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Pandemic Agreement and the New World of Global Health Governance

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Introduction

The WHO Pandemic Agreement (PA), adopted in May 2025, comes at a critical moment in Global Health Governance (GHG). While negotiations to finalise its most contentious provisions, Article 12—the Pathogen Access and Benefit Sharing (PABS) annex—are ongoing, the four-year negotiation process is a foundational moment for GHG. On the one hand, the final agreement has been described as a 'weak' document. Civil society practitioners, academics, and researchers have highlighted that the adopted version of the agreement will not provide the enforceable, binding systems needed to ensure that preparedness and response to the next pandemic do not penalise countries of the Global South. On the other hand, several practitioners within health diplomacy and geopolitics argue that it is a practical roadmap that reflects the realities of balancing national sovereignty and strategic country interests with the demands of creating a first-of-its-kind global legal regime governing pandemics.

This brief sheds light on the distinctive contribution of the making of the PA towards a more inclusive and equitable GHG system. The PA brings forth a set of new norms around equity, accountability, and transparency. As a 'Treaty' document, it was negotiated at the government level and highlighted entrenched challenges in the remaking of the global system at large. At the same time, it provided an opportunity for countries to address these challenges in a deliberative manner. The role of first-time-ever informal groups based on global health principles, such as the Group for Equity, is an important instance that demonstrates, even if in a limited way, South–South solidarity.

Negotiations for the PABS system have been extended until 2027 and include some of the most contentious issues within the PA. These remained unresolved in the Intergovernmental Working Group (IGWG) meetings on the PABS held between April and July 2026 and include the extent of benefit-sharing obligations for private manufacturers, liability and compensation in cases of vaccine injuries, and the tracking of pathogen materials and data. Resolving these contentions will determine whether there will be a PA at all: Article 31 of the Agreement states that the treaty will only be opened for signatures once the PABS is adopted.

We explore how evolving geopolitical dynamics, financing constraints, and equity concerns have shaped the PA and what this means for strengthening Pandemic Preparedness, Prevention and Response (PPPR), particularly for Low-Income Countries (LICs) and Lower-Middle-Income Countries (LMICs). The analysis draws insights from a CSEP webinar, *Power Shifts and Pandemic Preparedness: What Has the Pandemic Agreement Meant in a Multipolar World?*[1], secondary literature, and successive drafts of the PA. We argue that the PA represents an important normative step forward, but that its capacity to fully address underlying asymmetries in power, capacity, and access for PPPR has certainly been diluted. However, these contested dynamics are very much part of the reshaping of foundational architectures of global health systems. We therefore offer recommendations and pathways for strengthening PPPR both within and outside the PA.

Financing and Governing Pandemic Preparedness

The PA seeks to address two critical aspects of the global health landscape that limit PPPR, particularly for LMICs and LICs: financing and governance.

Recent estimates underscore the scale and urgency of sustained financial investment in pandemic preparedness. Glennerster et al. (2022) challenge the idea that pandemics are rare, exceptional events and instead point to the need to factor in the

[1] This closed-door, high-level webinar, held in September 2025, brought together Rachel Glennerster (President, Center for Global Development), Reuben Samuel (Program Area Manager, Country Preparedness & IHR, WHO South-East Asia Regional Office), K. Srinath Reddy (Founder & President, Public Health Foundation of India), and Boniface Hlabano (Lead, Africa Global Health Security Program, Amref Health).

likelihood of recurrent shocks. They estimate US$712 billion in annualised social losses, alongside roughly 1.2 million deaths each year attributed to pandemics.

Persistent inequity in the availability and distribution of financial resources for post-pandemic response and recovery is a key challenge. LMICs have fewer resources to access vaccines and other medical countermeasures. Gozzi et al. (2023) highlight that LMICs face significant delays in accessing vaccines compared to High-Income Countries (HICs). Their health systems have weaker adaptive capacity and slower economic recovery from pandemic-related shocks.

The final PA treaty proposes two mechanisms to address the financing challenges: the Coordinating Financial Mechanism (the Mechanism) and the Conference of the Parties (COP). Under the authority of the COP, the Mechanism intends to strengthen domestic funding, mobilise additional financial resources through innovative financing and grants, and leverage voluntary contributions from organisations and other entities supporting PPPR. Separately, Article 9 on Research & Development recommends that Member States seek funding for developing pandemic-related health products through public–private partnerships.

The global governance regime for pandemics and its structural limitations became clearly visible during COVID-19. The defining weakness was the loss of lives and livelihoods in LICs and LMICs due to unequal access to medical countermeasures and the lack of accountability for this failure of governance. Existing frameworks, such as the International Health Regulations (IHR) 2005, and global health actors, such as the WHO, were ineffective in addressing these challenges. They could not enforce compliance around key aspects of the IHR that overlap with PPPR, such as continuity of essential health service provision, human resources, financing, and policy, as well as legal, normative, and legislative instruments (Miyamoto et al., 2025).

The financing and governance challenges at the global level are further compounded by structural issues in health governance at the country level in LMICs and LICs. These include limited integration of PPPR in the health systems and persistent inequalities in surveillance and other technical capacities (Grabar-Kitarović & Phumaphi, 2023).

The PA seeks to address these challenges through the COP. Among other areas, its role will be to provide technical assistance, capacity-building, and research collaboration for equitable access to products, tools, technology transfer, and financing for national (as well as global and regional) initiatives. The new treaty proposes interventions such as the development of multisectoral national pandemic prevention and surveillance plans, capacity-building for surveillance and detection at the community level, and biosafety and biosecurity training practices.

However, a critical limitation of the final treaty—and perhaps one inherent to its nature as a treaty—is that several of its prominent provisions rely on largely non-binding commitments for signatories. This raises important questions about how far it can go in addressing concerns around enforceability and accountability,

particularly during an actual crisis. In that sense, it remains unclear what the Agreement will ultimately mean in practice for LICs and LMICs during a future pandemic, and whether it can meaningfully shift existing asymmetries in access and response capacity.

Despite these gaps and concerns, the PA makes important contributions to the global PPPR architecture. It places greater political attention on inequities in pandemic preparedness and platforms new mechanisms such as One Health and the COP. Thus, the PA is an important normative tool for sustaining focus and mobilising investment around pandemic preparedness.

National Sovereignty and the Making of a Global Public Good

The PA negotiations laid bare a key fault line in global governance for PPPR: How to reconcile national sovereignty with collective action when geopolitical conditions are hostile?

The global community is divided into two blocs. One has access to technology for medical countermeasures (vaccines, therapeutics, and PPE), surveillance and monitoring systems, data on pathogens, and the financial resources needed to strengthen national health systems. The other faces a high disease burden, greater exposure to emerging health risks through the human–environment interface, limited financial capacity to respond to pandemics, and weak health systems. The global community is therefore stuck in a deadlock between these two groups over how access to pandemic materials (vaccines), norms (responsibility to share resources), and systems (COP) are framed in the PA.

Strengthening global cooperation in the face of geopolitical shocks, such as the exit of the US from key multilateral bodies and existential questions about the value of the WHO, were important drivers of the initial push for the Agreement. It was led by the HICs, including the European Council President Charles Michel, and supported by groups such as the Friends of the Treaty. As the negotiations proceeded, protecting national sovereignty and advancing equity in PPPR emerged as key areas of contention across several provisions. For example, countries with a high risk of infectious diseases due to a deeper human–environment interface and weak financial and health system capacities have been reluctant to commit to interventions that require substantial financial resources. They also want to ensure that they have access to the outputs developed from pathogen data collected within their national boundaries and used by private actors.

These tensions were reflected in the use of qualifiers to core commitments in the final treaty—for example, "taking into account national circumstances" in Articles 4, 7, 15, and 19. This articulation made it possible to reach an agreement, but it leaves considerable room for interpretation, with implementation ultimately dependent on national priorities and capacities. In this sense, rather than resolving the tension between sovereignty and multilateralism, the PA appears to accommodate it,

embedding cooperation within nationally mediated frameworks while leaving the central questions of global accountability and inequity unresolved.

The negotiations also highlighted the growing importance of regional and political coalitions. Blocs such as Africa+, the EU, and the Group for Equity played a central role in articulating shared concerns and shaping negotiating positions. For example, Africa+ consistently foregrounded equity concerns, particularly in relation to the PABS annex. The first-time-ever coalition around a health governance principle, the Group for Equity, comprised countries such as India, Indonesia, and China, which have strong capacities in PPPR-related manufacturing and technology such as vaccines. By aligning with countries with weaker PPPR capacities, they have formed a formidable bloc arguing for equitable access to vaccines, therapeutics, and other health technologies (Schwalbe et al., 2025).

Indonesia took an assertive stance on equitable benefit-sharing during the Avian influenza India is enhancing its scientific capacity to detect pathogens and sequence genomic samples, boosting surveillance capacities and establishing laboratories from the district to national levels (NITI Aayog, 2024). These national-level initiatives are shaping the countries' global positions with respect to the PPPR regime that the PA is creating and helping to ensure that it is equitable and inclusive.

Other aspects of the PA, such as binding commitments and strong accountability measures, are being bolstered by cross-bloc coalitions (e.g., Africa+ and Group for Equity) and convergence of national-level positions, such as those of South Africa and Indonesia.

Overall, these developments point to a broader shift in which regionalisation is beginning to function as an important layer of global health governance. Rather than replacing multilateralism, these coalitions appear to be reshaping how it operates in practice. In this context, the making of the PA highlights both the possibilities and the limits of current governance arrangements, and points to the need for approaches that go beyond formal treaty provisions to build trust, operationalise equity, and navigate the balance between sovereignty and cooperation.

Strengthening PPPR Through and Beyond the Pandemic Agreement

PPPR and the PA

We recommend coordination among LICs and LMICs around three critical areas of the PA to sustain engagement and build trust by strengthening existing areas of cooperation.

Partnerships for technical capacity-building and manufacturing: Countries such as India, which already have significant manufacturing and surveillance capabilities, are well placed to partner with other LMICs to strengthen regional ecosystems and share experience in building health system and health security capacity.

Regional groupings as sites of mobilisation: The PA process has also underscored the importance of regional platforms (either as structured organisations or as coordination platforms) to implement and monitor the more regionally located aspects of PPPR such as One Health-related surveillance and supply chains for medical countermeasures. Given that countries enter negotiations with very different starting points, building a common minimum agenda at the regional level can help create pathways for broader consensus. Platforms such as ASEAN and BIMSTEC, alongside political groupings like Africa+, can play a useful role in aligning priorities and coordinating positions before these are taken to global forums.

Some initiatives are already underway. In Southeast Asia, for instance, key priorities include collaborative surveillance and bolstering regional vaccine manufacturing capacities. Through the regional stockpiling mechanism proposed in the ASEAN Vaccine Security and Self-Reliance (AVSSR) regional framework and the ASEAN Centre for Public Health Emergencies and Emerging Diseases (ACPHEED)'s public health emergency coordination plans, ASEAN countries have initiated efforts to strengthen inter-regional cooperation and technical capabilities. However, gaps around sustainable financing and the 'drawn-out, donor-dependent' implementation of a regional pooled procurement strategy necessitate further reform (Rahman-Shepherd et al., 2025).

Another example, drawing on the experience of the Africa+ bloc, is particularly instructive in demonstrating regional cooperation within the negotiations. Positions were shaped through prior consultations across a wide range of stakeholders, including civil society organisations, academia, and regional institutions such as the African Union and Africa Centres for Disease Control and Prevention (Africa CDC). Resilience Action Network Africa, together with 38 other civil society organisations, has called on African leaders and negotiators to continue pressing for a robust PABS framework grounded in equity and legal certainty, ensuring that mechanisms are put in place to track how pathogen data are used and benefits reach source communities.

In many cases, these platforms and channels may offer more immediate and actionable routes for consolidating cooperation around shared regional priorities than the global mechanisms.

Political coalition-building: Finally, the PA highlights the importance of coalition-building in sustaining political momentum. The emergence of groups such as the Group for Equity demonstrates how shared concerns can be translated into coordinated strategies and positions within negotiations. At the same time, engaging influential global leadership platforms such as the Group of Elders can help sustain high-level political attention and reinforce the framing of pandemic preparedness as a shared global priority and global public good.

PPPR Beyond the PA

To strengthen PPPR beyond the PA, key structural constraints in financing and governance have to be addressed. To that end, we recommend the following:

Enhanced resource allocation and diversification: As highlighted by Glennerster, Multilateral Development Banks (MDBs) could play a more proactive role by supporting pre-procurement financing of pandemic countermeasures before regulatory approval, thereby reducing delays in access. At the same time, cuts to Development Assistance for Health (DAH)—which peaked at US$80·3 billion in 2021 and fell to $49·6 billion in 2024 (Apeagyei et al., 2025), precipitated by factors such as the retreat of traditional donors—mean that countries will need to diversify how they mobilise resources. This could entail a combination of domestic financing, including innovative mechanisms, where possible, and private capital through public–private partnerships and philanthropy.

Inclusive consultative mechanisms: The PA process also highlights the importance of broader stakeholder engagement. Lessons from agreements such as the WHO Framework Convention on Tobacco Control suggest that involving civil society, technical experts, and advocacy coalitions can lead to more equitable and implementable outcomes. The relatively compressed timeline of the PA negotiations, prompted by pressures to finalise the treaty within a short timeframe, limited such engagement. This points to the need for complementary platforms, both regional and national, that can bring together diverse actors to inform positions and implementation strategies and sustain the PPPR conversation outside more rigid legal platforms.

Conclusion

The Pandemic Agreement reflects both the urgency of strengthening global pandemic preparedness and the challenges it faces in doing so in a fragmented and increasingly multipolar world. In its current form, the PA can be seen as a necessary, but not sufficient, step towards strengthening pandemic preparedness. Its reliance on largely non-binding commitments, combined with provisions that defer to national circumstances, raises important questions about how far it can ensure accountability in the face of a crisis. At the same time, the Agreement has helped to keep pandemics on the global agenda and created space for continued dialogue around issues such as pathogen access, benefit-sharing, and the broader architecture of preparedness. Several actors are now coming together in coalitions that span diverse geographies to build technical capacity and enhance surveillance capacity.

Taken together, these dynamics suggest that strengthening pandemic preparedness will require a more layered approach to governance—one that connects global norms with regional coordination and national action. In this sense, the PA is perhaps best understood not as an endpoint, but as one step in an ongoing process of building more resilient and equitable systems for responding to future pandemics.

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