

CONSIDERATIONS FOR INB-8 NEGOTIATIONS ON WHO PANDEMIC CONVENTION/AGREEMENT

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KEY POINTS

As we approach the INB-8 negotiations, scheduled for February 19 to March 1 in Geneva, it is imperative to address crucial elements that will shape the effectiveness of the WHO Pandemic Convention/Agreement. The AHF Global Public Health Institute, in partnership with the University of Miami Public Health Policy Lab, underscores the following critical items for consideration:

1 Equitable Access and Capacity Building:

Secure binding commitments for equitable access to technical knowhow for the production of vaccines and pandemic countermeasures. Additionally, ensure the development of manufacturing and distribution capacities across all regions and subregions.

4 Do NOT duplicate efforts by creating new financing mechanisms for PPPR:

Remove from consideration the proposed creation of two new funds for PPPR under Article 19. Instead, integrate and formalize the roles of established global health financing mechanisms, such as the Pandemic Fund and the Global Fund to Fight AIDS, Tuberculosis, and Malaria, in the agreement.

2 Accountability:

Implement well-defined accountability mechanisms within the agreement, which should include independent oversight to assess and monitor state compliance.

5 Elevate the Pandemic Fund as the primary financing mechanism for PPPR,

resourced sufficiently to cover the essential financing gaps in countries and regions.

6 Regional capacity-building prioritization:

Ensure that every region or subregion attains a minimum level of capacity to prevent, detect, and respond to infectious disease outbreaks of pandemic potential.

3 Specificity in financial commitments:

Establish agreed-upon formulas and benchmarks for funding obligations to ensure adequate financing for effective pandemic prevention, preparedness, and response (PPPR).

7 Formalize Civil Society and Non-State Actor Participation:

Urge the formal inclusion of civil society and non-state actors in future pandemic agreement deliberations, ensure their role in the agreement's implementation, and integrate their participation into independent oversight mechanisms for accountability.

Equity is the backbone of this agreement, and it involves ensuring that all nations, regardless of income or size, have equal opportunity to protect their citizens against health threats. This includes preparing for, detecting, and effectively responding to pandemics. Current disparities in pandemic preparedness and response have led to preventable illness, fatalities, and societal stress, disproportionately affecting vulnerable populations.¹ Among other things, these discrepancies arise from weak national healthcare systems, the centralized production of essential medications, vaccines, and strategic resources, as well as limited scientific and technological access for low- and middle-income countries.² Mere promises, however, will not achieve equity and effectiveness in pandemic prevention, preparedness, and response (PPPR). What is needed are binding commitments that are focused on: (1) Equitable access to scientific and technical knowhow for vaccines and countermeasures; (2) the development of manufacturing capacity across regions and subregions; (3) sustainable financing for PPPR capacity-building at regional, subregional and national levels; and (4) an enforceable accountability architecture.

Accountability and Compliance. The primary obstacle to the success of most international treaties is the lack of effective accountability and enforcement mechanisms.³ Research reveals that international agreements without enforcement mechanisms fail to achieve their intended outcomes.⁴ The existing global health legal architecture is deficient in mechanisms for oversight and enforcement of compliance is well established.^{5,6} For example, the Framework Convention on Tobacco Control and the International Health Regulations (IHR) – the two major treaties under the authority of the WHO – are “plagued by incomplete compliance.”⁷ Furthermore, incomplete compliance with the IHR, particularly on preparedness, has “contributed to COVID-19 becoming a protracted global health pandemic.”⁸ These mistakes should not be built into the proposed pandemic agreement.

Despite this understanding, there has been a collective failure to adequately address the issues of transparency, accountability, and enforcement (incentives and disincentives for compliance). We believe that the lack of specificity of Article 8 (preparedness monitoring and functional reviews), and the lack of binding obligations under Article 19 (implementation

capacities and support), in the October 30, 2023, draft of the agreement, are not fit for purpose. It is more troublesome that drafters of the agreement have yet to attempt to broach the issue of accountability in an enforceable manner. Thus, we are concerned that the absence of well-defined binding mechanisms for accountability and enforcement of compliance/non-compliance will render this agreement merely aspirational,⁸ which will severely undermine the primary purpose of the agreement: To prevent, prepare for, and, if necessary, respond to future pandemics.

While informed that it is unlikely that a comprehensive accountability and enforcement framework will be considered, we urge that Member States include at least some tangible form of independent oversight for accountability in the text of the agreement. Experience has proven that “relying solely on state self-reporting and peer-review mechanisms does not work.”⁹ This is a critical issue that should be negotiated upfront and not left for subsequent discussion after the pandemic agreement has been signed. Accurate and timely monitoring and assessment of compliance is key to understanding blind spots and enabling effective action, even if not mandated by the agreement. The world cannot afford to be flying blind for another decade because of incomplete and untimely reporting by member-states.¹⁰ Spark Street Advisors has put forth a reasonable and modest proposal that we endorse – and we urge that this position be considered.¹¹

Global Health Financing. Without adequate, sustainable financing, it is unlikely that the pandemic agreement will achieve its objectives. “One of the central failings of the IHR has been that its requirements for states to collaborate, including with respect to mobilizing financing, lacks specificity,” and that “without benchmarks, formulas, or other such details . . . the requirements have little force.”¹² While some form of “annual monetary contribution from Parties,” as outlined in the October 30, 2023 draft under Article 19, is welcomed – it does not go far enough because it lacks specific binding obligations. Notwithstanding, the proposed creation of two new funds for PPPR, under Article 20, is severely problematic and should be stricken from the agreement. Creating two new funds is misguided because it will unnecessarily duplicate efforts, create wasteful and counterproductive competition for donor resources, and increase the relative cost of administrative expenses needed to

achieve similar objectives.

Prioritizing PPPR necessitates ensuring that every region has achieved a minimum level of capacity in critical areas like surveillance, laboratory systems, and genomic sequencing,¹³ adequate and timely access to pandemic countermeasures,¹⁴ and sufficient national healthcare workforce capacity.¹⁵ In a contracted global economic environment, the focus should be on ensuring that existing financing mechanisms are adequately capitalized and money is efficiently distributed to countries and regions rather than used to create new administrative machinery.

The Pandemic Fund, launched in November 2022, and the Global Fund to Fight AIDS, Tuberculosis, and Malaria, in operation since 2002, have been deploying financial resources to support PPPR capacity building in low- and middle-income countries (LMICs). Adequate resource mobilization for both of these entities should be ensured, their operations with respect to PPPR streamlined, and their participation in the pandemic agreement formalized. This includes securing the estimated US\$ 10.5 billion annually needed for the Pandemic Fund to provide LMICs with the necessary gap-financing needed to achieve a fit-for-purpose PPPR architecture.¹⁶ While this may appear to be a large amount, it is a drop in the bucket when compared to the estimated US\$ 13.8 trillion lost because of COVID-19 between 2020 and 2024.¹⁷

To avoid duplication of efforts, Member States should consider elevating the Pandemic Fund as the primary financial mechanism for PPPR in the agreement. In this role, the Fund's Board must ensure that each respective region or subregion has access to necessary financing to develop capacities to detect and respond adequately to infectious disease threats of pandemic potential. This will require the deployment of financial resources to strengthen regional health institutions like the Africa CDC. For this purpose, the Pandemic Fund will need to address issues of representation on its Board and have a dedicated role to support the activities of the Conference of Parties and its Secretariat. The solution that is being presently discussed in Geneva – to create an overarching mechanism for the coordination of global health financing – is also a welcome proposal. It is important to note that this solution is not mutually exclusive with one that places the Pandemic Fund in a leading role for PPPR.

Civil Society Engagement. Together with communities and other non-state actors, civil society organizations are an integral part of the global health ecosystem, serving as a vital bridge in the partnership between the public and private sectors.¹⁸ They enhance the capitalization of global health financing, accelerate technological development, provide valuable technical expertise, and fulfill roles as mediators, implementers, watchdogs, and champions.⁷ During the COVID-19 health emergency, these organizations played crucial roles by aiding governments in the implementation of whole-of-society response strategies, working directly with communities in critical functions,^{19,20} accelerating the research, development, and distribution of COVID-19 vaccines and countermeasures,^{21,22} and promoting transparency and accountability.

Despite these and other unparalleled contributions, civil society voices remain sidelined in the decision-making processes of the WHO agreement and its implementation. Civil society is scarcely mentioned in the October 30, 2023, draft of the agreement—a missed opportunity to formalize and integrate these vital assets into the new global health architecture. Therefore, we urge those involved in negotiations to include civil society and other non-state actors' participation meaningfully in the design and implementation of the pandemic agreement.

From HIV/AIDS to the COVID-19 pandemic, history has shown the vital role that civil society, communities, and other non-government actors play in tackling global health crises. In this context, we advocate for the establishment of specific standards that ensure meaningful civil society and community engagement in the implementation processes of the agreement, which could prove useful to all parties. We also request that civil society voices be included in review mechanisms and national reporting processes as watchdogs and recommend that local communities be actively engaged as part of in-country surveillance networks. Furthermore, reputable international entities should be granted a special status, allowing them to engage more meaningfully with countries, especially during processes such as drafting this agreement and subsequent amendments.

Should you require more detailed briefings on any of the topics discussed above, please don't hesitate to contact our team at guilherme.faviero@ahf.org

The AHF Global Public Health Institute

The AIDS Healthcare Foundation is a global nonprofit organization that provides cutting-edge medicine and advocacy worldwide to over 1.9 million people in 46 countries. We are currently the world's largest provider of HIV/AIDS medical care globally, working to ensure the prevention, testing, and treatment of HIV and AIDS for all people, regardless of ability to pay. Since 1987, AHF has cared for millions of people living with HIV and AIDS, implementing new programs in communities and expanding the delivery of healthcare and influence over policy to more lives.

To address global health issues, AHF created the AHF Global Public Health Institute, which has been involved in promoting a legally binding global health agreement since before the COVID-19 pandemic. At the Institute, we leverage our applied research to enhance international health law, policy, and governance outcomes through advocacy. Our efforts are aimed at addressing and bridging the existing gaps in the global health security architecture, with the goal of helping the world prevent, prepare for, and respond to future pandemics.

In response to COVID-19, the Institute commissioned a study that led to the publication of "A Global Public Health Convention for the 21st Century" in the prestigious *Lancet Public Health*. This study served as the impetus for the launch of collaborative efforts that included the Panel for a Global Public Health Convention, an independent coalition of global leaders committed to strengthening the world's ability to prevent pandemics, the University of Miami Public Health Policy Lab, and the Global Pandemic Policy Group.

During the most critical phase of the COVID-19 pandemic, AHF acted through the Institute by initiating the SARS-CoV-2 Genomic Sequencing Fund. AHF extended this grant opportunity to faculty at institutions of higher learning, including research and academic institutions, to enhance research efforts and offer a distinct avenue for generating high-quality evidence concerning the rapidly proliferating variants worldwide. From 2021 to 2023, the Sequencing Fund has sponsored 15 projects in 14 countries, playing a pivotal role in bolstering genomic sequencing capabilities across the globe, particularly in low-and middle-income countries.

The University of Miami Public Health Policy Lab

The University of Miami Public Health Policy Lab is dedicated to advancing an equitable world that is accountable for the health of all people. It seeks to promote improved global health by advocating for evidence-based solutions. The lab was established in partnership with the AHF Global Public Health Institute in 2022, and is led by Dr. José Szapocznik, PhD.

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