DISCUSSION PAPER

FIGHTING PANDEMICS : EQUITY AS THE BACKBONE OF GLOBAL HEALTH GOVERNANCE

GLOBAL HEALTH ADVOCATES

The COVID-19 pandemic has shown the need for the international community to improve the way we approach global health, and how we manage health threats collectively. The pandemic forces us to rethink our model of cooperation, by putting the spotlight on our interdependence and the flaws of the international system.
What is the purpose of global cooperation, if it consolidates inequalities between and among countries? Our challenge in coming years will be putting equitable access at the heart of the political debate in every phase of pandemic preparedness and response, and avoiding the further polarization of privileged and under-severed countries.
Health equity could be defined as follows: the right for all human beings to have access to efficient health systems, medical tools and scientific advancements regardless of their social, economic and geographical condition.

With the forthcoming World Health Assembly (WHA) Special Session taking place from November 29th to December 1st, 2021, there is an urgent need to prioritize equitable access and global cooperation.
This discussion paper explores the role of equity in the pandemic preparedness and response (PPR) political dialogue, through an analysis of current and future global health mechanisms, identifying shortcomings in the global health governance architecture. The WHA Special Session will discuss calls to reform the International Health Regulations (IHR) and establish a new International Treaty for Pandemics. If adopted, this treaty[1] would be the second legislative document under the binding normative authority held by the World Health Organization (WHO) Constitution, twenty years after the Framework Convention on Tobacco Control (FCTC). Therefore, negotiations constitute an important occasion to reshape global cooperation around health equity. This paper provides avenues for a new global deal.

1. Security over equity: the weaknesses of the IHR
2. Beyond the IHR: limits of the approaches to health equity
3. What models for an equitable future ?

1. Security over equity: the weaknesses of the IHR

The existing architecture of global health governance relies on the 2005 revised version of the IHR. The IHR's purpose is to prevent, protect against, control, and provide "a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade". The IHR were crafted to ensure a balance between three main areas: health security, trade, and human rights.[2] The Regulations state that adopting restrictive health security measures should not undermine trade and human rights.
The IHR aims to ensure that member states are willing to develop, strengthen, and maintain their capacities to detect, assess, report on, and respond to health emergencies. These core capacities have been better defined by the WHO[3] and cover different areas: national legislation, policy and financing, coordination and National focal points communications, surveillance, preparedness, response, risk communication, human resources, and laboratories.

While health security emerges as a core value of the IHR, equity is never mentioned: this is a considerable gap in international law. Moreover, the structure of the IHR would make it difficult for countries to comply with equity principles, even if they had been incorporated. These gaps are linked to two main issues: the lack of implementation mechanisms for the IHR, and a feeble model of accountability. In order to fully address equity in the future, these areas must be reformed.

To better understand the rationale behind the IHR, and its deficiencies, we must note that the context in which the the regulation has shifted since. Enthusiasm about global governance has been replaced by nationalism and skepticism towards multilateralism.[4] While the IHR's implementation and accountability challenges are a direct result of ineffective planning, the issue of equity was never prioritised.

2. Beyond the IHR: limits of the approaches to health equity

The COVID crisis pushed the international community to put forward new instruments for health emergencies, intending to fill the IHR's gaps. These gaps, exacerbated by the COVID crisis, were managed through new models of global cooperation (like the Access to COVID-19 Tools Accelerator (ACT-A), proposals for the establishment of new political initiatives (such as the ones proposed by the Independent Panel for Pandemic Preparedness and Response (IPPPR), and the G20 High Level Independent Panel, or G20 HLIP), and working groups for legislative proposals or revisions (like the Pandemic Treaty).

While the two bodies proposed by the above mentioned panels do not directly address health equity, ACT-A represents a new model of global partnership to accelerate equitable access to COVID tests, treatments, and vaccines. This initiative helped promoting global solidarity, commitment to equity, and multilateral cooperation. ACT-A pushed the international community towards a common approach, convening the major global health actors under one framework in a relatively short period of time. Nonetheless, since ACT-A was conceived as a "super" public-private partnership (PPP),[5] putting in place an efficient model of governance was challenging.
ACT-A consists of four pillars (Diagnostics, Treatment, Vaccines, and the Health Systems Connector), each of which is managed by pre-existing agencies active in the field of global health. As a consequence, ACT-A is the sum of multiple governance models, rather than a coherent or unified structure. Moreover, the ACT-A's Facilitation Council, tasked with providing high-level guidance to the pillars and advocating for the initiative, has not been empowered enough to provide accountability. Thus, ACT-A has faced much criticism, especially in regards to access. According to the IPPPR report, ACT-A is perceived as "supply-driven and not sufficiently inclusive".[6] The instrument hasn't been able to counteract the vaccine inequity resulting from donor-countries buying up all available doses, and donating doses outside of COVAX's equitable distribution model.

Decolonizing health is key to equity, and must be prioritized by donor countries. According to Fifa Rahman, a civil society representative at ACT-A, there has been a "failure to integrate LMIC expertise in equal intellectual partnership". Although ACT-A tries to be inclusive with its regional cooperation groups and the inclusion of CSO representatives, it still follows a top-down model, with little meaningful consultation of low-and-middle-income-countries (LMIC) governments, nor with local CSOs in beneficiary countries.

With the special session of the WHA approaching, there is an immediate need to incorporate all these elements into the debate.

3. What models for an equitable future ?

The international community has experimented with different tools to address global health challenges. Given that pre-existing instruments failed to successfully tackle the pandemic, given ACT-A's successes and shortcomings, and other potential rearrangements currently under consideration, here are some avenues for a new global deal:

1. Equity should be at the heart of the debate

There are not many examples of public health intruments highlighting equity as a main goal. One ispiring initiative could be the Pandemic Influenza Prepardness Framework (PIP Framework). The latter, despite being soft law, is the only legislative document which prioritises benefit sharing in the field of human health. The concept establishes a trade: if a country shares virus samples, they are entitled to the benefits derived from that sharing, such as vaccines, diagnostics or medicines produced, and the sharing of technological know-how. **The PIP Framework mechanism is designed to ensure fairness between the sharing of virus samples, and access to the resulting benefits.** The system is shaped on mutuality, mandating laboratories and other institutions to provide benefits to countries that made those benefits possible by sharing biological samples of pathogens. This mechanism only applies to non-seasonal pandemic influenza (while the IHR follows the all-hazards approach, applicable to all pathogens[7]). Before the PIP Framework, global cooperation was unsatisfactory. HICs and their manufacturers would receive influenza samples from the WHO, then hoard the resulting benefit, resulting in a lack of access for the LMICs. COVID doubled down on this phenomenon, with privileged countries having no obligation to share benefits. The PIP Framework's model shows an alternative approach.

The international community could bind manufacturers to Standard Material Transfer Agreements (SMTA2s), pre-negotiated contracts that can play a crucial role during a public health emergency of international concern, which would consists of a party (like the WHO) granting access to biologic material from GISRS[8] to another party (manufacturer, research institution, etc), that is in turn obliged to provide the WHO the benefits, which will be transmitted back to countries lacking core capacities. **The constraint posed on manufacturers is still weak, but it is unprecedented and policy relevant from a public interest point of view.**

2. Non-binding models should be put under consideration.

Although hard law does not always correspond to better accountability, states continue to push for a treaty to be the model for further negotiations at the WHA special session. Considering the weaknesses of global governance (competition, geopolitical and economic interests at play), resorting to a binding legislative tool will be difficult, and

core points as equity risk being sacrificed. Sometimes, hard law instruments can be less effective and binding than expected. When we call for reinforced governance, more accountability, and sanctions, we don't necessarily suggest the adoption of a binding instrument. For example, despite being a non-binding tool, the Breast-Milk Code is considered to be an authoritative document, since it has led 84 countries to adopt domestic legislation for implementation.[9]

Moreover, the IHR revision of 2005 took nearly ten years to be negotiated[10] and has been criticized for its failure to provide the exact circumstances under which disease outbreaks must be declared a Public Health Emergency of International Concern, and for its lack of accountability for violations.[11]

3. Restructuring the financial and political architecture of WHO is desirable

Calls for a Pandemic Treaty have been part of the governance debate for a few months, leading to the neglect of other issues. Some actors,such as the World Bank and the G20 HLIP, suggested a shift away from the WHO model. Some others believe the WHA and the WHO remain the safest way to ensure democratic participation of member states, especially LMICs, because, despite being politically dominated by high-income countries, the Organisation still has an unprecedented model of cooperation. With its 194 member states, the governance model offered by the WHA is still the most diverse in existence.
However, **the WHO needs to improve its governance by increasing participation through assessed contributions demanded from member states, and considering a structural remodulation to separate technical from political guidance.[12]** We need the WHO to be as strong as possible. The more the Organization raises its assessed contributions, the more its normative authority will be ensured. As a consequence, countries will be more engaged and accountable.

4. Should we rely solely on the market to achieve access to health?

There is consensus that health systems (especially in low-income countries) were not prepared for a pandemic. Improving health systems will improve capabilities for surveillance, response and the delivery of tools. In recent years, Private-Public Partnerships (PPPs) have increased, absorbing health into market patterns.[13] PPPs were first used during the rise of neoliberalism in the 1970s, and became popular in the late 1990s, with the Kofi Annan reform of the United Nations (UN).[14] While there are some positive effects of PPPs, there are also many concerns. The increase in PPPs has created a situation where weak national health systems can't compete, and therefore they stop trying. This undermines health systems that are already struggling.
ACT-A has played a crucial role in this pandemic. As with many other PPPs, it was not meant to deliver capacity building and long term support, instead designed as pillars for the production of tools. The approach has been product-oriented, not enough focused

on accessibility to these tools. For example, products that were inherently less useful for LMICs (such as vaccines that need intense frozen-chains, require multiple doses, or are too expensive for LMICs to purchase) were prioritized from the early stages. As recently stated by the IPPPR, «this system does not achieve the right balance between innovation and global public goods.»[15]

As the Platform for ACT-A Civil Society & Community Representatives affirmed,[16] a significant shortcoming of ACT-A strategic review is the lack of in-depth research on how to reform the structure of the platform. Solutions for structural problems can be found in existing models like the PIP Framework, which is divided horizontally, cross-cutting, and sorted by function pillars. The structure of the PIP Framework includes three main pillars (virus sharing, benefit sharing, and governance) and constitutes a compromise between the classic PPP and a more equity based model.

Health threats, such as pandemics, pose a major challenge to the world: how are we to look beyond national and geopolitical divisions to build a system that works for everyone? Defining equity as a common goal to be achieved is necessary, but not sufficient. We need to design the framework to be more accountable from the beginning. Accountability matters not only for tracking financial investments, or being transparent on pricing, but also for measuring progress against equitable access. This requires looking at policies and rules that should be fixed in order to deliver better for people. Whether reforms will be effective for all will come down to the ambition of political leaders. Hopefully they want the same thing we do.

Global Health Advocates (GHA) is a French NGO which mission is to carry out political advocacy in France and with the EU institutions to ensure policies and resources are effectively addressing health inequalities. GHA is a member of the ACTION partnership.

https://www.ghadvocates.eu

GLOBAL HEALTH ADVOCATES

ENDNOTES

1 It is still not clear whether the instrument would be binding, but some evidence suggests it will, as suggested in The Working Group on Strengthening WHO Preparedness and Response to Health Emergencies. (2021).*Draft report of the Member States Working Group on Strengthening WHO Preparedness and Response to Health Emergencies to the special session of the World Health Assembly*, A/WGPR/5/2, WHO. https://apps.who.int/gb/wgpr/pdf_files/wgpr5/A_WGPR5_2-en.pdf

2 Gostin, L. O. (2014). *Global Health Law*. Harvard University Press.

3 IHR Core Capacities Monitoring Framework. (2011). *Checklist and Indicators for Monitoring Progress in the Development of IHR Core Capacities in States Parties,* WHO/HSE/IHR/2010.1.Rev.1, WHO. https://www.who.int/ihr/IHR_Monitoring_Framework_Checklist_and_Indicators.pdf

4 Wilson, K. (2020). *Populism and pandemics: The IHR was meant to address outbreaks like COVID-19, but nations have ignored it*, CBC. https://www.cbc.ca/news/opinion/opinion-international-health-regulations-who-covid-1.5500166

5 Storeng, K. T., de Bengy Puyvallée, A., & Stein, F. (2021). COVAX and the rise of the «super public private partnership» for global health. *Global Public Health*, 1–17. https://doi.org/10.1080/17441692.2021.1987502

6 The Independent Panel for Pandemic Preparedness and Response. (2021), *COVID-19: Make it the Last Pandemic*, IPPPR.

7 Global Influenza Surveillance and Response System

8 The IHR cover a wide spectrum of health hazards, irrespective of their source (biological, chemical and radio nuclear).

9 Toebes, B. (2015). International health law: An emerging field of public international law. *Indian Journal of International Law,* 55(3), 299–328. https://doi.org/10.1007/s40901-016-0020-9

10 Fidler, P. (2004) Revision of the World Health Organization's International Health Regulations. 8 (8)

11 Sekalala, S. (2017). Soft law and global health problems: Lessons from responses to HIV/AIDS, malaria and tuberculosis. In *Soft Law and Global Health Problems: Lessons from Responses to HIV/AIDS, Malaria and Tuberculosis* (page 312). https://doi.org/10.1017/9781107278950

12 Hoffman, S. J., & Røttingen, J.-A. (2014). Split WHO in two: Strengthening political decision-making and securing independent scientific advice. *Public Health, 128*(2), 188–194. https://doi.org/10.1016/j.puhe.2013.08.021

13 Cerezo, J. (2017) Towards the Privatization of Global Health: Do We Need Coca-Cola to Fight Coca-Cola? ISGlobal https://www.isglobal.org/en/healthisglobal/-/custom-blog-portlet/towards-the-privatization-of-global-health-do-we-need-coca-cola-to-fight-coca-cola-/5083982/8103?_customblogportlet_WAR_customblogportlet_entryId=5919404

14 Johnson-Sirleaf, E., Clark, H. (2021), *Losing time: End this pandemic and secure the future. Progress six months after the report of the Independent Panel for Pandemic Preparedness and Response,* IPPPR.

15 Velásquez, G. (2014). Public-Private Partnerships in Global Health: Putting Business Before Health? *South Centre*, 49.

16 Platform for ACT-A Civil Society & Community Representatives. (2021). *Statement on the ACT-Accelerator Strategic Review.*