PRELIMINARY COMMENTS ON THE DRAFT BUREAU'S TEXT OF THE WHO PANDEMIC AGREEMENT FOR THE CONSIDERATION BY THE INTERGOVERNMENTAL NEGOTIATING BODY IN APRIL 2024

Overarching comments:

The COVID-19 pandemic has shown that the prevalence of underlying conditions such as noncommunicable diseases (NCDs) increases the vulnerability of populations to pandemics in high-income and low-income countries. Some studies estimate 60 to 90% of COVID-19 deaths were attributable to either one or more of these comorbidities.[1] At the same time emerging data suggests that people living with NCDs also experience worse health outcomes from these existing conditions during pandemics as a result of service disruptions, delays, and cancellations of essential health services.[2,3] This has already been explicitly recognised by the world's leaders in the United General Assembly resolution 73/130.

We welcome continued active consultation with organisations from different segments of society and from around the world through the INB negotiations.

We encourage the INB to create further pathways for civil society engagement in the negotiating and drafting of the WHO Pandemic Agreement, including access to relevant documents (including drafts) and right to intervene within both plenary and working group sessions of negotiations. This includes finding pathways for the continued engagement of all relevant stakeholders, including non-state actors, in the proposed Intergovernmental Working Groups on Articles 20 (Conference of Parties), 12 (Pathogen Access and Benefit-Sharing System, PABS), and Articles 4 and 5 (One Health).

General Comments:

The NCD Alliance recognises the need to negotiate a text that enables WHO Member States to take clear and concrete coordinated action on pandemic prevention, preparedness and response, whilst also demonstrating opportunities for the mobilisation of resources to implement such an agreement effectively.

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[1] https://ijme.in/articles/non-communicable-disease-management-in-vulnerable-patients-during-covid-19/?galley=html

[2] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7248450/

[3] https://www.who.int/publications/i/item/9789240010291

1 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7248450/
2 https://www.who.int/publications/i/item/9789240010291

The NCD Alliance **welcomes the retained commitment to equity** in the latest draft of the report, as well as continued reference to advancing the achievement of universal health coverage in paragraph 12 and in Articles 1(i) and 6.1. We **remain concerned, however, that the definition of "persons in vulnerable situations"** fails to adequately capture those who may be at greatest risk and likely to suffer the greatest impact of any future pandemic. Whilst welcoming the inclusion of those in fragile and humanitarian settings, we consider that this definition is too narrowly confined to those "with disproportionate increased risk of infection, severity, disease or mortality", which is not aligned with definition of health in the WHO constitution. Strengthening this definition is essential to ensure the appropriate scope of Article 6.2(a) and Article 17.5, to deliver on equity as a goal and outcome of the agreement (Article 2), and to align with the principle of equity as set out in Article 3.4. The NCD Alliance continues to be concerned that the latest proposed text consistently fails to recognise the crucial role that non-state actors, and civil society in particular, plays in supporting the implementation of pandemic prevention, preparedness and response.

The NCD Alliance further **expresses concern that commitments to safeguard, protect, invest in, retain and sustain an adequate skilled and trained health and care workforce** have been substantially reduced in the current text of Article 7. We therefore urge Member States, to reinstate references to strengthening decent work conditions and addressing mental health and wellbeing as pre-requisites to retaining an effective health and care workforce prior to, during, and after pandemics. We also urge Member States to reinstate language on addressing inequalities and on the provision of financial and technical support, in order to strengthen and sustain a skilled and competent health and care workforce capable of preventing, preparing for, and responding to future pandemics.

Recommendations to Member States:

Taking the above observations into account, we recommend that throughout the continuation of the INB9 negotiations Member States work towards achieving a pandemic agreement that:

- **Retains the principle of equity** as a key driver for the Pandemic Agreement, as set out in Article 2.1. In order to ensure clarity on what this guiding principle entails, NCD Alliance recommends the insertion into the "use of terms" a definition of equity that clarifies this to be equity between and within states, as well as equity of access to relevant pandemic prevention, preparedness, response and reconstruction efforts for all individuals, in line with the Right to Health.

- Ensures the **definition of "persons in vulnerable situations"** as set out in Article 1 (i) is more closely aligned to the principles of the WHO Constitution and that in particular this definition recognises that health is a "state of complete physical, mental and social well-being" and reiterates that the "enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition". More specifically, we urge Member States to recognise that persons with chronic health conditions are those likely to be most severely affected by pandemics.

- **Retains the commitment to developing, strengthening and maintaining resilient health systems**, particularly primary care, with a view to **achieving universal health coverage**, as set out in Article 6.1. It is clear that without access to healthcare free at the point of delivery,

1 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7248450/
2 https://www.who.int/publications/i/item/9789240010291

and the resilient health systems that need to be in place to achieve this, it will not be possible to fully prevent, prepare for or respond to pandemics. Strong and resilient health systems also form a critical pillar of PPPR that is essential to ensuring equitable access to health services, including for people with chronic health conditions such as non-communicable diseases.

Reinstates language, and commitments,on safeguarding, protecting, investing in, retaining and sustaining an adequate, skilled and trained health and care workforce. In particular, we urge Member States to recognise the importance of investing in decent work conditions and addressing mental health and wellbeing in order to mitigate against health worker shortages and the risk of burnout as was so clearly evident during the COVID-19 pandemic. Achieving this requires: investment in effective health and care workforce planning; strengthening of pre- and in-service competency-based education and training; addressing disparities, inequalities, discrimination, stigma and bias; and clear policies to support the retention of health workers and minimize the negative impact of health workforce migration while respecting the freedom of movement of health professionals. We thereforeurge that these key elements of ensuring a health and care workforce is able to adequately prevent, prepare for, respond to, and recover from future pandemics are reintegrated into the final Pandemic Agreement text.

- Demonstrates support for the essential role that civil society plays in both contributing to the implementation of pandemic prevention, preparedness and response and in holding WHO Member States accountable for implementing such plans in a way that ensures adherence to the principles of equity, inclusion and the fulfilment of human rights, including the right to health. In particular, **we request Member States to support the reinsertion of specific language on the meaningful engagement of civil society,** as well as communities, as part of the whole-of-society approach, and throughout the text of Pandemic Agreement.

Specific comments and recommendations:

Based on the points above and the NCD Alliance's review of the latest negotiating text, we make the following comments and recommendations on specific articles within the text.

Article	Recommendations
Chapter 1. Introduction	
Article 1.	**Use of terms**

1 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7248450/
2 https://www.who.int/publications/i/item/9789240010291

	We express concern that the definition of "persons in vulnerable situations"" not only fails to include "persons with health conditions" as per the zero draft but also fails to align with the definition of health as set out in the WHO Constitution. Recognising the limitations of detail that can be included in the Pandemic Agreement, we nevertheless urge Member States to better reflect the breadth of vulnerability associated with health inequities in pandemics and to strengthen alignment with WHO's definition of health. As such we propose the following amendments to the text: "Persons in vulnerable situations" means individuals, groups or communities with a disproportionate increased risk if **[ADD: the non-enjoyment of the right to health]** including persons at increased risk of infection, severity, disease or mortality in the context of a pandemic; *Alternatively*, the definition could refer to: '… persons at increased risk of infection, severity, disease or mortality **[ADD: or other health-related harms]** in the context of a pandemic;' *OR* '… persons at increased risk of infection, severity, disease or mortality **[or other negative determinants of health]** in the context of a pandemic' We welcome the inclusion of the definition of "universal health coverage" as this is a critical component to ensuring everyone, everywhere can be protected from future pandemics. However, we urge Member States to ensure this definition aligns with that included in the 2023 Political Declaration of the High-Level Meeting on Universal Health Coverage. As such we recommend amending the text to read: "universal health coverage" means that all people have access, without discrimination, to the full range of quality health services they need, when and where they need them, without financial hardship, with a special emphasis on the poor, vulnerable, and marginalized segments of the population. It covers the full continuum of essential health services from health promotion to prevention, treatment, rehabilitation and palliative care, as well as essential, safe, affordable, effective and quality medicines and vaccines.
Article 3.	**Principles**
	We welcome the inclusion of principles on the full respect for the dignity, human rights and fundamental freedoms of all persons, on equity, and on solidarity, transparency and accountability. We are concerned, however, that no specific mention is made of the need to ensure non-discrimination, respect for diversity, the promotion of gender equity, and protection of persons in vulnerable situations. We are also concerned that the principle of equity no longer contains reference to equity among and within states, no longer acknowledges that equity requires special measures to protect persons in vulnerable situations, and fails to reference continued access to essential medical services. It is concerning the that principles of "responsibility", "recognition of different levels of capacity", and "inclusiveness" have been removed in the latest version

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	of the text. Furthermore, it is of concern that the principles of "solidarity, transparency and accountability" have been condensed into one combined principle that does not differentiate between the different elements of solidarity, transparency and accountability. In particular, we are concerned that suggested language on unequal development in the promotion of health and control of diseases, including both communicable and non-communicable diseases, has not been retained. In addition, we believe that the principle on solidarity, transparency and accountability would be further strengthened by making explicit reference to the progressive realisation of universal health coverage, as a critical tool in preparing countries to prevent and respond to future pandemics equitably. We also regret that principles on "community engagement", "non-discrimination and respect for diversity", and "rights of individuals at higher risk and in vulnerable situations" no longer exist in this latest negotiating text. We recommend strengthening the principles of this text in the following ways: **Article 3.2:** full respect, protection and fulfilment of dignity, human rights and fundamental freedoms of all persons, and the enjoyment of the highest attainable standard of physical and mental health of every human being, in accordance with the Charter of the United Nations and international human rights obligations. **Article 3.4:** equity as a goal and outcome of pandemic prevention, preparedness and response, striving for the absence of unfair, avoidable or remediable differences among and between individuals, communities and countries and enabling unhindered, fair, equitable and timely access to safe, effective, quality and affordable pandemic related products and services, information, pandemic-related technologies, social support, and continued access to essential medical services.
Chapter II. The world together equitably: achieving equity in, for and through pandemic prevention, preparedness and response.	
Article 6.	**Preparedness, health system resilience and recovery**
	We welcome the recognition within article 6.1 of the importance of strengthening and maintaining resilient health systems, particularly primary health care for pandemic prevention, preparedness, and response. We also welcome the reference to the need to ensure equity and resilience and the intention to for PPPR efforts to be achieved with a view to achieving universal health coverage. We welcome the amendments to article 6.2 (a) which recognises the importance of the timely provision of, and equitable access to, scalable clinical care, quality routine and essential health care services during pandemics and reiterates the importance of primary health care, mental health and psychosocial support. However, we believe this article could be further strengthened by highlighting the maintenance of referral health services, community intervention, and provision of care for patients with chronic conditions during pandemics, and by recognising the impact that backlogs and waiting lists for the diagnosis and treatment of other diseases and health

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	conditions, including care for patients with chronic conditions, have on pandemic preparedness and response. As such we recommend amending the language of article 6.2 (a) as follows: "timely provision of, and equitable access to, scalable clinical care, quality routine and essential health care services during pandemics, with a focus on primary health care (including referrals and community intervention), mental health and psychosocial support, and with particular attention to persons in vulnerable situations including those with chronic health conditions."
Article 7	**Health and care workforce**
	We are concerned that Article 7 no longer reflects the major challenges experienced by health and care workforce during the pandemic. The 2021 WHO working paper on the impact of COVID-19 on health and care workers[4] estimates that between 80 000 to 180 000 health and care workers could have died from COVID-19 in the period between January 2020 to May 2021 due to COVID-19 complications, burn out, violence targeting health and care workers, stress and lack of mental health and psychosocial support. In addition, WHO's 2023 Policy Brief assessing the impact of the COVID-19 pandemic on health professions[5] found that healthcare workers feared for their personal safety during the pandemic because of a lack of protective equipment, and the absence of any systematic support and security left many feeling undervalued. We therefore recommend reinstating specific language on decent working conditions, protection from violence and harassment and provision of mental health and psychological support to the workforce to Article 7.2. Furthermore, we recommend reinstating specific language on the need to address disparities, inequalities, discrimination, stigma and bias and ensuring the meaningful engagement of youths within Article 7. We also recommend the inclusion of references to national capacity building, especially for the essential public health functions and the national public health workforce within the pandemic treaty, in alignment with the International Health regulations (IHR) position. Based on these observations, we make the following suggested amendments to the text: Article 7.1: "Each Party, in line with its respective capacities and national circumstances, **commits** to take the necessary steps…" Article 7.2: "Each Party shall take appropriate measures to protect and ensure the continued safety, **mental health** and wellbeing and capacity of its health

[4] The impact of COVID-19 on health and care workers: a closer look at deaths. Health Workforce Department – Working Paper 1. Geneva: World Health Organization; September 2021 (WHO/HWF/WorkingPaper/2021.1). Licence: CC BY-NC-SA 3.0 IGO.
[5] Downey E, Fokeladeh HS, Catton H. What the COVID-19 pandemic has exposed: the findings of five global health workforce professions. Geneva: World Health Organization; 2023 (Human Resources for Health Observer Series No. 28).

1 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7248450/
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	and care workforce, including by **ensuring decent work conditions; tackling disparities, inequalities, discrimination and bias; establishing and maintaining national workforce planning systems and strategies; strengthening pre- and in-service competency-based education and training;** and ensuring priority access to pandemic-related health products during pandemics, thereby minimizing....”
Article 8	**Preparedness monitoring and functional reviews**
	We are concerned that the integration of Article 8 into Article 6 risks significantly reducing the attention given to quality monitoring and evaluation or Member States’ pandemic prevention, preparedness, response and recovery plans. In particular, we remain concerned that reference to the establishment of a global peer review mechanism to assess pandemic prevention preparedness and response capacities and gaps, as well as to promote and support learning among Parties no longer appears in this text. In addition, we strongly urge that the “inclusive, transparent, effective and efficient pandemic prevention, preparedness and response monitoring and evaluation system” to be developed includes indicators of preparedness for continued access to essential health services during pandemics. As such, we recommend the following amendments to this text: Current Article 6.5: “With the aim of promoting and supporting learning among Parties, best practices and accountability and coordination of resources, an inclusive, transparent, effective and efficient pandemic prevention, preparedness and response monitoring and evaluation system, with agreed targets and national, regional and global standardized indicators, shall be developed, implemented and regularly assessed, by WHO in partnership with relevant organizations, building on relevant tools, on a timeline to be agreed by the Conference of Parties. This mechanism shall aim to promote whole-of-government and whole-of-society engagement, alongside periodic global peer review efforts.”
Article 9	**Research and development**
	We welcome the retention of language in article 9.5 that emphasises the need to “support the transparent and public sharing of research inputs and outputs from research and development of government-funded pandemic-related products”. However, we believe that this article could go further by referencing the need to improve transparency of information regarding health products more broadly. We also believe the content of this article could be further strengthened by re-inserting reference to non-infectious diseases in recognition of the need for greater collaboration internationally on clinical trials for chronic health conditions which can impact on the effectiveness of pandemic prevention, preparedness and response plans. Taking this into account we propose the following amendments: **Article 9.3:** “The Parties shall… take steps to strengthen international coordination, collaboration, infrastructure and training to support well-designed and well-implemented trials, by developing, strengthening and sustaining

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	clinical trial capacities and research networks at the national, regional and international levels, including in low- and middle-income countries, and facilitating the rapid reporting and interpretation of data from such trials, to provide timely and appropriate responses to pandemics and address priority infectious and non-infectious diseases."
Article 12	**Access and benefit sharing**
	We welcome the establishment of the "WHO Pathogen Access and Benefit-Sharing System" (PABS System) to "ensure rapid, systematic and timely sharing of PABS Material and Information…" We recommend, however, that such a mechanism is broadened to include non-directly pandemic related products. Furthermore, in order for such a mechanism to be successful, we believe it must be fully integrated into national health systems, thereby enabling facilities to produce all health products for priority infectious and non-infectious diseases, as well as contributing to the financial sustainability of these facilities. Integration of these facilities into the health system will also support the retention of trained staff and improved access to essential health products in low- and middle-income countries. Based on this we therefore strongly urge that all relevant stakeholders, including non-state actors, are provided with the opportunity to contribute to the further elaboration of the modalities, terms and conditions and operational dimensions of the PABS System that will be further defined in the legally-binding instrument that is to be operational no later than 31 May 2026. We also encourage the PABS System to be developed as an integrated element of national health information management systems that can track the potential impact of burden of disease as well as public health risk on the rapid and timely control of public health emergencies of international concern and pandemics.
Article 20	**Sustainable Financing**
	We welcome the commitment to strengthen sustainable and predictable financing for the implementation of the Pandemic Agreement and the International Health Regulations (2005). However, we express concern that the text does not explicitly state how this mechanism will contribute to mobilizing resources for the maintenance of essential health services during and after a pandemic, which is a critical cornerstone of pandemic prevention, preparedness and response, nor does the text illustrate how this mechanism will support the progressive realisation of universal health coverage. We are also disappointed that the latest version of the negotiating text no longer contains reference to the importance of implementing financial protection as part of the achievement of UHC and pandemic recovery for patients and families. As such we recommend reinstating the following text, with suggested amendments, into article 20: Article 20.2 (c): "explore, and as appropriate, promote…innovative financing measures, including transparent financial reprogramming plans for pandemic prevention, preparedness and response, that address the full continuum of care

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	during and in the aftermath of a pandemic response, especially for developing country Parties experiencing fiscal constraints."
Chapter III	**Institutional and final provisions**
Article 21	**Conference of the Parties**
	To ensure inclusiveness of partners, we strongly recommend that the proposed Conference of the Parties, incorporates into its rules of procedure a clear mechanism for the meaningful engagement of civil society and other relevant stakeholders, in recognition of the vital role that such agencies play in ensuring effective pandemic prevention, preparedness and response.

For more information on the impact of COVID-19 on people living with NCDs and solutions for resilience and recover please refer to "A Global NCD Agenda for Resilience and Recovery from COVID-19".

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2 https://www.who.int/publications/i/item/9789240010291