GOVERNING PANDEMICS SNAPSHOT

A SERIES OF PERIODIC BRIEFINGS ON THE STATE OF GLOBAL REFORMS FOR PANDEMIC PREPAREDNESS AND RESPONSE (PPR) | JULY 2023

Welcome to the second issue of the Governing Pandemics Snapshot, a publication aiming to provide a concise, periodic overview on the state of efforts to strengthen global pandemic preparedness and response (PPR). This second issue provides updates on negotiations over the WHO Pandemic Accord and parallel talk on amendments to the International Health Regulations. It reexamines the financing of PPR and raises the question of how the ambitious new commitments envisioned for the WHO Pandemic Accord can be financed, especially considering the decrease in government spending on preparedness and insufficient donor pledges. Finally, it provides insights into the thorny question of how "medical countermeasures" might be handled in either accord, where North-South divides persist. In addition, there are questions about who will call the shots on a new global countermeasures platform – the G7, G20, or WHO?

More frequent updates are available on our timeline at governingpandemics.org. Feedback is welcome at globalhealth@graduateinstitute.ch.

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PANDEMIC ACCORD NEGOTIATIONS: UNVEILING INTENSE DIVERGENCE AMIDST STEADY PROGRESS

By Daniela Morich

In 2023, Member States resumed an intense and rapidly accelerating schedule of pandemic rulemaking negotiations. On February 1st, the Bureau of the Intergovernmental Negotiating Body (INB) – representatives of six countries elected to lead the process – released the Zero Draft of a World Health Organization (WHO) convention, agreement or other international instrument on pandemic prevention, preparedness and response (WHO CA+). The Bureau prepared this draft on the basis of a previous version of the instrument – the conceptual zero draft, and input received by Member States at the third meeting of the INB in December 2022.

During the fourth and fifth meetings of the INB, held from February 27 to March 3 and from April 3 to 6 respectively, Member States commenced deliberations based on this document. Throughout these sessions, delegates decided upon the process, its modalities, and successfully completed a first reading of the document. This marked the start of a challenging and laborious process, as delegates actively proposed edits and deletions to the Zero Draft's text projecting their own visions of an equitable global system for PPR.

Notably, these discussions were conducted behind closed doors, with delegates reiterating their decision to exclude non-state actors and other observers from the proceedings. As in the past, this choice has sparked significant criticism, particularly from civil society members, who continue to advocate for greater openness and transparency in the governance of the Pandemic Accord.

In order to tackle the most intricate and complex topics and promote dialogue, delegates requested the Bureau to arrange informal intersessional briefing sessions between INB 4 and INB 5. These sessions included the participation of experts and relevant stakeholders. The intersessional work focused primarily on the most controversial subjects such as pathogens and benefit sharing, the establishment of a reliable global supply chain and logistics network, the One Health approach, and access to technology and its transfer.

At the conclusion of INB 5, Delegates tasked the Bureau to develop a text based on input from INB 4, INB 5, and subsequent submissions, to guide the work of the June 12-16 resumed session of INB 5 and drafting group. The Bureau unveiled the draft text of the WHO CA+ on May 22. This text has provoked dissatisfaction from a wide range

of commentators, including member states, civil society, researchers, and industry representatives. Some observers have candidly expressed that the document lacks strength and weakened the text on critical issues such as research and development, technology transfer, and human rights.

Additional concerns were voiced at the opening session of the resumed INB5 and drafting group meeting on June 12. The Ethiopian delegate, on behalf of the 47 members of the African Region stated that, unfortunately, the Bureau's Text presents "*equity [...] in a weakened and reduced format"* adding that this draft *"even goes backwards from the inadequate equity measures [included] in the Zero Draft*." Not surprisingly, a new Group for Equity composed of 19 countries was established, a clear indication that equity will be non-negotiable going forward. Civil society also observed that there exists an imbalance in the distribution of hard obligations concerning prevention and surveillance, as compared to the softer obligations pertaining to equity, which is perpetuating a consistent divide between countries from the North and the South. Concurrently, representatives from some developed countries welcomed the stronger emphasis the text provides on prevention, which entails more stringent measures under the One Health approach.

During the drafting group meeting from June 12-16, delegates decided to focus on contentious provisions related to equity, including research and development, technology transfer, access and benefit sharing, liability, and supply chain logistics. To promote mutual understanding, the drafting group took the initiative to pilot informal meetings on specific articles. Selected member states were entrusted with the responsibility of guiding and moderating these meetings. The aim was to engage in in-depth exchanges of ideas, perspectives, and concerns. The pilot proved to be successful and further informal meetings have been scheduled during the intersessional period leading up to the next session of the INB, which is slated to take place on 17-21 July.

It is noteworthy that these discussions are occurring alongside an ongoing parallel process aimed at amending the International Health Regulations (IHR), which presently serve as the only legally binding framework for managing cross-border responses to infectious diseases and other transboundary health risks. Over the past months, negotiators have consistently emphasized the importance of achieving increased convergence and coordination between these two processes.

Though the final grand bargain may still be a considerable distance away, negotiators now have a clearer grasp of the intricate give-and-take process they must navigate in order to achieve it.

AMENDING THE INTERNATIONAL HEALTH REGULATIONS: WORK IN PROGRESS?

By Gian Luca Burci

In the first issue of this Snapshot, I summarized the launch by the 75th World Health Assembly (WHA) of the process to amend the International Health Regulations (IHR) and the first steps undertaken by the Working Group charged with negotiating an agreed package (WGIHR). Two major challenges confronting the WGIHR are firstly, the parallel unfolding of the negotiations towards a new "pandemic accord" and the many overlapping proposals, especially with regard to the contentious issue of "equity"; and secondly what I called in the first issue "an existential moment" for the IHR in view of the stated intention from Global South countries to expand the object and purpose of the instrument from its current limited scope.

Based on informal conversations with some delegates, there seems to be some optimism that negotiations may be concluded by the end of 2023 with an agreed package ready for consideration by the WHA in May 2024 alongside the final text of the pandemic instrument. The WHA has even been provisionally scheduled for the week of 27 May 2024 so that amendments adopted in 2024 will enter into force after one year instead of two, as decided by the WHA in 2022. We hope that such optimism is warranted considering that to date there have not yet been textual negotiations nor there seems to be an agreed roadmap for the rest of the process. To also note that the WHO African Region has reportedly confirmed during INB5 that it will not support either the pandemic instrument or the IHR if its proposals on "equity" are not satisfactorily addressed, thus confirming equity's role as a potential deal breaker across the board.

The WGIHR has been moving at an apparently slower pace than the INB and has only held three sessions since November 2022, with the fourth one scheduled in late July immediately after the sixth session of the INB, and the fifth and sixth ones taking place only in October and December, respectively. More activities have been taking place informally between sessions, e.g. facilitated informal consultations (scheduled for early July) on core capacities as well as collaboration and assistance – all topics with extensive proposed amendments. Compared with the intense focus on the INB among diplomats and in the specialized media, the WGIHR seems to have taken a backseat and the reason for that silence is an open question: is it because devoting the same attention to two processes is beyond the reach of delegations? And will work be kept in abeyance until July or is the Bureau working behind the scenes to facilitate progress?

The IHR amendment process has been unfolding in a different way from the parallel negotiation of the pandemic accord in the Intergovernmental Negotiating Body (INB). Unlike the INB, where progress is based on rounds of discussion and written comments on subsequent iterations of draft texts prepared by the Bureau, the WGIHR has to manage a vast amount of disparate proposed amendments and whittle them down to an agreed package. In order to rationalize discussions, the WGIHR clustered the proposed amendments in various thematic groups, with the July session expected to address the core of the "health security" component of the IHR, i.e. notification, verification and collaboration with WHO as well as the mechanism to declare a public health emergency and issue temporary recommendations. Under this rubric, proposals to have WHO publicly disclose lack of collaboration from states parties and to introduce intermediate and regional emergencies have received some criticism from the expert IHR Review Committee that submitted its report in February.

As noted above, one of the main procedural and political hurdles lies in the unresolved question of placement of overlapping proposals in the IHR and the pandemic accord. Some delegations are in favour of complementarity between the two texts in order to avoid overlaps and fragmentation, while Global South countries may probably insist that issues such as access to countermeasures, technology transfer and financing (the "equity" agenda) be reflected in both texts as an assurance of the Global North's commitment, especially from the USA that will most probably remain outside the pandemic accord. An important aspect of this conundrum is whether the pandemic accord should be limited to response to "pandemics" however defined and declared, while the IHR would continue to address disease outbreaks not reaching that threshold.

Much expectation is placed in a joint one-day meeting of the INB and WGIHR in July that should hopefully agree on criteria if not on a substantive division of work between the two processes. However, an initial informal meeting presided by the co-chairs of the two bodies reportedly failed to agree on modalities or even an agenda for the formal joint meeting, so also on this account optimism may be premature. Given the technical and political difficulties to decide upfront on a neat separation between the texts, one possible way forward floated informally by some participants is to return to the mandate of the WGIHR "to work on … proposed targeted amendments" to the IHR. Even though the range of proposed amendments show divergent interpretations of what "targeted" means, it is unquestionable that strengthening the current framework of the IHR (e.g. national focal points, collaboration with WHO, PHEIC, temporary and standing recommendations etc.) meets that definition. On that basis, member states may agree to initially start textual negotiations on a narrow range of amendments to build momentum, circumscribe the "difficult conversations" and postpone them to a later moment when the negotiations in the INB are more advanced and the contour of a possible agreement clearer.

PANDEMIC FINANCING: LOSING ON ALL FRONTS?

By Seyed-Moeen Hosseinalipour and Alessia Nicastro

By the end of July 2023, the Pandemic Fund Governing Board will meet in Washington D.C. to make the first round of decisions on disbursement of some $300-350 million in initial funding for pandemic preparedness. However, due to a woeful shortfall in funds raised for the ambitious new Pandemic Fund, hosted by the World Bank, most of the requests submitted by some 129 low- and middle-income countries will likely be denied.

The first two years of the pandemic saw a sharp rise in government spending for health while the general government expenditure trends remained mostly constant, indicating a great political will at country level to fund a response to an urgent health crisis.

However, in 2022 as inflation drove increased costs of living in energy and food, trends shifted, with a decline in governments' health spending – over which the World Bank has expressed concerns.

That has once more left health systems vulnerable, and unable to plan for future crises. Although pandemics and their governance continue to attract attention in Geneva, in relation to the ongoing negotiations over for a pandemic treaty and amendments to the International Health Regulations, recent developments suggest that countries are perhaps not as committed to Pandemic Prevention, Preparedness and Response (PPPR) financing as they initially seemed.

The Pandemic fund – status today

The ambitious Pandemic Fund, created late last year within the World Bank, has so far raised around $2 billion including the recently pledged $250 million by the United States, announced at the recent G7 Leaders Summit in Hiroshima.

But this is far short of the $10.5 billion estimated annual gap in PPPR donor requirement. After the first round of calls for proposals, requests for funding amounting to $2.5 billion have been

submitted in some 180 applications from 129 low- and middle-income countries.

All of these requests are competing for the relatively minuscule $300-350 million that the Fund currently has to disperse – meaning that most countries will likely not receive any funding at all – or very minimal funding at best.

Although the Fund may be able to raise more money through replenishment rounds, one recent study by the US-based Center for Policy Impact and University of Leeds, has concluded that "*total donor funding requirement is closer to US$ 15.5 billion, rather than US$ 10.5 billion; WHO and WB assume that donors are already providing 100% and 60% of the LIC and LMIC PPR costs respectively, which we believe does not hold outside of pandemic times.*" Nonetheless, even sticking with the US$ 10.5 billion and under the most favorable scenario of donors increasing the percentage of their GNI given to ODA by 2.5% each year – a mean of US$ 213 billion over 6 years, the PPPR donor requirement gap could not be filled.

PPPR funding in draft treaty – heavily referenced with few real commitments

PPPR financing represents a significant theme in negotiations over a pandemic accord. In the latest text released by the Bureau guiding the negotiations of the Intergovernmental Negotiation Body, Article 19.3(a) on "financing" refers to a fund "to be funded, inter alia, through the following sources: i. Annual contributions by Parties to the CA+, within their respective means and resources; ii. Contributions from pandemic-related product manufacturers; iii. Voluntary contribution by Parties and other stakeholders".
Additionally, the draft Article 19.3(b) calls for the creation of a second separate "voluntary fund", which would rely entirely on voluntary contributions by "all relevant sectors that benefit from good public health (travel, trade, tourism, transport)" foreseeing a considerable role of both public and private actors.

Article 19 also seems to privilege voluntary options over binding financing obligations, so it's unclear whether this fund could realistically be filled Additionally, it remains unclear if the disbursement of monies from the two funds foreseen by the Bureau's text would be somehow linked with another key set of issues raised by developing country demands – for example, the sharing of "benefits" derived by pharma from their sharing of data on new and emerging pathogens.

National and ODA commitments to fund PPPR also watered down

Furthermore, the Bureau's text has significantly diluted certain States' obligations included in the previous Zero Draft text.
For instance, following the suggestion of more than 60 countries, the document no longer includes the commitment by state parties to allocate a certain proportion of their domestic resources to PPPR. In fact, the obligation to dedicate 5% of their "current health expenditure" to PPPR (art. 19.1.c) was deleted from the most recent version of the text.

Likewise, more than 30 – mostly high-income – countries successfully lobbied for the removal of language on a parallel obligation by countries to allocate a specific percentage of GDP to international cooperation and assistance for PPPR (art. 19.1.d).

Converting debt repayments into pandemic preparedness investments

A new, promising financing option that has been included for consideration in the Bureau's text is the conversion of a portion of countries' debt repayment installments into PPPR investments.

A clause referring to this, Option A in Article 19.6 would establish a programme to "convert debt repayment into pandemic prevention, preparedness, response, and recovery investments in health".

Creative refinancing of developing country debt has become a rallying cry of Barbados Prime Minister Mia Mottley in her Bridgetown Initiative. Speaking at a recent conference on Non-Communicable Diseases in Small Island Developing States, Mottley stressed that the approach should be used to make badly needed investments in health as well as in climate mitigation and adaptation.

According to the World Bank's International Debt Statistics 2022, low-income countries' debt rose by 12% in two years (2020-2022) as a result of the pandemic.

Debt burdens hinder the ability of countries to recover and rebuild capacities and further distract resources away from the health sector. A recent OXFAM report revealed how development finance channeled billions into expensive for-profit hospitals in lower-income countries that deny access to healthcare to patients who cannot afford to pay.

WHO budget boost is one optimistic signal

Against this worrisome context, one optimistic note was sounded at the recently concluded 76th World Health Assembly in May that approved the organization's programme budget for 2024-2025, including a historic 20% increase in member states' assessed contributions to the agency's budget.

Although these funds will not be specifically for PPPR, they lay the ground for a more predictable and sustainable WHO's financial model which will hopefully strengthen its role and capacities in, inter alia, the PPPR domain.

In conclusion, the landscape for PPPR financing remains unclear and, to some extent, worrisome. There is no guarantee that the Pandemic Fund will be able to secure significantly more resources and the current options inside the pandemic instrument lack strong national and international commitments, while inflation and debt continue to rise.

As such, financing PPPR is faced with a multiplicity of challenges and risks of being underfunded once again. It takes strong political will and innovative thinking to raise sufficient resources and use them in the most efficient manner.

THE 'COUNTERMEASURES' JIGSAW: PLURALISM, FRAGMENTATION OR JUST CHAOS?

By Suerie Moon

Governing access to vaccines, drugs and diagnostics – "countermeasures" for brevity – is one of the most central and controversial issues at the center of pandemic policy debates. Different players each hold a piece or two of a jigsaw puzzle, but seem to be working with different guiding pictures. There are potential benefits from the pluralistic approach that is emerging, but also risks of an incoherent system that won't deliver when crisis strikes.

To help make sense of the seeming chaos, we look at rules, money and organizations, each in turn.

First, rules: The parallel negotiations to draft a pandemic accord and amend the International Health Regulations will shape who develops, produces, buys – and ultimately, is protected by – countermeasures.

Developing countries, including the 47-country WHO Africa region and 19-country Group for Equity[1] made clear at the June INB that countermeasures are their main priority. The "Bureau's Text" that is the current basis for treaty negotiations reflects persistent Global North-South divides on access to pathogens and benefit-sharing (ABS), intellectual property (IP) and technology transfer for regional production, for example. These three issues are also the subject of amendments proposed in the parallel IHR negotiations.

A key question is which instrument can or should govern countermeasures. While there are important technical legal issues, politically the two processes form a single package – meaning nothing will be agreed until everything is agreed across both sets of rules.

Simultaneously, governments are negotiating a political declaration for the UN General Assembly High-Level Meeting on pandemics in September 2023, in which references to countermeasures also prominently feature. But the Zero Draft of this non-binding statement suggests it will be broadly aspirational, and unlikely to go beyond norms and commitments that have been agreed for years. New York appears to be deferring to the ongoing Geneva negotiations over the pandemic treaty and IHR.

But rules aren't the only lever for countermeasures, money and organizations matter too. And here, it's instructive to look at the G7 and G20, where countermeasures have been top of mind. Under Japan's presidency, the G7 released at its May Hiroshima summit a "Vision for Equitable Access to Medical Countermeasures (MCMs)," with an emphasis on speed in innovation, and launched a "MCM Delivery Partnership for equitable access (MCDP)." Under India's presidency, the G20 is emphasizing regional R&D and manufacturing hubs, and the creation of a "Global Medical Countermeasures Coordination Platform (GMCCP)." The G20 process continues through the September 2023 summit in New Delhi, but it is already clear that each of these mini-lateral clubs have quite different visions for the future.

A key question is how the G7 MCDP is to work with the G20's GMCCP, and how either would work with the WHO's own proposed Medical Countermeasures Platform. At the World Health Assembly in May, some stakeholders raised concerns that the platform would reproduce the top-down centralized governance of the Access to COVID-19 Tools Accelerator (ACT-A), criticized for having left LMIC governments outside the decision-making that impacted their populations. On the other hand, a new pandemic could start any day, and proponents are calling for an interim solution until the INB and IHR processes conclude.

Meanwhile, many governments and organizations aren't waiting. The WHO mRNA hub in South Africa is developing an mRNA vaccine platform that plans to transfer the technology to 15 partner countries. Participating countries may then develop new vaccines on this platform, but are obliged to share any such novel technologies with each other. Countless national local production initiatives have also been launched, as governments seek to 're-shore' strategically important production of countermeasures. Governments are also strengthening their countermeasure R&D capacities with new initiatives at the European Union, Japan, African Union, and Indonesia, to

1 Bangladesh, Botswana, Brazil, China, Colombia, Dominican Republic, Fiji, India, Indonesia, Kenya, Malaysia, Mexico, Pakistan, Paraguay, Peru, Philippines, South Africa, Tanzania, Thailand

name just a few. Big funders like the Coalition for Epidemic Preparedness Innovations (CEPI) are continuing to make investments, though it remains unclear whether or how the newly-created Pandemic Fund will invest in countermeasures. The multinational pharmaceutical industry in its Berlin Declaration has offered to set aside a proportion of its production in pandemics for equitable distribution, while opposing the IP waiver that developing countries and civil society have supported.

With billions of lives and billions of dollars at stake, it is no surprise that everyone wants to call the shots. This pluralistic kaleidoscope of ideas, initiatives and players may mean action closer to home, with governments more in control over access to future countermeasures. But it also means fragmentation, with everyone pulling in different directions for their interests. South Africa and Norway, co-chairs of the ACT-A's government-led Facilitation Council, have tried to bring coherence to the chaos by convening across these initiatives through the "Johannesburg process." But this is an uphill slog given the scale of the interests at stake.

Mapping and tracking these developments is a critical first step. But it's not enough. Establishing the rules of the game may ultimately be the best shot we have at an internationally-coherent system, in which players coordinate with each other according to widely-agreed norms – bringing us back full circle to the importance of the pandemic treaty and IHR processes.