Intergovernmental Negotiating Body on the World Health Organization (WHO) Pandemic Convention (INB), which met in Geneva from 4 to 15 November 2024.

The 12th meeting of the intergovernmental negotiating body represented a further step in the negotiations on a global pandemic agreement. Although progress was made, the member states decided not to convene a special session of the World Health Assembly (WHA) in December. Instead, the aim is to conclude the negotiations in May 2025 for the next regular World Health Assembly.

WHO Director-General Dr Tedros Adhanom Ghebreyesus opened the round of negotiations by emphasising the importance of reaching an agreement in the near future: 'Perfection must not be the enemy of good.' Nevertheless, numerous delegations warned that content must take precedence over speed to ensure a robust agreement.

Agreement on the urgency, disagreement on the pace

In the first week of negotiations, the debate centred on the question of whether a special session of the WHA in December 2024 would be possible and tangible enough to adopt the agreement quickly. While the African Group and the USA in particular argued in favour of such a meeting to make rapid progress in view of current health crises - such as the outbreaks of Mpox, H5N1 and the Marburg virus - others, including the European Union and the Group for Equity[1], were sceptical.

EU Ambassador Lotte Knudsen emphasised that the content of the agreement was far more important than the timing of its adoption. It must be certain that the agreement is ready for adoption before convening a special session. This goal was too important to risk a leap of faith that was not backed up by tangible progress in the negotiations.

Germany's representative Björn Kümmel expressed a similar view, explaining that the agreement was like a menu that had to be 'tasty' for all member states for it to be accepted by all 194 countries. Consensus was the 'magic bullet'.

The co-chairs of the INB, Anne-Claire Amprou (France) and Precious Matsoso (South Africa), confirmed that there was clear agreement among the members of the WHO on the need for a pandemic agreement. Nevertheless, additional time was needed to clarify the remaining complex issues. According to Amprou, the member states wanted to ensure that an agreement was created that was not only robust in terms of content, but also sustainable in the long term.

However, WHO Director-General Dr Tedros Adhanom Ghebreyesus urged swift progress. He emphasised that the threat of new pandemics does not wait for an agreement. At the same time, he

[1] The Group for Equity comprises 29 countries, representing an interesting alliance of predominantly African, Latin American and South and Southeast Asian countries, namely: Argentina, Bangladesh, Botswana, Brazil, China, Colombia, Dominican Republic, Egypt, El Salvador, Eswatini, Ethiopia, Fiji, Guatemala, India, Indonesia, Iran, Kenya, Malaysia, Mexico, Namibia, Pakistan, Palestine, Paraguay, Peru, Philippines, South Africa, Tanzania, Thailand and Uruguay.

called on the negotiating partners to be willing to compromise. He presumably suspects that otherwise the time until the WHA could again become too short.

Key advances: Tangible results in research and production

Despite the continuing differences, the negotiations in Geneva were also able to make progress, which are seen as milestones on the way to a comprehensive pandemic agreement.[2] A broad consensus emerged, particularly in the area of research and development (Article 9). The member states agreed on measures to improve access to publicly funded research and its results. This includes, among other things, an obligation to organise clinical studies transparently and to promote the increased exchange of scientific data. These agreements are seen as a key step towards driving innovation in the field of pandemic prevention and making it available globally.

Another success relates to the promotion of local production of health products, as addressed in Article 10. Here, consensus was reached that aims to strengthen production capacities in developing countries. These measures are essential to increase the resilience of healthcare systems worldwide and at the same time reduce dependence on a few production locations in crisis situations. Strengthening local production structures, particularly on the African continent, is seen as key to ensuring access to vital medical supplies during future pandemics.

The negotiations also made progress on strengthening regulatory systems (Article 14). This article was fully 'greened' in the negotiations, which means that agreement was reached on the text. The resulting measures include the acceleration of regulatory processes in developing and newly industrialising countries to enable faster access to vaccines and other medical countermeasures. This has made an important contribution to reducing regulatory barriers in countries with lower capacities and strengthening their ability to respond effectively to health emergencies.

This progress shows that despite difficult negotiations and outstanding points of conflict in other areas, significant results have been achieved that could form the basis for a robust and equitable pandemic agreement.

The dispute over access to pathogens and the distribution of benefits

The Pathogen Access and Benefit Sharing Mechanism (PABS, Article 12) remains the most complex and controversial aspect of the negotiations. The aim of this system is to guarantee countries that provide genetic material from pathogens with pandemic potential equitable access to the vaccines, therapeutics and diagnostics developed from this material.

A central point of contention in the negotiations concerns the obligation to share benefits, in particular the question of how countries that provide genetic material or pathogens can receive a fair share of the resulting products. Developing and emerging countries see a binding PABS system as a fundamental measure to ensure equity. They argue that without such commitments, their countries, which often provide the raw material for research and development, could be excluded from the benefits of global health products. They demand that these countries benefit not only financially, but also in the form of products and technologies resulting from the utilisation of their genetic material.

In contrast, industrialised countries and representatives of the pharmaceutical industry warn that an obligatory PABS system could inhibit innovation. They fear that the obligation to distribute benefits would increase costs for companies and delay the development of new drugs or vaccines. These countries, including Germany, are in favour of a flexible, voluntary model, which they believe would create less bureaucracy and more incentives for the pharmaceutical industry.

Another controversial point relates to the delivery of real-time production during a pandemic. The current draft stipulates that a certain percentage - initially 20% - of the medical products produced during a pandemic should be transferred to the WHO or another global mechanism to ensure equitable access for all countries. Developing countries are demanding that this percentage of production be made available to them to quickly supply their healthcare systems in times of crisis.

[2] The latest version of the draft dated 15 November 2024 can be found here.

However, this percentage was reduced to 10% in the most recent negotiations, which was strongly criticised by African countries in particular. They argue that a further reduction would limit the ability of these countries to respond effectively to potential pandemics and provide their populations with the necessary medicines and vaccines.
The possibility of organising PABS in a separate annex was discussed controversially as a way out. Some delegations feared that this could devalue the mechanism. The group for equity called for clear obligations and a mechanism for independent verification of compliance.

Prevention and One Health as fundamental elements

Articles 4 (Prevention) and 5 (One Health) are key pillars of the envisaged pandemic agreement. Both articles aim to prevent the emergence and spread of future pandemics. Nevertheless, many questions regarding their exact form and implementation remain unresolved, which reduces the chances of an early conclusion.
Article 4 on prevention sets out key commitments aimed at strengthening global health preparedness. These include improving surveillance systems for the early detection of disease outbreaks, expanding laboratory capacities for the diagnosis of new pathogens, and developing prevention strategies against zoonotic diseases - i.e. diseases that can be transmitted from animals to humans. Prevention is particularly important with regard to zoonoses (such as the transmission of viruses from animals to humans) to minimise the risk of epidemics.
However, these commitments have met with resistance, particularly from countries with limited resources that are demanding support in implementing these measures. These countries argue that without external assistance - be it financial, technical or capacity - they are unable to effectively implement the necessary measures. Wealthy countries, including many European states, on the other hand, argue in favour of stricter prevention targets, as they believe that early detection and prevention of diseases would reduce global health risks and thus benefit all countries in the long term. This difference in interests has further complicated the debate on the exact wording and scope of prevention commitments.
Article 5 concerns the One Health approach, which emphasises the link between human, animal and environmental health. This integrative approach is supported in principle by most delegations and is also an important concern for Germany, as it recognises the close links between the various health systems and emphasises that the health of humans, animals and the environment is inextricably linked. In practice, this means that prevention and monitoring measures must not be pursued in isolation, but as part of a holistic approach that encompasses all areas - from animal health to environmental protection and human health.
However, there were also discussions about how specific the commitments should be and whether they should be included in the main text of the agreement or moved to a separate annex. Some delegations argued in favour of a comprehensive and detailed regulation in the main text to emphasise the urgency and importance of this approach. Others only wanted to outline this area in general terms and clarify specific details later, for example in an additional protocol or annex. This separation risks undesirable results.
However, an important step forward in this area is the inclusion of a commitment to cross-sectoral co-operation. This measure should ensure that the different sectors (healthcare, agriculture, environment) cooperate better with each other to enable a more comprehensive and effective response to health crises. However, the exact mechanism for implementing this co-operation remains controversial. There are different ideas about how this cooperation should be organised, who should take responsibility for coordination and how the sectors involved can share resources and data.
Overall, it is clear that despite some conceptual progress, the practical implementation of these key articles - particularly with regard to funding and the responsibility of the various stakeholders - remains a major obstacle to the conclusion of a comprehensive pandemic agreement.

Reactions and subsumption of the results

The decision not to call a special session was described by some as an 'absolute failure', while others welcomed it as a pragmatic step. Representatives of the African Group expressed disappointment as the postponement undermined the credibility of the process. The Equity Group, on the other hand, emphasised that the extra time was an opportunity to make substantial progress in areas such as PABS and prevention.

Helen Clark, the former Prime Minister of New Zealand, emphasised in a statement how urgently the world needed this agreement. She emphasised that it is unacceptable to continue to respond inadequately to health crises while lives are at stake.

The challenges of the coming year

The next round of negotiations will take place from 2 to 6 December 2024. This short but crucial session will set the course for the conclusion of the agreement in 2025. Informal meetings before and during this round of negotiations will be used to bridge existing differences and find urgently needed compromises.

The negotiations are under time pressure: in view of the tense geopolitical situation, the pressure on the negotiations is immense, according to co-chair Matsoso, and the open conflicts, particularly in the central articles 4 (Prevention), 5 (One Health) and 12 (PABS), must be urgently resolved to save the agreement.[3]

In the remaining negotiation period, it will be crucial to clarify the central points of contention. One of the main tasks remains the final agreement on the PABS mechanism. This should contain binding quotas and mechanisms that ensure that countries that provide pathogens receive a fair share of the products developed from them. The aim is to enable the equitable distribution of medical countermeasures (such as vaccines, therapeutics and diagnostics) that are needed to combat the pandemic.

Although the article on financing mechanisms (Article 20) was already 'founded' in May this year, the clarification of these issues remains a controversial topic. This is not only about the alignment with the provisions in the International Health regulations (IHR), the provision of global funds for the implementation of the agreement, but also about the obligation of the member states to provide sufficient funds in their domestic budgets. This is crucial to create the necessary capacities for prevention and One Health - measures that must be financed both globally and nationally.

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[3] This is according to an article on Health Policy Watch.