



# Coalition of Advocates for Global Health and Pandemic Preparedness



As members of the Coalition of Advocates for Global Health and Pandemic Preparedness, a group of organizations advocating for an integrated and holistic approach to preparedness that emphasizes equity, inclusion, and synergies of multiple global health programs in advancing preparedness, we share the following asks.

## Governance & Civil Society Engagement

Globally, civic spaces are shrinking as global anti-rights movements are gaining momentum. We, with decades of experience in the global HIV and NTD movements, have both demonstrated and learned the crucial role that civil society and communities play in multilateral governance and their impact on health outcomes. We urge Member States to agree to a governance structure for the Accord that safeguards meaningful civil society and community engagement.

## Financing

There is currently no text in the Pandemic Accord that commits Parties to any funding mechanism to properly resource the commitments therein. Any additional obligation created for Parties to the Accord, especially low and middle income countries, must be associated with a commensurate funding mechanism. We urge Member States to carefully consider the costs and challenges associated with creating a new parallel funding stream, especially considering ongoing conversations around GHIs coordination, and strive towards a solution that limits fragmentation and limits overlap with existing financing mechanism, in particular the Global Fund, Pandemic Fund, Gavi and the WHO Contingency Fund for Emergencies.

## Global Health Equity

The recently reinserted proposal on committing to attaching access conditions to publicly-funded R&D is imperative to retain in the final agreement. These commitments would constitute a gigantic step toward global health equity while advancing our global technological response capacity. Publicly-funded R&D should benefit the people most of all that contributed to that funding - these provisions would ensure a more even playing field in the medical countermeasures development market. While this proposal should by all means be retained, it should not have caveats and should apply to all publicly-funded R&D, regardless of level of funding.

The Pathogen Access and Benefits Sharing (PABS) system has been a contentious issue, but we believe that specific principles must be adhered to for the system to address global health equity concerns. Firstly, there must be a shared understanding of benefits as not limited to simple access to pathogen data, but to material benefits arising from the use of that data, i.e. financial compensation or reserves of countermeasures developed from that data. Secondly, if the system is opt-in, it must be opt-in for Parties to the agreement rather than ‘users’ of the PABS system, as it is very unlikely that manufacturers will opt-in voluntarily and engagement should be controlled by governments. Lastly, it must be fully considered at which point the PABS system will be triggered - is there a threshold for a formal pandemic declaration, or will it apply at any point of PHEIC declaration? We call on Member States to prioritize flexibility and trust in these negotiations to arrive at a satisfying agreement.

## Community Leadership

We know from 40 years of the HIV response, and have seen more recently with COVID-19, that civil society and communities are a key building block of effective pandemic responses. While we are encouraged that the accord makes mention of community engagement in several places, this terminology can often be misunderstood; it is important to emphasize more specifically the active role of community leadership and community-led responses in PPPR efforts, from planning and implementation to monitoring and coordination.

The current language in support of the health and care workforce in article 7 should be retained in the final agreement. We commend the attention to community health workers and language to address gender disparities and inequalities in the health workforce, especially investment in fair remuneration for women which compose 70% of the health workforce, yet remain unpaid or underpaid in many countries, to strengthen education and training, and to increase the safety of health and care workers. Frontline health workers, including nurses, midwives, community health workers, pharmacists, and others, provide much needed services to their communities and form the backbone of any resilient health system. They are critical for pandemic preparedness and response, maintaining quality health services during emergencies, and reaching the most marginalized and vulnerable communities.

## Pandemic Prevention and Animal Health

While we welcome the inclusion of Articles 4 and 5 as per the latest draft, there needs to be further clarification that Article 4 in particular refers to the prevention of spillover, rather than the further spread of outbreaks in people. Pandemics cannot be seen from a human perspective alone if it is known that the causative agent is likely to be zoonotic in origin. Parties need to strengthen animal health systems to detect, report and respond to zoonotic diseases that could have pandemic potential as quickly as possible.

We understand there are concerns from member states over the broad nature of the One Health concept. We suggest further obligations to clearly define how One Health applies to PPPR. Ultimately, the most important element that One Health brings to PPPR is multisectoral collaboration between the animal health sector and the human health sector; the need for formalization of this kind of collaboration needs to be better stated in the Article. This is imperative for prevention of spill-over and for preparing for outbreaks.