The Pandemic Agreement: What's Next?

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Abstract

The COVID-19 pandemic exposed critical weaknesses in global health governance, prompting the development of the WHO Pandemic Agreement, formally adopted by the World Health Assembly in May 2025 following a long and often contentious negotiation process. This landmark Agreement aims to overcome the shortcomings of the 2005 International Health Regulations by establishing legally binding commitments to enhance pandemic preparedness, equity, and international solidarity. However it revealed deep geopolitical divisions, raising concerns about its legitimacy and enforceability. Key provisions include improved surveillance, data sharing, protection for healthcare workers, and equitable access to medical countermeasures. However, its effectiveness may be undermined by vague language, unresolved issues such as pathogen sharing, and the absence or abstention of influential states, including the United States. Implementation challenges are compounded by political fragmentation, sovereignty concerns, and disparities in national capacities. The Agreement's success will depend on sustained political will, robust accountability mechanisms, and meaningful national adoption. Furthermore, debates over the definition of a "pandemic" and the WHO's limited enforcement powers highlight the ongoing tension between multilateral cooperation and national sovereignty. While the Agreement represents a significant step forward, it is not a panacea. Its promise lies in its potential to catalyse coordinated global action, but only if supported by genuine commitment and adaptive governance. As the world faces future health threats, the Pandemic Agreement must evolve into a practical tool for resilience, equity, and collective security.

A Divided World

The COVID-19 pandemic revealed many weaknesses in global health governance . In 2021 an Independent Panel for Pandemic Preparedness and Response, convened by the World Health Organization, described the global response as being marked by delay, disjointed action, and inequity, and concluded that the existing international health architecture, particularly the International Health Regulations (2005), was inadequate to prevent or manage such crises [1]. It called for a new global framework convention to strengthen pandemic preparedness and response, grounded in equity, accountability, and transparency. It emphasised that such an agreement should include binding commitments, mechanisms for independent oversight, and sustainable financing to ensure that future outbreaks do not escalate into global catastrophes.

After a lengthy and, at times, acrimonious set of negotiations, a text finally emerged in April 2025, and on 20 May 2025, the World Health Assembly (WHA) took a historic step by adopting the text in plenary session and by consensus. Yet, just like the negotiations, this process was not exactly smooth. Before any resolution is taken to the WHA plenary, it is discussed in Committee A, which is responsible for technical and health-related matters. It was there, the night before the plenary, that Slovakia requested a formal vote. The vote was significant not only for its strong support, with 124 countries in favour, including all 47 African Member States, but also for the geopolitical divisions it revealed. Eleven countries abstained, including Iran, Israel, Italy, the Netherlands, Poland, Russia, and Slovakia [2]. Their abstentions reflected domestic legal constraints on the ability of the delegates to act without references to their capitals, a process complicated by time zones, concerns over sovereignty and enforcement mechanisms, and obligations related to resource sharing and data transparency. Meanwhile, 46 Member States, including the United States, were absent from the room, which continued its disengagement from WHO processes, a trend that began under the first Trump administration [3]. These absences and abstentions are far from trivial; they highlight serious challenges to the treaty's legitimacy and suggest potential difficulties in its implementation. In this divided context, the Agreement's adoption marks progress in global health governance and underscores the enduring barriers to collective action in a politically fragmented world.

Understanding the Pandemic Agreement

The Pandemic Agreement, formally known as the WHO Convention on Pandemic Prevention, Preparedness, and Response, was born out of the hard lessons of COVID-19. The pandemic exposed significant shortcomings in global coordination, inequities in access to medical countermeasures, and the limitations of existing frameworks such as the International Health Regulations (IHR) (2005) [4]. The Agreement's central aim is to promote equity and international solidarity by transforming aspirational principles of global health security into concrete, legally binding commitments. Its provisions include strengthening surveillance systems, ensuring early warning and data sharing, protecting healthcare workers, promoting

the transfer of technology and expertise, and enabling more equitable access to the real-time production of medical countermeasures such as vaccines and diagnostics [5].

The Agreement represents a significant milestone in global health governance by establishing more straightforward rules and shared responsibilities. It acknowledges that pandemics are not merely biological events but crises with far-reaching societal, economic, and political consequences. For many low- and middle-income countries, the Agreement offers hope for greater equity and a stronger voice in global decision-making, counterbalancing the often unilateral actions of wealthier nations. The creation of this binding agreement demonstrates the international community's capacity to learn from past crises, even in an era marked by rising nationalism and scepticism towards multilateralism.

The Pandemic Agreement and the International Health Regulations: Evolution or Redundancy?

As noted above, the impetus for the Pandemic Agreement stems from the recognition that the International Health Regulations (2005), while intended as the cornerstone of the international legal framework for public health emergencies, are no longer sufficient in today's interconnected world. The 2009 H1N1 pandemic and the 2014 Ebola outbreak exposed serious gaps: several states failed to notify the WHO promptly or could not develop adequate surveillance and response systems, despite their legal obligations. These shortcomings and the WHO's limited ability to enforce compliance highlighted the challenges of coordinating international responses within a system grounded in national sovereignty [6].

To address these issues, a process was launched to amend the IHR (2005), alongside a parallel initiative to develop a new instrument that would go beyond the IHR's scope. The Pandemic Agreement is intended to complement the IHR by codifying principles of equity and solidarity, addressing long-term preparedness and systemic challenges, bridging the gap between international commitments and practical implementation, clarifying existing obligations, introducing new ones, and strengthening compliance mechanisms.

However, this new legal instrument also reveals a central paradox in global health governance: unless the political dynamics that undermined the IHR, particularly the tension between multilateral cooperation and national sovereignty, are resolved [7], the Pandemic Agreement may face similar limitations [8]. The WHO was not designed to override national sovereignty but to support countries through coordination and guidance, and it lacks direct enforcement powers. The actual test of the Agreement will be whether it can inspire governments to move from rhetorical commitments to tangible, coordinated action. Ultimately, the question remains: does the Agreement represent a necessary evolution, or does it merely add another layer of well-meaning obligations constrained by the same financial and political realities?

Persisting Challenges in Implementation

Like many international agreements, the Pandemic Agreement is the product of extensive negotiation and compromise. Over more than three years, Member States engaged in intense rounds of formal and informal discussions. Some of the most ambitious proposals were diluted or omitted altogether to secure broad support [9]. Early drafts had included strong provisions for technology transfer, intellectual property flexibility, and robust resource sharing mandates. However, these elements were softened, left vague, or qualified with cautious language in the final text. As a result, though it will eventually be legally binding, the Agreement often relies on aspirational or ambiguous terms. This strategy, aimed at achieving consensus, may ultimately limit the Agreement's effectiveness when decisive action is needed.

Moreover, adoption marks only the beginning of a long and complex process [10]. One of the most contentious elements, the Pathogen Access and Benefit-Sharing (PABS) Annex, remains under negotiation [11]. The World Health Assembly (WHA) resolution has set a one-year deadline for Member States to report on progress. The Agreement will not be open for signature until this Annex is finalised. Following that, each country must undertake its ratification process, and it will only enter into force once at least 60 countries have ratified it. Thereafter, countries must incorporate the Agreement's provisions into national law and policy. This will be particularly challenging in states with divided political systems, strong sovereignty concerns, or limited institutional capacity. The implementation timeline includes monitoring mechanisms and periodic reviews beginning in 2026, but meaningful change will depend on the quality of national adoption and sustained mutual accountability [12]. As with previous frameworks, there is a risk that bold commitments may not translate into practical outcomes.

Governance Complexities in a Shifting Political Landscape

Effective governance of the Pandemic Agreement will require international coordination and strong regional and national engagement. Each WHO region faces distinct challenges: fluctuating resource availability in Africa, political fragmentation in Europe, and significant disparities in health infrastructure across the Americas and Asia. Achieving coherence across these diverse contexts will demand flexibility and sustained political and technical commitment from the Conference of the Parties (COP), the WHO, and national governments.

Further complicating the landscape is the current geopolitical uncertainty surrounding the WHO itself. The United States' withdrawal [13], public scepticism about the Agreement, and calls from the US Secretary of Health and Human Services to establish alternative health alliances [14], combined with the reluctance of other influential states, pose a threat to both the legitimacy and the practical impact of the Agreement.

There are also unresolved debates about the definition of a “pandemic”. The term remains subject to ongoing scientific, political, and symbolic contestation. Definitions that are too narrow risk excluding other critical public health threats, such as antimicrobial resistance and syndemics [15]. Conversely, overly broad definitions may dilute focus and urgency. The Agreement’s treatment of this issue remains a concern and will require periodic reassessment as global health challenges evolve.

Conclusion: A Necessary Step, But Not the Final Word

Looking ahead, the global health community cannot afford to be complacent. The approval of the Pandemic Agreement must be followed by genuine political will, sustained investment, and a readiness to address the persistent weaknesses in global health governance. As the COP and its rules are established, it is vital that the WHO and its Member States ensure high-level political engagement, prioritise the development of independent accountability mechanisms, implement transparent peer reviews of national preparedness, and create practical incentives for compliance that go beyond legal obligations.

Strengthening regional and inter-regional cooperation [16], investing in national health system capacities, and fostering open dialogue on sovereignty and solidarity will be essential. Ultimately, the promise of the Agreement will only be fulfilled if global, regional, and national health actors translate legal commitments into concrete, coordinated action, making preparedness an aspiration and a measurable reality. Only through continued commitment, honest reflection, and adaptive governance will the world be better prepared for future emergencies.

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