CSP CADERNOS DE SAÚDE PÚBLICA
REPORTS IN PUBLIC HEALTH

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ESSAY

The proposal for an international convention on the response to pandemics: in defense of a human rights treaty for global health

A proposta de convenção internacional sobre a resposta às pandemias: em defesa de um tratado de direitos humanos para o campo da saúde global

La propuesta de convención internacional sobre la respuesta a las pandemias: en defensa de un tratado de derechos humanos para el campo de la salud global

Leandro Luiz Viegas [1]
Deisy de Freitas Lima Ventura [2]
Miriam Ventura [3]

doi: 10.1590/0102-311X00168121

Abstract

In November 2021, the World Health Organization (WHO) launched the negotiation of a convention, agreement, or other international instrument on the response to pandemics. In this essay we defend and justify the position that this new pact should be a human rights treaty, as an indispensable condition for the prevention of new pandemics and for efficiency of the global response when they occur. After briefly reviewing the origin of the negotiations, we present the principal normative contents that reflect a human rights approach: the establishment of the rule of inseparability between quarantine and social protection measures; regulation of access to pharmaceutical technologies. Next, in a section dedicated to the future treaty's effectiveness, we classify the existing proposals as technocratic adjustments, such as alterations in the procedure for declaring emergencies; mechanisms of transparency and control such as the adoption of a mechanism of Universal Periodic Review (UPR), similar to that of the UN Human Rights Council, to monitor States' health-related obligations; coercive powers to be granted to the WHO or another agency such as inspections in national territories by independent scientists; and mechanisms of political coordination such as the creation of a Global Health Threats Council. We conclude that there is a risk of adoption of a more efficient surveillance system to alert the developed world of threats coming from developing countries rather than a treaty capable of contributing to preventing more vulnerable populations from continuing to be devastated by increasingly frequent pandemics.

Pandemics; World Health Organization; Human Rights; Global Health; International Law

Correspondence
L. L. Viegas
Faculdade de Saúde Pública, Universidade de São Paulo.
Av. Dr. Arnaldo 715, São Paulo, SP 01246-904, Brasil.
llviegas@usp.br

[1] Faculdade de Saúde Pública, Universidade de São Paulo, São Paulo, Brasil.
[2] Instituto de Relações Internacionais, Universidade de São Paulo, São Paulo, Brasil.
[3] Instituto de Estudos em Saúde Coletiva, Universidade Federal do Rio de Janeiro, Rio de Janeiro, Brasil.

Introduction

This essay argues that the new international pandemic treaty, currently under negotiation at the World Health Organization (WHO), will be able to prevent new health catastrophes only if it undertakes a human rights approach to international emergencies. The goal of this text is to mobilize the Brazilian academic community, especially in the fields of collective health, human rights, law, and international relations, calling for the follow-up of the debate about the new treaty, in a critical and constructive way. Although Brazil has given up its former leading role in the field of global health, and it is being identified today as an adversary of the international human rights agenda [1], we still believe that research centers, institutions, and social entities may contribute to this debate, including the chance of giving inputs to activist networks' actions from the Global South focused on the health field.

Considering the obvious shortcomings of the international response to the pandemic and the role played by the Law in national responses, the importance of a new treaty should not be underestimated. The dizzying legislative output on COVID-19 has served both to regulate previously unregulated situations and to establish exceptions to the existing legal order due to the pandemic. The health crisis has been pointed out as a possible pretext for authoritarian drifts in countries ruled by populist leaders [2], and is also perceived as a risk of erosion of consolidated democracies, which may move towards states of exception due to the fact that supposedly temporary rights-restricting measures may become permanent [3,4]. In most countries, the courts are constantly mobilized to evaluate whether such measures are duly justified, efficient and proportionate in relation to the duty to protect public health. In States experimenting a situation of health catastrophe, the judiciary has been the stage of a dispute between actors who seek to ensure the implementation of basic measures to contain the spread of the virus and those who seek to curb those measures [5,6].

Given the large heterogeneity of national response plans to COVID-19, we find that the abundance of standards and sentences is not synonymous with the predominance of a human rights approach. A human rights approach can be defined as one that recognizes the close relationship between health and human rights, that human rights violations can impact health, and that public health policies can affect, either negatively or positively, those human rights [7]. The right to health, in turn, was recognized by Article 12 of the *United Nations International Covenant on Economic, Social and Cultural Rights* (ICESCR) in 1966 as the right of everyone to the enjoyment of the highest attainable standard of physical and mental health [8].

A human rights approach specific to pandemics requires recognizing those rights as a social phenomenon whose prevention requires the protection of individual prerogatives that may be threatened by States; but it equally implies a critique of the social, economic, political and legal structures that prevent people from achieving the right to health [9]. In practice, the difference between a human rights approach and any other approach to a pandemic can be identified in the prioritization of response plans, which must be set in a way to avoid disproportionate repercussions of the disease on the most vulnerable populations. These priorities include an emergency dimension, mainly through the design and implementation of goals, capable of ensuring a fairer distribution of scarce financial and human resources during the crisis, creating or increasing specific public policies for this purpose, as well as encompassing a structural dimension, through medium and long-term goals related to the social determinants of health. It is therefore, not just a matter of the imperative to contain the spread of disease, but also concerns to the political objective of containing the damage impinging people's rights.

In April 2020, the WHO proposed a human rights approach to COVID-19 [10] which included specific measures on the following topics: stigma and discrimination caused by the disease, gender equality and violence against women, and protection of vulnerable populations; shortages of supplies and equipment; and obligations regarding international assistance and cooperation with developing countries; as well as conformity of quarantine measures and other measures restricting rights within the *Siracusa Principles*. This implies that such measures must respect the principle of legality, pursue a legitimate aim, be proportionate and not arbitrary or discriminatory [11]. Certainly, a vast literature will address in the coming years in detail the impact of COVID-19 on these issues in specific places, regions, or countries. Given the information available today, it seems consensual that the health crisis has highlighted or exacerbated the tensions present in each of the items on this agenda, and that governments and societies have not been able to address them satisfactorily.

Considering this finding, it is natural that the effectiveness of international recommendations and norms in the response to the pandemic has been the subject of discussion, in particular the *International Health Regulations* (IHR) [12], approved within the WHO in 2005, which is the legal instrument aimed at curbing the international spread of disease. Although the IHR is in effect in 196 States since 2007, including Brazil [13], it is far from central to the multilateral response to COVID-19. The IHR provide in detail the capacities that States need to develop to respond to emergencies, and guarantee that their implementation will be done with full respect for dignity, human rights, and fundamental freedoms (Art. 3.1). However, though obligatory for States, the IHR do not empower the WHO to monitor effective compliance with these obligations. The irrelevance of the only legal regime that could have prevented a health catastrophe of this magnitude is explained, at least in part, by the resistance of States to submit to a collective security mechanism based on recommendations from WHO experts that would supposedly compromise short-term national interests, configuring a classic problem in international relations [14] as well as in international law.

It is in this context that the World Health Assembly (WHA), WHO's principal governing body, has decided to convene an extraordinary meeting in November 2021 to examine the benefits of drafting a WHO convention, agreement or other international instrument on pandemic preparedness and response aimed to establish an intergovernmental drafting and negotiation process [15].

Through documentary research and non-systematic literature review, we collected the main proposals circulating around the new treaty and classified them into four categories: technocratic adjustments, transparency and control mechanisms, coercive powers that could be granted to WHO or a new agency, and political coordination mechanisms. We defined as main proposals those that are repeated in the researched documents and articles, or those that seem innovative from the perspective of the institutional evolution of the global health field.

The essay is structured as follows: in the first section, we will briefly review the origin of the proposal to negotiate a new international agreement; in the second and third sections, we will address the main contents that, in our opinion, must appear in the treaty for it to be considered a human rights instrument. Those contents are also essential for the prevention of new pandemics and for the efficiency of the global response, namely the institution of the rule of inseparability between quarantine and social protection measures, and the potential advance in the regulation of access to pharmaceutical technologies. Finally, we will dedicate the fourth section to the main proposals aimed at ensuring the effectiveness of the future treaty, which we will address critically.

The origin of the proposed international regulation of pandemics

According to Article 19 of the WHO Constitution [16], the WHA may adopt conventions on any matter within the competence of the organization by a two-thirds majority vote. Unlike health regulations, a convention needs to be formally ratified by States according to their constitutional rites in order to be considered binding. To date, the only convention approved within the scope of the WHO is the Framework Convention on Tobacco Control (FCTC), in 2003, which is in force in 182 States [17]. Brazil was one of the protagonists of this process [18]. Despite the broad adherence, specificity and relevance of its agenda, the FCTC faces challenges to ensure the effective implementation of its provisions [19].

The idea of a new international covenant in global health emerged with greater force about a decade ago [20,21] and has been affirmed over the years with the creation of civil society initiatives such as the Framework Convention on Global Health Alliance (https://fcghalliance.org/about/about-the-fcgh-alliance/#background), based in Geneva, Switzerland. The advent of COVID-19 strengthens this movement, leading members of the G7, WHO, and G20 to discuss the potential usefulness of a new treaty [22].

In March 2021, the adoption of a new treaty was proposed by the WHO Director-General and the President of the European Council, as well as by 25 Heads of State and Government (among them some with decisive role in global health, such as South Africa, Germany, France, Norway and the United Kingdom; from Latin America, only Chile and Costa Rica) [23]. According to proponents, the new treaty would not replace the IHR, which would become part of a broader legal framework. Negotiating a treaty was also recommended by the most important bodies evaluating the interna-

tional response to COVID-19: the Independent Panel on Pandemic Preparedness and Response [24]; and the Review Committee on IHR Functioning during COVID-19, created by WHO, but composed of independent experts [25]. Without making specific reference to a treaty, the Global Preparedness Monitoring Board, an independent body created in 2017 by the UN Secretary-General in response to the Ebola crisis, proposed to organize a summit on global health security with participation of international financial institutions to formulate a framework for preparedness and response to health emergencies, comprising mechanisms for financing, research and development, social protection and mutual accountability, among other aspects [26].

By September 2021, there was no consensus on what the new treaty would contain, nor on the appropriateness of starting to negotiate it while the pandemic is still not under control in much of the world, nor on the real willingness of States to make new commitments, given the selfishness that has marked national responses to the crisis [27] and adverse geopolitical conditions [28]. As for the content of the treaty, no detailed proposals had circulated publicly by September 2021. A list of issues was proposed by the Review Committee on the Functioning of the IHR during the COVID-19 [25]. While ensuring that the IHR will be maintained, the Committee proposes three thematic axes for the new treaty: prevention and protection, covering zoonotic risks, coordination with environmental treaties (for example, on issues such as biodiversity and trade in endangered species), and health emergency planning and preparedness by States; response to emergencies, with commitments regarding information exchange between States, increasing international cooperation for research and innovation, increasing and optimizing manufacturing capacities and distribution of inputs and treatments, among others; and, finally, enabling factors, which would be sustainable funding modalities for States and processes for peer and expert evaluation of their performance – such as verification and inspection procedures, means of dispute settlement, and sanctions for noncompliance – and the protection of human rights and privacy in the context of surveillance technologies, among other aspects.

The proposal offers no detail. Moreover, and without detracting from its importance, it is evident that it is far from a human rights approach, as already defined in the Introduction. In this sense, we consider that the Inter-American Commission on Human Rights (IACHR) has offered parameters of what would be a human rights approach to the pandemic by guiding the member States of the Organization of American States (OAS) through three seminal resolutions. The first interprets the conventional obligations of the States in the face of the health crisis, offering a true frame of reference for national responses [29]. The second deals in detail with the rights of people with COVID-19, their family members, and caregivers [30], while the third deals with the thorny issue of access to vaccines [31]. In the present essay, we will delve into just two aspects that are mentioned in Inter-American law, and which seem to us the most important for the future treaty on pandemics, in order to be considered a human rights treaty.

It is important to emphasize that the influence of a treaty goes beyond the dimension of international relations, since international law, when incorporated into national legal orders by means of the respective constitutional procedures, can be invoked in domestic institutions processes, including public administration and jurisdiction. In this sense, the provisions of an international treaty on the pandemic could be invoked in domestic litigation as a way to recognize or reinforce States' international human rights obligations. It follows that, depending on its focus and content, the new treaty could, in theory, contribute to improve the benefits for human rights of the intensification of the judicialization of health that has occurred as a result of the pandemic.

The recognition of the inseparability between quarantine measures and social protection

Contrary to popular belief, the role of social and economic inequalities in the spread of disease, and in the multiplication of the damage they cause, did not come to the fore with COVID-19. This phenomenon already emerged clearly in studies on emergencies declared by the WHO earlier: influenza A/H1N1 (2009-2010, originating in the United States and Mexico) [32], the congenital Zika virus syndrome (2016, with epicenter in Brazil) [33], the spread of poliovirus (since 2014 and to the present, in countries at declared war, such as Syria, or with diffuse violence, such as Nigeria) [34] and the Ebola virus disease (2014-2015 in West Africa and 2019-2020 in the Democratic Republic of Congo) [35].

In the case of COVID-19, a consistent literature reiterates this phenomenon, demonstrating that inequalities not only compromise the efficiency of national responses, but also lead to a disproportionate impact of the disease on the most vulnerable [36,37], including with regard to mortality [38,39]. We emphasize that especially in developing countries, one of the greatest obstacles to curbing COVID-19 is the inability of large populations to adhere to basic sanitation recommendations. Limitations on access to alcohol gel, sanitation, safe drinking water, decent housing and food, education, and other social determinants of health limit or make basic hygiene conditions impossible to prevent contagion.

Furthermore, measures that restrict the movement of people, especially the closing of commercial activities, bring about an abrupt and significant reduction in income for millions who are part of the informal labor market, causing an increase in food insecurity and hunger [40]. Along with formal workers who have not been exempted from face-to-face work, informal workers are forced to decide between the risk of contagion and the risk of starvation, which potentially entails, besides the increase in cases, deaths, and sequelae, intense psychological suffering. The false opposition between health protection and economic survival also provides fertile ground for the rise of conservative populism [1], advocate of the idea that "the economy cannot stop", and that disease should follow its natural course, with as little state regulation as possible, what has been called "epidemiological neoliberalism" [41].

The literature also shows that the efficiency of the States' responses to COVID-19 has been compromised by actions and omissions during the last decades that have reduced the health systems' capacity for surveillance, containment and mitigation of epidemics, through disastrous political decisions that have accentuated economic inequality, job insecurity and the weakening of public services, making a large part of the population vulnerable to diseases [42]. According to João Nunes, the pandemic of COVID-19 is the product of global vulnerability resulting from the expansion of neoliberalism, especially from the 1980s, when fiscal adjustment policies focused on curbing public spending were adopted, implying a drastic reduction in the budgets of public health systems worldwide [42].

In the international community, there is consensus that social protection should play a key role in the response to pandemics. A coordination mechanism created around the G20 that brings together 25 international agencies (including the World Bank), called the Social Protection Inter-Agency Cooperation Board [43], recognizes the need to encourage adherence to prevention measures through various initiatives, including emergency income programs and exemption from paying for essential services such as electricity, gas and water [44]. By April 2021, 126 States had introduced or adapted social protection measures due to COVID-19, with more than 500 of them still in effect in May 2021 [45]. However, they have been largely insufficient and delayed in many regions of the world. The levels of poverty and extreme poverty in Latin America increased dramatically during the pandemic, with worsening levels of inequality, employment, and labor market participation, especially for women [46].

For these reasons, the inseparability between the adoption of quarantine measures and social protection measures must be explicitly enshrined in international law. A treaty that does not address structural elements will condemn international cooperation to failure. It should also include the guarantee of universal and equitable access to pharmaceutical technologies, among other issues that condition the achievement of the new treaty's objectives.

Pandemic and health apartheid: an upsurge in the struggle for access to pharmaceutical technologies

Since the 1990s, access to pharmaceutical technologies has been a major theme in global health and human rights activism, and also on the agendas of governments in this field. Their rational use and the sustainability of health systems are considered fundamental strategies to enable quality and effective health care. The international bodies specialized in human rights recognize access to medicines as an essential component of the right to health, as a right derived from the aforementioned Art. 12 of the ICESCR [47]. Considering that the intense and rapid development of science and technology has not been reflected in the expansion of human rights, it seeks to make this provision compatible with Art. 15.1 of the same Covenant, which recognizes the rights (b) to the benefits of scientific progress and its applications and (c) intellectual property rights in relation to the technological and scientific innovations developed, in order to enable States to meet the health needs of the population. However, neither the market nor States and international institutions have responded adequately to these

needs [48]. The business dynamic in healthcare and public-private partnerships has produced a global shortage of healthcare resources [49], and even available inputs become less and less affordable for countries and people. The unequal distribution of benefits and risks of innovations is evident, and is related to economic globalization and the declining power of States vis-à-vis the private sector.

In November 2001, within the scope of the World Trade Organization (WTO), on the initiative of developing countries – with expressive leadership of Brazil – it was adopted the *Doha Declaration on the Agreement on Trade-Related Aspects of Intellectual Property Rights* (TRIPS) and Public Health. This famous declaration holds that intellectual property commitments should be interpreted and implemented in a manner supportive of WTO members' right to protect public health and, in particular, to promote access to medicines for all [50]. Despite its importance, the declaration encounters great difficulties in implementation, and the difficulty of access to medicines is no longer restricted to low-income countries or to a limited scope of diseases [51].

Specifically in relation to COVID-19, in April 2020, a report by the UN Secretary General advocated easing intellectual property and focusing on treatments and vaccines for COVID-19 as global public goods [52]. Still within the UN, this position was reaffirmed by the Office of the High Commissioner for Human Rights [53] and the Committee on Economic, Social and Cultural Rights [54]. In the same period, the WHO created the *Access to COVID-19 Tools (ACT) Accelerator* mechanism with the goal of producing 2 billion doses of vaccines, 245 million drugs, and 500 million tests. The rules stipulate that middle-income countries, such as Brazil, must pay for the vaccine, and that some 95 low-income countries, lacking access to bilateral agreements, would have free access [55]. Under the ACT, the WHO has set up a kind of multilateral clearinghouse called the Covax Facility, for global action in centralizing funding, ordering, purchasing and equitable distribution [56].

Nevertheless, WHO initiatives have not been able to avoid the flagrant concentration of doses in rich countries, which have about 15% of the world's population and 45% of available doses, leading its Director-General, Tedros Adhanom, to define the current global COVID-19 vaccine situation as a "catastrophic moral failure" [57] and "sanitary apartheid" [58]. Vaccine research, development, and manufacturing countries such as the United States, members of the European Union, China, and India concentrate most of the global supply of vaccine doses and restrict their export. This is compounded by protection of intellectual property rights over important technologies and disputes over protective equipment and diagnostic kits for the coronavirus [59]. By May 2021, only 3% of people in Latin America and the Caribbean had been fully vaccinated against COVID-19, a "*symptom of over-reliance on imports of essential medical supplies*" [60], given that less than 4% of the medical supplies in use during the response to COVID-19 came from the region. Among the risks arising from this failure, the delay or lack of worldwide vaccination could imply the occurrence of repeated epidemic outbreaks of COVID-19, with viral mutations that may escape vaccines, the emergence of planetary endemic zones of the disease, and the occurrence of eventual outbreaks that cross borders of vaccinated countries, leading the world to a perpetual return to square one by "*not vaccinating widely and turning vaccines into sources of profit, with high cost patents, paying royalties incompatible with the national economies of exploited and colonized countries*" [56] (p. 9).

Against the backdrop of the limits of the international cooperation, the debate over the global flexibilization of product patents has become an unavoidable object for the new treaty. In October 2020, South Africa and India requested WTO permission for all countries to opt out of granting and enforcing patents and other intellectual property related to COVID-19 drugs, vaccines, and other technologies during the pandemic until all people are immunized [61]. In March 2021, the initiative had the support of about 80 countries, the WHO, and organizations such as Doctors Without Borders, but was blocked by the United States, the European Union, and other developed countries, with Brazil being the only developing country opposed to the proposal [62]. Together with Australia, Canada, Chile, Colombia, Ecuador, New Zealand, Norway and Turkey, Brazil advocates a "third way" which would consist in assigning to the WTO the mediation of contacts between developers and manufacturers of pharmaceutical technologies, with a view to: (i) ensuring the identification and use of installed capacity for the production of these medicines; (ii) facilitating the conclusion of licensing agreements for the transfer of technology, expertise and know-how; and (iii) identifying and resolving, on a consensual basis, any trade barriers to the production and distribution of these products, including those related to intellectual property [63].

In our view, the formula proposed by South Africa and India should be in the new pandemic treaty, because, as Tedros Adhanom inquires [62], *"If a temporary waiver to patents cannot be issued now, during these unprecedented times, when will be the right time?"*. But the flexibilization of intellectual property meets resistances within the WHO, despite the speech of its Director-General and the initiatives already mentioned. In May 2021, the WHA adopted a resolution that does not provide for the suspension of patents or technology transfer, which could reduce the costs of vaccines and expand global production, leaving room only for the adoption of voluntary technology transfer measures [64].

The question then arises: assuming that typical issues of a human rights approach to pandemics, such as social protection and access to pharmaceutical technologies, are contemplated by the new treaty, can we expect that it will actually be respected by States? This is what we seek to answer in the following section.

A "WHO with teeth"? Critical analysis of transparency and control mechanisms

In parallel to the negotiation of the new treaty, numerous proposals for reform of the WHO, the IHR and other health-related international instruments are circulating, most of them aimed at strengthening the normative power of the WHO in global health governance. Therefore, the prospects for the implementation of the new treaty are directly related to the evolution of this institution as a whole, now in full boiling state.

In diplomatic jargon, to say that an international organization "is toothless" means that it has no power to impose sanctions on States for failure to fulfill their obligations, which is precisely the case with the WHO. The IHR merely stipulate that States Parties and the Director-General shall submit reports to the WHA (Art. 54). To this end, the WHO has instituted the State Party Annual Report (SPAR), which is a data collection instrument equivalent to a self-assessment, carried out by States since 2010. Available on a public access platform (https://extranet.who.int/e-spar#capacity-score), such data have a doubly limited degree of reliability. Firstly, WHO has no means of compelling a State to participate in the assessment. In 2019, for example, 175 States (89%) provided their data; in 2020, only 164 did so (84%) [65]. Secondly, a mechanism that relies on States' exemption to assess their own capacities tends to offer a watered-down view of the true state of IHR implementation at the global level, which has led to a growing call for an external and independent assessment instrument.

In 2014, the *Global Health Security Agenda* was launched, parallel to the WHO, under the leadership and coordination of the United States, which has among its objectives the promotion of IHR implementation control mechanisms [66]. This agenda, together with other partners, has strongly supported WHO in implementing independent evaluations on the capacities developed by the States, called Joint External Evaluations, which depend on the consent of the States; by 2021, more than 100 countries had already agreed to undergo this type of evaluation [67]. Brazil is not among them. By 2019, Africa had been the continent that adhered the most to external evaluations, covering 40 of the 47 States in the WHO Regional Office for Africa (over 80%); the result of these evaluations led to the conclusion that no African State had managed to implement the national capacities required by the IHR [68]. A 2018 study found strong evidence of correlation between the degree of implementation of IHR-required capabilities, health indicators, and the performance of States' health systems [69].

The slow and flawed implementation of national capacities required by the IHR has been evident since its first implementation at the time of the influenza A/H1N1 pandemic (2009-2010). Since then, several panels and committees have produced recommendations for improving global pandemic preparedness, such as the need to strengthen WHO in aspects such as its funding, normative and coordinating role, and adjustments to the IHR [70,71,72]. There is consensus on the fact that the WHO does not have the means to act immediately and independently, nor to ensure the material conditions for all member States, particularly the least developed, to be able to install the minimum capacities to respond to such events. COVID-19 brought back to the global health agenda the old topic of WHO crisis and reform [73], with proposals for reform ranging from simple changes in the procedure for declaring emergencies, to questioning the WHO's role in pandemic preparedness and response.

Starting with technocratic adjustments, several proposals aim at modifying the WHO emergency declaration mechanism. While the previous versions of the IHR (from 1951 and 1969, the last one

modified in 1973 and 1981) aimed at fighting specific diseases, such as smallpox and plague, the current version of the regulation has as its axis a new legal institute [74]. This is a Public Health Emergency of International Concern (PHEIC), defined as any extraordinary event that may pose a risk to the public health of other States due to the international spread of disease, potentially requiring a coordinated international response [12]. The concept of disease, in turn, includes any affliction, regardless of origin or source that represents or may represent a significant harm to humans [12]. It is the responsibility of the WHO Director-General, with the assistance of an Emergencies Committee, to identify and declare the existence of a PHEIC. We have referred earlier in this article to the emergencies that have already been declared since the new IHR came into force. The multiplicity and complexity of causes and characteristics of these events make comparisons between them difficult, but it is clear that the defining elements of a PHEIC are not its actual severity and lethality, but its potential international reach. That is, what matters is to prevent the threat from leaving the place where it should stay [75]. Thus, the WHO convened other committees to review the Middle East respiratory syndrome (MERS-CoV) outbreaks between 2013 and 2015, a yellow fever outbreak in 2016, and an Ebola outbreak in 2018, which concluded that such events were not PHEICs despite their potential severity. The hesitations of the Directorate-General in declaring an emergency are often pointed out, for fear of being accused of exaggeration, especially by the states in which the threats are originated, who are concerned about the economic and political effects of such a declaration [74]. There are also fears that the declaration will have little impact on the international community, and/or that the degree of adherence of states to the WHO's emergency recommendations will be low [14]. There is consensus in the literature about the lack of transparency regarding the criteria used by the WHO when deciding whether or not an event is an international emergency [76,77,78,79,80]. In this regard, it was proposed to create an emergency alert scale, with different levels of threat severity, which would allow drawing attention to an event without necessarily declaring an emergency [81]. It has also been proposed that PHEICs can be declared regionally, limited to countries contiguous to the country or countries of the emergence of a threat [81]. It is worth noting, however, that technocratic solutions can further complicate the process and will not overcome the real difficulties of implementing the IHR: the limited powers of the WHO, the lack of political will of States to comply with international recommendations, and insufficient funds to finance preparedness and response at the international and national levels [14].

With regard to transparency and control mechanisms, the aforementioned Independent Panel that analyzed the performance of States and the WHO during the pandemic [25] ratified the proposal to adopt a Universal Periodic Review (UPR) mechanism similar to the one done by the UN Human Rights Council. This proposal was put forward in 2019 by a group of African countries and is explicitly supported by the WHO Director-General [82]. The UPR is considered a typical instrument of the strategy of international human rights institutions known as "naming and shaming", also called "the mobilization of shame", which in short consists of exposing the conduct of States to the disapproval of their peers and public opinion. Established in 2006 as a major institutional innovation in the field of human rights, the UPR allows the performance of all UN member States to be subject to peer review over cycles of four and a half years, in which the reviewed State is the target of recommendations and has the obligation to react to each of them, expressing its acceptance or refusal, regardless of its power, its resources and the importance it enjoys in the international arena [83]. We deem that this proposal has a greater chance of being accepted by states and could have beneficial effects for the global visibility of the public health agenda, as well as for broadening the interface between human rights and global health.

In relation to coercive powers, there are proposals to give WHO the power to adopt sanctions against defaulting States [24,25], such as restricting travel by its rulers and freezing assets abroad [84]. It was also proposed that an agency independent of WHO should be created with the duty of investigating outbreaks of pathogens and their origin, or with checking whether states are fulfilling their duty to share data [84]. The new technical body would supposedly not be subject to the pressures that constrain intergovernmental organizations such as the WHO. However, it is important to consider the risks of undermining the already limited powers of the organization. There is no doubt about the need to give the WHO the power to check official notifications from member States about potential threats and to alert the international community when a country is not acting responsibly and transparently [24,25,85]. A suggestion put forward is that the WHO should adopt a regime similar to the one

regarding the nuclear weapons non-proliferation regime, with the possibility of conducting on-site inspections, deploying independent scientists to investigate the potential existence of new and dangerous pathogens [84].

Finally, as for policy coordination mechanisms, a wide range of recommendations emanate mainly from the Independent Panel [24]. Among them is the creation of a Global Health Threats Council, through a UN General Assembly resolution. Linked to the G20 and composed of Heads of State and Government, with the participation of civil society and the private sector, this body would have the mission to build a political commitment to pandemic preparedness that remains active during an emergency, but also in between one emergency and another; to ensure the complementarity of collective action at all levels of the international system; to monitor the progress made by States in relation to the goals and indicators established by the WHO; and holding accountable the actors involved in the management of emergencies. In addition, the Council would guide the allocation of international cooperation resources, in particular a new international financing mechanism to be set up by the G20 and WHO member states, which would mobilize USD 5-10 billion per year. This proposal reflects the understanding that elevating health issues to the level of Heads of State and Government would bring political leadership to the field of global health, a hypothesis that seems to us still far from being proven. Moreover, we are concerned about the use of the expression "threat to global health" as a catalyst for this leadership, which could favor a securitarian approach to health issues. There is a tendency to present the countries of the Global South as a source of threats, addressing the issue of access to national data and the possibility of inspections in developing countries as a way to ensure the security of the developed world [86]. Therefore, confining the response to international emergencies to the prism of security would condemn global health to an endless succession of periods of "war" interspersed with "truces" focused on surveillance systems rather than on addressing the causes of epidemics, linked to the social determinants of health [75].

Final considerations: consolidation of the global health field or *fuite en avant*?

The inception of negotiations regarding an international treaty on pandemics reflects the recognition by States of something that the scientific community and international organizations have been announcing for decades, in vast documentation generally ignored by the general public: the question is not "if" new pandemics will occur, but "when" [23]. Nonetheless, diplomatic negotiations depend on the political will of the States, and it is not certain how much conviction about the need for a treaty will survive after mass vaccination and the expected control of COVID-19 in numerous countries.

The ability of WHO to fulfill its mission also depends on the political will of States. To grant the organization powers restricted to monitor compliance with national obligations relating to health surveillance and other issues of interest to wealthier countries, will mean neglecting the obligations relating to the adoption of a human rights approach, as addressed in this essay. In this way, we face the risk of having a treaty that sets up an efficient surveillance system for the benefit of rich countries (a warning capacity so that viruses and other threats do not leave the places where they are supposed to stay, especially in the developing world), instead of a treaty that actually intends to act to prevent new pandemics or reduce their negative impact on the health of populations.

Recognizing that human rights are crucial to the success of prevention and response actions, if they are not given a prominent place in the treaty under consideration, and if there are no means to ensure their effectiveness in the context of pandemics, we will therefore risk facing a *fuite en avant*. This expression, literally translated from French as "headlong rush" [87], can be defined as a roughly reckless action taken to escape unwanted dangerous circumstances. In the present case, it means plunging into a long-term challenge to divert the focus from previous issues, whose solution could be provided in the short to medium term through less complex instruments and consensus, such as, for example, WHA resolutions able to be adopted by majority vote. Thus, by not addressing the structural elements that turn epidemics into health catastrophes, the WHO and multilateralism may emerge further weakened from this process, while vulnerable populations will continue to be devastated by increasingly frequent pandemics.

Contributors

The authors equally participated in the study conception, elaboration and revision of the final version of the article.

Additional informations

ORCID: Leandro Luiz Viegas (0000-0002-3867-9798); Deisy de Freitas Lima Ventura (0000-0001-8237-2470); Miriam Ventura (0000-0001-8520-8844).

Acknowledgments

L. L. Viegas was supported by the Brazilian Graduate Studies Coordinating Board (CAPES; funding code 001). D. F. L. Ventura is a Research Productivity Fellow (Level 1B) of the Brazilian National Research Council (CNPq). M. Ventura had a postdoctoral fellowship from CNPq.

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Resumo

Em novembro de 2021, a Organização Mundial da Saúde (OMS) deu início à negociação de uma convenção, acordo ou outro instrumento internacional sobre a resposta às pandemias. Neste ensaio, defendemos e justificamos a tese de que o novo pacto deve ser um tratado de direitos humanos, como condição indispensável para a prevenção de novas pandemias e eficiência da resposta global quando elas ocorrem. Após o breve resgate da origem das negociações, apresentamos os principais conteúdos normativos que correspondem a um enfoque de direitos humanos: a instituição da regra de indissociabilidade entre medidas quarentenárias e de proteção social; e a regulamentação do acesso a tecnologias farmacêuticas. A seguir, em seção dedicada ao tema da efetividade do futuro tratado, classificamos as propostas existentes em ajustes tecnocráticos, como alterações no procedimento de declaração de emergências; mecanismos de transparência e controle, a exemplo da adoção de um mecanismo de Revisão Periódica Universal (RPU), similar ao do Conselho de Direitos Humanos das Nações Unidas, para monitorar obrigações dos Estados relacionadas à saúde; poderes coercitivos que seriam outorgados à OMS ou outra agência, tais como inspeções nos territórios nacionais realizadas por cientistas independentes; e mecanismos de coordenação política, como a criação de um Conselho Global de Ameaças à Saúde. Concluímos que há risco de adoção de um sistema mais eficiente de vigilância para alertar o mundo desenvolvido sobre ameaças oriundas de países em desenvolvimento, em lugar de um tratado capaz de contribuir para evitar que populações mais vulneráveis continuem sendo devastadas por pandemias cada vez mais frequentes.

Pandemias; Organização Mundial da Saúde; Direitos Humanos; Saúde Global; Direito Internacional

Resumen

En noviembre de 2021, la Organización Mundial de la Salud (OMS) inició negociaciones de una convención, acuerdo u otro instrumento internacional sobre una respuesta a las pandemias. En este ensayo, defendemos y justificamos la tesis de que el nuevo pacto debe ser un tratado de derechos humanos, como condición indispensable para la prevención de nuevas pandemias y eficiencia de la respuesta global cuando se produzcan. Tras un breve recordatorio del origen de las negociaciones, presentamos los principales contenidos normativos que corresponden a un enfoque de derechos humanos: la institución de la regla de indisociabilidad entre medidas cuarentenarias y de protección social; y la regulación del acceso a tecnologías farmacéuticas. A continuación, en la sección dedicada al tema de la efectividad del futuro tratado, clasificamos las propuestas existentes en ajustes tecnocráticos, como alteraciones en el procedimiento de declaración de emergencias; mecanismos de transparencia y control, como por ejemplo la adopción de un mecanismo de Revisión Periódica Universal (RPU), similar al del Consejo de Derechos Humanos de las Naciones Unidas, para monitorear obligaciones de los Estados relacionados con la salud; poderes coercitivos que serían otorgados a la OMS o a otra agencia, tales como inspecciones en territorios nacionales, realizadas por científicos independientes; y mecanismos de coordinación política, como la creación de un Consejo Global de Amenazas a la Salud. Concluimos que existe riesgo de adopción de un sistema más eficiente de vigilancia para alertar al mundo desarrollado sobre amenazas oriundas de países en desarrollo, en lugar de un tratado capaz de contribuir para evitar que poblaciones más vulnerables continúen siendo devastadas por pandemias cada vez más frecuentes.

Pandemias; Organización Mundial de la Salud; Derechos Humanos; Salud Global; Derecho Internacional

Submitted on 06/Jul/2021
Final version resubmitted on 16/Sep/2021
Approved on 17/Sep/2021