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EDITORIAL ANALYSIS

The World Isn't Prepared for the Next Pandemic

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 The Indian Express

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INTERVIEW ANGLE

"The WHO declared a global health emergency over Ebola in May 2026 — what institutional reforms would make India's pandemic preparedness architecture more resilient?"

EDITORIAL SUMMARY:

The Indian Express argues that the Bundibugyo Ebola PHEIC and May 2026 hantavirus cluster in South America reveal that despite COVID-19, global pandemic preparedness remains dangerously underfunded and institutionally fragmented. The WHO financing crisis — aggravated by the US withdrawal in January 2025 — and the stalled Pandemic Treaty negotiations leave the world exposed. The editorial calls for a binding Pandemic Treaty with equity provisions, WHO financing reform, and a stronger One Health surveillance architecture, with India positioned to lead the Global South in these negotiations.

THE ALARM IS SOUNDING AGAIN

In May 2026, the World Health Organization declared Bundibugyo Ebola a Public Health Emergency of International Concern (PHEIC) — the highest alert level under the International Health Regulations (IHR, 2005). Simultaneously, health authorities in South America reported a cluster of hantavirus cases with cross-border transmission characteristics. Neither outbreak has reached pandemic scale. But both share a diagnostic: the global preparedness infrastructure built after COVID-19 is not functioning as designed.

The COVID-19 pandemic (2019–2023) infected over 700 million people and killed more than seven million, with economic losses exceeding \$13 trillion. It was the most consequential infectious disease event since the 1918 influenza pandemic. Six years later, the institutional architecture meant to prevent a repeat remains voluntary, fragmented, and underfunded.

COVID-19'S UNLEARNED LESSONS

COVID-19 exposed four structural failures in global health governance:

COVAX and equity failure: The COVID-19 Vaccines Global Access (COVAX) facility — co-led by GAVI, CEPI, and WHO as part of the Access to COVID-19 Tools (ACT) Accelerator — aimed to deliver vaccines to 20% of the population of low- and middle-income countries by end-2021. It fell far short. High-income countries placed bilateral advance purchase agreements with manufacturers, queue-jumping the multilateral mechanism. By the time COVAX deliveries scaled up, some participating countries had already achieved domestic herd immunity, while low-income countries were in a third or fourth wave.

PPE nationalism: In early 2020, several states — including European Union members — banned exports of personal protective equipment, surgical masks, and ventilators. The World Trade Organization's framework offered no expedient remedy. Countries with domestic manufacturing capacity used it domestically regardless of need elsewhere.

IP waiver delays: India and South Africa tabled a proposal at the WTO in October 2020 for a temporary TRIPS waiver covering COVID-19 vaccines, therapeutics, and diagnostics. A narrow waiver covering only vaccines was not agreed until June 2022 — eighteen months after the proposal and well past the peak vaccine scarcity window.

ACT-Accelerator underfunding: The ACT-Accelerator — the umbrella mechanism covering vaccines (COVAX), diagnostics (FIND), therapeutics, and health system strengthening — was chronically underfunded throughout the pandemic, with a cumulative shortfall of over \$15 billion against its estimated need.

THE WHO FINANCING CRISIS

The World Health Organization operates on a hybrid financing model: assessed contributions (mandatory, based on GDP and population) and voluntary contributions (discretionary, often earmarked for donor priorities). Assessed contributions have historically covered less than 20% of WHO's programme budget. Voluntary contributions, including from the United States, filled the gap — but with strings attached.

In January 2025, the second Trump administration formally initiated US withdrawal from WHO — following the same playbook as the first Trump administration in 2020 (reversed by President Biden in January 2021). This time, the withdrawal is proceeding. The US has been WHO's largest single contributor — approximately 18% of the regular budget and a higher share of voluntary contributions. The financial impact has forced the WHO to announce programme budget cuts affecting outbreak response and technical assistance to fragile states.

The structural lesson is clear: an international health organisation whose financing is hostage to a single member state's domestic politics cannot be the pillar of global pandemic preparedness.

THE STALLED PANDEMIC TREATY

Following COVID-19, WHO member states agreed in 2021 to negotiate a new international instrument on pandemic prevention, preparedness, and response. The Intergovernmental Negotiating Body (INB) was constituted and has been negotiating since 2022.

The central sticking point is the Pathogen Access and Benefit Sharing (PABS) mechanism. Developing countries — led by a bloc including India, South Africa, Indonesia, and Brazil — demand binding commitments: when a country shares a pathogen sample with WHO for vaccine development, it must receive a guaranteed share of any resulting vaccine supply at affordable prices, and the IP in the resulting vaccine must be subject to binding licensing commitments. Developed countries and the pharmaceutical industry resist binding IP transfer obligations, arguing that compulsory licensing would deter R&D investment in pandemic-relevant platforms.

WHO member states missed the May 2024 World Health Assembly (WHA) deadline for a Treaty text. As of May 2026, negotiations continue without a binding instrument in sight.

ONE HEALTH: THE FRAMEWORK WITHOUT TEETH

The One Health approach recognises that human, animal, and environmental health are inextricably linked — most emerging infectious diseases are zoonotic (crossing from animals to humans). The WHO, FAO, UNEP, and WOA (World Organisation for Animal Health) launched the One Health Joint Plan of Action (JPA) in 2022 for the period 2022–2026.

The JPA identifies priority areas: antimicrobial resistance, zoonotic diseases, food safety, and environment-health nexus. But its implementation is voluntary and dependent on national health systems, many of which lack the surveillance infrastructure, laboratory capacity, or epidemiological workforce to detect emerging threats at the animal-human interface before they escalate.

The Bundibugyo Ebola outbreak — Bundibugyo is a species of Ebolavirus first identified in Uganda in 2007 — is a case study in One Health failure. The spillover from fruit bats or other reservoir hosts to humans in a forest-edge community is preventable with adequate wildlife surveillance and community health worker presence. Neither was in place.

CEPI AND THE MARKET FAILURE IN NEGLECTED PATHOGENS

The Coalition for Epidemic Preparedness Innovations (CEPI) was founded at the World Economic Forum in Davos in January 2017 following the West African Ebola crisis (2014–2016). Its mandate is to accelerate vaccine development against epidemic threats before pandemics emerge.

CEPI's 100-Days Mission — to produce a validated vaccine prototype against any known pathogen within 100 days of a PHEIC being declared — demonstrated partial success with COVID-19: several platform vaccines (mRNA, adenoviral vector) moved from gene sequence to Phase I trial within 65–70 days in early 2020. The mission is technically achievable with modern platforms.

The persistent market failure lies with low-frequency, high-impact pathogens. Bundibugyo Ebola, Nipah virus, Lassa fever, and Crimean-Congo haemorrhagic fever infect too few people in too poor a population to attract private R&D investment. CEPI funds development for these diseases, but its budget (approximately \$2 billion pledged at its 2022 replenishment) is insufficient to run multiple simultaneous development programmes and maintain manufacturing readiness.

INDIA'S STAKE AND RESPONSIBILITY

India occupies a unique position in global health governance. The Serum Institute of India (SII) is the world's largest vaccine manufacturer by volume, producing over 1.5 billion doses annually. Bharat Biotech developed Covaxin, an inactivated whole-virion COVID-19 vaccine. Together, SII and Bharat Biotech supplied the majority of COVAX doses delivered to low-income countries. India's vaccine manufacturing capacity is, in effect, global public health infrastructure.

This gives India both credibility and leverage. India's voice in Pandemic Treaty negotiations carries weight that few other developing countries can match. India's position — as a vaccine manufacturer with export commitments to the Global South, and as a country with a large and still-developing domestic health system — is distinctive: it bridges the Global North's manufacturing and technology interests and the Global South's equity demands.

India has used this position inconsistently. At the WHA, India has co-sponsored equity provisions in the Treaty negotiations. But India's domestic pandemic response — delayed vaccine rollout in mid-2021, oxygen supply failures, and data transparency concerns — weakened its moral authority at precisely the moment it was needed.

UPSC MAINS ANALYSIS

GS Paper 2 — International institutions; GS Paper 3 — Science and Technology; Health

Key arguments:

- Bundibugyo Ebola PHEIC and May 2026 hantavirus cluster demonstrate pandemic preparedness infrastructure gaps despite COVID-19.
- WHO financing crisis: assessed contributions cover less than 20% of budget; US withdrawal (January 2025) removes 18%+ of regular budget.

- Pandemic Treaty stalled on PABS (Pathogen Access and Benefit Sharing) — developing nations vs developed nations **impasse**; missed May 2024 WHA deadline.
- COVAX equity failure: missed 20% low-income coverage target; TRIPS waiver agreed June 2022 — 18 months after proposal.
- One Health JPA (2022–2026): voluntary; implementation gaps in wildlife surveillance and zoonotic disease monitoring.
- CEPI 100-Days Mission: technically demonstrated with COVID-19 platforms; chronic funding gap for neglected pathogens.
- India = world’s largest vaccine manufacturer; COVAX’s primary supplier; uniquely positioned to bridge G7 and Global South in Treaty negotiations.

Counterarguments:

- Binding PABS provisions may deter private R&D investment in pandemic-relevant platforms, worsening the market failure for neglected pathogens.
- WHO structural reform is slow; member states that resist assessed contribution increases will not easily be persuaded to relinquish voluntarism.
- India’s own domestic pandemic response shortcomings (2021 oxygen crisis, delayed rollout) reduce its moral authority in global health governance.

Keywords: PHEIC, International Health Regulations 2005, COVAX, ACT-Accelerator, Pandemic Treaty / INB, PABS, TRIPS waiver, WHO financing, assessed vs voluntary contributions, US WHO withdrawal January 2025, One Health JPA 2022, CEPI 100-Days Mission, Bundibugyo Ebola, Serum Institute of India, Bharat Biotech, Covaxin.

The Indian Express’s core argument is that the world is not prepared for the next pandemic — and the reason is not technological but political. The Pandemic Treaty is stalled because states cannot agree on who owns the pathogen samples and who gets the resulting vaccines. WHO is underfunded because its largest contributor uses its chequebook as a foreign policy instrument. India can change both equations: as the world’s vaccine supplier, it has a seat at every table and a stake in every outcome. The question is whether New Delhi is willing to lead rather than observe.

Sources: [Indian Express](#), [World Health Organization](#), [CEPI](#), [PIB](#)

● KEY ARGUMENTS AT A GLANCE

The Bundibugyo Ebola PHEIC and the May 2026 hantavirus cluster in South America demonstrate that COVID-19’s institutional lessons have not been translated into binding preparedness architecture — the Pandemic Treaty is stalled, WHO financing is eroding, and One Health surveillance remains voluntary.

✓ SUPPORTING

- The WHO’s financing model — heavily dependent on voluntary contributions rather than assessed contributions — creates structural instability; the US withdrawal from WHO in January 2025 under President Trump removed the single largest contributor.
- The Pandemic Treaty negotiations stalled in 2024 on the Pathogen Access and Benefit Sharing (PABS) mechanism, with developing nations demanding binding equity provisions that developed nations resist, and WHO member states missed the May 2024 World Health Assembly deadline.
- COVAX, the COVID-19 vaccine equity mechanism, fell short of its 20% coverage target for low-income countries by end-2021, demonstrating that voluntary solidarity instruments fail precisely when they are most needed.
- India is the world’s largest vaccine manufacturer — Serum Institute of India and Bharat Biotech supplied COVAX — and has both the credibility and the interest to lead a reformed global health governance architecture.

⚠ COUNTER

A binding Pandemic Treaty with mandatory PABS and IP-waiver provisions may discourage private-sector investment in pandemic-relevant R&D, as manufacturers would face compulsory licensing before recouping development costs — a genuine market-failure risk CEPI’s 100-Days Mission is designed to address.

→ WAY FORWARD

India should champion a three-track reform: push for a binding Pandemic Treaty with enforceable TRIPS flexibilities and PABS provisions through the G20 and Global South bloc; advocate WHO reform that increases assessed contribution floors and limits earmarked voluntary funds; and scale CEPI funding for neglected pathogens that lack commercial vaccine markets.

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MAINS ANSWER FRAMEWORK
QUESTION

Despite the COVID-19 pandemic, global pandemic preparedness remains dangerously fragmented. Critically examine the institutional failures in global health governance and suggest reforms India should champion. (250 words)

INTRODUCTION

The WHO's declaration of Bundibugyo Ebola as a Public Health Emergency of International Concern (PHEIC) in May 2026, alongside a hantavirus cluster in South America, underscores that despite the COVID-19 pandemic's devastation, the world's pandemic preparedness architecture remains fragmented, underfunded, and institutionally inadequate.

BODY

COVID-19 exposed four systemic failures: COVAX equity shortfalls (the mechanism missed its 20% low-income country coverage target by end-2021); PPE nationalism (countries including EU members banned medical supply exports in early 2020); the IP waiver impasse (the TRIPS waiver for COVID-19 vaccines was not agreed until June 2022, eighteen months after the issue was tabled); and ACT-Accelerator underfunding. The WHO's financing crisis has worsened since: the US withdrawal from WHO in January 2025 removed the largest single contributor from an already voluntarily-funded organisation.

The Pandemic Treaty — negotiated by the Intergovernmental Negotiating Body (INB) since 2022 — stalled in 2024 on the Pathogen Access and Benefit Sharing (PABS) mechanism. Developing countries demand binding commitments that pathogen samples shared with WHO will yield vaccines accessible to their populations; developed countries resist binding IP transfer obligations.

The One Health Joint Plan of Action (launched 2022, covering WHO, FAO, UNEP, and WOA) remains a coordination framework with implementation gaps. The Coalition for Epidemic Preparedness Innovations (CEPI), founded at Davos in 2017 with a 100-Days Mission to produce a vaccine prototype against any known pathogen within 100 days of a PHEIC, demonstrated partial success with COVID-19 but faces a chronic funding gap for low-frequency pathogens — precisely the Bundibugyo Ebola class of threat.

India's role is pivotal: the Serum Institute of India and Bharat Biotech were COVAX's largest suppliers, giving India both credibility and leverage in treaty negotiations.

CONCLUSION

India should use its G20 and Global South convening power to push for a binding Pandemic Treaty with enforceable TRIPS flexibilities, advocate WHO financing reform to increase assessed contribution floors, and fund CEPI's neglected pathogen programme. Pandemic preparedness is not charity — for a country that supplies vaccines to half the world, it is core national interest.

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