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Advancing Equity In The Pandemic Treaty

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Soon after, or even before, North American and European regulatory agencies issued emergency authorizations for COVID-19 vaccines, high-income governments pre-purchased most of the world's supply of these lifesaving medical products. The inevitable result was a severe global supply shortage. When COVID-19 began marching across countries and continents, high-income populations had significant rates of vaccine coverage, while much of the rest of the world waited or went without. A similar story could be told for COVID diagnostics and therapeutics, along with oxygen and ventilators.

Even within countries, in both the global north and south, there were deep inequities. Lockdowns and physical distancing disproportionately burdened migrants, workers in informal

sectors, small businesses, women, and the elderly.¹ These and other disparities underpinned the critical need to address equity as an international priority.

The World Health Organization (WHO) and partners were quick to understand equity's importance. They launched COVAX, the vaccine pillar of the Access to COVID-19 Tools (ACT) Accelerator in April 2020.² The ACT Accelerator (ACT-A)³ was a ground-breaking global collaboration to accelerate the development, production, and equitable access to COVID-19 tests, treatments, and vaccines. At the same time, COVAX often found itself in a disadvantageous bargaining position. For example, by the time COVAX was sufficiently organized to negotiate supply deals, many higher-income countries had already completed agreements, thus relegating COVAX to the back of the queue.

There were other skewed incentives as well. When South Africa rapidly reported the Omicron variant and shared the genetic sequencing data, it and many of its neighbors endured crippling travel and trade restrictions. South Africa was punished for doing the right thing. As the Bill & Melinda Gates Foundation put it: "Southern Africa: Last in line for vaccines, first in line for travel bans."⁴

Now that the pandemic is entering its fourth year, there is a broad consensus around equity's importance. Even countries that hoarded supplies during the acute phase of COVID-19 seem to understand that the international community must find a means to ensure fairer allocation of medical resources when the next health crisis hits. But there has been little agreement about the concrete steps needed to operationalize fairer access and benefit sharing. That is, what are the workable mechanisms that could reduce the divide between richer and poorer populations?

To address the cavernous divide in equitable access, the O'Neill Institute for National and Global Health Law (a WHO collaborating center) at Georgetown University, the Foundation for the National Institutes of Health (FNIH), and the Joint United Nations Programme on HIV/AIDS (UNAIDS) convened a global consultation at UNAIDS headquarters on January 16-17, 2023 to examine equity models for a pandemic agreement. The aim was to find existing equity models in global health and in wider international regimes that effectively address inequalities. During the convening, global experts identified three dimensions of health disparities: how health disparities manifest, how equity could be promoted across key pandemic prevention and preparedness factors, and how to incorporate existing equity models into pandemic governance reforms.

The World Health Assembly, the governing body of the WHO, has appointed an Intergovernmental Negotiating Body (INB) to develop a pandemic convention, agreement, or other instrument (referred to as the CA+) under the WHO constitution. The vision presented in the February 2023 Zero Draft of the CA+ aims "to achieve greater equity ... through the fullest national and international cooperation."⁵

The Zero Draft includes an expansive definition of equity. The INB will have to engage in challenging negotiations among higher- and lower-income countries toward a shared vision of what equity will look like. For higher-income countries, a high priority is to facilitate open and cooperative sharing of scientific information, including pathogen samples and genomic sequencing data. For lower-income countries, the priority is to ensure affordable access and sharing of the benefits of scientific research. Forging consensus among these disparate priorities will be the greatest challenge.

It is important, therefore, that the negotiators develop specific, measurable metrics that directly impact equity. The mechanisms and metrics agreed upon should allow the public to evaluate whether a more equitable system is emerging through this new regime. Our global consultation made one vital point: Equity won't just happen. We need to plan and prepare for equity, and we need international norms with which nations must comply to achieve the fairness we strive for.

Manifestation Of Health Disparities In The Global/National Response

WHO defines health equity as “the absence of avoidable or remediable differences among groups of people whether those groups are defined socially, economically, demographically, or geographically.”⁶ Equity is achieved when everyone can attain their full potential for health and well-being.

Health disparities are often a function of the conditions in which people are born, grow, live, work, play, and age, as well as biological determinants. Consequently, health inequities manifest as a result of a complex interplay of factors, including economic, political, and legal components, with specific social norms and distributional processes that affect each person. These factors are often referred to as social determinants of health⁷ or fundamental causes of disease. In concert, social determinants shape the fabric of our everyday lives, impact health, and control access to treatment in public health and health care systems.

The social determinants cycle, as depicted in the graphic above, generates disparities that create social gradients in health in national and global contexts: The most disadvantaged have the worst health outcomes and, in the context of COVID-19, are also the most vulnerable to further worsening health conditions⁸ and death from the virus.

These conditions are often made worse by discrimination, stigma, and prejudice, frequently based on race, ethnicity, religion, gender identity, or sexual orientation. This discrimination and stigma most often affect women and girls, older people, and people with disabilities. Discrimination can be embedded within institutions and systems,⁹ leading to whole populations being underrepresented in decision-making, receiving inferior services, or suffering more adverse health outcomes.

The quality of response has varied across countries and regions leading to inequities in resource distribution, access to healthcare, and outcomes. They manifest in poor financing

structures; sub-standard environmental policy;¹⁰ unpredictable access to good health care, medical equipment and technology;¹¹ adverse export and trade measures; and distrust of public health communication and education. Health disparities are symptoms of broader underlying economic inequities that reflect structural and systemic barriers and biases across sectors. The INB has recognized that systemic challenges are pervasive and the early drafts of the CA+ indicate a desire to address them.

The February 2022 Zero Draft And Where Equity Could Be Implemented

The February 2022 Zero Draft sets out its objective to prevent pandemics, save lives, reduce disease burden, and protect livelihoods by strengthening global capacities to respond to major epidemic events. It is grounded in the same constitutional provision as the Framework Convention on Tobacco Control,¹² which is the WHO's Article 19 power "to adopt conventions or agreements with respect to any matter" within the WHO's purview.¹³ It is guided by 18 foundational principles, including equity, transparency, solidarity (or coordination across jurisdictions and sectors), common but differentiated responsibilities, and capabilities in pandemic prevention, preparedness, response, and recovery of health systems. The draft handles a number of vexing pandemic preparedness and response issues through that lens.

Technology And Trade

Article 6 of the agreement would establish a WHO Global Pandemic Supply Chain and Logistics Network (the Network) supported by its signatories; the aim is to maintain an adequate, equitable, transparent, robust, agile, effective, and diverse supply chain. Notably, the provision would state that parties should not impose regulations that interfere with the distribution of pandemic-related products.

Article 7 seeks to improve manufacturing capacities in lower- and lower-middle-income nations, calling for the development of multilateral mechanisms that promote and incentivize improved transfer of pandemic-related product technology with an emphasis on developing countries. Article 8 seeks to harmonize regulatory body decision-making, and Articles 9 and 10 recognize the need to increase research and development of pandemic-related products. Most of the language in these articles aims to promote transparency of information related to pandemic products and to promote resilient national, regional, and international ecosystems.

Article 10 also calls for the creation of a WHO Pathogen Access and Benefit-Sharing System (PABS). PABS would require signatories to provide sample "pathogens with pandemic potential" to a WHO-overseen laboratory, which would sequence their genomes and publish them in a publicly accessible database, thus promoting wide access to key data while curtailing intellectual property (IP) claims that would otherwise limit access. The draft foresees negotiating a specialized instrument that would set the parameters for the system.

The draft acknowledges that there is a balance to be struck, “recognizing that protection of intellectual property rights is important for the development of new medicines” while “also recognizing concerns about the negative effect on prices and on the production of, timely and equitable access to, and distribution of vaccines, treatments, diagnostics and health technologies and know-how.” Some countries are seeking more substantial use of IP waivers found in existing investment and trade agreements¹⁴ while some life sciences companies posit that the global IP system accelerates the scientific development needed to defeat pandemics.¹⁵

The global community is evaluating the various partnerships that emerged during the pandemic’s acute phase, from the COVAX facility to the commercial arrangement among the University of Oxford, AstraZeneca, and the Serum Institute of India to mass produce Vaxzevria (previously COVID-19 Vaccine AstraZeneca) for low- and middle-income Countries (LMICs), to determine how to accelerate the availability of emerging pandemic technology.

Although flawed in some ways, COVAX provides an important model for how technologies developed through publicly funded research can be made widely available and how public-private partnerships can enhance global manufacturing capacity. A pandemic agreement could contemplate the establishment of a COVAX-like facility, which would pool vaccine purchasing for the developing world, but it would need to apply learnings from the prototype. As noted above, by the time COVAX was organized, many industrialized countries had completed supply agreements with manufacturers, so their orders received priority over the deals COVAX eventually completed. To mitigate such a problem, a facility would need to be established immediately, in advance of future pandemics. Equity requires preparation and foresight.

COVAX’s dependence on supply from one particular manufacturer—the Serum Institute of India—became an unfortunate access barrier too, as India prohibited the export of vaccines when it experienced a surge in COVID-19 cases in the spring of 2021.¹⁶ To reduce this risk, a facility should be prepared to procure vaccines from multiple sources. A stronger commitment would be for states to legislate domestically that they would not prohibit the export of countermeasures to such a facility.

Moreover, the agreement could address the structure and planning of clinical trials that facilitate access in an ethical and transparent manner. As part of its data gathering and sharing system, the agreement could facilitate clinical trials in diverse regions to expand access and to promote safety and efficacy.

Health Systems

The CA+ seeks to implement resilient health systems rooted in universal health coverage and to increase collaboration across jurisdictions for genomics networks. This goal is supported by the strengthening of a skilled and competent health care workforce across all countries and by actively identifying capacity gaps to work toward continuous improvement. The Zero Draft

recognizes that this requires predictable, sustainable, and sufficient financial, human, logistical, and technical resources.

Consistent with the right to health, pandemic responses should be constructed to curtail discrimination and to consider the health needs of people at high risk and in vulnerable situations. For example, Article 14 calls for people living under restrictions on the freedom of movement, such as quarantines and isolation, to have sufficient access to medications, health services, and other necessities.

Holistic Engagement

The CA+ advocates for collaboration and coordination between and within countries. Article 16 promotes meaningful engagement of communities, civil society, non-state actors, and the private sector as part of a whole-of-society response to pandemics. It argues for meaningful inclusion of all communities as well as steps to address social determinants of health. Article 17 recognizes that public health literacy is critical to pandemic preparedness, and so each signatory would have a responsibility to promote educational and public awareness programs.

Recognizing the deep, interconnected relationship between and among animals, humans, and their environment, and that many emerging infectious diseases are caused by zoonotic pathogens, Article 18 adopts a One Health approach to pandemic responses. The One Health approach fosters coordination among actors in environmental, animal, and human health systems, while strengthening synergies among efforts to address drivers of pandemics such as climate change, biodiversity loss, ecosystem degradation, and increased risk of human-animal interactions.

For example, agricultural and factory farm workers are a particularly vulnerable population that could be prioritized. Farm workers are, for instance, at a higher risk of contracting highly pathogenic avian influenza and other zoonotic diseases. To mitigate this risk, the pandemic agreement could coordinate national programs to disburse efficacious and safe doses of H5N1 vaccine from stockpiles during their replenishment, which could be offered to these workers with their support and informed consent. This would have the potential to prevent outbreaks within human populations, provide important protection to an exposed group, and reduce wastage.

Strengthening prompt data sharing on drivers and occurrences of outbreaks among the animal, human, and environmental sectors is critical to preempting zoonotic risks. Agricultural workers are likely to be the first to observe or experience a possible epidemic event. Helping them improve the conditions of animals on their farms to reduce the risk of disease emergence and spread among those animals, and putting systems in place to transmit warnings, are in everyone's interest.

Financing

At the global level, there is almost no infrastructure for reliable pandemic funding. The World Bank's Pandemic Fund invests in low- and middle-income countries to strengthen pandemic prevention, preparedness, and response capacities,¹⁷ but is significantly underfunded. During the pandemic, many countries scrambled to establish social support and income loss programs, while also endeavoring to procure equipment, diagnostics, and vaccines. The collapsing economic environment only served to increase pressure. Addressing equity requires adequate financing, and Article 19 aims to work with financial sectors to strengthen fiscal capacities to respond to pandemics while reducing the dramatic economic shocks to global and national economies that occur during catastrophic epidemic events.

A pandemic agreement could address equity and financing by incorporating a mechanism similar to the International Financing Facility for Immunisation (IFFIm),¹⁸ which frontloads funding for vaccine programs by issuing Vaccine Bonds on the capital markets that are backed by the legally binding commitments of sovereign donors (whose funding pays back the investors). This model combines an equity objective with a meaningful compliance mechanism. Alternatively, the INB could specifically set the stage to work with IFFIm, which has a nearly two-decade track record in the capital markets and immunization as part of its existing mandate.

Financial mechanisms for post-pandemic recovery should also be considered, particularly concerning health care infrastructure. A protocol developed in concert with and harmonized with other international and regional mechanisms, in addition to the CA+, could ensure that the health sector is as adequately supported as other parts of the economy during periods of recovery.

In addition, the governing body of the CA+ could establish a standing committee on sustainable financing to regularly ideate and propose to Member States emerging opportunities to finance the global pandemic preparedness and response regime. Critically, such a committee would need to be an inclusive group involving representatives of ministries of finance and treasuries, along with others who are conversant in economics, financial services, donor and investor relations, and capital markets. Advocacy for more official development assistance alone is unlikely to be successful. Inclusivity also requires the involvement of private-sector voices who, while not accountable to Member State capitals, can provide perspectives and opportunities for Member State consideration.

Communication

The Zero Draft endorses efforts to improve public health communication and strengthen trust in public health experts and biomedical research—critical issues that came to the fore during the COVID-19 pandemic's acute phase. There is an urgent need to take a new approach to building public trust and addressing misinformation and to seriously evaluate how to adjudicate information to help people make informed decisions. The pandemic agreement

could lay out a set of standards that underpin the universal peer review system that appears in Article 13 or a peer review system tailored for the pandemic context. It could craft new standards for publishing non-peer-reviewed pre-prints, carefully balancing the opportunity to inject new perspectives into the public arena while tamping down public confusion when some of the early findings are discredited. It could commit the WHO to crafting a very basic suite of pandemic-related public health information tools that could be translated without undue burden or cost into any language.

A pandemic agreement could also consider being prescriptive regarding the ethical obligations of persons appointed to the agreement's governing bodies and secretariat to reinforce public confidence. Finally, an independent commission under the WHO's auspices, or via a mechanism incorporated into the agreement, could be tasked with understanding and propagating trust in a holistic manner, then providing learnings ahead of the inevitable next storm.

Operationalizing Equity

By January 2022, the International Monetary Fund estimated that the COVID-19 pandemic would cost more than US \$12.5 trillion.¹⁹ With only a small portion of that amount, preparedness and prevention measures could have averted countless deaths and misery and begun addressing the vast disparities that emerged between vulnerable and privileged populations. In light of this, and as a new pandemic agreement is being forged, what can actually be done now to operationalize equity?

Adopt Achievable, Measurable Metrics

There are preexisting, evidence-based metrics and targets that are geared toward addressing equity and that coincide with pandemic preparedness and prevention. For example, UN Sustainable Development Goal 3, "Good Health and Well-Being," provides a 2030 target for achieving universal health coverage, "including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all."²⁰ The International Covenant on Economic, Social, and Cultural Rights also addresses inequality, discrimination, and aid during times of public health emergencies. PEPFAR, the Global Fund, the Bill & Melinda Gates Foundation, the WHO, and others have created metrics in other epidemic contexts that could be readily adopted so that the Member States can track progress.

Regularly Evaluate The Balance Of Innovation And Access

Public officials are tasked with crafting policy that inevitably requires tradeoffs between competing principles. Here, the question is how to balance spurring innovation while providing equitable access to innovation. Some have argued that governments took on too much of the business risk of commercial enterprises involved in designing vaccines and therapeutics and

could have extracted more public value, for example, by ensuring that obligations were in place to distribute successful countermeasures more equitably. Others have argued that the terms and conditions of those investments were essential to the research and development that led to the creation of new technologies in record time.

There is not an easy solution, although decision-makers must acknowledge that any choices they make concerning this balance will likely have significant collateral consequences that cannot be wished away. This will require sober assessment and re-assessment over time.

Invest In Manufacturing And Regulatory Capacity In Low- And Middle-Income Countries

There is much momentum to set in place infrastructure that makes fewer regions and countries fully import-dependent. For example, the WHO launched the mRNA vaccine technology transfer hub in 2021 to build capacity in LMIC to produce mRNA vaccines through centers of excellence and training (the mRNA vaccine technology hub).²¹ The first hub is located at Afrigen, Cape Town, South Africa, and will work with a network of technology recipients (spokes) in LMICs. Moreover, as many industrialized nations and multinational corporations have an interest in creating and sustaining stable markets, they may be incentivized to provide much-needed co-financing and in-kind support for these kinds of projects designed to diversify manufacturing of medical products.

Map Vulnerabilities

Using evidenced-based frameworks and governance tools to translate the social determinants of health into action at the country level, the INB could commission a comprehensive census, mapping, and analysis of vulnerable communities. Meanwhile, negotiations could inform how the pandemic agreement may support, or indeed prioritize, the needs of these communities.

Integrate Communities

Community participation must be adequately addressed, not just in Geneva where the agreement's negotiations take place, but in countries where implementation will occur and where people's lives and livelihoods are at stake. People must have a say in what an equitable future looks like when their well-being, and that of their families, neighbors, and communities, hangs in the balance.

Conclusion

Every human being has equal worth. Everyone, wherever they live, has similar aspirations for a healthy and secure life. The COVID-19 pandemic exposed and magnified deep disparities across and within the world's societies. The adoption of a Pandemic Treaty would be truly historic. Yet the test of the agreement will be whether it can achieve fairer allocation of

lifesaving medical products and achieve a healthier, more equitable world. What is most important is that the mechanisms to achieve these lofty goals are up to the task.

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