



FRIENDS
OF THE GLOBAL FIGHT



Analysis of the zero draft of the UN Declaration on Pandemic Prevention, Preparedness, and Response (PPPR)

Context

This analysis was developed by members of the Coalition of Advocates for Global Health and Pandemic Preparedness, a group advocating for an integrated and holistic approach to preparedness that emphasizes equity, inclusion, and synergies of multiple global health programs in advancing preparedness. The zero draft of the UN Declaration on PPPR comes following a Multistakeholder Hearing held in May 2023 and is available [here](#). The final Declaration text will be adopted at the UN High-Level Meeting on PPPR on September 20, 2023.

Overall analysis

Many provisions in the draft Declaration are positive, recognizing and affirming key points in global PPPR architecture. We are supportive of the inclusion of recognition of vaccine inequity, affirmation of key principles of equity and non-discrimination, support for the health workforce, strengthening One Health capacities, and support for WHO. However, there are very few, if any, concrete targets set.

The Declaration is missing commitments to specific numbers or targets for national PPPR strategies. One major area is the need for commitments to mobilize additional financing (both resources for existing funding mechanisms such as the Pandemic Fund and the Global Fund to Fight AIDS, Tuberculosis, and Malaria – which is the largest funder of PPPR worldwide through both the C19RM fund and its core funding – and for surge financing mechanisms including but not limited to the WHO Contingency Fund for Emergencies and the IMF Resilience and Sustainability Trust), and baseline preparedness capacities. The Declaration would be overall strengthened with such targets and would do much more to move the world's ability to prepare and respond, providing specific commitments to which civil society and communities can hold countries accountable.

Also missing from the Declaration overall, and in particular in the section on Overarching Health Related Issues, is recognition of and specific ways to commit countries to both learning from and building on the global responses to ongoing epidemics including but not limited to

HIV/AIDS, TB, malaria, polio eradication efforts, other neglected disease outbreaks such as Ebola, Marburg, and cholera, and antimicrobial resistance (AMR). This is a huge missed opportunity and is a clear indicator of the inability of the world to build on the existing health and community infrastructures, integrate responses, and avoid erecting isolated pillars in global health architecture. Many of the capacities indicated by PPPR monitoring frameworks exist in these responses and can be expanded and strengthened for broader pandemic preparedness purposes. In addition, the HIV/AIDS, TB, and malaria responses have taught us much about the need to center community-led responses and meaningfully engage civil society to achieve success and meet people where they are to prevent spread. The existing, ongoing responses should be the foundation for any future pandemic preparedness and response efforts and the exclusion of these responses is stark.

A critical weakness in the current draft of the Declaration is that it promotes bio-medical PPPR approaches and lacks focus on the people and communities at the center of PPPR. The role and leadership of communities and civil society, including community-led services and infrastructures, need to be recognized and centered in the Declaration. Pandemics begin in communities and end in communities. In every global disease response, the evidence demonstrates that community leadership and community-led service delivery are vital for resilient and sustainable PPPR and for building trust with clear, consistent, co-created public health interventions that support information sharing, service delivery, and reliable communication.

The clauses relating to access to pandemic-related tools and products are strong, and notably stronger than those in the first draft of the INB Pandemic Accord. We call on Member States to retain this language and implement our suggestions to strengthen it further, namely to not only encourage voluntary licensing and technology transfer in the event of a pandemic threat, but to also encourage compulsory licensing and transfer of know-how when necessary. While we appreciate the reiteration of countries' ability to implement flexibilities provided in the TRIPS agreement, we recognize that often some countries wield influence to block other countries from implementing these flexibilities. To alleviate this pressure, the Declaration should explicitly call for access provisions in any and all research & development and purchasing agreements that utilize public investment.

Finally, by holding the next high-level meeting on PPPR in 2025 rather than 2026, we will have just under a year and a half between the (slated) adoption of the Pandemic Accord and the second high-level meeting, and that timing would work well for a review of what is in the Accord, where countries are in those commitments as a baseline, what needs to be adjusted, and what financial commitments need to be made to meet those targets.

Textual Edits (*changes in red*)

PP4. Express concern also that the inequities in access to COVID-19 **vaccines are stark products, including therapeutics, vaccines, diagnostics and other medical tools, are stark,**

with 22% of the population fully vaccinated in lower-income economies compared to 75% in high-income economies, as of 19 December 2022; (Based on WHA A76/6)

PP6. Express concern further that the COVID-19 pandemic has reversed years of progress made in many areas, with the latest available data suggesting that continued disruptions have affected health **and community** systems and health outcomes worldwide and evidence of its full impact will emerge in years to come; recognize that robust and resilient health services are core to delivering on the Sustainable Development Goals, including ending HIV/AIDS, tuberculosis, and malaria and advancing universal health coverage, recognizing the opportunity for alignment and synergies that the three high-level meetings on pandemic preparedness, prevention, and response, universal health coverage, and ending tuberculosis present; (Based on WHA A76/37)

PP 10. Reaffirm political will at the national, regional and international levels to prevent, prepare for and respond to pandemics, and promote international cooperation and global solidarity for advancing health **and community** systems resilience and recovery, informed by and aligned with the work of the Intergovernmental Negotiating Body and of the Working Group on Amendments to the International Health Regulations (2005); (Based A/RES/77/275, OP5)

Addition following P10. Recognise the need for health and community systems that are strong, resilient, functional, well-governed, responsive, accountable, integrated, community-led, people-centered and capable of quality service delivery, supported by a competent health and community workforce, adequate health and community infrastructure, enabling legislative and regulatory frameworks as well as sufficient and sustainable funding; (A/RES/74/2, Verbatim 10)

PP12. Recognize also the need to tackle health inequities and inequalities, within and among countries, through political commitment, policies and international cooperation, including those that address social, economic and environmental and other determinants of health and ensure that no one is left behind, with an endeavor to reach the furthest behind first, founded on the dignity of the human person and reflecting the principles of equity, equality and non-discrimination, **as well as to empower those who are in vulnerable situations and address their physical and mental health needs which are reflected in the 2030 Agenda for Sustainable Development, including all children, youth, persons with disabilities, people living with HIV/AIDS, older persons, Indigenous Peoples, refugees and internally displaced persons and migrants, people living with HIV, men who have sex with men, sex workers, transgender people, people who use drugs, particularly those who inject drugs, and people in prisons and other closed settings;** (Based on A/RES/74/2, OP11 and OP70)

PP15. Recognize the need to support developing countries in building expertise and in developing local and regional manufacturing capacities for tools, including by building on efforts under the COVID-19 Vaccine Global Access (COVAX) Facility **and RDT manufacturing investments in coordination with G20 and FIND, including by establishing**

mechanisms to ensure transfer of technology, such as building on efforts of the WHO mRNA Technology Transfer hub, with a view to developing improved global, regional and local manufacturing, handling and distribution capacities while further enabling the increased use of health technologies and the digital transformation of health and community systems; (Based on A/RES/76/257, Verbatim-PP17)

PP17. Recognize further the important role played by the private and public sector, and the role of public finance, in research and development of innovative medicines, encourage the use, where appropriate, of alternative financing mechanisms for research and development as a driver of innovation for new medicines and new uses for medicines and continue to support voluntary initiatives and incentive mechanisms recognize pandemic-related health products as global public goods and that separate the cost of investment in research and development from the price and volume of sales; commit to attach conditions ensuring equitable access to the outputs of publicly funded R&D by people who need the most, particularly in developing countries, to facilitate equitable and affordable access to new tools and other results to be gained through research and development; (Based on A/RES/74/2, Verbatim PP53)

PP18. Recognize further the potential of digital health technologies in strengthening secure communications in health emergencies, implementing and supporting public health measures and bolstering national response efforts to pandemics, epidemics and other health emergencies, to protect and empower individuals and communities, while ensuring that the same rights that people have offline must also be protected online, including the right to privacy [REMOVE 'personal data protection'], and recognise that these rights can and should be avoided and minimized by adapting or adopting adequate regulation or other appropriate mechanisms, in accordance with applicable obligations under international human rights law, and the need to narrow the digital divide including by building on the global strategy on digital health 2020-2025; (A/RES/75/176, OP3 and OP6, A/RES/74/2HLM, 66, and WHA 74/7, PP31)¹

PP19. Recognize further the critical role of and efforts made by health and community workers, 70 percent of whom are women, yet face a 24 percentage point pay gap compared to men across the health and care sector, and other front-line and essential workers, including humanitarian personnel, around the world aimed at addressing pandemics through measures to protect the health, safety and well-being of people, and emphasizing the importance of providing health, community outreach and other essential workers with the necessary protection and support; (A/RES/75/157, PP16)

¹ Rationale: Multiple UN resolutions recognise and include language to address the governance gap, as well as the WHA in the context of health (WHO Global Digital health strategy). The escalation in use of digital health technologies, including pandemic surveillance technologies, carries huge risks for human rights, particularly the rights of marginalized populations, including women and girls, migrants, LGBTI+ communities, people who sell sex work, people who inject drugs, etc. It is therefore critical that the declaration includes commitments that seek to mitigate against such risks while both calling for increased digitalisation and use of technologies.

PP21. Recognize further the need to invest in training, developing, recruiting and retaining a skilled health **and community** workforce, including doctors, nurses, midwives and community health **and outreach** workers, as fundamental to strong and resilient health **and community** systems to prevent, prepare and respond to pandemics and health emergencies, and improve working conditions and management of the health **and community** workforce to ensure the safety of health **and community** workers; (Based on WHO EB152(5) PP8 & PP9 + SDG3.c)

PP22. Recognize further the fundamental role of primary health care **and community-led systems** in preventing, preparing and responding to pandemics, through achieving universal health coverage and other health-related Sustainable Development Goals and targets, as envisioned in the Alma-Ata Declaration and the Declaration of Astana, and further recognize that primary health care, ~~including community-based and community-led services;~~ brings people into first contact with the health system and ~~is~~ **are** the most inclusive, effective and efficient approaches to enhance people's physical and mental health, as well as social well-being, noting that primary health care and **community-led** health services should be high quality, safe, comprehensive, integrated, accessible, available and affordable for everyone and everywhere, noting the work of the World Health Organization on the operational framework for primary health care; (Based on A/RES/74/2 OP13 and OP46, and WHO EB152(5) PP5)

PP23. Recognize also that primary health care **and community-led systems** ~~can~~ contribute to raising public awareness and addressing misinformation and disinformation, including during public health emergencies, and in preventing, preparing for and responding to infectious disease outbreaks; (Based on A/RES/77/287, PP13)

Addition under PP23: Recognize the importance of and right to patient-centered care; community and individual pandemic-related health literacy and access to accurate health information; and people's, community leadership and involvement in their own health care, including with respect to self-testing, treatment adherence, symptom monitoring, and other aspects of self-care; (New language)

PP24. Recognize further the need to strengthen epidemic prevention by **building on and further investing in existing infrastructure and** sharing experience and best practices, **including lessons from the ongoing responses to the global HIV/AIDS, tuberculosis, malaria epidemics, polio eradication efforts, and COVID-19,** and to raise the level of preparedness, including early warning systems, in order to have the earliest and most adequate response to any epidemic that may arise, and recognizing also the value of an integrated One Health approach that fosters cooperation between the human health, animal health and plant health, as well as environmental and other relevant sectors; (Based on A/RES/76/301, ~~Verbatim~~ PP12)

PP29. Welcome the launch of the Pandemic Fund in November 2022, to strengthen national health emergency preparedness, response and resilience in low-income and middle-income countries and recall that financing effective national, regional and global health emergency preparedness will require approximately US\$ 30 billion per year, outside

current Official Development Assistance levels, of which \$10.5 billion per year is needed in global contributions, recognizing the need for countries to contribute according to their capacity and implementing the “all contribute, all benefit, all decide” principles of Global Public Investment; (WHA A76/10, PP19, WHA A76/10, PP17)

Addition under OP2: Recognize the need to strengthen and accelerate regulatory processes and guidance adoption and dissemination activities at the World Health Organization and to facilitate countries reliance upon and adoption of the same; (New language)

OP4. Address the particular **intersecting** needs and vulnerabilities of **populations at the greatest risk, including** children, youth, persons with disabilities, people living with HIV/AIDS, older persons, migrants, refugees, internally displaced persons and indigenous peoples, **men who have sex with men, sex workers, transgender people, people who use drugs, and people in prisons and other closed settings**; which may include assistance, health care and psychological and other counseling services, in accordance with relevant international commitments, as applicable, and in line with national contexts and priorities; (Based on A/RES/74/2, OP71 and A/RES/76/257, OP5)

Addition following OP4. Commit to creating enabling environment and allocating funds to community- and civil society-led systems and organizations to lead on activities to implement societal enablers, particularly trust and social cohesion building and working with communities at the greatest risk those targeting key and vulnerable populations; (Based on 2022 OHCHR Annual Report on Human Rights and HIV/AIDS, paragraph 54c)

OP7. Ensure further the safe, timely and unhindered access of humanitarian personnel and medical personnel responding to pandemics, as well as their means of transport, supplies and equipment **through international agreements to lift restrictions on international movement of personnel and relevant materials, including visa requirements, tariffs, and import restrictions**, and to support, facilitate and enable transportation and logistical supply lines, in order to allow such personnel to efficiently and safely perform their task of assisting affected populations; (Based on A/RES/77/31, OP6)

Addition under OP9: **Mainstream a gender perspective on a systems-wide basis when designing, implementing and monitoring health policies, taking into account the specific needs of all women and girls, with a view to achieving gender equality and the empowerment of women in health policies and health systems delivery; (A/RES/74/2, Verbatim 69)**

OP11. **Promote Ensure** equitable distribution of and increased access to quality, safe, effective, affordable and essential medicines, including **generics** therapeutics, vaccines, diagnostics and health technologies, to ensure affordable quality health services and their timely delivery; (Based on A/RES/74/2, OP49)

OP 12. ~~Promote~~ **Ensure** increased access to affordable, safe, effective and quality medicines, including ~~generics~~ therapeutics, vaccines, diagnostics and health technologies, reaffirming the World Trade Organization Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement) as amended, and also reaffirming the 2001 World Trade Organization Doha Declaration on the TRIPS Agreement and Public Health, which recognizes that intellectual property rights should be interpreted and implemented in a manner supportive of the right of Member States to protect public health and, in particular, to promote access to medicines for all, **and take appropriate measures to support the application of time-bound waivers of intellectual property rights during a pandemic and notes the need for appropriate incentives in the development of new health products;** (Based on A/RES/74/2, OP51)

Addition under OP12: Call to review and revise national laws and regulations to fully incorporate public health flexibilities, including those under the TRIPS Agreement and the 2001 World Trade Organization Doha Declaration on the TRIPS Agreement and Public Health and refrain introducing intellectual property provisions beyond TRIPS requirements in unilateral actions and bilateral/regional trade and investment negotiations and agreements that could undermine the ability to use TRIPS flexibilities for access to medicines. (New language)

OP14. Explore, encourage and promote a range of innovative incentives and financing mechanisms **and ensure attaching conditions to public funding agreements for equitable access to the output of health research and development**, including a stronger and transparent partnership between the public and the private sectors as well as academia, acknowledging the important role played by the private **and public** sector in research and development of innovative medicines, while recognizing the need for increasing public health-driven research and development that is needs-driven and evidence-based, guided by the core principles of safety, affordability, effectiveness, efficiency, equity and considered as a shared responsibility, as well as appropriate incentives in the development of new health products and technologies; (Based on A/RES/74/2, OP52 and OP53)

OP15. ~~Promote~~ **Ensure** the transfer of technology and know-how, ~~and, encourage~~ research, innovation and commitments to **non-exclusive voluntary licensing, where possible**, and require such commitments in agreements where public funding has been invested in research and development ~~for pandemic prevention, preparedness and response~~, to strengthen local and regional capacities for the manufacturing, regulation and procurement of needed tools for equitable and effective access to vaccines, therapeutics, diagnostics and essential supplies, as well as for clinical trials, and to increase global supply through facilitating, or **if appropriate, mandating** transfer of technology **within the framework of relevant multilateral agreements** encouraging and incentivizing medical product manufacturers to seek regulatory approval in all relevant markets; (Based on A/RES/76/257, ~~Verbatim~~-OP11)

OP17. Call to ~~improve~~ **ensure** timely and equitable access to quality, safe, effective and affordable vaccines, therapeutics, diagnostics and other health technologies, inter alia, through building capacity for local and regional production, especially in low- and middle-income countries, technology transfer **including, but not limited to, the full use of public health safeguarding intellectual property flexibilities, and cooperate with, support to voluntary initiatives and mechanisms, on mutually agreed terms, cooperation with, support to and the development of patent pools and other initiatives,** such as, but not limited to, the World Health Organization COVID-19 Technology Access Pool, **the World Health Organization mRNA Technology Transfer Hub,** and the Medicines Patent Pool, and promoting generic competition in line with the World Health Organization road map for access to medicines, vaccines and other health products, 2019–2023; (**Based on A/RES/76/257, Verbatim PP21**)

OP22. Reaffirm the **multilateral goal of solidarity alongside national sovereignty** and the primary role and responsibility of governments at all levels to **chart national** paths towards pandemic prevention, preparedness and response, in accordance with national contexts and priorities, which is critical for minimizing public health hazards and vulnerabilities as well as delivering effective prevention, surveillance, early warning, response and recovery in health emergencies; (Based on A/RES/74/2 OP6 and A/RES/76/257 PP6)

OP23. Provide strategic leadership at the national level for the achievement of pandemic prevention, preparedness and response by strengthening legislative and regulatory frameworks, promoting greater policy coherence and ensuring sustainable and adequate financing to implement high-impact policies to protect people from pandemics and health emergencies, and comprehensively address social, economic and environmental and other determinants of health by working across all sectors through a whole-of-government and health-in-all-policies approach and by engaging stakeholders in an appropriate, coordinated, comprehensive, integrated and whole-of-society action and response, **and by developing specific national strategies to be presented to the World Health Assembly, with respect to integration with international agreements including the INB Pandemic Accord and UN Declaration on PPPR;** (Based on A/RES/74/2, OP57 and OP59)

Additional under OP24: Build effective, accountable, transparent and inclusive institutions at all levels to end corruption and ensure social justice, the rule of law, good governance and health for all and encourage the development of multisectoral public policies that create equitable health-promoting environments that empower individuals, families and communities to make healthy choices and lead healthy lives; (Based on A/RES/74/2, 56 and A/66/L.1, 43a)

Addition under OP24: Commit to the repeal of harmful criminal laws, including the removal of all policies and practices associated with the criminalisation of populations such as sex workers, men who have sex with men, transgender individuals, and people who use drugs and of health services they need, and the introduction of legal protections against discrimination for such populations; (2021 Global AIDS Strategy 2021-2026, 144c)

OP25. Recognize that emergency coordination must be embedded in strengthened national health **and community** systems and linked to multiple sectors and systems, be enacted by a well-resourced and protected health **and community** emergency workforce; underpinned by data, integrated analytics, research and innovation, be informed by dynamic assessments and monitoring of threats, vulnerabilities and functional capabilities, and have strong links to regional and global support, coordination and collaboration structures and mechanisms across all phases of the health emergency cycle of preparing, preventing, detecting, responding and recovering; (WHA A76/10, OP45)

OP26. Commit to strengthening objective, evidence-based, **independent** and multisectoral monitoring and accountability for required action and results for pandemic prevention, preparedness and response; (New language)

OP28. Recognize the need to strengthen relevant stakeholder participation, ensure ownership and sustainability, while including those most affected by health emergencies, by integrating communities in global health governance processes, through transparent information-sharing, ~~and~~ inclusive processes **and formal representation in decision-making structures for PPPR strategies and responses, including global governance structures and international panels, and by enabling civil society and community-led monitoring mechanisms;** (New language)

OP29. Resolve to address the global shortfall of health workers in accordance with the Global Strategy on Human Resources for Health: Workforce 2030 by investing in education, employment and retention, strengthening the institutional capacity for health **and community** workforce governance, leadership and planning, and protecting all health **and community** workers from all forms of violence, attacks, harassment and discriminatory practices, while recognizing that health, **community** and care worker safety and patient safety are inseparably connected; (Based on A/RES/74/2 OP60 + SG Report on UHC, advanced version + WHO Technical Brief on Health and Care Workers)

OP31. Continue to scale up efforts and strengthen cooperation to promote the training, development, recruitment and retention of competent, skilled and motivated health workers, **including** community health workers, and mental health professionals, guided by target 3.c of the 2030 Agenda; (Based on A/RES/72/4, OP62)

Addition under OP32: Community-led organizations must be fully included and integrated into national pandemic responses, including continuing COVID-19 responses, and involvement cannot be limited to consultation, information-sharing, and participation in programme implementation, with recognition that the views of community-led organizations are essential at the level of policy development, planning, design and evaluation of interventions, and that community engagement at every level must be actively supported and facilitated through the provision of protective equipment, recognition as providers of

essential services, and consideration in budgetary planning; (UNAIDS, Holding the line: communities as first responders to COVID-19 and emerging health threats)

Addition under OP33: Recognise that privatization of essential social services, if not adequately monitored, regulated, and controlled, could lead to worse health outcomes in pandemics, and ensure that all healthcare providers are strictly monitored and regulated at the national, county and local levels, and ensure that any private sector involvement does not undermine public health provisions, is driven by patient-centered needs, has a demonstrated public health impact, has strong transparency and accountability mechanisms in place, and supports human rights; (New language)²

Addition under OP34: Strengthen pandemic preparedness and response mechanisms recommitting to ending the epidemics of AIDS, TB and malaria (SDG 3.3) and by sharing experience and best practices with the ongoing responses to the global HIV/AIDS, tuberculosis, and malaria epidemics, and by building on existing infrastructure, supply chains, social movements, and civil society and community groups, recognizing that there has been a substantial foundation built in these responses and acknowledging the integral role of civil society and communities in identifying outbreaks, preventing spread, socializing new technologies, strengthening public health measures, and implementing response programming; (Based on A/75/L.95, page 21-22)

Addition under OP34: Recognize that increased investments in ongoing global responses, through the Global Fund, Gavi and other programs, and disease-focused responses including but not limited to HIV/AIDS, tuberculosis, malaria, and other neglected disease outbreaks such as Ebola, Marburg, and cholera, are critical to building and strengthening pandemic preparedness and response systems; (Based on A/75/L.95, 49)

OP42. Commit to leveraging existing financing tools, including but not limited to by increasing funding to the Global Fund to Fight AIDS, TB, and Malaria; the Pandemic Fund; and Unitaid; and to explore potential options to mobilize additional timely, reliable, equitable, predictable and sustainable funding for pandemic prevention, preparedness and response, including through the Multilateral Development Banks' capital adequacy reviews, the World

² Rationale: There is a growing body of evidence to suggest that the increased engagement of the private sector in global health, without clear guiding principles and binding regulations, is leading to actions that do more harm than good, including undermining public health systems and negatively impacting the most marginalized and vulnerable populations. Research has highlighted privatization and commercialisation in healthcare led to worse and inequitable health outcomes during the COVID-19 pandemic. For example, research from GI-ESCR highlights that after decades of commercialisation, Kenya lacks the necessary medical resources to have more effectively responded to COVID-19 and for future ones.# Despite these growing concerns, the role of institutions such as development finance initiatives have gained increased prominence, and the promotion of public-private partnerships to increase the involvement of the private sector in health continues. For more information on better regulation on the use of ODA to the private sector, please see the civil society principles for ODA-funded private sector in global health.

Bank Evolution Roadmap, and the IMF's Resilience and Sustainability Trust, as well as funding for rapid surge financing response in the event of a public health emergency of international concern, and to consider strengthening global health financing mechanisms, as well as their roles and responsibilities, with recognition of the need to coordinate and harmonize financial investment mechanisms to maximize potential benefit and lessen burden on countries and organizations seeking resources, and reiterate that the fulfillment of all official development assistance targets remains crucial and recall the respective commitment of many developed countries to provide official development assistance equal to 0.7 percent of gross national income (Based on A/RES/76/257, OP10)