



Contesting Global Health Justice: Normative Limits and Legal Debates of the Pandemic Treaty

Rama Agung Nur Pratama¹, Muhammad Hafriady², Rasendriya³

¹² Master of Law Program, Gadjah Mada University, Yogyakarta, Indonesia

³ Institut für Friedenssicherungsrecht und Humanitäres Völkerrecht/Institut, Ruhr-Universität Bochum, German

*Corresponding author : ramaagungr@gmail.com

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Abstract

Background: The COVID-19 pandemic exposed structural weaknesses in global health governance, particularly in unequal access to vaccines, health technologies, and financing between developed and developing countries. It also revealed the limitations of IHR 2005 in addressing such disparities. In response, the Pandemic Treaty was developed to strengthen the legal framework for global health emergencies. **Methodology:** This study employs a normative juridical approach based on literature analysis of key international legal instruments, guided by Lawrence O. Gostin's framework of global solidarity for health equity. **Objective:** It examines the Treaty's normative design in addressing justice-related gaps and analyzes the legal debates that shape the Treaty. **The Findings:** The research shows that the Treaty attempts to fill normative gaps in the IHR by introducing provisions on local manufacturing, technology transfer, pathogen access and benefit-sharing, transparency in procurement contracts, needs-based allocation, and collective financing mechanisms. However, the formulation of these provisions reflects ongoing legal debates regarding the choice of legal basis within the WHO framework, the degree of binding obligations, and the tension between mandatory and voluntary commitments. **Originality:** This study argues that the Treaty represents a normative shift toward equity-based global health governance, yet its effectiveness remains constrained by its reliance on soft-law formulations and political consensus. It highlights that these limitations are not merely technical but stem from deeper structural tensions within international law concerning sovereignty, equity, and global solidarity.

Keywords: pandemic treaty; global health governance; global solidarity; health equity

Abstrak

Latar Belakang: Pandemi COVID-19 mengungkap kelemahan mendasar dalam tata kelola kesehatan global, terutama terkait ketimpangan akses terhadap vaksin, teknologi kesehatan, dan pendanaan antara negara maju dan berkembang. Kondisi pandemi akhirnya mendorong pembentukan Pandemic Treaty yang ditujukan untuk mereformasi tata kelola kesehatan global. **Metodologi Penelitian:** Penelitian ini menggunakan pendekatan yuridis normatif melalui studi kepustakaan terhadap instrumen hukum internasional utama, dengan menggunakan kerangka teori *global solidarity for health equity* dari Lawrence O. Gostin. **Tujuan Penelitian:** Penelitian ini bertujuan untuk menganalisis sejauh mana desain normatif Pandemic Treaty mampu mengatasi tantangan keadilan dalam tata kelola kesehatan global dan menelaah perdebatan hukum yang



membentuk proses perumusannya. **Hasil Penelitian:** Penelitian menemukan bahwa Pandemic Treaty berupaya menutup kekosongan norma dalam IHR 2005 melalui pengaturan produksi dan transfer teknologi kesehatan, sistem *pathogen access and benefit-sharing*, transparansi kontrak, alokasi berbasis kebutuhan, dan mekanisme pembiayaan kolektif antara negara maju dan berkembang. Namun, ketentuan-ketentuan tersebut sangat dipengaruhi oleh perdebatan hukum yang belum terselesaikan, terutama terkait dasar hukum dalam kerangka WHO, tingkat kekuatan mengikat, isu kekayaan intelektual, dan proses penegakannya. **Urgensi:** Penelitian ini berargumen bahwa Pandemic Treaty mencerminkan pergeseran normatif menuju tata kelola kesehatan global berbasis keadilan, tetapi efektivitasnya masih dibatasi oleh dominasi pendekatan *soft law* dan kompromi hukum pada negara-negara perunding.

Kata Kunci: perjanjian pandemi; tata kelola kesehatan global; solidaritas global; keadilan kesehatan

A. Introduction

In recent years, the world has once again been confronted with emerging global health threats reminiscent of the early phase of the *Coronavirus Disease 2019* (hereinafter referred to as COVID-19) pandemic. Reports from the *World Health Organization* (WHO) indicate a significant increase in newly emerging infectious diseases with pandemic potential, such as new variants of Influenza A (H5N1)¹, the spread of the Nipah virus in South Asia², and the emergence of other zoonotic diseases closely linked to climate change and environmental degradation.³ The pattern of these disease outbreaks suggests that pandemics are no longer rare events occurring once in a century, but rather recurrent phenomena within an evolving global dynamic shaped by increased human mobility, ecological transformation, and disparities in health system capacities among states. This condition inevitably affects the structure of global health governance and the relationships among states, thereby necessitating the development of a renewed global framework to effectively address such challenges.

Looking back, the experience of the COVID-19 pandemic demonstrated that the existing framework of international law has not been fully capable of responding to global health crises in an effective and equitable manner. Various challenges, ranging from unequal

¹Kat Lay and Kat Lay Global health correspondent, "Are We Ready for Another Pandemic?," *Global Development*, *The Guardian*, January 2, 2025, <https://www.theguardian.com/global-development/2025/jan/02/are-we-ready-for-another-pandemic>.

²"Nipah Virus Infection - Bangladesh," accessed January 1, 2026, <https://www.who.int/emergencies/disease-outbreak-news/item/2025-DON582>.

³Jihee Jeon and Eunyong Kim, "Exploring Future Pandemic Preparedness Through the Development of Preventive Vaccine Platforms and the Key Roles of International Organizations in a Global Health Crisis," *Vaccines* 13, no. 1 (2025): 56, <https://doi.org/10.3390/vaccines13010056>.

access to vaccines⁴, medical equipment, and health technologies⁵, to delayed cross-border responses, revealed that current international instruments are inadequate to address large-scale global health emergencies.⁶

In this context, the *International Health Regulations 2005* (hereinafter referred to as IHR 2005) serves as a key instrument aimed at ensuring coordinated responses to disease outbreaks during global health emergencies.⁷ However, the IHR 2005 primarily emphasizes obligations related to notification and outbreak coordination, without substantively regulating mechanisms for international solidarity, emergency financing, or equitable distribution of health resources during a *Public Health Emergency of International Concern* (hereinafter referred to as PHEIC).⁸ This normative gap has given rise to legal debates concerning the extent to which the IHR 2005 can be considered an adequate legal basis for establishing international obligations to ensure equity in global health governance. Furthermore, the dynamics observed during the pandemic also revealed the limitations of other international legal regimes, particularly in relation to intellectual property rights. Debates surrounding flexibilities under the *Agreement on Trade-Related Aspects of Intellectual Property Rights* (TRIPS), including the proposed TRIPS Waiver, highlight the tension between the protection of exclusive rights and the fulfillment of the right to health. Similarly, global initiatives such as the *COVAX Facility*⁹, alongside prolonged debates on the limitation of intellectual property rights within the

⁴Sabrina Nadila, "KRISIS COVID-19: PERSPEKTIF HUKUM INTERNASIONAL TERHADAP PANDEMI: (Covid-19 Crisis: An International Law Perspective to Pandemics)," *Majalah Hukum Nasional* 50, no. 2 (2020): 261–80, <https://doi.org/10.33331/mhn.v50i2.65>.

⁵In terms of medical devices and health technologies, the COVID-19 pandemic exposed a significant gap in technological development between developed and developing countries. This condition has further exacerbated inequalities, as access to health technologies remains largely limited to privileged groups. For further reading, see: Emnet Getachew et al., "Digital Health in the Era of COVID-19: Reshaping the next Generation of Healthcare," *Frontiers in Public Health* 11 (2023): 942703, <https://doi.org/10.3389/fpubh.2023.942703>.

⁶"Covid-19: Global Response Was Too Slow and Leadership Absent, Report Finds | The BMJ," accessed January 1, 2026, <https://www.bmj.com/content/373/bmj.n1234.full>.

⁷Nelson Aghogho Evaborhene et al., "The WHO Pandemic Treaty: Where Are We on Our Scepticism?," *BMJ Global Health* 8, no. 6 (2023): e012636, <https://doi.org/10.1136/bmjgh-2023-012636>.

⁸The IHR provides technical and coordinative guidance for states in detecting, reporting, and responding to cross-border disease outbreaks; however, it does not incorporate enforcement mechanisms or equitable burden-sharing arrangements related to financing, vaccine distribution, and technology transfer. For further discussion, see: Haytham A. Sheerah et al., "Navigating Hurdles: A Review of the Obstacles Facing the Development of the Pandemic Treaty," *Journal of Epidemiology and Global Health* 14, no. 3 (2024): 580–85, <https://doi.org/10.1007/s44197-024-00233-5>.

⁹COVAX, short for COVID-19 Vaccine Global Access Facility, is a global initiative designed to ensure equitable and fair access to COVID-19 vaccines worldwide, particularly for low- and middle-income countries. It constitutes the vaccine pillar of the *Access to COVID-19 Tools (ACT) Accelerator*, launched in April 2020 by the WHO, the European Commission, and the Government of France, with the primary objective of providing equitable access to diagnostics, therapeutics, and vaccines for COVID-19. The COVAX initiative aims to prevent vaccine nationalism and to ensure that all countries have equal opportunities to access COVID-19 vaccines. For further discussion, see: Getzgz, "Shared Health Governance, Mutual Collective Accountability, and Transparency in COVAX: A Qualitative Study Triangulating Data from Document Sampling and Key Informant Interviews," *JOGH*, December 8, 2023, <https://jogh.org/2023/jogh-13-04165/>.

framework of the TRIPS Waiver¹⁰, demonstrate the inadequacy of existing legal arrangements in ensuring equitable access to essential health technologies.¹¹ These conditions reinforce the argument that there are normative gaps and fragmentation within global health law that require further legal regulation. In response to these limitations, Member States of the *World Health Assembly* (WHA) in 2021 agreed to initiate the development of a new international legal instrument known as the *Pandemic Treaty*. This treaty is designed to strengthen pandemic prevention, preparedness, and response through more comprehensive regulatory provisions, including local manufacturing, technology transfer, pathogen access and benefit-sharing mechanisms, transparency in procurement contracts, and collective financing. Following an extensive negotiation process, the text of the *Pandemic Treaty* was ultimately adopted in May 2025.

However, the formulation of the *Pandemic Treaty* is not devoid of fundamental legal debates. First, there is an ongoing debate concerning the legal basis for the establishment of the treaty within the WHO framework, particularly regarding the use of Article 19 of the WHO Constitution and its implications for the binding nature of the instrument. Second, there are debates regarding the degree of binding force of the treaty's provisions, including the use of mandatory versus aspirational normative formulations. Third, questions arise as to the relationship between the *Pandemic Treaty* and existing international legal instruments, particularly the IHR 2005, in terms of normative coherence and the potential for overlap or fragmentation. These debates indicate that the development of the *Pandemic Treaty* is not merely a matter of global policy response but also reflects an ongoing process in the evolution of international law.

Within this framework, the issue of justice emerges as a central dimension in legal debates on global health governance. Various analyses in global health governance emphasize that states' capacities to prevent and respond to outbreaks are significantly shaped by structural inequalities in access to technology, financing, health system capacity, and information.¹² Lawrence Gostin argues that the effectiveness of global governance largely depends on the extent to which international mechanisms are able to ensure benefit-sharing, cross-border solidarity, and respect for human dignity.¹³

¹⁰ There have also been proposals to waive certain provisions of the TRIPS Agreement concerning health products and technologies related to COVID-19, including a temporary suspension of intellectual property obligations (such as vaccine patents) to facilitate the prevention, containment, and treatment of COVID-19. For further discussion: Jillian Kohler et al., "Improving Access to COVID-19 Vaccines: An Analysis of TRIPS Waiver Discourse among WTO Members, Civil Society Organizations, and Pharmaceutical Industry Stakeholders," *Health and Human Rights* 24, no. 2 (2020): 159–75.

¹¹ Anika Klafki, "Post-Pandemic Reform Discussions in International Health Law: The Reform of the International Health Regulations and the New WHO Pandemic Agreement Proposal," *European Journal of Risk Regulation* 16, no. 2 (2025): 744–52, <https://doi.org/10.1017/err.2024.79>.

¹² Richard Mahoney et al., "Global Regulatory Reforms to Promote Equitable Vaccine Access in the next Pandemic," *PLOS Global Public Health* 3, no. 10 (2023): e0002482, <https://doi.org/10.1371/journal.pgph.0002482>.

¹³ Oghenowede Eyawo and A. M. Viens, "Rethinking the Central Role of Equity in the Global Governance of Pandemic Response," *Journal of Bioethical Inquiry* 17, no. 4 (2020): 549–53,

Based on the foregoing, this study formulates two main legal questions. First, how does the normative design of the *Pandemic Treaty* address the urgency of justice in global health governance in the post-pandemic context? Second, how do legal debates shape the substance of the *Pandemic Treaty*? This study employs a normative-descriptive juridical approach to analyze the *Pandemic Treaty* as a new international legal instrument within the framework of global health governance under the auspices of the WHO. The normative approach is conducted through a systematic examination of the legal substance of the *Pandemic Treaty*, as well as relevant international legal instruments, including the *International Health Regulations 2005* (IHR 2005), the *Doha Declaration on the TRIPS Agreement and Public Health* (2001), and the *World Health Assembly Resolution WHA74.7 (2021)*, to assess the extent to which the treaty is designed to strengthen principles of justice and global solidarity in health. This research further adopts a *statutory approach*, focusing on the analysis of binding legal texts and formal international instruments that constitute the regulatory framework of global health law. In addition, a *conceptual approach* is employed to examine the underlying legal principles and doctrines, particularly those relating to equity, solidarity, and the right to health, as reflected in the evolving discourse of international law. The descriptive dimension of this study is used to outline the legal dynamics surrounding the treaty-making process, including normative tensions between global solidarity and state sovereignty, as well as between the interests of developed and developing countries, particularly in addressing the inequities exposed during the COVID-19 pandemic.

The analysis is grounded in Lawrence O. Gostin's theory of *global solidarity for health equity*, which conceptualizes health as a global public good and emphasizes the importance of international cooperation based on equity, shared responsibility, redistribution of resources, and equitable access to health technologies. This research is conducted through a literature-based study utilizing primary, secondary, and tertiary legal materials. It is limited to a normative analysis and does not extend to post-adoption implementation of the *Pandemic Treaty*. Additionally, the study acknowledges the limited availability of data concerning developments in the negotiation process following its adoption in May 2025. Nonetheless, these limitations do not diminish the relevance of the study in explaining the urgency of global health justice and the legal dynamics underlying the formation of the treaty. Previous studies have examined the urgency, processes, and challenges in the development of the *Pandemic Treaty* from various perspectives, including bioethics, international law, and global governance. A study by Sheerah et al. (2024) identifies six major obstacles in the treaty-making process, namely the lack of political will among developed countries, unequal access to medical resources, unsustainable financing, the absence of effective compliance mechanisms, issues of state sovereignty, and data transparency. The study emphasizes that global justice can only be achieved if high-income countries are willing to share technology and resources

<https://doi.org/10.1007/s11673-020-10001-2>; Jeffrey V. Lazarus et al., "Implications from COVID-19 for Future Pandemic Global Health Governance," *Clinical Microbiology and Infection* 30, no. 5 (2024): 576–81, <https://doi.org/10.1016/j.cmi.2023.03.027>.

equitably with developing countries.¹⁴ Meanwhile, Na Schwalbe (2025), through an analysis of the negotiation process, argues that the *Pandemic Treaty* also serves as a means for the WHO to reassert its institutional legitimacy. However, Horton contends that the formulation of the *Pandemic Treaty* remains heavily shaped by power struggles between developed and developing countries, particularly in relation to key provisions such as *Pathogen Access and Benefit-Sharing* (PABS).¹⁵

B. Discussion

1. The Normative Design of the Pandemic Treaty in Addressing Justice in Global Health Governance

1.1. International Health Law in the Context of Global Governance

Initially, the concept of health law existed primarily within the private sphere, emphasizing the relationship between patients and medical professionals.¹⁶ Over time, however, health law has evolved to intersect with the public domain, as states have come to recognize that societies face a wide range of health-related challenges that require regulation through national legal systems.¹⁷ As developments progressed, it became increasingly evident that with the rise of human mobility, global trade, and urbanization, health threats are no longer confined to local contexts. Disease outbreaks such as cholera, smallpox, influenza, HIV/AIDS, Ebola, and yellow fever demonstrate that health is a transboundary issue requiring global governance. This condition has led to the emergence of global health law as a branch of international law that seeks to regulate the responsibilities of states and non-state actors in preventing, responding to, and recovering from global health crises.

In this context, the ideas of George J. Annas and Lawrence O. Gostin play a crucial role in shaping the conceptual framework of modern global health law. There are notable differences in the points of departure of international health law development according to these two scholars. George J. Annas adopts a perspective grounded in a human rights approach and bioethics, rooted in historical experiences of medical experimentation and human rights violations.¹⁸ In contrast, Lawrence O. Gostin views health as a shared global

¹⁴ Haytham A. Sheerah et al., "Navigating Hurdles: A Review of the Obstacles Facing the Development of the Pandemic Treaty," *Journal of Epidemiology and Global Health* 14, no. 3 (2024): 580–85, <https://doi.org/10.1007/s44197-024-00233-5>.

¹⁵ Nina Schwalbe et al., "The Pandemic Treaty: A Forensic Review of Process and Pitfalls," *Global Public Health* 20, no. 1 (2025): 2522916, <https://doi.org/10.1080/17441692.2025.2522916>.

¹⁶ Before the emergence of the concept of global health law, health-related matters were largely considered a private domain confined to the relationship between patients and physicians. In its early development, this relationship was paternalistic in nature, whereby physicians held absolute authority in determining the best medical treatment without active participation from the patient.

¹⁷ Lawrence O. Gostin and Allyn L. Taylor, "Global Health Law: A Definition and Grand Challenges," *Public Health Ethics* 1, no. 1 (2008): 53–63, <https://doi.org/10.1093/phe/phn005>.

¹⁸ According to George J. Annas, the development of bioethics, health law, and modern human rights cannot be separated from the traumatic experiences of World War II, the Holocaust, and the Nuremberg Trials in 1947. In his reflection, Annas highlights the involvement of Nazi physicians in various inhumane medical experiments, such as high-altitude and freezing experiments, which inflicted extreme suffering and

concern that requires collective cross-border responses, particularly in the post-Cold War era marked by the acceleration of globalization in political, economic, and social domains. Gostin highlights that the emergence of infectious diseases such as Severe Acute Respiratory Syndrome (SARS) demonstrates that health threats are no longer local but global in nature, as they spread rapidly across borders and produce widespread impacts. This condition underscores the need for global coordination and legal frameworks involving all states to strengthen international health governance.¹⁹

The debate regarding these differing starting points opens space for a broader understanding of how global health law is connected to the concept of global governance. To further elaborate on the conceptual foundation underlying the approaches of both Gostin and Annas, this study briefly outlines the concept of global governance. In general, global governance refers to systems of regulation, coordination, and decision-making involving multiple actors across borders to effectively address challenges that require collective action.²⁰ David Held (1995) defines global governance as a set of institutions, norms, policies, and practices that regulate interactions and responsibilities among actors at the global level.²¹ James Rosenau (1992) emphasizes that global governance is not synonymous with global government. Rather, it represents processes through which the world order is shaped by a combination of state and non-state actors without a single central authority.²² Anne-Marie Slaughter (2004) further explains that global governance operates through networks of institutions and national authorities that interact in establishing global standards and policies. Thus, global governance can be understood as a cross-border collaborative mechanism that regulates transnational issues that cannot be resolved by individual states alone, including health-related issues. Ultimately, the

often resulted in the death of research subjects. These medical atrocities formed part of the charges in the Doctors' Trial, where 23 physicians were prosecuted for human rights violations and war crimes. From this context emerged the Nuremberg Code, which for the first time explicitly established the principle of *informed consent* as a foundational ethical and legal requirement in medical research involving human subjects, see further: George J Annas, *American Bioethics after Nuremberg: Pragmatism, Politics, and Human Rights*, 2005.

¹⁹ International efforts to coordinate responses to transboundary disease threats date back to the 19th century. A series of International Sanitary Conferences beginning in 1851 sought to establish common standards for quarantine and outbreak reporting, particularly in response to cholera and plague. This was followed by the establishment of the Office International d'Hygiène Publique (OIHP) in 1907 and the League of Nations Health Organization (LNHO) after World War I, both of which served as precursors to modern international health cooperation. However, it was not until 1948, with the establishment of the WHO as a specialized agency under the United Nations, that global health governance acquired a more robust and enduring institutional framework. WHO was mandated to achieve "the highest attainable standard of health for all peoples" through global coordination, policy standardization, and the development of international legal instruments under the Constitution of the WHO.

²⁰ Wafa Abu El Kheir-Mataria et al., "Global Health Governance and Health Equity in the Context of COVID-19: A Scoping Review," *Healthcare* 10, no. 3 (2022): 540, <https://doi.org/10.3390/healthcare10030540>.

²¹ David Held, "Cosmopolitan Democracy and the Global Order: Reflections on the 200th Anniversary of Kant's 'Perpetual Peace,'" *Alternatives: Global, Local, Political* 20, no. 4 (1995): 415–29.

²² James N. Rosenau and Ernst-Otto Czempiel, eds., *Governance without Government: Order and Change in World Politics*, 1st ed. (Cambridge University Press, 1992), <https://doi.org/10.1017/CBO9780511521775>.

purpose of global governance is to regulate interactions among states and non-state actors in addressing global challenges and achieving global stability.²³ In the field of health, global health governance refers to the system of norms, institutions, and international actors that play roles in regulating, financing, and responding to transnational health challenges. Frenk and Moon (2013) define it as “the collective actions and institutions designed to deal with health issues that transcend national boundaries.”²⁴ Meanwhile, Kickbusch and Gleicher (2012) view global health governance as a form of multi-actor coordination aimed at achieving global health equity and resilience through principles of solidarity and shared responsibility.²⁵

The actors involved in global health governance are diverse and reflect the complexity of power relations within the system. First, the WHO serves as the primary institution in setting standards and coordinating international health policies, for example through the IHR. Second, member states remain the central actors, as they possess sovereignty in implementing domestic policies and in negotiating international agreements such as the Pandemic Treaty. Third, other international organizations, including the World Bank, the World Trade Organization (WTO), and the United Nations Development Programme (UNDP), also play significant roles, as their policies influence global health financing and regulation. Despite the increasing diversity of the global health governance ecosystem, several fundamental challenges persist. First, power asymmetry between developed and developing countries results in unequal distribution of health resources such as vaccines, medical technologies, and funding. Second, institutional overlap among various international organizations leads to policy fragmentation and weak coordination, particularly during health emergencies.²⁶ Third, an equity gap emerges due to the absence of effective international legal mechanisms to ensure solidarity, accountability, and fair distribution of health benefits. The COVID-19 crisis has made these problems more

²³ Ana Luisa Jorge Martins and Rômulo Paes-Sousa, “The Paradox of Growing Technical Capacities with Low Global Governance: A Review of Voluntary National Reviews’ SDG Health-Related Indicators,” *Globalization and Health* 20, no. 1 (2024): 50, <https://doi.org/10.1186/s12992-024-01051-x>.

²⁴ Julio Frenk and Suerie Moon, “Governance Challenges in Global Health,” *New England Journal of Medicine* 368, no. 10 (2013): 936–42, <https://doi.org/10.1056/NEJMra1109339>.

²⁵ Ilona Kickbusch and David Gleicher, *Governance for Health in the 21st Century*, Health Policy (WHO, n.d.).

²⁶ However, with globalization and the increasing complexity of health challenges, ranging from HIV/AIDS, influenza pandemics, COVID-19, to climate change, multiple institutions have emerged with overlapping mandates. For instance, the World Trade Organization (WTO), through the TRIPS Agreement, significantly influences access to medicines and vaccines, despite its primary focus on trade rather than health. Similarly, organizations such as UNAIDS, Gavi, the Vaccine Alliance, and Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) often operate with overlapping roles in financing, vaccine distribution, and disease-specific interventions. This institutional overlap reflects what scholars describe as fragmentation in global health governance, where multiple actors operate across intersecting mandates without a unified hierarchical authority.. See also: Neil Spicer et al., “‘It’s Far Too Complicated’: Why Fragmentation Persists in Global Health,” *Globalization and Health* 16, no. 1 (2020): 60, <https://doi.org/10.1186/s12992-020-00592-1>; Mette Eilstrup-Sangiovanni and Oliver Westerwinter, “The Global Governance Complexity Cube: Varieties of Institutional Complexity in Global Governance,” *The Review of International Organizations* 17, no. 2 (2022): 233–62, <https://doi.org/10.1007/s11558-021-09449-7>.

visible, as weaknesses in global governance led to delayed responses, unequal access, and insufficient legal frameworks to guarantee equity.

These conditions give rise to the understanding that global health issues cannot be separated from questions of justice and equity. The paradigm of international health law should not be limited to regulating disease prevention or cross-border coordination but should also function as a normative framework determining how the right to health and health resources are distributed fairly among states with differing economic capacities and infrastructures. Lawrence O. Gostin emphasizes the importance of “global solidarity for health equity,” which calls for a more equitable sharing of responsibilities and resources. In this perspective, health is understood as a global public good that requires international legal regulation to ensure that all states, regardless of their economic or political power, have access to adequate health systems, vaccines, and medical technologies. This perspective underlies the formation of the Pandemic Treaty, which is expected to strengthen cross-border solidarity mechanisms in addressing future pandemic threats.

Meanwhile, George J. Annas’s perspective, which emphasizes human rights and bioethics, implies that all international health policies and regulations must place human dignity at their core. Bioethical principles such as non-maleficence, autonomy, beneficence, and justice must not be neglected in the development of global health instruments, including the Pandemic Treaty. Furthermore, international health law that disregards these humanitarian values risks creating new forms of inequality. From these two perspectives, it is evident that global health law is constructed upon two principal theoretical pillars: the ethical and human rights pillar emphasized by Annas, and the global governance and justice pillar advanced by Gostin. These perspectives provide direction for both the substantive content and the structural design of the Pandemic Treaty. Accordingly, the Pandemic Treaty should not merely regulate technical coordination among states but must also uphold justice and global solidarity in addressing health threats that are inherently borderless and transnational.

1.2. The Legal Nature and Normative Design of the Pandemic Treaty: Assessing Justice in Global Health Governance

The COVID-19 pandemic has demonstrated that the IHR 2005 is inadequate in addressing principles of justice and solidarity in the distribution of global health resources. The IHR primarily regulates state obligations concerning outbreak reporting and cross-border response coordination, yet it fails to engage with issues of distributive justice, emergency financing mechanisms, and the responsibilities of developed countries toward developing countries. As a result, during the pandemic, low-income countries faced significant challenges in accessing vaccines, medical supplies, and health technologies necessary to protect their populations. This disparity underscores that pre-2025 international health law remained grounded in a *containment-based regulation* paradigm,

focusing on limiting disease spread without addressing structural inequalities in power and resource distribution among states.

In this context, the initiative to establish a Pandemic Treaty emerged as an effort to fill the normative gaps that have not been accommodated within the existing international health law regime. Although the Pandemic Treaty was adopted by the World Health Assembly in 2025, the instrument has not yet been opened for signature or ratification by states, as several key components of the PABS mechanism remain under further negotiation. This situation raises fundamental questions regarding its legal status, binding force, and effectiveness as an instrument of international law in governing global health governance. The incomplete legal status of the Pandemic Treaty invites further examination of its legal nature within the framework of international law. Although formally adopted by the World Health Assembly, the instrument does not yet fulfill the constitutive elements of a binding international treaty, particularly in the absence of signature, ratification, and entry into force. This raises the question of whether the Pandemic Treaty should be understood as a conventional treaty under the Vienna Convention on the Law of Treaties, or rather as a form of *emerging legal framework* with predominantly political and normative commitments. The reliance on voluntary cooperation, flexible obligations, and the absence of enforcement mechanisms further complicate its classification as a strictly binding legal instrument. Consequently, the Pandemic Treaty occupies an ambiguous position between *hard law* and *soft law*, reflecting ongoing tensions between state sovereignty and the need for collective global health governance.

Notwithstanding its incomplete legal status, a normative analysis of the Pandemic Treaty remains both relevant and necessary. As an adopted instrument reflecting negotiated consensus among States, the current draft text embodies emerging legal norms, principles, and institutional designs that are likely to shape the future architecture of global health governance. In international law scholarships, draft or pre-entry-into-force instruments are frequently examined to assess their normative direction, coherence, and potential effectiveness, particularly when they address urgent global concerns. Therefore, analyzing the Pandemic Treaty at this stage allows for a critical evaluation of whether its normative framework can address structural inequalities and advance justice, even before it becomes formally binding. In its normative design, the Pandemic Treaty expands the scope of international health law by establishing *equity, solidarity, accountability, and transparency* as foundational principles of global health governance. These values are explicitly affirmed in the Preamble and Article 3 of the Pandemic Treaty, which recognize that each State retains full sovereignty over its national health policies (*sovereign right of States*), while simultaneously being bound by a collective responsibility to ensure equitable access to pandemic prevention, preparedness, and response measures. Accordingly, justice is not merely conceived as an outcome, but also as a guiding principle that informs international decision-making processes in the field of health (*substantive principle*). The conceptual framework advanced by Lawrence O.

Gostin, as discussed in the previous section, views health as a form of *global solidarity for health equity*, emphasizing that health constitutes a *global public good* that cannot be safeguarded exclusively by individual states. Rather, it requires international legal mechanisms capable of ensuring the fair distribution of resources and responsibilities across states. In this regard, the Pandemic Treaty is expected to shift the paradigm of international health law from a narrow focus on disease containment toward an *equity-based governance* model, one that prioritizes fairness and shared responsibility in global health governance.

This article examines how the Pandemic Treaty seeks to advance justice in global health governance through three main analytical components. First, it undertakes a substantive normative analysis of the Treaty's key provisions, focusing on three core areas: (1) the distribution of production and technology (Articles 10–11), which regulate *sustainable and geographically diversified local production* as well as *technology transfer and know-how*; (2) access to pathogens and benefit-sharing (Article 12), which emphasizes *PABS* mechanisms; and (3) the distribution of health products and financing (Articles 13, 14, and 18), which encompass the *global supply chain* and a *coordinating financial mechanism*. This analysis is based on the May 2025 draft text of the Pandemic Treaty. Second, the article analyzes the institutional dimension of global health governance to assess how the Treaty's institutional architecture may address and potentially rectify existing structural inequalities. Third, the analysis evaluates the extent to which the Pandemic Treaty realizes the dimension of global justice as conceptualized by Lawrence O. Gostin.

First, concerning the distribution of production and technology as regulated under Articles 10 and 11. These provisions reflect the commitment of States Parties to address structural inequalities in manufacturing capacity and access to health technologies, one of the most prominent challenges revealed during the COVID-19 pandemic. Article 10, entitled *Sustainable and Geographically Diversified Local Production*, establishes the obligation of States Parties to ensure a more equitable and sustainable geographical distribution of health production facilities. This provision requires states to strengthen national and regional manufacturing capacities, particularly in developing countries, through infrastructure development, workforce training, and both public and private investment support. In addition, Article 10 promotes the establishment of long-term partnerships between producers in developed and developing countries to ensure supply chain resilience and production readiness during public health emergencies. The WHO is mandated to support the implementation of this provision through technical assistance, investment facilitation, and the development of rapid production capacities during pandemic emergencies. In line with this, Article 11 on *Transfer of Technology and Cooperation on Related Know-How to Produce Pandemic-Related Health Products* extends the dimension of justice into the realm of innovation and knowledge. This provision requires States Parties to facilitate and incentivize technology transfer on a “mutually

agreed” basis, including through licensing arrangements²⁷, training, and financial support. It further includes commitments to expand access to non-exclusive licensing for developing countries²⁸, promote the publication of relevant licensing agreements²⁹, and encourage patent holders to reduce or waive royalties during pandemics.³⁰ Moreover, states are encouraged to promote collaboration with WHO technology transfer hubs and to disclose relevant production data to enhance global transparency and efficiency. Significantly, Article 11 also reaffirms the right of states to utilize flexibilities under the TRIPS Agreement and the Doha Declaration on the TRIPS Agreement and Public Health as safeguards for the protection of public health interests.

However, the language employed in Article 11 reveals inherent limitations that leave room for political compromise between developed and developing countries. The phrase “as mutually agreed” renders technology transfer voluntary in nature, rather than establishing a legally binding obligation. This significantly weakens the enforceability of the justice-oriented norms that the treaty seeks to advance. Developed countries are thus able to retain their exclusive intellectual property rights, while developing countries are left with merely normative assurances, lacking certainty in practical implementation.

²⁷ Although compulsory licensing has existed and was utilized during the pandemic, many countries were unable to manufacture vaccines independently due to various constraints, including limited financial resources and complex manufacturing processes, some of which are also protected by intellectual property regimes. See further: WooJung Jon, “The WHO Pandemic Agreement: Why Countries Will Not Use Compulsory Licensing – and How to Fix It,” *BMJ Global Health* 10, no. 9 (2025), <https://doi.org/10.1136/bmjgh-2025-020856>.

²⁸ Developed countries or patent-holding pharmaceutical companies are encouraged to grant licenses to multiple entities in other countries, particularly in developing countries.

²⁹ Drawing from the widespread use of confidential agreements between governments and pharmaceutical companies during the pandemic, both states and companies entering licensing arrangements are expected to ensure transparency. For instance, during the COVID-19 pandemic, vaccine procurement was conducted through confidential bilateral contracts between governments and pharmaceutical companies such as Pfizer, Moderna, and AstraZeneca. These contracts were not publicly disclosed, resulting in several consequences: (1) purchasing countries lacked information regarding the prices paid by other states; (2) countries with weaker bargaining positions, typically low-income countries, were unable to negotiate fairer prices due to the absence of comparative data; and (3) empirical studies have shown that prices for the same vaccines varied significantly across countries. This situation has been described by the WHO as *vaccine apartheid*, reflecting the deep inequalities in global vaccine access. See further: “Covid-19: Vaccine Pricing Varies Wildly by Country and Company,” accessed January 2, 2026, https://finance.yahoo.com/news/covid-19-vaccine-pricing-varies-044212280.html?guce_referrer=aHR0cHM6Ly93d3cuZ29vZ2xlLmNvbS8&guce_referrer_sig=AQAAAG9XsN06msg9iR9qR1Zbb-i2H-C-sqpVP3D01bPCWX0AOy45b7lJRdTve1qEap1rpMXR2m6-dCiLkPJqmECeOjU-96ASRYCLDeXfgvQ7EU68M9WS1sd6UtmK9WNGK2wMyC3QkfsNKUWIRkvnu-Y0vrVuyfqWUcOfvCioOdQi8Gj0&guccounter=2.

³⁰ In general, vaccines, medicines, and medical devices are protected by patents, meaning that only patent holders, typically large pharmaceutical companies, possess the exclusive right to manufacture and commercialize such products. Other states or manufacturers wishing to produce the same products must obtain licenses from patent holders and pay royalties.

Second, concerning PABS. This set of provisions seeks to address structural inequalities arising from the fact that pathogens or viruses with pandemic potential³¹ often originate in developing countries, particularly those characterized as biodiversity hotspots.³² In contrast, developed countries are typically the primary actors responsible for developing health products and technologies, including vaccines, therapeutics, and diagnostic tools. This asymmetrical relationship creates a pattern in which developing countries serve as the main contributors of pathogens, genomic sequence data, and biological samples used in research and development, yet do not receive equitable access to the resulting innovations and patented products generated by developed countries. To address this imbalance, the Pandemic Treaty introduces the PABS, as set out in Article 12. PABS is designed as a multilateral system under the coordination of the WHO, regulating both access to biological materials and pathogen sequence data with pandemic potential (*PABS materials and sequence information*) and the equitable sharing of benefits arising from their use.³³ Under this system, manufacturers that obtain access to pathogens are required to allocate 20% of their real-time production of vaccines or therapeutics to the WHO, consisting of 10% as donations and 10% at affordable prices for developing countries. In addition, PABS includes provisions on capacity-building, the promotion of non-exclusive licensing for manufacturers in developing countries, and the strengthening of tracking systems and transparency in the flow of biological data.

Third, the issue of inequitable distribution of vaccines, diagnostics, and medical supplies is addressed through Articles 13 and 14 of the Pandemic Treaty. By establishing a *Global Supply Chain and Logistics Network* coordinated by the WHO, the Treaty seeks to ensure that the allocation of essential health products during a pandemic is based on public health needs rather than financial capacity or geopolitical influence, while also preventing vaccine hoarding by wealthier states. This mechanism aims to guarantee that resources necessary to combat pandemics are distributed rapidly and equitably. Substantively, this represents a step toward *health equity*, as WHO, through the Global Supply Chain and Logistics Network, attempts to shift the logic of vaccines and other

³¹ Examples of pathogens with significant public health impact include the SARS-CoV-2, the H5N1 virus causing avian influenza, the *Mycobacterium tuberculosis* bacterium responsible for tuberculosis, and the *Plasmodium falciparum* parasite causing malaria.

³² Developing countries, particularly those located in tropical and subtropical regions in Asia, Africa, and Latin America, are characterized by high levels of biodiversity (biodiversity hotspots). Such environments often serve as natural reservoirs for viruses, bacteria, and emerging pathogens with zoonotic potential. Moreover, many developing countries continue to rely on livestock-based economic activities, which account for approximately 75% of zoonotic disease transmission from animals to humans. See further: Bayissa Chala et al., "Re-Emerging COVID-19: Controversy of Its Zoonotic Origin, Risks of Severity of Reinfection and Management," *International Journal of General Medicine* 16 (September 2023): 4307–19, <https://doi.org/10.2147/IJGM.S419789>; Yashpal Singh Malik et al., "Emerging and Zoonotic Virus Challenges of Developing Nations," *The Open Virology Journal* 12, no. 1 (2018), <https://doi.org/10.2174/1874357901812010042>.

³³ Pathogen sequence data with pandemic potential refers to genetic information (DNA or RNA sequences) of viruses, bacteria, or other microorganisms that may cause pandemics. Through such genetic data, researchers can identify new variants, predict transmission dynamics, develop vaccines, design diagnostic tools, and monitor mutations that may emerge over time.

health products from market-based commodities to public goods serving collective needs. However, it is important to note that the Treaty does not grant WHO any enforcement authority. As a result, the global supply chain mechanism risks functioning merely as a coordinative strategy without compulsory instruments, particularly when states choose to prioritize national interests by stockpiling resources or restricting exports, as was observed during the early stages of the COVID-19 pandemic.

Article 14 seeks to address the widespread use of confidential contracts and the monopoly over pricing information. The COVID-19 pandemic revealed how states entered into agreements for the procurement of vaccines, diagnostic tools, and therapeutics with pharmaceutical companies through bilateral contracts that were not subject to public disclosure. This situation enabled certain countries to secure vaccine supplies earlier than others, created a lack of transparency regarding whether vaccines were purchased at fair prices, and generated uncertainty concerning the timeline of availability for other states. For instance, the European Union, the United States, the United Kingdom, and Canada secured large quantities of vaccines through such confidential agreements well before other countries, leaving regions such as Africa, South Asia, and Latin America with limited access after the needs of wealthier states had been fulfilled. By requiring contract transparency and establishing procedures for priority allocation to countries facing the greatest difficulties, this provision aims to protect low-income countries from “take-all” practices and advance purchasing strategies employed by wealthier states. Transparency in contractual arrangements is expected to reduce disparities in bargaining power and prevent pharmaceutical companies from imposing discriminatory pricing. However, once again, this provision does not establish any enforcement mechanism in cases where states or manufacturers refuse to disclose contractual information. Article 18 introduces the Coordinating Financial Mechanism (CFM) as an effort to provide financial resources to strengthen pandemic prevention, preparedness, and response capacities, particularly in low-income countries. However, the CFM is built on voluntary contributions. Drawing from the experience of similar funding deficits that undermined COVAX and other multilateral initiatives, the absence of predictable and sustainable funding will significantly constrain the WHO in mobilizing global supply chains and ensuring equitable allocation of health products. These three sets of provisions clearly embody a strong normative commitment to solidarity. Nevertheless, their legal and financial foundations remain dependent on the voluntary commitments of states. In the absence of mandatory allocation obligations, sanctions for non-compliance with transparency requirements, and fixed financial contributions, these mechanisms risk reproducing the very structural inequalities they seek to address. The discussion now turns to the institutional mechanisms established under the Pandemic Treaty. The creation of the Conference of the Parties (COP) under Article 19 serves as a key mechanism to address imbalances in global health decision-making. During the COVID-19 pandemic, developing countries were often positioned merely as objects of rules formulated without their meaningful participation. The COP seeks to correct this

imbalance by providing a deliberative forum in which all States Parties can participate, set implementation standards, adopt guidelines, and monitor compliance.

Articles 21 and 22 emphasize a non-punitive approach based on cooperative accountability through reporting mechanisms and technical support coordinated by the WHO Secretariat. In contrast to international trade regimes that rely on sanctions, such as the dispute settlement system of the WTO, the Pandemic Treaty adopts what is commonly referred to as a model of mutual accountability. This approach seeks to accommodate political sensitivities surrounding state sovereignty, particularly given the significant resistance toward global instruments perceived as interfering with domestic policy decisions (for example, lockdown measures, large-scale social restrictions, or vaccine mandates). These provisions aim to strike a balance between global health governance and the principle of state sovereignty, thereby encouraging state participation without fear of external intervention. However, this non-punitive model raises concerns regarding its effectiveness, particularly in the context of the need for rapid and coordinated responses, as demonstrated during the COVID-19 pandemic. Furthermore, when compared to the peer review mechanism of the Universal Health Preparedness Review (UHPR), the mechanisms under the Pandemic Treaty appear more specific in scope, particularly concerning data sharing, access to health products, and capacity-building. This creates a significant risk of duplication, where states may be required to report similar information to two different mechanisms simultaneously.

This provision seeks to accommodate proportionality between global health objectives and the principle of state sovereignty, thereby ensuring that states remain willing to participate without fear of external intervention. However, this non-punitive model raises concerns regarding its effectiveness, particularly in the context of the need for rapid and responsive coordination, as demonstrated during the COVID-19 pandemic. Furthermore, when compared to the peer review mechanism of the Universal Health Preparedness Review (UHPR) under the WHO, the mechanisms established under the Pandemic Treaty appear more specific in scope, particularly in relation to data sharing, access to health products, and capacity-building. This creates a significant risk of duplication, whereby states may be required to report similar information to two different mechanisms simultaneously. The establishment of the Pandemic Treaty fundamentally represents a corrective response to the failures of previous global governance frameworks, which were unable to integrate principles of justice into binding legal structures. Through its provisions on production, technology transfer, pathogen sharing, benefit-sharing, as well as the distribution of health products and financing, the Treaty seeks to operationalize the argument of Lawrence Gostin that global health can only be achieved through global solidarity for health equity. It also aligns with the perspective of George J. Annas, who emphasizes that global health governance must be grounded in human rights and bioethics, with human dignity at the centre of all international policymaking. Despite its limitations, particularly its continued reliance on the voluntary commitments of developed states, the Treaty provides an initial foundation

for rights-based global health governance, in which principles of equity, transparency, and participation are institutionalized within international decision-making structures. Accordingly, the Pandemic Treaty can be understood as a meaningful response to the post-pandemic urgency for justice in the aftermath of COVID-19.

2. How Legal Debates Shape the Substance of the Pandemic Treaty

The substance of the Pandemic Treaty cannot be understood as the outcome of a purely technical drafting process. Rather, it is the product of sustained legal contestation embedded within the treaty-making process itself. Since its initiation in 2021, following a proposal by European Council President Charles Michel in response to the systemic failures exposed by the COVID-19 pandemic, the development of the treaty under the auspices of the WHO has evolved into a complex legal arena in which competing interpretations of obligation, equity, and sovereignty are continuously negotiated and translated into normative provisions.³⁴

Formally, the process began with the establishment of the Intergovernmental Negotiating Body (INB) by the World Health Assembly in 2021, followed by the development of successive draft texts, including the zero draft, Bureau Text, and Negotiating Text between 2022 and 2024.³⁵ However, these procedural stages are not merely technical. Instead, they function as arenas through which states articulate, contest, and negotiate their legal positions. The persistence of bracketed provisions and the extension of negotiations beyond 2024 illustrate that the core challenges are not procedural delays, but unresolved legal disagreements.³⁶ The next stage in the process is the development of the zero draft, which serves as the initial framework for intergovernmental negotiations.³⁷ The WHO defines the zero draft as the first comprehensive text that will subsequently undergo multiple rounds of review, revision, and negotiation.³⁸ Between 2022 and 2023, the Intergovernmental Negotiating Body (INB) developed this text through several key iterations, including the zero draft in February 2023, the Bureau Text in May 2023, and the Negotiating Text in October 2023. During this stage, states began to form alliances based on their respective interests. Developing countries, including those organized within the Group of Equity and the African Group, have consistently advanced claims grounded in distributive justice, advocating for binding commitments on equitable access to vaccines, sustainable financing, and mandatory technology transfer. In contrast, developed countries, such as members of the European Union and the United States, have

³⁴ "Global Leaders Unite in Urgent Call for International Pandemic Treaty," accessed January 2, 2026, <https://www.who.int/news/item/30-03-2021-global-leaders-unite-in-urgent-call-for-international-pandemic-treaty>.

³⁵ "An International Agreement on Pandemic Prevention and Preparedness - Consilium," accessed January 2, 2026, <https://www.consilium.europa.eu/en/policies/coronavirus-pandemic/pandemic-treaty/>.

³⁶ "An International Agreement on Pandemic Prevention and Preparedness - Consilium."

³⁷ *Zero Draft of the WHO CA+ for the Consideration of the Intergovernmental Negotiating Body at Its Fourth Meeting*, n.d.

³⁸ *Bureau's Text of the WHO Convention, Agreement or Other International Instrument on Pandemic Prevention, Preparedness and Response (WHO CA+)*, n.d.

emphasized flexibility, voluntary cooperation, and the protection of existing legal regimes, particularly intellectual property rights.³⁹

Negotiations were conducted intensively through both plenary sessions and informal working groups, with the WHO employing color-coded annotations to indicate the status of agreement within the text.⁴⁰ Nevertheless, by the conclusion of the ninth meeting in May 2024, more than 200 paragraphs remained unresolved.⁴¹ Consequently, the World Health Assembly (WHA) extended the negotiation timeline until May 2025, with the possibility of convening a special session should consensus be reached earlier.⁴² Politically, the negotiations have been marked by persistent tensions between developed and developing countries. Global South states have advocated for a binding PABS mechanism, while industrialized countries have resisted mandatory technology transfer obligations that could potentially undermine their commercial interests.⁴³

Within this broader configuration, the role of individual states further demonstrates how legal debates are operationalized in practice. Indonesia, for instance, has emerged as an active actor in global health diplomacy, consistently advocating for principles of equity, solidarity, and the protection of national sovereignty.⁴⁴ Aligning itself with Global South positions, Indonesia has emphasized that the Pandemic Treaty must ensure equitable access to vaccines, therapeutics, and diagnostics, promote technology transfer, and operationalize benefit-sharing through mechanisms such as PABS. At the same time, Indonesia has maintained a firm legal stance on preserving domestic policy autonomy, rejecting interpretations that would grant the WHO authority to impose internal public health measures without state consent.⁴⁵ This dual positioning illustrates how states navigate and shape legal debates by translating broader normative principles into concrete negotiating positions, thereby contributing to the treaty's evolving substance.⁴⁶

³⁹ Sharifah Sekalala et al., "Navigating Time Equity: Balancing Urgency and Inclusivity in Pandemic Treaty Negotiations," *PLOS Global Public Health* 4, no. 4 (2024): e0003118, <https://doi.org/10.1371/journal.pgph.0003118>.

⁴⁰ WHO, (2024), *Kesepakatan pencegahan, kesiapsiagaan, dan respons pandemi*, <https://www.who.int/ruang-berita/pertanyaan-dan-jawaban/item/pencegahan-pandemi-kesiapsiagaan-dan-respons-sesuai>

⁴¹ "Ninth Meeting of the Intergovernmental Negotiating Body (INB) for a WHO Instrument on Pandemic Prevention, Preparedness and Response," accessed January 2, 2026, [https://www.who.int/news-room/events/detail/2024/03/18/default-calendar/ninth-meeting-of-the-intergovernmental-negotiating-body-\(inb\)-for-a-who-instrument-on-pandemic-prevention-preparedness-and-response](https://www.who.int/news-room/events/detail/2024/03/18/default-calendar/ninth-meeting-of-the-intergovernmental-negotiating-body-(inb)-for-a-who-instrument-on-pandemic-prevention-preparedness-and-response).

⁴² *Proposal for the WHO Pandemic Agreement*, n.d.

⁴³ Schwalbe et al., "The Pandemic Treaty."

⁴⁴ "Indonesia Dorong Kesetaraan Akses Lewat Pandemic Treaty," June 1, 2024, <https://kemkes.go.id/id/indonesia-dorong-kesetaraan-akses-lewat-pandemic-treaty>.

⁴⁵ antaranews.com, "Indonesia nilai WHO Pandemic Agreement kemenangan multilateralisme," Antara News, May 23, 2025, <https://www.antaranews.com/berita/4852873/indonesia-nilai-who-pandemic-agreement-kemenangan-multilateralisme>.

⁴⁶ "Pandemic Agreement Disahkan di WHA 78: Indonesia Tegaskan Komitmen Global untuk Ketahanan Kesehatan," May 25, 2025, <https://kemkes.go.id/id/pandemic-agreement-disahkan-di-wha-78-indonesia-tegaskan-komitmen-global-untuk-ketahanan-kesehatan>.

In parallel with the Pandemic Treaty negotiations, the WHA also initiated the revision process of the International Health Regulations (IHR 2005), which includes more than 300 proposed amendments, six new articles, and two additional annexes. To ensure coherence between the two instruments, the WHO convened joint sessions between the IHR negotiating team and the INB.⁴⁷ The final stage of the process involves the completion of the treaty text and its adoption by the WHA. Upon reaching consensus, member states are expected to sign the agreement and proceed with domestic ratification in accordance with their respective legal systems. This stage also includes the establishment of implementation mechanisms, financing arrangements, and transparent and accountable global monitoring systems.⁴⁸ These procedural developments give rise to several key legal debates that ultimately shape the substantive content of the Pandemic Treaty. One of the most significant ways in which legal debates shape the treaty's substance is through the determination of the nature and strength of obligations. A central divide emerges between developing and developed countries regarding whether key commitments (such as equitable access to vaccines, technology transfer, and pandemic financing) should be legally binding.⁴⁹ Developing countries, particularly those aligned in equity-oriented coalitions, advocate for binding obligations as a means of correcting structural inequalities exposed during the COVID-19 pandemic. In contrast, developed countries favor more flexible, non-binding approaches that preserve national discretion and protect existing legal regimes, particularly in the field of intellectual property. This tension is directly reflected in the treaty's textual language, where provisions are frequently framed using soft-law formulations such as "should," "encourage," or "as mutually agreed." As a result, the treaty's normative content reflects a compromise that prioritizes political acceptability over legal enforceability.⁵⁰

A second key legal debate concerns the constitutional basis of the Pandemic Treaty within the framework of the WHO, particularly the choice between Article 19 and Article 21 of the WHO Constitution. This issue has profound implications for the legal character, implementation mechanisms, and overall effectiveness of the treaty. Article 19 empowers the World Health Assembly (WHA) to adopt international conventions or agreements that are legally binding upon ratification by member states, as exemplified by the Framework Convention on Tobacco Control (FCTC).⁵¹ In contrast, Article 21 authorizes the WHA to adopt international regulations that enter into force more automatically for member states, unless they explicitly opt out, but generally carry weaker legal obligations. The choice between these two legal bases reflects a deeper structural tension

⁴⁷ *Proposed Workplan, Meeting Schedule and Updates, as Appropriate, to the Method of Work*, n.d.

⁴⁸ "Getting in Formation: WHO Constitutional Heads of Power and the Pandemic Agreement," *Opinio Juris*, March 13, 2024, <https://opiniojuris.org/2024/03/13/getting-in-formation-who-constitutional-heads-of-power-and-the-pandemic-agreement/>.

⁴⁹ Haytham A. Sheerah et al., "Navigating Hurdles: A Review of the Obstacles Facing the Development of the Pandemic Treaty," *Journal of Epidemiology and Global Health* 14, no. 3 (2024): 580-85, <https://doi.org/10.1007/s44197-024-00233-5>.

⁵⁰ Schwalbe et al., "The Pandemic Treaty."

⁵¹ WHO, (Kutipan Negara-negara anggota mengajukan nama-nama organisasi masyarakat sipil, industri, dan akademis untuk disetujui)

between the need for effective global coordination and the preservation of state sovereignty. Developed countries have generally favored the use of Article 21, emphasizing efficiency, flexibility, and the ability to ensure rapid implementation without lengthy domestic ratification processes. Conversely, developing countries have advocated for Article 19, arguing that binding treaty obligations subject to national ratification are essential to maintaining legal certainty, democratic legitimacy, and domestic control over international commitments. The absence of consensus on this issue has contributed to ongoing uncertainty regarding the binding nature of the Pandemic Treaty, ultimately influencing the cautious and often non-mandatory language found in its draft provisions.⁵² .

Third, legal debates also shape the treaty through its relationship with existing instruments, particularly the IHR 2005. While both frameworks address pandemic preparedness and response, they differ in scope and legal design. The IHR focuses primarily on surveillance, notification, and emergency response obligations, whereas the Pandemic Treaty seeks to expand governance into areas such as equitable access, supply chains, and benefit-sharing. Efforts to harmonize these instruments through joint negotiation sessions have not fully resolved concerns regarding overlapping mandates and institutional authority. Consequently, the treaty's substance reflects an ongoing negotiation over the boundaries of global health governance, raising questions about legal coherence and the risk of fragmentation within the international legal system. Another area where legal debates significantly influence the treaty's substance is enforcement and compliance. The absence of strong enforcement mechanisms, such as sanctions, binding dispute settlement procedures, or compulsory compliance measures, indicates the limits of consensus among states. Instead, the treaty adopts a cooperative and non-punitive model based on reporting, peer review, and technical assistance. This design reflects a compromise between the demand for accountability and the insistence on preserving state sovereignty. However, it also results in a form of "symbolic legalization," where the treaty carries normative aspirations without sufficient coercive force to ensure implementation. Thus, legal debates over enforcement directly shape the treaty's limited capacity to produce binding and enforceable outcomes.

The issue of sovereignty further illustrates how legal contestation informs the treaty's substance. Many states express concern that a strong international instrument could intrude upon domestic decision-making, particularly in areas such as public health measures, vaccination policies, and border controls. In response, the treaty incorporates language that emphasizes national sovereignty, flexibility, and voluntary cooperation. While this approach facilitates broader participation, it also constrains the development of robust international obligations, thereby shaping the treaty into a framework that prioritizes coordination over compulsion.

⁵² "Getting in Formation."

Finally, debates over intellectual property and access to medical countermeasures play a central role in shaping the treaty's normative content. Developed countries and pharmaceutical stakeholders emphasize the importance of strong intellectual property protections to sustain innovation, while developing countries advocate for mandatory technology transfer, equitable benefit-sharing, and mechanisms such as PABS. The resulting provisions reflect a negotiated compromise in which principles of equity are acknowledged but not fully operationalized through binding commitments. This outcome demonstrates how legal debates over competing rights, innovation versus access, are resolved through diluted or hybrid norms that balance, but do not reconcile, these competing interests. Importantly, these legal debates are embedded within broader political dynamics, including the division between Global North and Global South. However, rather than treating these dynamics as purely political, they should be understood as competing legal interpretations of fairness, responsibility, and obligation in international law. The alignment of states into negotiating blocs demonstrates how legal arguments are mobilized to advance interests, thereby influencing the structure and content of the treaty.⁵³ In conclusion, legal debates shape the substance of the Pandemic Treaty in multiple and interrelated ways: by determining the binding nature of obligations, influencing the choice of legal basis, defining the relationship with existing legal instruments, limiting enforcement mechanisms, constraining sovereignty intrusions, and structuring access to health technologies. The resulting treaty is therefore best understood not as a fully coherent legal instrument, but as a negotiated normative framework that reflects the balance of competing legal claims, interests, and interpretations within global health governance.

C. Conclusion

This article arrives at two principal conclusions corresponding to the research questions formulated at the outset. First, concerning how the normative design of the Pandemic Treaty addresses the urgency of justice in global health governance in the post-pandemic context, the analysis demonstrates that the Treaty represents a significant normative shift in international health law. It moves beyond the traditional containment-oriented framework embodied in the IHR 2005 toward a more equity-driven model grounded in principles of solidarity, fairness, and shared responsibility. Through its provisions on geographically diversified production and technology transfer (Articles 10–11), the establishment of the PABS system (Article 12), the regulation of equitable distribution and transparency in global supply chains (Articles 13–14), and the creation of a Coordinating Financial Mechanism (Article 18), the Treaty explicitly targets the structural inequalities that were exposed during the COVID-19 pandemic. Normatively, the Treaty reflects an attempt to operationalize justice not merely as an aspirational value but as a guiding principle embedded within the architecture of global health governance. In line with the conception of “global solidarity for health equity,” it repositions health as

⁵³ “Pandemic Agreement Disahkan di WHA 78: Indonesia Tegaskan Komitmen Global untuk Ketahanan Kesehatan,” May 25, 2025, <https://kemkes.go.id/id/pandemic-agreement-disahkan-di-wha-78-indonesia-tegaskan-komitmen-global-untuk-ketahanan-kesehatan>.

a global public good that necessitates collective legal obligations across states. At the same time, it incorporates a human rights-based orientation by emphasizing transparency, participation, and equitable access to essential health resources. However, despite this progressive normative framework, the Treaty's reliance on voluntary commitments, flexible language, and the absence of enforceable obligations significantly constrains its capacity to fully realize distributive justice in practice. As such, while the Pandemic Treaty establishes an important foundation for justice-oriented global health governance, its effectiveness ultimately depends on the political will of states and the future strengthening of its legal mechanisms.

Second, concerning how legal debates shape the substance of the Pandemic Treaty, the analysis shows that the Treaty is fundamentally the product of sustained legal contestation rather than a purely technical drafting process. Core aspects of its normative content, including the binding nature of obligations, the choice of legal basis within the WHO framework, the design of enforcement mechanisms, and the regulation of intellectual property and technology transfer, have been shaped by competing legal interpretations advanced by different groups of states. In particular, the persistent divide between developed and developing countries has played a decisive role in determining the Treaty's final structure. While developing countries have consistently advocated for binding commitments to ensure equity, technology transfer, and financial support, developed countries have emphasized flexibility, voluntary cooperation, and the protection of existing legal regimes, especially in relation to intellectual property rights. These competing positions are directly reflected in the Treaty's textual formulation, which frequently adopts soft-law language and cooperative mechanisms in place of mandatory obligations and sanctions. Debates over state sovereignty further reinforce this design, leading to a model of governance that prioritizes coordination and mutual accountability rather than coercive enforcement. In addition, unresolved questions regarding the Treaty's relationship with the IHR 2005 and the potential for institutional overlap illustrate how legal fragmentation continues to shape its development.

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