The neglected issues of global health security that we should prepare for in our society

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According to the World Health Organization (WHO), the prevalence of the Omicron variant of coronavirus disease 2019 (COVID-19) is decreasing worldwide after its peak in January 2022, but the Omicron mutants, BA.4 and BA.5, have been reported to be present in 58 countries and 62 countries, respectively, and the numbers of patients are increasing in Portugal and the United States. Fortunately, there seems to be no change in the fatality rate, but the transmissibility, immune escape, and hospitalization rate are increasing [1]. The inflow of BA.4 and BA.5 into the Republic of Korea is also expected to increase. The number of patients in the Republic of Korea has recently been about 7,000 per week (132 per 1 million), which is 98% lower than in the third week of March (7,887 per 1 million), which was the peak of the pandemic. As a sero-epidemiological survey [2] showed that the antibody positivity rate was 94.9%, temporary herd immunity might have been reached; however, the proportion of natural infections rose from 0.6% in January to 36.1% in April, and many breakthrough infections have occurred despite a very high tertiary vaccination rate. COVID-19 infections continue to occur due to viral circulation in the community in the school-age population and among young people with low vaccination rates; this means that the outbreak of COVID-19 will continue for the time being. Furthermore, although the elderly (aged 60 or older) account for a decreasing proportion of COVID-19 patients, the fourth vaccination rate among the elderly is only 30.1%, and the number of deaths among the elderly is expected to increase in the near-term future. In particular, with the lifting of the social distancing measures and the waning of immunity acquired by vaccination and natural infection, we will need to prepare for the possibility of an increase in COVID-19 patients among school-age children and young adults during the vacation season. Worldwide, 6.3 million official deaths due to COVID-19 have been recorded; however, there have been approximately about 14.91 million more deaths than reported, corresponding to 9.49 million more deaths than have been globally reported as directly attributable to COVID-19. The estimates of excess deaths—with 7.89 million in lower- to middle-income countries, and 640,000 in low-income countries [3]—indicate inequality in access to public health goods, including vaccines and therapeutics, which must be addressed by global health alliances and solidarity. In the midst of the issue of excess mortality, the Democratic Republic of Korea (North Korea) announced that COVID-19 cases have officially occurred in that country. According to the KCNA Watch, a fever whose cause could not be identified explosively spread across the country starting in late April, and more than 350,000 people contracted this fever in a short span of time, of whom at least 162,200 had healed completely as of early to mid-
May. On May 12, approximately 18,000 people caught this fever nationwide and, at that time, up to 187,800 people were isolated and receiving medical treatment. Six people had died [4]. The number of cases then spiked, and as of June 24, there were 4,657,190 cases of fever, 73 deaths, and 17,250 fever cases reported per day [5]. Therefore, it seems that the worst has passed. Nevertheless, the WHO said that the situation is “getting worse, not better,” and we therefore need more detailed information to make an accurate judgment. However, questions are being raised about the unexpectedly low mortality rate. It seems that accurate numbers of patients could not be officially reported to the WHO due to the lack of capacity for polymerase chain reaction confirmation tests. As a lack of therapeutic drugs has made it difficult to manage symptomatic patients, and severe cases have been reported, the Republic of Korea (South Korea) is also preparing to help North Korea with the donation of basic essential drugs, COVID-19 therapeutics, and vaccines from a humanitarian point of view. Despite the refusal of the COVAX vaccine, international aid for control of the outbreak is expected to be essential, as closure of the border is unlikely to be feasible for long without essential medicine and vaccination.

The 75th WHO World Assembly was held in the last week of May 2022. There were many intense discussions regarding the limitations of WHO leadership and how to prepare countries to respond to the current unprecedented pandemic. Broadly speaking, the discussions dealt with the possibilities of a pandemic treaty, revised international health regulations (IHR), or both simultaneously. Reasons in favor of a pandemic treaty are that 61 out of 194 countries have already recognized the need for a treaty, the management of zoonotic diseases is difficult to resolve through the current IHR governance system without cooperation with the World Organization for Animal Health, and a new treaty is needed for the One Health Framework. Some countries argued that the United States, China, and Brazil are negative about a new treaty, that the World Trade Organization’s TRIPS Article 27 (2) (Exceptional Drug Patents if Public Health Needs) and Article 31 (Enforcement of Compulsory Drug Enforcement) are likely to be revised without a new treaty, and that it is easier to revise IHR than to make treaties (as exemplified by the Framework Convention for Tobacco Control, which took 12 years to enter into effect). Both sides raised the problem of a persistent budgetary shortage and the need for a new secretariat.

As scholars in favor of the new treaty, Haik Nikogosian and Ilona Kickbusch [6] argued that a treaty under Article 19 of the WHO Constitution could resolve issues beyond the scope of IHR (2005). They categorized these issues into 5 groups that cannot be covered by IHR: Politically, a treaty would attract the much-needed attention and commitment from the highest levels of state and government. Legally, treaties are gradually translated into national laws in most legal systems after ratification. From an institutional perspective, a treaty would allow a dedicated governing body—a Conference of the Parties—to regularly review and resolve evolving matters. From a multisectoral perspective, the ratification and subsequent introduction of a treaty into a country’s national laws creates a binding framework for all relevant sectors and the government as a whole. The last set of issues that a treaty could resolve would be those that do not reasonably fall under the scope of Article 21 of the WHO Constitution for Regulations, which is the only other type of binding instrument that the WHO can use. This treaty on pandemics would be an expression of true political will to act collectively in response to unprecedented pandemics.

The other group of scholars in favor of the treaty is exemplified by the Panel for a Global Public Health Convention. These scholars—Barbara M. Stocking and Lawrence Costin et al.—usually discuss the possibility of a Global Health Treaty, but at this panel, they discussed a Framework Convention limited to the field of infectious diseases [7]. I talked about the possibility of a treaty with them. They argued that the most important reasons for needing a treaty are as follows: first, the lack of compliance during COVID-19; second, the fact that a treaty must be signed at the head–of-state level; and third, the possibility that a treaty could prevent outbreaks from developing into pandemics. One of the key measures required in the treaty would be country preparedness, which would require significant external financing for low- and some middle-income countries. The other key measures would be transparency and external verification. Another advantage of a Framework Convention is that it can also have a number of protocols covering different issues. These protocols could be revised as our understanding of pandemics continues to grow, and new protocols for specific areas could be developed at the request of the Conference of Parties. First of all, the most important mechanism is verification and compliance, which will make us safer than we are.

However, the 75th WHO World Health Assembly focused on revising IHR, not on forming a new treaty, and the zero draft report of the Working Group on Strengthening WHO Preparedness and Response to Health Emergencies to the 75th World Health Assembly was adopted. The recommendations were as follows [8]: (1) WHO’s political leadership; (2) cooperation and collaboration; (3) WHO at the center; (4) financing; (5) sustainability of COVID-19 innovative mechanisms; (6) global surveillance; (7) strengthening IHR implementation, compliance, and potential amendments.

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and (8) equity. There is no doubt that revision of IHR is an important current issue, but I am not sure that our government and related non-state actors continue to pay attention to and express their opinions both regarding IHR revision and the possibility of a new treaty, which will become an important topic in global health diplomacy. Active involvement of the government and academia of the Republic of Korea in this project will make our nation one of the leading countries in the field of global health.

Notes

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Conflicts of Interest
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