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INTRODUCTION

The proposal for a pandemic treaty acknowledges shortcomings of the current response to COVID-19 and the need for the international community to better prepare for and be ready to respond to a future pandemic. The proposal aims to promote and structure international cooperation to strengthen surveillance, alerts and response, and trust in the international health system.¹ Such concerted action is necessary to prevent the outcomes witnessed during this pandemic from repeating in the future.

A range of proposals as to what the pandemic treaty might encompass have been put forth, and they similarly prioritize addressing many of the major deficits in the response to the COVID-19 pandemic, such as global inequity in access to vaccines and national health systems being ill-equipped to respond effectively to the pandemic. In addition to this, pandemic preparedness and response and prevention of future pandemics also require prioritization of addressing the underlying causes of those failures in response and unjust outcomes, which are rooted in inequity.

Another treaty proposal, for a Framework Convention on Global Health (FCGH), has sought to address root causes of inequity within and between countries, such as those that were both revealed and exacerbated by the COVID-19 pandemic, through advancing the right to health. A similar approach in a pandemic treaty, emphasizing implementation of standards and mechanisms that embody principles of human rights to achieve equity, would serve the purpose of pandemic prevention, preparedness, and response, while addressing inequities and paving a way for everyone to enjoy the right to health.

THE PERVASIVENESS OF INEQUITY

Inequities in risk of exposure, morbidity and mortality due to COVID-19

As of mid-October 2021, the number of deaths reported worldwide due to the COVID-19 pandemic is approaching 5 million²—likely a significant underestimate—and these deaths have disproportionately affected poor and historically marginalised communities all over the world. In high-income countries, such as the United Kingdom, disadvantaged areas in which life expectancy is lower, unemployment rates are higher, housing is overcrowded, and child poverty is higher have the highest COVID-19 mortality rates.³ In the United States, poor people and those with fewer years of education are more likely to die from COVID-19.⁴ Racial disparities in COVID-19 related deaths are clear as individuals from Black, Asian, and minority ethnic backgrounds in the UK⁵ and individuals from racial and ethnic minority groups in the United States are more likely to die from the disease.⁶ Similarly, indigenous

¹ European Council. (2021) An International treaty on pandemic prevention and preparedness. Available at <https://www.consilium.europa.eu/en/policies/coronavirus/pandemic-treaty/>

² World Health Organization. WHO Coronavirus (COVID-19) Dashboard. Available at: <https://covid19.who.int/> (accessed 14 October 2021).

³ What geographic inequalities in COVID-19 mortality rates and health can tell us about levelling up. The Health Foundation. Available at: <https://www.health.org.uk/news-and-comment/charts-and-infographics/what-geographic-inequalities-in-covid-19-mortality-rates-can-tell-us-about-levelling-up>. Accessed October 8, 2021.

⁴ Seligman B, Ferranna M, Bloom D.E. (2021) Social determinants of mortality from COVID-19: A simulation study using NHANES. *PLOS Medicine* 18(1): e1003490. <https://doi.org/10.1371/journal.pmed.1003490>.

⁵ Apea V.J., Wan Y.I., Dhairyawan R., et al. (2021) Ethnicity and outcomes in patients hospitalised with COVID-19 infection in East London: an observational cohort study. *BMJ Open*: 11:e042140. doi: 10.1136/bmjopen-2020-042140.

⁶ Seligman B., Ferranna M., Bloom D.E. (2021) Social determinants of mortality from COVID-19: A simulation study using NHANES. *PLOS Medicine* 18(1): e1003490. <https://doi.org/10.1371/journal.pmed.1003490>

communities, globally, have suffered disproportionately negative impacts from the pandemic due to systemic racism and structural inequalities.⁷

Although a greater absolute number of reported deaths are larger in several high-income regions, such as in North America and Western Europe,⁸ the case-fatality ratio disproportionality affects low- and middle-income countries (LMICs).⁹ There are also inequalities in vaccination rates between LMICs and high-income countries (HICs). In mid-June 2021, after approximately the first 6 months of the global COVID-19 vaccine rollout, people in HICs had received over 80 times more doses per person than people in LICs. Even four months later, doses per person were over 30 times greater in HICs compared to LICs.¹⁰

Inequalities due to the COVID-19 is also seen in the consequences of measures taken in response to the pandemic. Lockdowns and their economic fallout has disproportionately affected vulnerable groups including those with lower-paying jobs, such as informal workers, and workers in transportation, services, and tourism, who are unable to work remotely.¹¹ This has resulted in a loss of 255 million full time-equivalent jobs worldwide, representing 8.8% of global working hours in 2020 and a labor income loss of US\$3.7 trillion (4.4% of 2019 GDP).¹² Moreover, lockdowns have restricted people's movement, making it difficult for them to access health services, especially for non-COVID-19-related conditions, such as other infectious diseases, NCDs, or sexual and reproductive health.¹³ Marginalised social groups, such as people with disabilities, migrant workers, ethnic and religious minorities, refugees, and displaced people, have been impacted more heavily by the measures taken to control the pandemic than the general population.

Additionally, marginalised groups have experienced higher levels of psychological distress during the COVID-19 pandemic in comparison to the general population. Rates of conditions such as depression, anxiety, and substance use disorder have all increased throughout the pandemic. Researchers propose that these effects point toward troubling short and long term social and emotional impacts among members of marginalised groups.¹⁴

COVID-19 has also been named a “syndemic,” whereby those with existing medical conditions, such as people suffering from NCDs or people who have inadequate living and working conditions, are at higher

⁷ Indigenous Peoples Have Been Disproportionately Affected by COVID-19 – Senior United Nations Official Tells Human Rights Council. United Nations Human Rights Council. Published September 28, 2021. Available at <https://www.ohchr.org/EN/HRBodies/HRC/Pages/NewsDetail.aspx?NewsID=27556&LangID=E> Accessed October 9, 2021.

⁸ World Health Organization. WHO Coronavirus (COVID-19) Dashboard. Available at: <https://covid19.who.int/> (accessed 14 October 2021).

⁹ Mortality Analyses. Johns Hopkins Coronavirus Resource Center. Available at <https://coronavirus.jhu.edu/data/mortality>. Accessed October 11, 2021.

¹⁰ Our World in Data. Available at https://ourworldindata.org/grapher/covid-vaccination-doses-per-capita?country=OWID_WRL~Low+income~High+income. Accessed October 19, 2021.

¹¹ ILO Monitor: COVID 19 and the world of work. Seventh edition. *International Labour Organization*. Published January 25, 2021. Available at https://www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/documents/briefingnote/wcms_767028.pdf. Accessed October 12, 2021.

¹² Ibid.

¹³ Hrynick T.A., Lorenzo S.R. & Carter S.E., COVID-19 response: mitigating negative impacts on other areas of health. *BMJ*. Available at <https://gh.bmj.com/content/6/4/e004110>. Accessed October 10, 2021.

¹⁴ Galea, S., Merchant, R. M., Lurie N. (2020). The mental health consequences of COVID-19 and physical distancing: The need for prevention and early intervention. *JAMA Intern Med*. Published online April 10, 2020. <https://doi.org/10.1001/jamainternmed.2020.1562>

risk of acquiring and dying from the disease.¹⁵ COVID-19 interacts with and exacerbates existing NCDs and health-harming social conditions which fall disproportionately on disadvantaged communities, who also suffer worse due to inequities in access to health care, especially where there is a lack of universal health coverage.¹⁶

A pandemic of inequity within and between countries

While the COVID-19 pandemic has been with us for nearly two years, yet another pandemic, that of health inequity, was first documented among social classes in the mid-1800s,¹⁷ and likely stretches back many centuries longer. The pandemic of inequity is even more lethal than COVID-19: by one estimate it is responsible for about 16 million premature deaths every year, approximately the same as half a century ago.¹⁸

Like the inequities of the COVID-19 pandemic, the pandemic of inequity is visible both within and between countries. While slowly narrowing, differences in life expectancy internationally remain stark as it is 17 years lower in LICs than HICs (64 versus 81 years, 2019 data).¹⁹ Domestic inequities are equally as gaping.²⁰ In Washington, DC, for example, residents of several low-income neighborhoods with predominantly Black populations have life expectancies about a quarter-century lower than high-income neighborhoods with predominantly white populations.²¹ According to the latest available data, in Ethiopia, Guatemala, and Indonesia, skilled health personnel attended 85%, 92%, and 96% of births, respectively, for women with at least a secondary education, but for women without any formal schooling only 22%, 42%, and 43% births, respectively, were attended by skilled health personnel.²²

Globally, immense inequities in wealth and power contribute to the health inequities between countries. Health spending in high-income countries is over 70 times higher than in low-income countries -- where the \$41 per capita (2017) is far below what is needed for universal health coverage.²³ Global inequities

¹⁵ Horton R. (2020) Offline: COVID-19 is not a pandemic. *The Lancet* 396(10255): 874; Bambra C., Riordan R., Ford J., Matthews F. (2020) The COVID-19 pandemic and health inequalities. *Journal of Epidemiology and Community Health* 74(11): 964.

¹⁶ Islam M.M. (2019) Social Determinants of Health and Related Inequalities: Confusion and Implications. *Front Public Health* 7:11; doi:10.3389/fpubh.2019.00011; Bambra C., Riordan R., Ford J., Matthews F. (2020) The COVID-19 pandemic and health inequalities. *Journal of Epidemiology and Community Health*; 74(11): 964.

¹⁷ Gibbons M.C. A historical overview of health disparities and the potential of eHealth solutions. NCBI. Published Oct 4, 2005. Available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1550690/>. Accessed Oct 9, 2021.

¹⁸ Garay. J. et al. Global health inequity 1960-2020. PEAH. Available at <http://www.peah.it/2021/04/9658/>. Accessed October 8, 2021.

¹⁹ Life expectancy at birth, total (years). World Bank. Available at: <https://data.worldbank.org/indicator/SP.DYN.LE00.IN>. Accessed October 8, 2021.

²⁰ Health equity programs of action: an implementation framework. At 5. Published January 2019. Available from <https://oneill.law.georgetown.edu/wp-content/uploads/2019/05/HEPA-Guide-v20-5-19-19-1.pdf>. Accessed October 10, 2021.

²¹ Virginia, C. MAP: How long people in your city are expected to live. Published April 15, 2021. Available at <https://www.nbcnews.com/news/us-news/map-neighborhood-life-expectancy-united-states-n979141>. Accessed October 12, 2021.

²² "The Global Health Observatory: Health Equity Monitor: Births Attended by Skilled Health Personnel (in the Two or Three Years Preceding the Survey) (%)," World Health Organization. Available at [https://www.who.int/data/gho/data/indicators/indicator-details/GHO/hem-births-attended-by-skilled-health-personnel-\(in-the-two-or-three-years-preceding-the-survey\)-\(-\)/](https://www.who.int/data/gho/data/indicators/indicator-details/GHO/hem-births-attended-by-skilled-health-personnel-(in-the-two-or-three-years-preceding-the-survey)-(-)/). Accessed October 12, 2021.

²³ Global spending on health: a world in transition. Global report 2019. World Health Organization. Available at https://www.who.int/health_financing/documents/health-expenditure-report-2019.pdf. Accessed October 10, 2021; International corporate tax avoidance and domestic government health expenditure. World Health Organization. Available at <https://www.who.int/bulletin/volumes/97/11/18-220897.pdf>. Accessed October 11, 2021.

have been made evident during COVID-19, as higher-income countries have been able to pay premium prices for scarce supplies of COVID-19 diagnostics, treatments, and vaccines.²⁴

Health inequities are presently entrenched in the fabric of daily life. While unequal access to quality health services plays a significant role in creating and perpetuating these inequities, the social, economic, political, and environmental determinants of health play an even larger role.²⁵ Underlying inequities in these realms—as diverse as education and employment, clean air and clean water, income and wealth, violence and the criminal justice system, and basic features of a person’s identity—are inequities in the distribution of wealth and other resources and, perhaps above all, of power.²⁶ Accordingly, even as there is one health-focused Sustainable Development Goal (SDG 3), all 17 SDGs are directly or indirectly connected to health equity.²⁷

Different dimensions of inequities often reinforce one another. Children may be out of school due to violence or poverty that forces them to work to support their families, leading to reduced future employment possibilities. Lower income, in turn, leads to reduced access to health care, safe housing, nutritious food, and the ability to live in a neighborhood with clean air. The poor health of children might make them less productive, further harming their health and exacerbating health inequities throughout the life course, likely increasing the risk that poor health and health inequities are passed to the next generation.

Consequently, while targeted measures are needed and can make a considerable difference, rectifying inequities in health requires a systemic approach to address the pervasive marginalization of large segments of society. Establishing systems that enable people experiencing marginalization and health inequities to have power—to exercise their right to participate in decision-making,²⁸ to have the civic space required for advocacy and to hold the government accountable—will result in the greater possibility to close, and ultimately end health inequities.

ADDRESSING UNDERLYING DETERMINANTS OF HEALTH TO CLOSE INEQUITIES AND BOOST PANDEMIC PREVENTION, PREPAREDNESS, AND RESPONSE

The determinants of health are the conditions in which people live and grow that affect their health, positively or negatively. They involve multiple levels of society, including social, physical, and economic environments and are most often shaped by factors beyond an individual’s control.²⁹ Due to the syndemic nature of the current pandemic and, likely, future pandemics, vulnerable groups, such as people with existing medical conditions or people living in inadequate conditions shaped by social

²⁴ Bradley J. In scramble for coronavirus supplies, rich countries push poor aside. *The New York Times*. Published April 9, 2020. Available at <https://www.nytimes.com/2020/04/09/world/coronavirus-equipment-rich-poor.html>. Accessed October 10, 2021.

²⁵ Magnan, S. Social Determinants of Health 101 for Health Care: Five Plus Five. National Academy of Medicine. Published October 9, 2017. <https://nam.edu/social-determinants-of-health-101-for-health-care-five-plus-five/>. Accessed October 11, 2021.

²⁶ Health equity programs of action: an implementation framework. At 61. Published January 2019. Available from <https://oneill.law.georgetown.edu/wp-content/uploads/2019/05/HEPA-Guide-v20-5-19-19-1.pdf>. Accessed October 10, 2021.

²⁷ Ibid.

²⁸ UN Committee on Economic, Social and Cultural Rights, General Comment 14, at para. 11.

²⁹ Social determinants of health. World Health Organization. Available at https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1. Accessed October 12, 2021; Whitehead M., Dahlgren G. (1991) What can be done about inequalities in health? *The Lancet* 338(8774): 1059-63.

determinants of health, will be more at risk of becoming infected and dying from pathogens. Therefore, for a pandemic treaty to be effective it should address the underlying determinants of health.

According to the WHO the social determinants of health, such as education, housing, or work environment, contribute to between 30–55% of health outcomes,³⁰ and, as such, are crucial for pandemic prevention. For example, a novel pathogen that is airborne or waterborne more easily spreads in overcrowded living conditions or in poor sanitary conditions where people cannot wash their hands. Simple measures to maintain personal hygiene are nearly impossible in some deprived areas or communities with poor housing and sanitation infrastructure.

Commercial determinants of health involve the “structures, rules, norms, and practices by which business activities designed to generate wealth and profit influence patterns of health and disease across populations”.³¹ The commercial sector plays a key role in creating healthy or unhealthy environments for people, which in turn affect their consumption, exposure and use of chemicals and unhealthy products, such as tobacco, alcohol, ultra-processed foods, and sugar-sweetened beverages.³² Such unhealthy products associated with the commercial determinants of health accounts about one third of all global deaths.³³ Commercial practices, such as marketing or lobbying politicians to influence policy, allow for drastic negative health outcomes, while there is often no option for those impacted by these practices to avoid or combat them.³⁴

Environmental determinants of health, for example air pollution, water contamination, or exposure to hazardous materials and chemicals, also contribute to disease and illnesses. According to the WHO, an estimated 11.4 million annual deaths – 21.2% of total deaths globally – are attributable to environmental risk factors.³⁵ These risk factors are a result of a combination of commercial practices and products, as noted above, as well as inadequate development infrastructure. Similarly, planetary health concerns the ways that human activity impacts the natural environment which in turn impacts health outcomes, such as the interaction between deforestation and wet markets.³⁶

Worldwide, whether a person enjoys or benefits from these determinants of health is linked to structural and systemic injustices. Exposure to racism and racial discrimination leads to adverse health consequences.³⁷ Prejudice and discrimination, racism, caste systems, sexism and opportunity based

³⁰ Social determinants of health. World Health Organization. Available at https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1. Accessed October 12, 2021.

³¹ Freudenberg, N (2020). 'The Commercial Determinants of COVID-19: Implications for Public Health Action and Research' [PowerPoint presentation]. Milken Institute School of Public Health, Centre on Commercial Determinants of Health. Available at: https://www.youtube.com/watch?v=6RqK1a8oT_w. Accessed: 20 September 2020.

³² Noncommunicable diseases. World Health Organization. Available at: <https://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases>. Accessed October 11, 2021.

³³ Global Burden of Disease Collaborative Network. Global Burden of Disease Study 2019 (GBD 2019) Results. Seattle, United States: Institute for Health Metrics and Evaluation (IHME), 2020. Available from <http://ghdx.healthdata.org/gbd-results-tool?params=gbd-api-2019-permalink/8da7740310919fbc7c506d80512d8a3a>. Accessed: 1 October 2021.

³⁴ Mialon, Melissa. An overview of the commercial determinants of health. *Globalization and health* vol. 16,1 74. 17 Aug. 2020, doi:10.1186/s12992-020-00607-x

³⁵ Gibson, J. M. Environmental determinants of health. Available at https://link.springer.com/chapter/10.1007/978-3-319-71812-5_37. Accessed October 10, 2021.

³⁶ Wolfe N.D. et al. Bushmeat hunting, deforestation, and prediction of zoonotic disease. NCBI. Published December, 2005. Available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3367616/>. Accessed October 11, 2021.

³⁷ Williams, D.R. and Mohammed, S.A. (2013) Racism and health I: Pathways and scientific evidence. *American Behavioral Scientist* 57, 1152-1173. <https://doi.org/10.1177/0002764213487340>

on socioeconomic status are often institutionalized and drive processes that cause unjust and unnecessary inequalities, such as those seen during the COVID-19 pandemic. Rectifying this requires a transformation in how we approach the determinants of health, who is involved in decision making processes, and concerted efforts at national, regional, and global levels to protect everyone's human rights, including during times of health emergencies.

THE POTENTIAL OF A PANDEMIC TREATY

In their call for a pandemic treaty, world leaders state that the goal of the treaty “would be to foster an all-of-government and all-of-society approach, strengthening national, regional and global capacities and resilience to future pandemics.”³⁸ As seen during the COVID-19 pandemic, health systems in LMICs and HICs buckled under the pressure and swiftness of the disease outbreak. Moreover, international cooperation has, in many cases, been dwarfed by nationalistic approaches on the part of many high-income countries to the peril of low- and middle-income countries. The pandemic treaty would aim to enhance international cooperation to improve, among other things, data-sharing, research, and local, regional and equitable access to vaccines, medicines, diagnostics and personal protective equipment.³⁹

A pandemic treaty could address the failings of the global COVID-19 response and provide for other measures to ensure a strengthened response to future pandemics. A pandemic treaty should strengthen the power and authority of the WHO to lead in times of public health emergencies.⁴⁰ It could establish an independent entity which would be authorized to enter countries to monitor public health capacities and investigate disease outbreaks in real-time, enabling the fastest possible global response and not hampered by domestic concerns that may impede full transparency and honesty.⁴¹ The pandemic treaty could update and expand required public health capacities, better aligning them with monitoring tools, such as through the Joint External Evaluations, and extending them to broader health system capacities.

A pandemic treaty should take a One Health approach, recognizing the connections between the environment and human and animal health. It might require enhanced regulation of markets that sell live animals,⁴² for example, as a step towards closing them entirely while countries implement measures to ensure that people who rely on them for food and for their livelihoods have access to other food sources and ways to make a living. The sale and use of wild animals could be banned altogether.

³⁸ Michel, C. et al. “COVID-19 shows why united action is needed for more robust international health architecture”. Published March 30, 2021. Available at

<https://www.consilium.europa.eu/en/press/press-releases/2021/03/30/pandemic-treaty-op-ed/>. Accessed October 10, 2021.

³⁹ European Council. An International treaty on pandemic prevention and preparedness. Available at <https://www.consilium.europa.eu/en/policies/coronavirus/pandemic-treaty/>. Accessed October 9, 2021.

⁴⁰ 9 steps to end covid-19 and prevent the next pandemic: essential outcomes from the World Health Assembly. JAMA. Published June 10, 2021. <https://jamanetwork.com/journals/jama-health-forum/fullarticle/2781169>. Accessed October 11, 2021.

⁴¹ Gostin L., Friedman E.A. & Dueck L. The world needs a post-pandemic health treaty with teeth. Foreign Policy. Published April 5, 2021. Available at <https://foreignpolicy.com/2021/04/05/who-un-pandemic-treaty-health-regulations/>. Accessed October 10, 2021.

⁴² Associated Press. UN: Live animal markets shouldn't be closed despite virus. May 8, 2020. <https://wtop.com/europe/2020/05/un-market-where-virus-may-have-started-shouldnt-be-closed/> Accessed October 11, 2021.

The pandemic treaty could also work to strengthen existing instruments to emphasize human rights, national and global equity, and global solidarity. For example, the vague language in the International Health Regulations related to international cooperation⁴³ could become specific, perhaps most effectively through defining mandatory funding contributions that might be based on WHO assessed contribution levels. The temporary, targeted proposed waiver of TRIPS Agreement intellectual property protections for health technologies required to combat COVID-19 being discussed at the World Trade Organization⁴⁴ could be inscribed in the pandemic treaty. Similarly, the treaty could require open data and other information, enabling national and global pandemic response based on the best evidence and responding to the inequitable distribution of medical technologies.

To further equitable distribution, the treaty could establish a permanent version of COVAX that extends to a broader range of medical technologies, requires participation of treaty ratifiers, limits or prohibits separate pre-purchase agreements, and takes a more nuanced approach to equitable distribution, focusing on treating all people, rather than all countries, equally.⁴⁵ Other powerful visions exist along similar lines, like a Pandemic Open Vaccine Access Accelerator.⁴⁶ The pandemic treaty could direct or support the WHO Director-General in establishing an equity task force for any future global public health emergency to ensure WHO's efforts maximally promote equity and help guide national efforts.⁴⁷

As proposed, the pandemic treaty provides a focus on global solidarity and cooperation that has been lacking during the COVID-19 pandemic. A look towards preventing a repeat of current global inequities in the current response is clear and welcome. Yet given the extent of inequity, a pandemic in itself—including its multifaceted links to pandemics of disease, a more comprehensive approach is needed. This more comprehensive approach would serve to rectify inequities, address broader determinants of health which themselves contribute to pandemics, and aim to achieve the right to health for all people. Such an approach is required to truly deliver the requisite preparedness and response for pandemics and also prevent future pandemics.

THE TRANSFORMATIVE TRAJECTORY OF A PANDEMIC TREATY THAT TACKLES INEQUITY AND ADVANCES THE RIGHT TO HEALTH

Grounding a response to disease outbreak in the right to health would provide the necessary infrastructure to address the deep inequities—shaped by underlying determinants of health—that precede and are exacerbated during the pandemics and other health emergencies. The proposal of a Framework Convention on Global Health (FCGH)⁴⁸ demonstrates how a treaty might be built around

⁴³ International Covenant on Economic, Social and Cultural Rights. United Nations. <https://www.ohchr.org/en/professionalinterest/pages/cescr.aspx>, art. 2(1).

⁴⁴ TRIPS Council Agrees to continue discussions on IP response to COVID19. World Trade Organization. Published July 20, 2021. https://www.wto.org/english/news_e/news21_e/trip_20jul21_e.htm. Accessed October 11, 2021.

⁴⁵ Emanuel E.J., Persad G., Kern A., et al. (2020) An ethical framework for global vaccine allocation. *Science* 369: 1309-1312.

⁴⁶ Basu K., Gostin L. & Hassoun N. Pandemic preparedness and response: Beyond WHO's access to COVID-19 tools accelerator. Brookings. Published April 28, 2021. <https://www.brookings.edu/research/pandemic-preparedness-and-response-beyond-the-whos-access-to-covid-19-tools-accelerator/>. Accessed Oct 10, 2021.

⁴⁷ <https://www.thelancet.com/action/showPdf?pii=S0140-6736%2820%2931145-4>

⁴⁸ FCGH Alliance. FCGH Briefing Paper (2018). Published March 2018. Available at <https://fcghalliance.org/wp-content/uploads/2019/02/FCGH-briefing-paper-March-2018.pdf>. Accessed October 7, 2021.

the right to health to eliminate health inequities and progressively realize the right to health and prevent disease, which would work towards preventing disease outbreaks from becoming pandemics.

The FCGH proposal offers standards and mechanisms that oblige and empower governments to implement the treaty's provisions as well as concretize avenues for the public and civil society to engage in decision-making that affect their health. It would operationalize key principles of human rights—accountability, participation, and equity. Because of the shared risk of a pandemic, shared responsibilities are required, including resourcing the right to health, building strong health systems, and fostering the trust and solidarity needed to enhance global health security. These elements are essential to maintaining pandemic preparedness and response capacities at national and global levels, to prevent future pandemics, and would bolster the effectiveness of a pandemic treaty.

Accountability

Accountability is a core principle of human rights. Governments must be meaningfully held accountable for fulfilment of their duties under human rights law in order for rights to be realized. A pandemic treaty might incorporate national health accountability strategies as part of a global health accountability framework that would operate to ensure responsibilities, including those under the right to health, are being carried out.⁴⁹

Accountability mechanisms would demand transparency and resource allocation disclosure requirements, for example, and standards to deter any misuse of public health resources. Ideally, these would be developed in consultation with civil society, and the local communities that are most directly impacted by state shortcomings in implementing and enforcing the right to health. Moreover, this global health accountability framework could extend to multilateral organizations, corporations, foundations, NGOs, and other actors whose work impacts the right to health. These accountability mechanisms would be shored up by building capacities among communities, civil society, and governments to assert and enforce the government's obligations under the treaty. In addition, the pandemic treaty would also clarify that the right to health takes precedence over corporate rights.⁵⁰

A treaty that works to strengthen accountability of governments and institutions to the people they serve would create stronger health systems that protect health workers and the public. During the COVID-19 pandemic, many health systems have suffered as governments have not been held fully accountable for their responsibilities to ensure that all people have access to healthcare and the underlying determinants of health, especially among marginalized and vulnerable communities who have suffered the most.⁵¹ When accountability mechanisms are in place and enforced, services, funding, and resources are more likely to be allocated equitably, whether nationally, regionally, or globally.

⁴⁹ Ibid.

⁵⁰ FCGH Alliance. Key Principles of an FCGH. Available at <https://fcghalliance.org/key-principles-of-an-fcgh>. Accessed October 7, 2021.

⁵¹ Matsoso, P., Buss P., & Haynes, L.K. Reform or Revolution in Global Health? Project-Syndicate. Published June 7, 2021. Available at <https://www.project-syndicate.org/commentary/pandemic-inequity-framework-convention-on-global-health-by-precious-matsoso-et-al-2021-06>. Accessed October 8, 2021.

Participation

Accountability requires full participation of the population, that people have a say in decisions that affect their health, and that there be processes in place to facilitate meaningful participation in decision making processes.⁵² Participatory processes make sure that measures taken to improve people's health, including addressing commercial, social, environmental, and other determinants of health, reach all populations and respond to their needs and priorities. Such processes also contribute to the universality and inclusivity of a health system, features necessary to build trust in the health system to facilitate response to the health needs of particular communities or the population as a whole.⁵³

During the COVID-19 pandemic, people have resisted socio-behavioral recommendations or mask and vaccine mandates instituted by the health system, often reflecting a mistrust in the health system. During times of crisis or emergency, people must be able to rely on and trust their governments, and a history of working alongside government to address community needs would build this confidence, as well as trust. Participation measures ensure that even the most marginalized populations can participate in health-related decisions, including pandemic and other health emergency planning. By ensuring that these populations' needs and circumstances are accounted for, people have the confidence to follow measures and the means to do so, whether sufficient access to testing and vaccines or food and medicine during lockdowns, isolation, and quarantine.

To incorporate participation, a pandemic treaty might incorporate tools and mechanisms that require governments to engage communities in setting local priorities and in decision-making processes that establish law and policy relating to health and public health emergencies.⁵⁴ Avenues of participation might include legislative hearings or notice and comment periods or new and more accessible processes for which participation of the public and civil society organizations would be required, such as participatory budgeting and district health committees.⁵⁵ These participatory processes would provide genuine opportunities for all members of the public, including civil society organizations, to influence decisions and prevent inequities that arise, especially regarding underlying determinants of health, when large swaths of a population are left out.

Equity

The COVID-19 pandemic “exposed the extent of systemic health inequities and how those inequities can exacerbate a public-health crisis, putting everyone at risk.”⁵⁶ Efforts to address these inequities through platforms set up at the WHO, through philanthropic efforts, and at the WTO have failed to achieve equity in access to life-saving medicines and treatments. The ability of a pandemic treaty to prepare and then respond to a disease outbreak will only be as effective as the infrastructure in which it

⁵² Friedman, E., and Hevia, M. On the Framework Convention on Global Health. Think Global Health. Published August 25, 2020. Available at <https://www.thinkglobalhealth.org/article/framework-convention-global-health>. Accessed October 9, 2021.

⁵³ Ibid.

⁵⁴ Hevia, M. Una Convención sobre la salud global. Clarion. Published June 20, 2020. Available at https://www.clarin.com/opinion/convencion-salud-global_0_5odhMSCco.html. Accessed October 7, 2021.

⁵⁵ Ibid.

⁵⁶ Matsoso, P., Buss P. & Haynes, L.K. Reform or Revolution in Global Health? Project-Syndicate. Published June 7, 2021. Available at <https://www.project-syndicate.org/commentary/pandemic-inequity-framework-convention-on-global-health-by-precious-matsoso-et-al-2021-06>. Accessed October 9, 2021.

operates—nationally, regionally and internationally. If that infrastructure is unjust or inequitable, then any response, including within the framework of the treaty, will be inequitable.

The pandemic treaty should endeavor to close inequities and their underlying determinants within and between countries. The treaty might include requirements that countries directly address discriminatory practices that may prohibit vulnerable groups from accessing resources, such as through developing national health equity programs of action that confront the structural impediments which perpetuate discrimination.⁵⁷ Internationally, a focus on equity would address states' extraterritorial duties under the right to health. In this regard, the pandemic treaty might include agreements that promote equitable allocation of scarce medical equipment and technologies and strict limits on export controls thereof, listing the circumstances under which they are permissible. The pandemic treaty might also set standards as to states' responsibilities to ensure that businesses do not undermine the right to health nationally or abroad through, as evidenced during the COVID-19 pandemic, creating unaffordability and scarcity of urgently needed drugs and tools.⁵⁸

Through this approach, national health systems would be prepared to respond to novel and emerging diseases across its entire population, equipping its pandemic preparedness and response apparatuses with the necessary tools for an equitable implementation and equitable outcomes. Moreover, through such requirements and standards around equity the pandemic treaty can contribute to closing the equity gap and advance the right to health.

ADVANCING RIGHT TO HEALTH IS A STRATEGY FOR PANDEMIC PREVENTION, PREPAREDNESS, AND RESPONSE

The call for a pandemic treaty acknowledges that the world is unprepared for the next pandemic. It also reflects an appetite among world and global health leaders for a binding instrument that will promote the international solidarity and cooperation needed to successfully respond to future pandemics. A pandemic treaty that embodies core principles of human rights and aims to promote equity will address the day-to-day indignities, systemic discrimination, and racism that lead to inequities, including within health systems, which create the conditions for pandemics. Legally binding obligations that address underlying determinants of health through elevating equity and human rights principles will provide sustainable gains towards pandemic prevention, preparedness, and response.

These values, which are at the core of the FCGH proposal, are certainly relevant and applicable in the context of a pandemic treaty. Collaterally, pursuing human rights and equity as part of the pandemic treaty would further other global commitments, such as the 2030 Agenda for Sustainable Development and its Sustainable Development Goals. This approach may also contribute to progress on achieving universal health coverage, which would contribute to improved surveillance, diagnostic, and treatment capacities as more people come in contact with the health system. Finally, it would lay the groundwork for a path towards a broader treaty, such as what the FCGH proposes, that would make significant improvements in people's health in areas outside of the context of pandemics and other health emergencies, especially for marginalized and vulnerable groups who, unjustly, suffer most from global

⁵⁷ FCGH Alliance (2020) Draft articles on equity. Available at https://fcghalliance.org/wp-content/uploads/2020/01/1-2020_DraftFCGHArticlesOnEquity.pdf. Accessed October 8, 2021.

⁵⁸ Ibid.

health inequities and right to violations. This trajectory would represent a powerful global response to the suffering and loss of life that results from pandemics caused by abnormal and unexpected public health events as well as the vast inequity that has become a tragic norm around the world.

The proposal for a pandemic treaty comes at a time when the global community is in critical need of the international cooperation, solidarity, action, and resources it proposes. It also comes at a time of some of the greatest inequity the world has seen, and the COVID-19 pandemic has glaringly demonstrated the urgent need to address inequity and underlying determinants of health. A pandemic treaty that has principles of human rights and equity at its heart will serve to strengthen pandemic prevention, preparedness, and response while leading the global community towards the full achievement of the right to health.