

Textual suggestions on the zero-draft of the Pandemic Accord

Assessment and textual suggestions

In a [previous publication](#), Wemos outlined general comments on the zero-draft of the Pandemic Accord. Our assessment of the zero-draft is mixed. The text includes some important elements for achieving global, equitable access to medical products, but unfortunately the character of these texts is too voluntary. In order to make substantial impact, these should be made more specific and binding.

Additionally, the texts on the health and care workforce and financing leave much room for improvement. The zero-draft leaves much to be desired on financial equity and omits reforms to the international financial architecture to free up necessary domestic resources. Funding for pandemic prevention, preparedness and response needs to be additional to current funding to prevent competition between global health funds and causes.

In this current publication, Wemos assesses the articles of the zero-draft in detail and provides suggestions for textual changes. With this, we want to inform governments on specific amendments that need to be made to increase the value of the Pandemic Accord and make sure that health equity is at the core of pandemic prevention, preparedness and response.

Accountability and compliance mechanism

Ahead of the zero-draft publication there has been substantial discussion on whether the new instrument should be legally binding or not. The current text is a mix of voluntary articles and legally binding articles. Unfortunately, there is no description or mentioning of a mechanism that holds governments to account for the agreements made in the Pandemic Accord. The WHO Member States should negotiate an accountability and compliance mechanism that oversees the implementation of mandatory elements of the Pandemic Accord. This mechanism should take into consideration the lessons learnt of the International Health Regulations (IHR).

Common but differentiated responsibilities

Some WHO Member States have contested the inclusion of the principle 'common but differentiated responsibilities' as a concept relevant to global health and pandemic prevention, preparedness and response, as it was first developed in connection with environmental and climate change law. According to Wemos, this principle definitely is relevant and applicable to pandemic prevention, preparedness and response. The unequal division of pandemic-related resources and capabilities (due to underlying economic and technological disparities), as well as the unequal burden placed on health systems in the face of a common threat such as a pandemic, justifies the use of common but differentiated responsibilities (based on need and capability) within the framework of the Pandemic Accord. Considering this, the language that is currently present in the zero-draft should be maintained to ensure an equitable, collaborative and effective response to global health crises.

Preamble 43

According to Wemos, preamble 43 should be central in the formulation of articles related to access of pandemic-related medical products. The preamble describes concerns that intellectual property barriers can pose threats and barriers in the realisation of the right to health for all. Additionally, it states that any future response to pandemics should not be based on a charity model. As Wemos we support this pre-amble and support any (sub-)article that promotes the self-reliance and self-sufficiency of countries through regional manufacturing. The Pandemic Accord should focus on the structural causes of inequity and provide responses that are not based on charity models.

Textual suggestions per article

Below, Wemos provides textual suggestions per article or sub-article of the zero-draft of the Pandemic Accord. The amendments are indicated with the colours red and green. The green text indicates an addition from our side, and the red text indicates an elimination of text as it was originally published in the zero-draft. The italic paragraph below each article or sub-article provides arguments for the suggested amendments.

Article 4

4.12: [...] without fear of discrimination or distinction based on race, religion, **sexual orientation, gender identity**, political belief, economic or social condition.

Article 6

6.4: The Parties **commit do not to** impose regulations that unduly interfere with the trade in, or of, pharmaceutical raw materials, **and** ingredients, **intermediate and final products used as medical countermeasures**, mindful of the need for unhindered access to pandemic-related products.

The original text specifically refers to the need for free trade of pharmaceutical raw materials and ingredients to exist, but this should also apply to intermediary or finalised products that governments can use to promote and protect the health of societies in times of pandemics.

Article 7

7.1: The Parties **recognize make sure** that inequitable access to pandemic-related products (including but not limited to vaccines, therapeutics and diagnostics) **should be is** addressed by increased manufacturing capacity that **is more equitably, geographically and strategically distributed. facilitates regions and countries in their self-reliance, autonomy and ability to equitably access the beforementioned products.**

It is important that this article emphasizes the importance of regional manufacturing, but the original text does not emphasize the desired impact enough according to Wemos. Geographically and strategically distributed manufacturing is the first step in creating equitable access, but the next step is to make sure that this also leads to self-reliance and autonomy of countries and regions. Our proposed amendments underline these objectives.

7.2: The Parties, working through the Governing Body for the WHO CA+, shall strengthen existing and develop innovative multilateral mechanisms that promote and incentivize relevant transfer of technology and know-how for production of pandemic-related products, **on mutually agreed**

~~terms~~, to capable manufacturers, particularly in developing countries. A WHO mechanism for the sharing of intellectual property, know-how and data for pandemic-related products will be in place to promote equitable access and self-reliance of the Member States, notably developing countries.

If technology and know-how can only be transferred on “mutually agreed terms” between pharmaceutical companies and governments, we are at risk of not being able to maximise manufacturing capacity in crises situation. Therefore, we suggest removing this part of the text. Additionally, equity and self-reliance must be at the core of any sharing mechanism of intellectual property, know-how and data. Lessons can be learnt from the Covid-19 Technology Access Pool (C-TAP) when structuring a new, similar mechanism.

7.3A: coordinate, collaborate, facilitate and incentivize manufacturers of pandemic-related products to transfer relevant technology and know-how to capable manufacturer(s) (as defined below) ~~on mutually agreed terms~~, including through technology transfer hubs and product development partnerships, and to address the needs to develop new pandemic-related products in a short time frame;

Please see the explanation under 7.2.

7.3C: ~~encourage entities, including manufacturers within their respective jurisdictions, that conduct research and development of pre-pandemic and pandemic-related products, in particular those that receive significant public financing for that purpose~~, enforce entities who receive public financing for the purpose of developing or manufacturing pandemic-related products, and encourage similar entities who do not receive public funding, to grant ~~on mutually agreed terms~~, licences to capable manufacturers, notably from developing countries, to use their intellectual property and other protected substances, products, technology, know-how, information and knowledge used in the process of pandemic response product research, development and production, in particular for pre-pandemic and pandemic-related products; and

Similar to the comments under 7.2, the text should refrain from terms like “mutually agreed terms”. Additionally, ambiguous terms like “significant” and “encourage” should be removed. Governments

should make sure that any public funding used for research and development of pandemic-related products is leveraged to ensure equitable access.

7.4A: will take appropriate measures to support time-bound waivers of the TRIPS agreement or other previously agreed barriers around intellectual property rights, like bilateral trade agreements, intellectual property rights that can will accelerate or scale up manufacturing of pandemic-related products during a pandemic, to the extent necessary to increase the availability and adequacy equitable distribution of affordable pandemic-related products;

The original text in the zero-draft is too vague and ambiguous when it comes to time-bound waivers around intellectual property and the obligations that countries have in supporting these waivers. Our suggested amendments set out what regulations should be waived more specifically. These proposed amendments would set out clear obligations for countries to support waivers of the TRIPS agreement and therefore take away important barriers in maximising manufacturing capacity of pandemic-related products in times of health emergencies of international concern.

7.4D: shall encourage all research and development institutes, including manufacturers, in particular those receiving significant public financing, to waive, or manage as appropriate, royalties on the continued use of their technology for production of pandemic-related products.

Similar critique as made in the previous comments on the ambiguity of the word “significant”.

Article 9

9.2: With a view to actively promoting greater sharing of knowledge, data and intellectual property and to improve transparency, each Party, when providing public funding for research and development for pandemic prevention, preparedness, response and recovery of health systems, shall, ~~taking into account the extent of the public funding received:~~

Article 9.2 has a considerable potential to improve the access to pandemic-related products as it leverages the public funding of governments that are often of critical importance in the research and development and manufacturing of goods. The conditions that should be put on public funding, should be implemented without any regards of their amount. Additionally, it is important that agreements are

made on the use of intellectual property when public funding is involved in the research and development process.

9.2B: ~~endeavour to~~ include terms and conditions on the net prices of products, amount of public funding involved in the specific research and development and manufacturing process, allocation, data sharing and transfer of technology, ~~as appropriate,~~ and publication of contract terms;

Article 9.2B is of pivotal importance in the Pandemic Accord for the reasons mentioned under 9.2. Governments should not just be supported in attaching conditions on the topics above, but they should be obligated to do so. In addition to the original text, there should also be transparency on the amount of public funding involved in the research and development and manufacturing process, as well as on the net prices paid. Increased transparency on both elements will improve the information position of Member States when negotiating prices for pandemic-related products.

9.2E: establish appropriate conditions for publicly funded research and development, including on distributed manufacturing, licensing, technology transfer, and pricing policies.

We call upon the WHO to come up with a toolkit containing ready-to-use legal clauses that governments or publicly funded research institutions can use in their licensing agreements with pharmaceutical companies.

9.3B: making it compulsory for manufacturers that receive public funding for the production of pandemic-related products to disclose net prices and contractual terms for public procurement in times of pandemics, ~~taking into account the extent of the public funding received;~~ and

Wemos finds it important to maintain the word 'compulsory'. Based on experiences from previous pandemic and interpandemic times, pharmaceutical companies and governments will not make this information publicly available if not made mandatory. Additionally, the final part of this sub-article should be removed as it can lead to ambiguous interpretations of the text.

Article 12

12.1: Each Party shall take the necessary steps to safeguard, protect, invest in and sustain a skilled, trained, competent and committed health and care workforce, at all levels, in a gender-responsive manner, with due protection of its employment, civil and human rights and well-being, consistent with international obligations and relevant codes of practice, with the aim of increasing and sustaining capacities for pandemic prevention, preparedness and response, while maintaining essential health services. *The Parties are expected to comply with pre-existing norms and agreements for health workforce requirements, such as the [Health Workforce Requirements for Universal Health Coverage and the Sustainable Development Goals](#), the [Global Health and Care Worker Compact](#), the [Working for Health Action Plan](#), and the [WHO Global Code of Practice on the International Recruitment of Health Personnel](#).*

Propose new clause **12.2A** as follows:

The Parties, in their capacity as bilateral or multi-lateral development donor, shall allow the use of development funds for the strengthening of health workforces, including recurring costs of health and care workers, of all cadres, according to the needs of the recipient health systems, and their needs in terms of health workforce resilience, and capacities for pandemic prevention, preparedness and response.

Propose new clause **12.5** as follows:

Given the ever-increasing globalisation of the health labour market, the Parties shall invest in stronger reporting and monitoring of international recruitment and mobility of health and care workers, including the impact of excessive outmigration on sending countries' health workforce resilience, and capacities for pandemic prevention, preparedness and response. The Parties are strongly encouraged to commit to the development of fair and ethical bilateral agreements between the source and destination countries, based on equal partnerships and with clear benefits for individual health workers, source countries and destination countries.

The current text of Article 12 fails to recognize the health workforce as a shared global responsibility and does not acknowledge the continuous migration and mobility of health and care workers from

low(er)-income countries to high(er)-income countries, resulting in an unequal availability of health workers both regionally and globally, and thus in avoidable disparities in pandemic preparedness and response. Our textual suggestions aim to mitigate that.

Article 19

19.1C: commit to prioritize and increase or maintain, including through greater collaboration between the health and finance ~~and private~~ sectors, as appropriate, domestic funding by allocating in its annual budgets not lower than 5% of its current health expenditure to pandemic prevention, preparedness, response and health systems recovery, notably for improving and sustaining relevant capacities and working to achieve universal health coverage; and

The word 'private' should be removed as increasing domestic funding is a public sector responsibility. Private finance, including through blended finance, cannot replace the unique function of public funding.

19.1D: commit to allocate, in accordance with its respective capacities, ~~XX%~~ a percentage (TBD) of a country's ~~of its~~ gross domestic product, whose GDP exceeds a certain threshold (TBD), to be allocated to global health (including but not limited to international cooperation and assistance on pandemic prevention, preparedness, response and health systems recovery), particularly for developing countries, including through international organizations and existing and new mechanisms.

Wemos believes high-income countries should commit to spending a predetermined percentage of GDP (perhaps a fair-share percentage) on global health that goes beyond conventional ODA funding and is sufficient to meet global health needs. This funding could be used for (amongst other things) pandemic prevention, preparedness and response and health systems recovery and strengthening. As pandemic prevention, preparedness and response is a multisectoral, interdisciplinary, work area it should include funding from non-ODA streams.

Propose new clause **19.6** as follows:

The Parties shall commit to collaboratively reform the international financial architecture, encompassing measures tackling unsustainable levels of debt-servicing, especially to external creditors such as a debt resolution framework under United Nations aegis including fair and comprehensive debt-cancellation and restructuring for all countries in need, measures advancing tax justice such as a United Nations framework convention on tax, and measures combating illicit financial flows, with the goal of augmenting domestic resources dedicated to pandemic prevention, preparedness and response efforts. This collective endeavour will involve engaging through bilateral, regional and global channels, ensuring transparent, accountable decision making while fostering synergy and minimizing duplication of efforts.

Systemic factors outside the direct health sector seriously impair the ability of low- and middle-income countries to invest the proper domestic resources in their healthcare systems with the purpose of working towards Universal Health Coverage. For effective pandemic prevention, preparedness and response, it is essential that these external factors in the global financial architecture are addressed.

Please note:

We are aware that it is unlikely that agreements related to concrete commitments to spend X% of GDP or fair-share arrangements will make it into the final Pandemic Accord agreement. However, we know that the current approach to financing is neither sufficient nor appropriate and is simply not working. The Pandemic Fund (which was founded on an estimated USD 10 billion of funding per year) has only raised about USD 1.6 billion in pledges falling far short of the funding targets. We therefore would like WHO Member States to see the above comments as an invitation to start a discussion about what is possible regarding financing, and where is space for improvement.