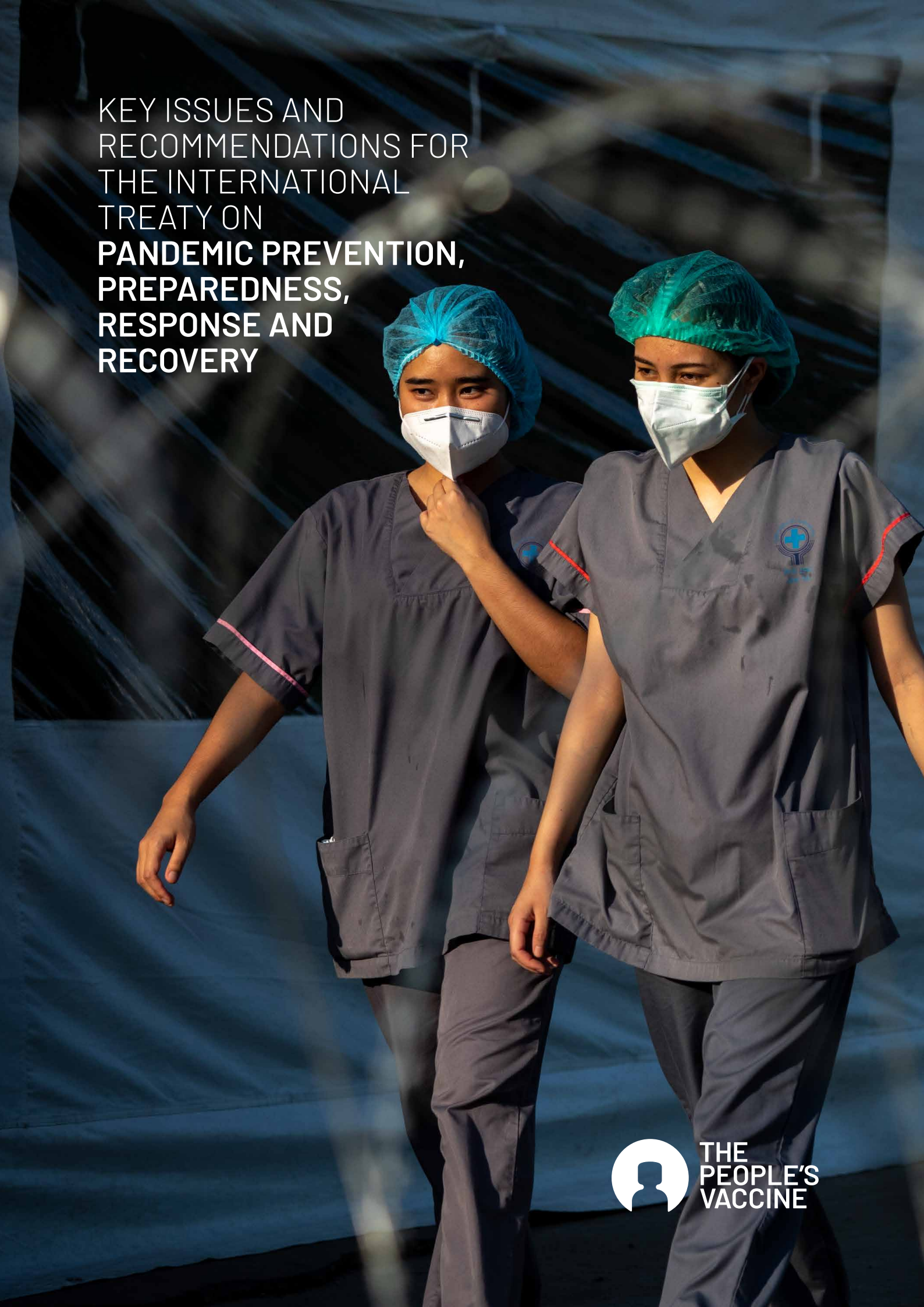
KEY ISSUES AND RECOMMENDATIONS FOR THE INTERNATIONAL TREATY ON **PANDEMIC PREVENTION, PREPAREDNESS, RESPONSE AND RECOVERY**



THE PEOPLE'S VACCINE

SUMMARY OF RECOMMENDATIONS

A. INNOVATION AND ACCESS TO MEDICAL COUNTERMEASURES

1. Ensure public financing for biomedical research and development (R&D)
2. Create conditions for government funded R&D
3. Mandate technology transfer
4. Share relevant intellectual property
5. Streamline regulatory standards and procedures to market medical countermeasures
6. Ensure greater transparency on all aspects of innovation and access to countermeasures
7. Create diversified manufacturing especially in low- and middle-income countries (LMICs)

B. GOVERNANCE OF PANDEMIC PREVENTION PREPAREDNESS AND RESPONSE (PPPR)

The governance of pandemic prevention, preparedness and response must be inclusive, transparent, and coordinated to promote national and regional actions through:

1. Inclusive mechanisms of governance, with all governments and civil society fairly represented
2. Transparency and accountability to citizens on pandemics
3. Coordination at all levels national and global

C. INVESTMENT IN RESILIENT HEALTH SYSTEMS

Invest in comprehensive public health systems to achieve access to free quality health care for all with the capacity to prevent and respond to future outbreaks

1. Invest in health workers' training, remuneration, and retention, including of community health workers, and in medical supplies, infrastructure, health information systems
2. Invest in and prioritize comprehensive Primary Health Care
3. Enable participation of communities and civil society in decision making

Donors, whether governments, multilateral institutions, philanthropic entities, or others must support governments' plans for building resilient health systems as a global public good.

D. SURVEILLANCE

1. Provide incentives for countries to notify World Health Organization (WHO) of detected pathogens and avoid penalizing those who warn the world of pathogens or variants
2. Invest continuously in community health care, building trust with communities and building and updating capacity of health workers
3. Enhance the capacity of developing countries in the use of surveillance technologies
4. Mandate a "One Health" approach
5. Mandate collaboration between scientists and between countries in generating and sharing data

E. FINANCING PANDEMIC PREPAREDNESS AND RESPONSE

1. Commit to using Global Public Investment to finance PPPR
2. Implement a financial transaction tax
3. Create a global tax system that is based on fairness and transparency

INTRODUCTION

Several outbreaks, epidemics and pandemics have raised alarms about the lack of capacity to deal with these health crises at national and global levels. For example, HIV has raised many socio-economic, key population, and gender issues in addition to access to medical countermeasures. The Ebola and Zika outbreaks, and now monkeypox, highlight the lack of investment in research and development (R&D) for diseases endemic in the South. They also proved that the existing international system for R&D is not adequate for effective pandemic preparedness and response. The shortcomings are particularly evident in the global failure to deliver equitable access to COVID-19 vaccines as people in the North queue for their second or third booster doses while Africans wait for their first dose.

The inequality of products relevant to pandemics is a symptom of the failure of the global system of financing innovation and ensuring access to medical technologies. The system relies on market incentives to finance R&D and determine supply through granting intellectual property rights (IPRs) to developers, which lead to monopolies for pharmaceutical companies. Even when public funding plays a major role in financing R&D, as is the case for COVID-19 vaccines and medicines, governments still leave critical decisions on production, allocation, and price to the companies.

Meanwhile, the current legal mechanism of the International Health Regulations does not include measures to guarantee equitable access to medical technologies.

Countries must learn from these challenges in order to prevent and prepare for future health crises, and to respond and recover should they happen.

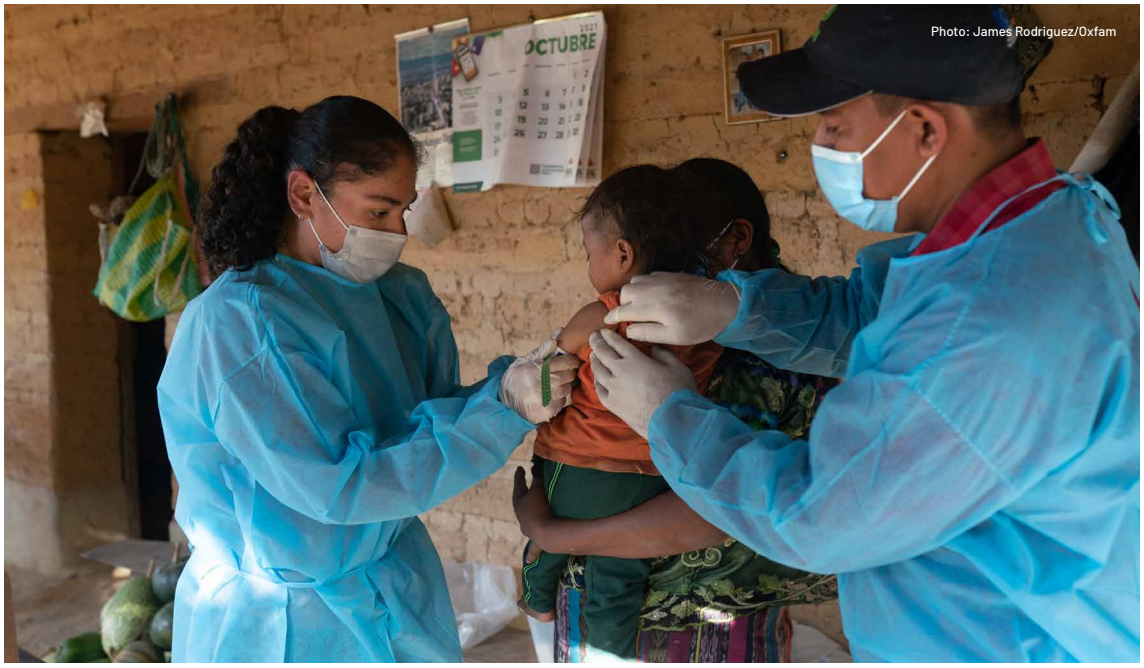


Photo: James Rodriguez/Oxfam

NEGOTIATIONS ON A PANDEMIC TREATY

In December 2021, the World Health Assembly passed a resolution to set up a process for WHO Member States to negotiate a new legal instrument (often called a 'pandemic treaty') so that countries can effectively, and equitably address future pandemics. The negotiations offer a key opportunity to address these challenges and to adopt effective measures to enhance R&D, manufacturing, and achieve equitable access to medical countermeasures.

WHO member states tasked an Intergovernmental Negotiating Body (INB) with drafting the instrument to be negotiated in 2022-2023 and approved in 2024. During INB meetings, Member States debate the key issues that should be covered by the treaty. Civil society and other stakeholders are allowed as observers in those meetings and can deliver short statements. The forthcoming INB meeting in December 2022 is an opportunity for governments to start translating general themes into concrete commitments and practical mechanisms.

Between August and December, there is a period of intensive consultations with member states and other stakeholders including civil society (CS).

The The People's Vaccine Alliance (PVA) proposes that the treaty sets up measures to ensure that medical countermeasures are treated as global public goods. This will allow for effective R&D and equitable access to medical countermeasures based on human rights and equity principles.

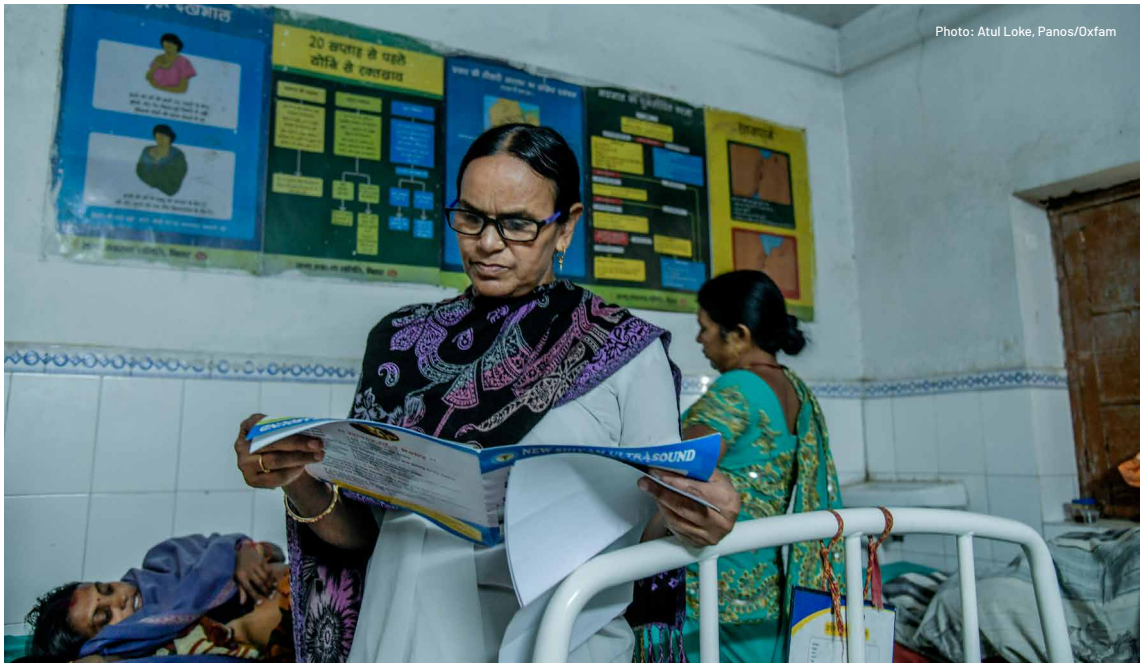


Photo: Atul Loke, Panos/Oxfam

PRINCIPLES

The treaty must include the following principles as central to its activities:

1. Human rights. These are central to the treaty in terms of process and content. The right to health, which places obligations on "states to secure the prevention, treatment and control of epidemic, endemic, occupational and other diseases", and includes the right to access affordable medicines. The human right to the fruits of science asserts that states recognize "the right of everyone to enjoy the benefits of scientific progress and its applications".

2. People centered approach. Full participation of CS throughout the treaty process is essential to enable inclusive design, implementation and monitoring of the treaty at local, national, regional and global levels. The approach also upholds the rights of marginalized and vulnerable people to participate and to access benefits of health care and science.

3. Equity. Equitable representation and decision-making power in all aspects of the treaty must be secured. For example, the "donor-recipient" mode of operation must be uprooted, and instead equal and democratic participation implemented. Moreover, actions to ensure equitable access to countermeasures must be mandated not only for justice and human rights for all but also in recognition that pathogens do not differentiate between people depending on their birthplace or color, race, age, disability, economic position, gender and so on.

THE KEY ELEMENTS IN THE LEGALLY BINDING PANDEMIC INSTRUMENT

There are several key issues that must be addressed in the treaty including: innovation and equitable access to medical countermeasures; governance; sharing data and technology; building resilient health systems; surveillance, governance and transparency; and financing the treaty implementation. This paper addresses these issues with a special focus on innovation and access to medical technologies.

A. INNOVATION AND ACCESS TO MEDICAL TECHNOLOGIES

Previous and current pandemics have illustrated the faults in the global system of R&D and supply of countermeasures for pandemics. HIV illustrated the problem of high unaffordable prices, Ebola and Zika showed the problems of lack of innovation for diseases of the South, while COVID-19 demonstrated huge inequality in access due to inadequate supply and unfair allocation of products. In fact, these faults are not confined to pandemics but rather reflect systemic problems with innovation and access to medical technologies.

The shortcomings of the current R&D system stem from insufficient long-term funding but also lack of sufficient government decision-making power in determining access to medicines. Governments rely on pharmaceutical companies to develop, produce, and supply medical countermeasures which then control the market.

An expert group discussed these issues and made seven recommendations that provide a good foundation for the treaty to address innovation and access to countermeasures. This paper is guided by and builds on these recommendations.

1. FINANCING FOR BIOMEDICAL RESEARCH AND DEVELOPMENT (R&D)

COVID-19 and monkeypox have illustrated the need for, and value of sustained long-term public funding of R&D especially for viruses with pandemic potential. Private investors and pharmaceutical companies tend not to invest in R&D for diseases that have a small market (i.e. where demand is considered low); are unlikely to produce a high profit; or where there is uncertainty as to whether any resulting product would be needed (as is the case for pathogens with pandemic potential).

These factors explain the lack of private investment in diseases endemic in Africa like monkeypox due to their negligible commercial value. The virus has been endemic in Africa for over 50 years without interest in monkeypox-specific R&D for tests, vaccines, or medicines. The vaccine and medicine currently being used for monekypox are funded by the US government over decades to protect against another virus (smallpox). Interest in R&D for monkeypox has only now arisen because the virus is present in the northern hemisphere. This is a repeat of the case of Ebola where a researched vaccine was shelved due to the lack of a lucrative market.

In the period before the start of the pandemic, R&D pipelines targeting pathogens most likely to cause a pandemic were largely empty. However, after the pandemic hit, the portfolio of experimental drugs and vaccines to treat coronavirus filled up – while the R&D effort by 20 of the world's largest pharmaceutical companies into other priority emerging infectious diseases remains worryingly low.

Public funding on the other hand seeks public health benefit and can therefore finance for health needs irrespective of the size of the potential market. The relationship between financing R&D and pricing of resulting medical technologies also requires fundamental change. Pharmaceutical companies try to justify high prices of medicines, such as antiretrovirals (ARVs) for HIV, by claiming they are necessary to recoup the costs of R&D.


Photo: Rodger Bosch/The Biovac Institute

However, there is no way of verifying such claims nor of ensuring resulting prices are affordable for all, even in a pandemic. As a result, health experts and many civil society organizations have long called for the delinking of financing for innovation from the price of a resulting medicine. Financial incentives for innovation can take different forms including direct grants, tax incentives, prize funds and competitive intermediaries, which act as pension funds, or a mixture of these or other forms.

The treaty should:

- Pioneer a commitment by all countries to gradually increase their contributions to medical R&D as an agreed % of their GDP.[1] In addition to supporting national R&D programmes, governments should also contribute to jointly funding medical countermeasures in a fair manner ensuring that the resulting products are global public goods. The treaty should also promote and provide mechanisms for coordination and collaboration to increase the effectiveness of the joint effort, with an emphasis on including developing countries' institutions and researchers to enhance their expertise and manufacturing capacities.
- Encourage research collaboration and financing of the WHO mRNA hubs and spokes, and other regional initiatives based on shared technology. Importantly, investment in such different R&D models should also be prioritized by multilateral initiatives that fund health technology development such as CEPI.[2]

- Adopt Global Public Investment (GPI), a system of international public finance, in which governments cooperate to secure international public policy outcomes via fractional contributions from general government revenue. GPI is based on the principles of: all contribute, all benefit, and all decide. The treaty should also explore funding via the implementation of a financial transaction taxes to finance R&D (see Financing section below).
- Commit to funding several different approaches to incentivize R&D including delinking financing from price of products, prize funds, buy-outs (where governments buy IP from a private developer of technology), and tax incentives.
- Commit to funding R&D for diseases endemic in the South before they break into pandemic threat and
- Commit to public funding of clinical trials that compare the efficacy of similar products (e.g. comparing the efficacy of vaccines produced by different companies or those that have different mechanisms of action) as companies have no incentives to fund such trials.

2. CREATE CONDITIONS FOR GOVERNMENT FUNDED R&D

Public sector medical funding is normally driven by public health needs. It finances high-risk research. It tends to discover medicines that have significant therapeutic benefits. Public funding for different stages of research has been critical in the production of vaccines and other medical technologies as clearly illustrated in the case of COVID-19. However, while the extraordinary financial rewards for the pharmaceutical companies are clear, it is questionable whether the public received a fair return on investment.

For example, having received $10 billion in government funding to develop, boost manufacturing capacity, run clinical trials, and deliver its COVID-19 vaccine, Moderna then sold the vaccine back to governments with a huge 66 percent net profit margin. The public funding from individual governments and collective bodies such as CEPI did not seem to have any conditionality on price, allocation, or data sharing and technology transfer to increase supply, including for developing countries.

The inevitable result of allowing pharmaceutical companies to control supply, price and allocation of publicly funded life-saving technologies at times of global emergency is inequality and injustice in access to COVID-19 products. Public health objectives are thus undermined since controlling the virus requires timely, universal and equitable access to vaccines and other technologies across all countries according to public health need, and not simply to the highest bidders. This is a massively inefficient use of public spending.

To avoid a repeat of such inequality in access, the treaty must therefore mandate governments to attach conditionalities to public funding of R&D and to advance other purchasing commitments for:

- Fair allocation of products globally, according to public health criteria designed by WHO based on public health and scientific evidence.
- Affordable pricing with full transparency on R&D costs including a breakdown between private and public investment.
- Technology transfer including to developing countries to maximize supply by enabling diverse production in the South and North.
- Sharing IP rights through, for example, the Medicine Patent Pool or mechanisms like the WHO COVID-19 Technology Access Pool (C-TAP).
- Commitment to reinvest part of the company's profits from products which benefited from public funding in R&D, for new, better adapted, or improved technologies.

3. MANDATE TECHNOLOGY TRANSFER

At the start of outbreaks and pandemics, there is usually a shortage of supply of medical technologies. Higher income countries compete to secure as much as possible even at the expense of availability to the rest of the world. The result is illustrated by the inequality of access to COVID-19 products. After nearly two years of vaccine availability, only 22% of people in Africa are fully vaccinated.

Instead of competing for limited supplies, countries should collaborate to maximize supply by sharing technology and waiving relevant intellectual property rights. Technology transfer collaboration should be prioritized with countries and regions in the Global South where access challenges are at their greatest. Such collaboration should recognize the intellectual assets and capacity in the Global South that can contribute to the further development of products. Governments in the South must also take leadership in developing capacity for technology absorption, development, and creation.

There are lessons to be learnt from treaty-based mechanisms in other sectors, which should inform this process, including the Multilateral Fund established under the Montreal Protocol to protect the ozone layer which has supported technology transfer through paying for, for example, royalty costs.

The treaty should mandate governments to:

- Promote collaborative innovation between scientists in the North and South through funding conditions and other policies. Building R&D and capacity for absorption and development of technology in LMICs is not only beneficial to those countries but to all countries to accelerate and improve R&D and to maximize supply of medical technologies.
- Mandate sharing of relevant medical technology to prevent and respond to pathogens of pandemic potential (in advance of and during pandemics) with capable producers internationally including in LMICs. The WHO COVID 19 Technology Access Pool (C-TAP) provides an example for sharing and facilitating technology transfer.
- Mandate governments to provide fair share finance for technology transfer according to their means.

4. SHARE RELEVANT INTELLECTUAL PROPERTY (IP)

Intellectual property covers a variety of rights that can act as barriers to technology transfer and production in developing countries including patents, clinical trial data, trade secrets and know-how, copyrights, and industrial designs. IPRs enable right holders to have a monopoly on production, supply, allocation, and price irrespective of who funded the R&D.

Voluntary sharing of IP during COVID-19 was limited, ad hoc and late. In most cases products remained under the full control of pharmaceutical companies, many of which did not share the IPRs. Relying on voluntary sharing of IP is inadequate to achieve the necessary large-scale and rapid access to products to deal with pandemics.

Therefore, the treaty should commit governments to:

- Prepare their national laws to be able to use non-voluntary sharing of the rights to patents, data, know-how and biological resources needed for pandemic response. Governments must ensure that their national law include the TRIPS flexibilities and allow for the automatic waiving of relevant IPRs triggered by the WHO declaring a Public Health Emergency of International Concern.[3]
- Ensure that bilateral and plurilateral agreements are not a barrier to accessing medical countermeasures and technologies. The pandemic treaty should require that States not enforce provisions in those other agreements when they conflict with a pandemic treaty obligation, for example, to share technology and know-how and scale manufacturing of affordable counter measures.

- Commit to the full use of the TRIPS flexibilities such as compulsory licensing to force sharing of IP with the objectives of increasing supply and fair allocation of products, as well as decreasing the price via generic or biosimilar competition.
- Commit to not in any way obstructing or seeking to dissuade other countries from making full use of existing TRIPS flexibilities.
- Mandate benefit sharing of biological resources, inventions, data, and other inputs as well as countermeasures.[4] The Pandemic influenza preparedness Framework (PIF) for the sharing of influenza viruses and access to vaccines and other benefits provides an example where genomic data are shared in exchange for making flu products available and affordable. The Pandemic treaty must insist on benefit sharing of material, data, technologies, and products to be available for all countries beyond the country of origin for genetic material and the country where countermeasures are developed or produced.

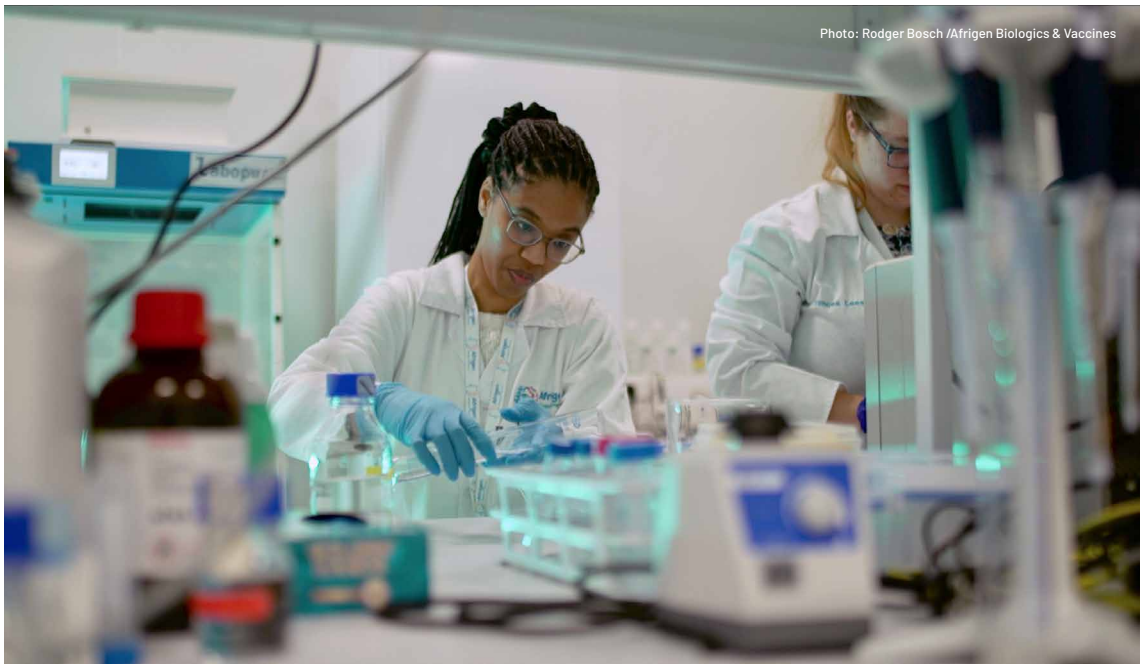


Photo: Rodger Bosch /Afrigen Biologics & Vaccines

5. STREAMLINE REGULATORY STANDARDS AND PROCEDURES TO MARKET MEDICAL COUNTERMEASURES

A clear and streamlined regulatory pathway is essential to avoid barriers to innovation and access to products.

Therefore, the treaty should:

- Define a clear and streamlined regulatory pathway that is based on collaboration between regulatory authorities.
- Enhance the role of the WHO pre-qualification scheme and collaborative registration procedures and ensure they are fully financed.
- Commit regulatory authorities to share information to avoid duplication, inefficiencies and enhance access to products including through a global repository of data.

6. ENSURE GREATER TRANSPARENCY

Medicine innovation and access are shrouded in secrecy across all aspects of the value chain. This significant information and power asymmetry between producers and governments and procurement agencies results in high prices and inequitable access, with negative impacts for public health.

The treaty should therefore mandate transparency on:

- The cost of R&D including active pharmaceutical ingredients (APIs), clinical trials, manufacturing, marketing, and other costs.
- Public and charitable funding contributions to the cost of R&D and production.
- Price of products charged to all procurers in all countries.
- Patent and other IP information in all countries both filed and granted.
- Clinical trials, including protocols and results irrespective of the outcome of the trial.
- Regulatory information.

There is also a clear lack of data essential for decision making such as the cost of technology transfer and of creating regional manufacturing hubs. Member states should request WHO to work with other partners to commission independent studies including by using evidence from previous and current hubs and studies on production of COVID-19 vaccines.

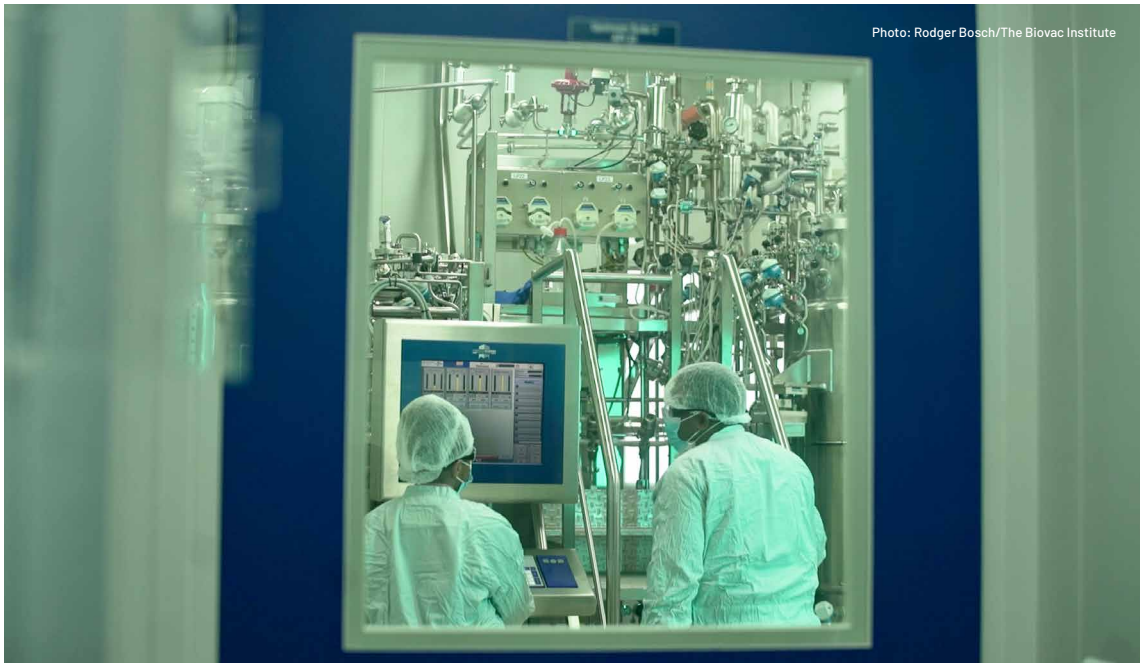


Photo: Rodger Bosch/The Biovac Institute

7. DIVERSIFY MANUFACTURING

COVID-19 clearly illustrated that even if biotechnology companies develop a product, they tend to partner with other established pharmaceutical or contract manufacturing companies and almost entirely in the North. These contracts largely maintain exclusive control on supply, allocation and price in the hands of the originator company.

Diversified manufacturing especially with autonomy from the IP holder has several benefits including a) increasing supply for all; b) making medical technologies available to developing countries, c) developing industrial capacity, and d) enabling competition and therefore lowering prices.

The treaty should therefore:

- Mandate governments to invest in their national capacity for the absorption, development and creation of technology. National political and financial leadership is critical for securing supplies of affordable quality countermeasures in the South.
- Mandate governments to fund regional manufacturing capacity and to create the necessary conditions, including investment in science, to attract further investment while maintaining public health objectives.
- Promote national and global procurement from regional hubs in the South, even if at higher price in the early stages of manufacturing, to ensure the sustainability of newly established facilities by providing stable demand.

B. GOVERNANCE OF PANDEMIC PREVENTION, PREPAREDNESS AND RESPONSE

The HIV and COVID-19 crises provide key lessons for governance at local, national, and global levels. There is a huge difference between the creation, development and performance of the global and national structures created for HIV and for COVID-19. For example, the Global Fund for HIV, TB and Malaria was co-created by governments from the North and South with a strong and important participation of CS and other stakeholders. The result is an inclusive governing structure designed by all participants and not by a handful of high-income countries or philanthropic donors. This governance structure is mirrored at national level by the Country Coordinating Mechanism where decisions are meant to be made about programmes, funding and implementation. Clear policies on transparency have exposed and helped to deal with and prevent corruption and have built trust and accountability.

In contrast, ACT-A was created for COVID-19 by donors (including philanthropists) with the aim of accelerating access to medical countermeasures in developing countries. Participation of governments from lower income countries, who would be responsible for delivering the products, was very limited. Civil society organizations were initially excluded and participation since has been inadequate. ACT-A decision making happens centrally including on product type, quantity and delivery time. For example, recipient countries did not know what vaccines they would receive, how many doses or when. This made it difficult to plan and implement vaccination campaigns.

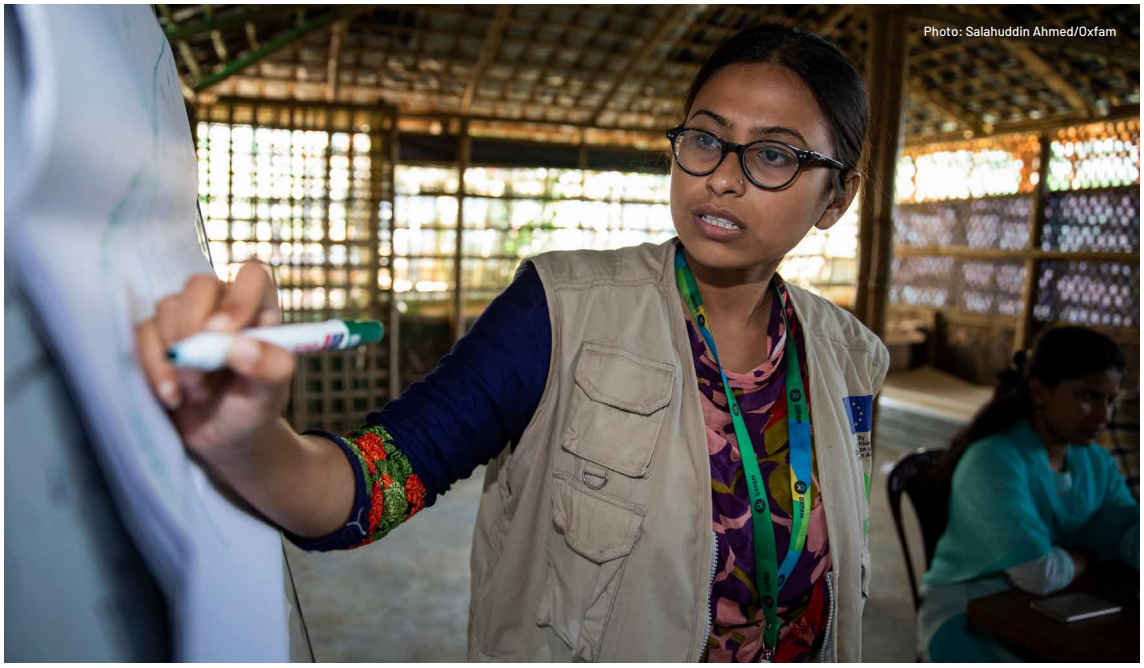


Photo: Salahuddin Ahmed/Oxfam

The governance of pandemic prevention, preparedness and response must be inclusive, transparent, and coordinated to promote national and regional actions through:

1. INCLUSIVE MECHANISMS OF GOVERNANCE

The Global Fund provides an example of an inclusive model of governance in terms of co-creation and decision making by Northern and Southern governments, CS and other relevant stakeholders. Indeed, the Global Fund uses terms such as implementers of programmes and not 'recipients' or 'beneficiaries' of funds. The structure enables a system of transparency and accountability for all involved.

The treaty must be inclusive in terms of:

- The process of negotiation and design must be inclusive of CS, communities and all governments as well as other relevant stakeholders. For example, the process should continue to open opportunities for public and regional consultations as well as contributions from all governments.
- Commitment from all governments to include CS and other relevant stakeholders in planning, implementing, and deciding on all policies and activities relevant to pandemics and potential pandemics at national and global levels. CS must be enabled to utilize its own mechanisms to ensure fair selection of representatives.
- Representative inclusion of governments from the South in any global mechanism (e.g., via WHO regions or other regionally agreed selection processes). Donors/high-income countries must not get to decide how developing countries are represented.
- Governments' commitment to consultative design and decision making at regional, national and subnational levels. The Global Fund Country Coordinating Mechanisms provides a model for national consultative decision making.

2. TRANSPARENCY AND ACCOUNTABILITY

Inclusive decision making creates the necessary environment to enable transparency, public accountability and trust. However, the treaty must also include a clear commitment to ensure transparency and accountability on decision making, strategies, planning, implementation, and monitoring actions.

Therefore, the treaty should ensure that all governments and other relevant stakeholders commit to:

- Making public all information on decision making processes, strategies, plans, funding, implementation, and impacts, including both positive and negative results. All such information needs to be open to public scrutiny.
- Enabling CS to monitor all strategies, plans, funding, and actions.
- Ensuring open access to journalists to all information related to pandemics and potential pandemics.
- Transparency related to countermeasures - see the first section on countermeasures above.

3. COORDINATION AT ALL LEVELS

While global coordination between agencies involved is critical, the creation of yet another global or international body specifically for pandemics is unnecessary, costly, and would divert decision making power and resource away from developing countries where it is needed most. The WHO's mandate already authorizes the organization to coordinate global responses and to interact with other relevant agencies especially those dealing with animals and the environment.

The treaty must state that:

- Coordination of pandemic action internationally is the responsibility of the WHO including collaboration with animal and environmental agencies.
- Governments are responsible for leading all policies, strategies, and activities at national level.
- Regional bodies such as the African Union (AU) are enabled to lead on regional coordination, including in ensuring access to countermeasures.

C. INVESTMENT IN RESILIENT HEALTH SYSTEMS

Before COVID-19, the Ebola crisis in West Africa revealed the failings of Africa's health systems. It was clear that resilient public health systems:

- Must be able to continue providing normal health care and be capable and ready to detect and respond to outbreaks before they become epidemics or pandemics.
- Must be public and free at the point of use to ensure equity and universality.
- Require long-term investment in its six key elements: an adequate number of trained health workers; available medicines and medical supplies; robust health information systems, including surveillance; appropriate infrastructure; sufficient public financing and a strong public sector to deliver equitable, quality services.

Given that pandemics start as outbreaks in a small locality in a given country or territory, having a resilient health system capable of preventing and dealing with any outbreaks is of utmost importance to prevent a pandemic from occurring and affecting other countries. Therefore, investing in the building of resilient public health systems is fundamental to pandemic prevention and of universal benefit – a global public good.

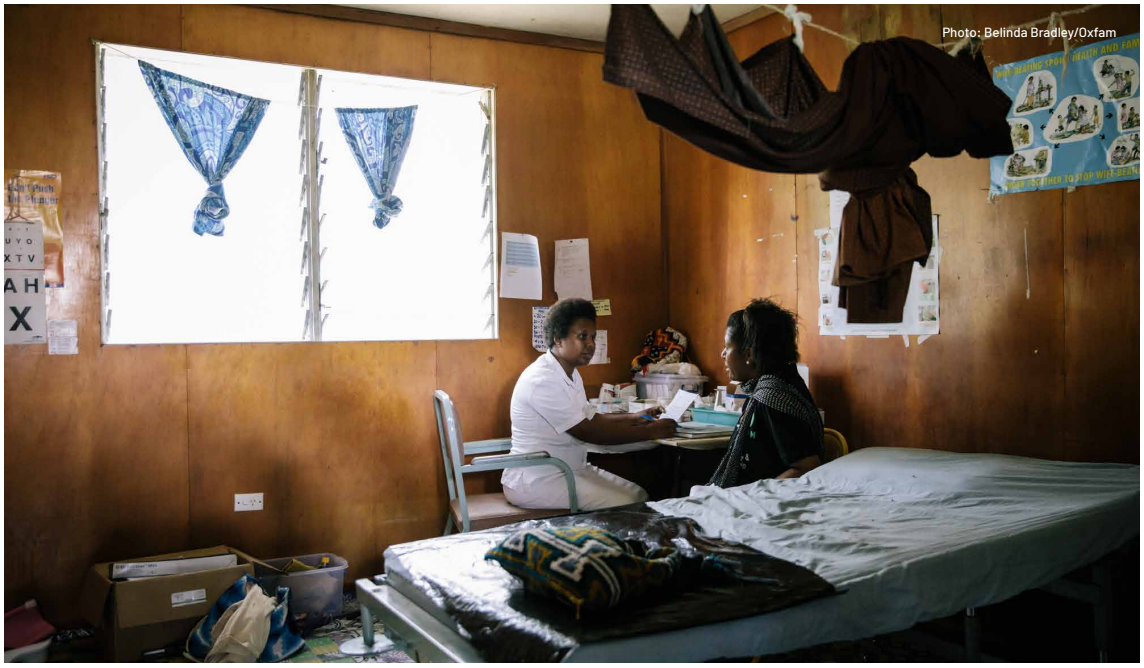


Photo: Belinda Bradley/Oxfam

The treaty should ensure government commitment to:

- Invest in comprehensive public health systems to achieve access to quality health care for all with the capacity to prevent and respond to future outbreaks. Governments must be required to develop long-term costed plans to build and maintain resilient health systems that can serve health needs and health security, remove direct fees for health services and drive down out-of-pocket expenditure on health care as mandated under the Sustainable Development Goals. Governments must demonstrate how they will progressively reach minimum agreed thresholds on health sector expenditure as a proportion of GDP and government total expenditure.
- Invest in health workers' training, remuneration, and retention, including of community health workers, and in medical supplies, infrastructure, health information system and management with long-term costed plans to reach minimum WHO recommended health worker ratios.
- Invest in and prioritize comprehensive Primary Health Care (PHC), the basic building block in providing health care; surveillance and notification of outbreaks; and in fostering community trust (see points on surveillance below).
- Enable participation of communities and civil society in decision making to build trust between governments and people; ensure accountability; ensure that services reach vulnerable and marginalized groups; promote awareness of diseases and to combat misinformation.

Donors whether governments, multi-lateral institutions, philanthropic entities, or others must:

- Support governments' plans for building resilient health systems as a global public good that achieves health care for all and builds capacity to deal with outbreaks and pandemics.
- Rethink the traditional donor/recipient relationships that in the past have skewed the provision of health services towards specific projects and policies, at the expense of comprehensive universal free health care.
- Commit to longer-term funding for health systems, making annual allocations for financing the development of health services over a 10-year period, provided that plans are well implemented.
- Support countries to introduce effective measures to enable them to raise domestic resources via progressive taxation.

D. SURVEILLANCE

Public health surveillance is defined as "the continuous, systematic collection, analysis and interpretation of health-related data." There are some surveillance systems for specific pathogens such as: the early warning and response system for outbreaks of disease established in 2006 by the WHO; the Food and Agriculture Organization (FAO); the World Organization for Animal Health (OIE); and the WHO's global influenza surveillance and response system. These systems are based on networks that conduct viral surveillance for the early detection of spillover from wildlife to livestock and humans before they become outbreaks, and thus prevent potential epidemics and pandemics.

The Independent Panel for Pandemic Preparedness and Response recommended a global system of surveillance that enables early detection and rapid response as well as authorizing the WHO to collect data from multiple sources.

The treaty should include commitment from governments and international bodies to:

- Provide incentives for countries to notify WHO of detected pathogens and avoid penalizing those who warn the world of pathogens or variants. For example, West African countries were late in notifying Ebola for fear of economic and trade impact, which happened in the form of flight bans. South Africa and Botswana were also punished by many countries via flight bans (thus obstructing movement of people and trade) following their swift notification of new COVID-19 variants.
- Invest continuously in community health care, building trust with communities and building and updating capacity of health workers. Effective surveillance is inadequate without PHC workers, who have the people's trust and the skills to detect, notify and collect samples and data of emerging diseases.
- Enhance the capacity of developing countries in terms of development of technology, the use of artificial intelligence and genomic sequencing to understand how the virus is spreading and to evaluate the effectiveness of interventions.
- Mandate collaboration between human, animal, and environmental health - One Health approach.
- Mandate collaboration between scientists and between countries in generating and sharing data.

E. FINANCING PANDEMIC PREPAREDNESS AND RESPONSE

The current donor-recipient model and emergency donor mechanisms such as ACT-A have failed to support countries in time to prepare or respond to pandemics whether it was flu or COVID-19 or to outbreaks such as Ebola.

For pandemic preparedness and response sufficient, sustained, long-term public funding from all countries is essential for national and global actions. The WHO and the World Bank estimate the cost of strengthening the capacity of low-income countries and middle-income countries to prepare for pandemics as an additional US $10.5 to US $15 billion per year over the next five years, with sustained investments in subsequent years. This is needed at country, regional and global levels, but it is on top of other major funding gaps for urgently needed health systems strengthening.

Currently there is a lack of independent and comprehensive estimates of the funds needed for various countries to prevent, prepare, and respond to pandemics or for developing, manufacturing, and delivering pandemic countermeasures. It is important that WHO, with other stakeholders including scientists, public health experts and CS work out the funding required to finance all the required activities, including to meet Sustainable Development Goals health goals, and for governments to pay for the data collection and analysis.

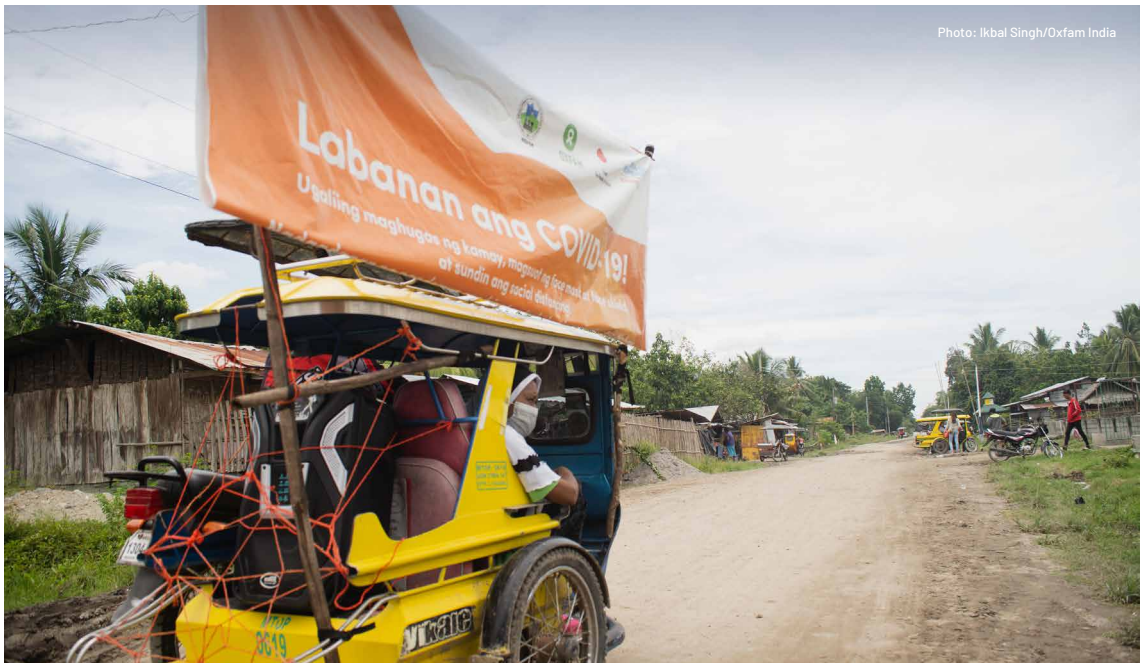


Photo: Ikbal Singh/Oxfam India

The World Bank and a group of donors announced a new World Bank-hosted Financial Intermediary Fund (FIF) for pandemic prevention, preparedness and response. This FIF is expected to be finalized by the G20 by the close of 2022. The proposed governance of the FIF is outdated giving initial donors the power to hold all decision making including the design of the fund and criteria for funding. The proposed FIF ignores the lessons learnt from other successful funding models such as the Global Fund. CS has criticized the lack of co-creation and representativeness; it's unclear design; its governance model as well as its low financing targets. After intense advocacy by CS, it was agreed to allow two seats for CS organizations.

The treaty needs to direct governments to progressive and sustainable financing models to raise the resources necessary for pandemic prevention, preparedness, response and recovery (PPPR) including:

- A commitment to using GPI to finance PPPR, which relies on fair share public investments to ensure equity in access to countermeasures, to reduce volatility through statutory financing; and to incentivize all countries to work for a common framework of action instead of nationalism. GPI promotes a system where all countries contribute according to ability and all benefit according to needs. It does not require the creation of a "new fund" but requires governments' commitment to funding what is required e.g. building resilient public health system, surveillance capacity, R&D for countermeasures, regional procurement, regional preparedness and so on.
- Governments to implement a financial transaction tax. The revenue can be used to fund R&D, health systems and other aspects of PPPR.
- Governments to create a global tax system that is based on fairness and transparency. The system includes mechanisms such as ensuring that multinational corporations pay their fair share of taxes by reducing harmful tax practices and strengthening measures against tax avoidance; strengthening the capacity of national revenue authorities to collect tax and curb illicit financial flows; and making corporate and personal income taxes more progressive, through setting top rates for large companies and the richest individuals at higher levels.

This document was written in September 2022 by Mohga Kamal-Yanni with input from Piotr Kolczyński, Anna Marriott and members of the People's Vaccine Alliance Policy Group

Notes

[1] For example, in 2017 Senator Bernie Sanders proposed a fund of 0.55% of US GDP to reward researchers and developers for medical innovation for specific health objectives.

[2] Coalition for Epidemic Preparedness Innovations

[3] Some countries already allowed their laws to override IP during the COVID-19 emergency including the German Epidemic Protection Act and Israel issuing compulsory licensing on one product.

[4] Mechanisms used for this purpose may include an Open Source Dividend, the basic idea of which is to set aside a portion of the commercial rewards from a medical product to be shared with persons or communities that openly shared knowledge, data, materials, and technology on a royalty-free and non-discriminatory basis.

Photos

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