Public Health Association of Australia submission to the Australian Government's consultation on *Preparing for, and responding to, future pandemics and other international health emergencies.*

Contact for recipient:
A: Department of Health and Aged Care
E: International@health.gov.au

Contact for PHAA:
Terry Slevin – Chief Executive Officer
A: 20 Napier Close, Deakin ACT 2600
E: phaa@phaa.net.au **T:** (02) 6285 2373

19 September 2023

Contents

Public Health Association
AUSTRALIA

The **Public Health Association of Australia** (PHAA) is Australia's peak body on public health. We advocate for the health and well-being of all individuals in Australia.

We believe that health is a human right, a vital resource for everyday life, and a key factor in sustainability. The health status of all people is impacted by the social, commercial, cultural, political, environmental and economic determinants of health. Specific focus on these determinants is necessary to reduce the root causes of poor health and disease. These determinants underpin the strategic direction of PHAA. Our focus is not just on Australian residents and citizens, but extends to our regional neighbours. We see our well-being as connected to the global community, including those people fleeing violence and poverty, and seeking refuge and asylum in Australia.

Our mission is to promote better health outcomes through increased knowledge, better access and equity, evidence informed policy and effective population-based practice in public health.

Our vision is for a healthy population, a healthy nation and a healthy world, with all people living in an equitable society, underpinned by a well-functioning ecosystem and a healthy environment.

Traditional custodians - we acknowledge the traditional custodians of the lands on which we live and work. We pay respect to Aboriginal and Torres Strait Islander elders past, present and emerging and extend that respect to all other Aboriginal and Torres Strait Islander people.

Introduction

PHAA welcomes the opportunity to provide input to the national consultation on *Preparing for, and responding to, future pandemics and other international health emergencies* as part of Australia's contributions to the negotiations for a new legal instrument on pandemic prevention, preparedness and response (hereafter, 'Pandemic Treaty'), and targeted changes to the International Health Regulations (IHR) through the World Health Organization (WHO).

This submission aims to address the critical questions posed by the Australian Government, focusing on identifying key priorities that should be addressed in the development of a new international pandemic instrument and changes to the IHR. We focus on three areas of core interest to PHAA: (i) equitable access to pandemic-related products such as vaccines, therapeutics, diagnostics and other equipment; (ii) health systems and public health workforce; and (iii) OneHealth.

Our relevant policy position statements include:

- Health Equity
- Trade Agreements and Health
- One Health

PHAA Response to the Australian Government consultation on Preparing for, and responding to, future pandemics and other international health emergencies

Consultation Questions

Question 1: How can international cooperation be improved to more effectively prevent, prepare for, and respond to, future pandemics and other international health emergencies?

International cooperation is paramount in addressing global health crises. Collaborative efforts must transcend national boundaries and prioritise solidarity to achieve optimal outcomes. The COVID-19 pandemic highlighted serious failures in international cooperation and solidarity that must be addressed in order to prevent, prepare and respond more effectively to future pandemics. We outline some of these failures below. Our recommendations for addressing these issues are set out in our response to Question 2.

Equitable access to pandemic-related products:

Inequities in access to pandemic countermeasures including vaccines, therapeutics and diagnostics have been catastrophic and have persisted throughout the pandemic. By November 2022, almost two years after the first COVID-19 vaccines were administered, 13 billion doses had been rolled out around the world but the supply in low-income countries (LICs) was only sufficient to achieve a vaccination rate of less than 25% [1]. At the time of writing (September 2023), 74% of those in high-income countries (HICs) had received at least two doses in comparison with 28% of those in LICs; the proportion of those in HICs with at least one dose was 80% in comparison with less than 33% in LICs [2]. Similarly, LICs received only a 0.4% of the first diagnostic tests [3], and very late and slow access to therapeutics, including antivirals [4].

Some of the underpinning factors which must be addressed in global legal instruments if we are to see different outcomes in future pandemics include:

- Billions of dollars in public funding were provided for developing vaccines and other products [5] with few or no conditions placed on the funding to ensure equitable access to, or affordable pricing of, the resulting products [6].
- Manufacturing of COVID-19 medical products was concentrated in the Global North, and manufacturers were reluctant to share intellectual property, technology, and know-how with manufacturers in the Global South [6].
- The global intellectual property regime underpinned by the World Trade Organization Agreement on Trade-Related Intellectual Property Rights (TRIPS) requires WTO members to provide minimum standards of intellectual property protection, thus it presents a barrier to rapid widespread manufacturing of products needed in a pandemic. While TRIPS allows for compulsory licensing (CL), its CL provisions are difficult and cumbersome to use during a global health emergency, do not cover some types of intellectual property that are relevant to vaccines and did not enable production of COVID-19 products on the scale needed [7]. Efforts to negotiate a temporary TRIPS waiver for COVID-19 health products and technologies resulted in a much narrower exception than what was originally envisaged [4,8] and failed to secure an outcome that has yet enabled manufacturing in LMICs.
- Global governance mechanisms set up to equitably distribute products (the ACT-Accelerator and its vaccines arm, COVAX), failed to deliver promised amounts of products in a timely way. COVAX delivered less than half of the promised two billion doses by the end of 2021 [9].
- The pharmaceutical industry held too much power over the distribution of products and the terms of contracts [10].
- High-income countries reserved the bulk of vaccine supplies, leaving too little for low and middle-income countries (LMICs), and resorted to vaccine charity and diplomacy, largely only when their own populations had been vaccinated [1]. Donated doses were often delivered in unpredictable ways and close to expiry dates, making it difficult for recipient countries to absorb and distribute them [1].
- In the early stages of pandemic, vaccine demands were high across the globe. However, a lack of transparency of information around the vaccine supply chain (including availability of active and non-active ingredients, equipment required and other materials) led to significant uncertainty from nations whether their vaccine requirements would be met. Producers of vaccines reported reductions in vaccine production but did not report on the supply chain issues which led to this situation [11]. As a result, some countries took their own initiative to manage supply chain risks. Nonetheless, these were countries which housed vaccine manufacturers, and therefore did so to protect interests of their own vaccine supply.

- During the pandemic, there was a disparity in cost of vaccines, with some LMICs paying nearly double the cost for each vaccine compared with HICs [12].
- Historically, many LMICs have participated in vaccine development, yet have not benefited from their participation [13]. Some LMICs even feel exploited for their participation in health research, which is driven with significant agendas from funders [14].

Health systems and the public health workforce:

The COVID-19 pandemic also exposed weaknesses in national health systems around the globe - and highlighted the interrelations between health, social and economic systems. The Organisation for Economic Co-operation and Development reports that: "those living in deprived areas, migrant populations, and ethnic minorities are at higher risk of catching and dying from the virus than other groups, and they also face significant indirect health impacts of the COVID-19 pandemic - both mental health impacts and disruption of routine care," [15].

We saw widening inequities, not just in terms of supplies and access to protective equipment, medicines, and vaccines, but also the social and economic implications of lockdowns at both local and national levels. These widening inequities have resulted in a consequent reversal of progress made in the first 7.5 years of the Sustainable Development Goals (SDGs), undoing decades of prior progress in public health. Global unemployment rates have returned to levels not seen since the 2008 global financial crisis, and the economic injustices experienced by developing countries, have left them with fewer options and resources to address the SDGs [16]. The UN estimates that if current trends persist, around 575 million people will remain living in extreme poverty by the year 2030 [16].

Strengthening health systems that address the determinants of health requires a resilient public health workforce, equipped with the knowledge and skills to deal with these complex and whole-of-system challenges. Coupled with the pandemic, other public health emergencies and humanitarian disasters included protracted conflicts across multiple regions, and climate-related incidents including severe weather events, floods, and fires; have exacerbated disruption, and placed further strain on the workforce, to deliver essential health and care services.

Even before the pandemic there were concerns about a health workforce shortage, with projections estimating there would be a global shortage of 10 million by 2030 [17]. The pandemic has left one in three health workers with anxiety or depression, and almost half are burnt out [18], further exacerbating the forecast shortage. Countries on the WHO health workforce support and safeguard list [19], that already have significantly less health workers per population are experiencing worsened impacts due to increasing workforce migration to developed countries [17], including Australia.

The health and care workforce are critical to health system resilience and progress towards Universal Health Coverage and the SDGs [20]. Every country needs a resilient health system with a strengthened national public health workforce capable of delivering all the Essential Public Health Functions (EPHFs) [21]. This requires establishing well-defined competencies for public health and emergency response personnel, to protect the public's health and to improve the health of the public – especially in times of misinformation and distrust as was illustrated during the pandemic. We also need to know who contributes to this workforce and what they can do, for recruitment of surge personnel and to enable work across borders, both nationally and internationally.

The WHO has developed a public health and emergency workforce roadmap [22] which defines the various categories of the workforce, including the core workforce and other professions that contribute to public health either on an ongoing basis or as part of surge capacity in times of emergency. The associated toolkits developed during the design phase define the essential public health functions, provide a framework for competency-based public health education and training, and outline a standardised

approach for mapping and measuring the public health workforce. The focus of this project is currently shifting from design to implementation with the aim to utilize these toolkits in 100 countries by 2024 [23].

One Health:

Most emerging infectious diseases in humans (more than 60 percent) are zoonotic with the majority of these (around 70 percent) originating in wildlife. The COVID-19 pandemic is the latest example of a major disease of probable animal origin [24].

Some of the major underlying drivers of zoonotic emergence are human population growth, changes in land use and biodiversity loss that negatively impact ecosystem integrity and functions and pose increased health risks at the human-animal-plant–environment interface [24].

The proposed Treaty and amendments to IHR primarily focus on the early detection, and reaction to the appearance of human illness following pathogen spillover and spread. Strategies to reduce the probability of spillover events are under-prioritised and under-utilized. Inclusion of strategies to prevent spillover would be synergistic with planned post-spillover actions and should be included in the overall preparedness discussions and recovery financing [25].

Programs for the surveillance and management of zoonotic diseases and risks vary between countries with a trend towards greater capacity in high income countries where risks are relatively low. There is no obligation for routine reporting of zoonotic risks and incidence in humans and animals (a One Health system). Current animal health systems globally are largely weaker than human health systems and often designed to support animal production and trade outcomes, which makes them unsuitable for surveillance for zoonotic disease emergence [26].

International cooperation to improve prevention, detection and response for future pandemic emergencies could be enhanced by:

- *Prevention:* Development of global databases to make available data on the underlying drivers of zoonotic disease emergence including data on livestock and wildlife populations, land use and land use change and food systems structures.
- *Detection:* Development of harmonised guidelines on the structure and minimum outputs of integrated One Health surveillance systems for zoonotic disease incidence and risks.
- *Response:* Explore mechanisms to fund One Health systems to detect and respond to spillover closer to the original source.

References for Question 1

1. Gleeson, D., Townsend, B., Tenni, B. F., & Phillips, T. (2023). Global inequities in access to COVID-19 health products and technologies: A political economy analysis. *Health & Place*, *83*, 103051. https://doi.org/https://doi.org/10.1016/j.healthplace.2023.103051
2. Our World in Data. (2023). Coronavirus (COVID-19) Vaccinations. Accessed from https://ourworldindata.org/covid-vaccinations, 19 September 2023.
3. Balakrishnan, V.S. (2022). 2 years of the access to COVID-19 tools-accelerator. Lancet Infect. Dis. 22, 948. https://doi.org/10.1016/S1473-3099(22)00378-4
4. Gleeson, D., Scheibner, J., & Nicol, D. (2023). Proposals to waive intellectual property rights for pandemic response products in the World Health Organization pandemic accord need Australia's support. *Medical Journal of Australia*, *219*(2), 46-48. https://doi.org/https://doi.org/10.5694/mja2.51990
5. Gold, E. R. (2022). What the COVID-19 pandemic revealed about intellectual property. *Nature Biotechnology*, *40*(10), 1428-1430. https://doi.org/10.1038/s41587-022-01485-x

6. Baker, B.K. and Thrasher, R. (2022). From Business as Usual to Health for the Future: Challenging the Intellectual Property Regime to Address COVID-19 and Future Pandemics. Boston University International Law Journal, Vol. 41, Northeastern University School of Law Research Paper No. 429, Available at SSRN: https://ssrn.com/abstract=4187162
7. Amin, T., & Kesselheim, A. S. (2022). A Global Intellectual Property Waiver is Still Needed to Address the Inequities of COVID-19 and Future Pandemic Preparedness. *INQUIRY: The Journal of Health Care Organization, Provision, and Financing*, *59*, 00469580221124821. https://doi.org/10.1177/00469580221124821
8. Rutschman, A. (2023). Ministerial Decision on the Trips Agreement (WTO). *International Legal Materials, 62*(2), 289-294. https://doi.org/10.1017/ilm.2022.47
9. de Bengy Puyvallée, A., & Storeng, K. T. (2022). COVAX, vaccine donations and the politics of global vaccine inequity. *Globalization and health*, *18*(1), 26. https://doi.org/10.1186/s12992-022-00801-z
10. Torreele, E., Wolfe, D., Kazatchkine, M., Sall, A., Ruxrungtham, K., Fitchett, J. R. A., Liu, J., Kobinger, G., Vaca-González, C., Gómez, C., Terblanche, P., Swaminathan, S., Olliaro, P., & Clark, H. (2023). From private incentives to public health need: rethinking research and development for pandemic preparedness. The Lancet Global Health. https://doi.org/10.1016/S2214-109X(23)00328-5
11. Oddleifson, D. A., Kayani, J., Shrivastava, R., Tan, J., Winters, M., Forman, H., & Omer, S. B. (2022). Assessment of the COVID-19 vaccine market landscape in 2021 relative to challenges in low- and middle-income countries. Human Vaccines & Immunotherapeutics, 18(6). https://doi.org/10.1080/21645515.2022.2124781
12. Jimenez, D. (2021). Covid-19: Vaccine Pricing Varies Wildly by Country Company. Pharmaceutical Technology. Retrieved 14/9/23 from https://www.pharmaceutical-technology.com/analysis/covid-19-vaccine-pricing-varies-country-company/
13. Fidler, D. P. (2008). Influenza Virus Samples, International Law, and Global Health Diplomacy. Emerging Infectious Diseases, 14(1), 88-94. https://doi.org/10.3201/eid1401.070700
14. Faure, M. C., Munung, N. S., Ntusi, N. A. B., Pratt, B., & De Vries, J. (2021). Considering equity in global health collaborations: A qualitative study on experiences of equity. PLOS ONE, 16(10), e0258286. https://doi.org/10.1371/journal.pone.0258286
15. Berchet, C., J. Bijlholt and M. Ando (2023), "Socio-economic and ethnic health inequalities in COVID-19 outcomes across OECD countries", OECD Health Working Papers, No. 153, OECD Publishing, Paris, https://doi.org/10.1787/6c2a96c9-en
16. United Nations (2023). The Sustainable Development Goals Report 2023: Special edition Towards a Rescue Plan for People and Planet https://unstats.un.org/sdgs/report/2023/The-Sustainable-Development-Goals-Report-2023.pdf
17. Mathieu Boniol et al., (2022). 'The Global Health Workforce Stock and Distribution in 2020 and 2030: A Threat to Equity and "Universal" Health Coverage?', BMJ Global Health 7, no. 6 (27 June): e009316, https://doi.org/10.1136/bmjgh-2022-009316
18. Kwaku Agyeman-Manu et al., (2023). 'Prioritising the Health and Care Workforce Shortage: Protect, Invest, Together', The Lancet Global Health 0, no. 0 (May 17), https://doi.org/10.1016/S2214-109X(23)00224-3
19. World Health Organization (2023). 'WHO Health Workforce Support and Safeguards List 2023', March 8, https://www.who.int/publications-detail-redirect/9789240069787
20. World Health Organization (2021). 'Building Health Systems Resilience for Universal Health Coverage and Health Security during the COVID-19 Pandemic and Beyond WHO Position Paper'. World Health Organization, https://apps.who.int/iris/handle/10665/346515

21. Haldane, V et al. (2021). 'Health Systems Resilience in Managing the COVID-19 Pandemic: Lessons from 28 Countries', Nature Medicine 27, no. 6 (June): 964–80, https://doi.org/10.1038/s41591-021-01381-y
22. World Health Organization (2022). National workforce capacity to implement the essential public health functions including a focus on emergency preparedness and response: roadmap for aligning WHO and partner contributions. Geneva: Licence: CC BY-NC-SA 3.0 IGO https://www.who.int/publications/i/item/9789240050402
23. World Health Organization (2022). National workforce capacity to implement the essential public health functions including a focus on emergency preparedness and response: action plan (2022–2024) for aligning WHO and partner contributions. Geneva: Licence: CC BY-NC-SA 3.0 IGO. https://www.who.int/publications/i/item/9789240060364
24. FAO, UNEP, WHO, and WOAH (2022). One Health Joint Plan of Action (2022-2026). Working together for the health of humans, animals, plants and the environment. Rome. https://doi.org/10.4060/cc2289en
25. High level expert panel on One Health (OHHLEP) (2023). 'Prevention of zoonotic spillover: From relying on response to reducing the risk at source.' https://www.who.int/publications/m/item/prevention-of-zoonotic-spillover
26. Mubareka, S., Amuasi, J., Banerjee, A., Carabin, H., Jack, J. C., Jardine, C., Jaroszewicz, B., Keefe, G., Kotwa, J., Kutz, S., McGregor, D., Mease, A., Nicholson, L., Nowak, K., Pickering, B., Reed, M. G., Saint-Charles, J., Simonienko, K., Smith, T., Parmley, E. J. (2023). Strengthening a One Health approach to emerging zoonoses. Facets (Ottawa), 8, 16–79. https://doi.org/10.1139/facets-2021-0190

Question 2: What issues do you think need to be prioritised to guide the world's future preparation for, and responses to, future pandemics and other international health emergencies?

To guide future pandemic preparation and responses, the submission underscores the importance of the following priorities:

Equity and access to pandemic-related products: Prioritise equitable access to vaccines, treatments, and resources for all nations, irrespective of their economic status. The Australian Government should support the inclusion of provisions in the pandemic treaty that have been recommended by experts to address the problems we have outlined above, including:

- Mandate, or at least incentivise, manufacturers of pandemic-related products to transfer technology and know-how to capable manufacturers in low and middle-income countries (LMICs) [1,2];
- Tie public funding for research and development (R&D) of pandemic-related products to licensing of manufacturers in LMICs [1,3];
- Commit Member States to supporting time-bound intellectual property waivers during pandemics [1,2];
- Affirm the rights of Member States to apply flexibilities provided for in the TRIPS Agreement, such as compulsory licensing, to the fullest extent [1];
- Require increased transparency related to public funding for R&D of pandemic-related products, including public dissemination of the results, terms and conditions and contractual terms for public procurement [1], and transparency of procurement processes [2];

- Establish a mechanism overseen by the WHO to ensure equitable distribution of pandemic-related products and ensure a subset of pandemic-related products are reserved for WHO for distribution to LMICs.
- Ensure *t*ransparent information sharing and reporting on global supply chain of ingredients, materials and equipment required for producing pandemic related products [4], to enable better identification and equitable remedy of any bottlenecks or shortages in production.
- Those participating in health research such as vaccine trial and development should receive health resources as recognition of their contributions, risk associated with participation, as well as to encourage ongoing participation [5,6]. There should also be mandates for demonstration of meaningful and equal collaborations between HICs and LMICs in health research particularly where government research funding is involved [7-9].
- Ensure resources are provided to LMICs to support the development of appropriate infrastructure for storage, transport and distribution of pandemic-related products [6].

Health systems and public health workforce: Health system resilience requires universal health coverage and continued service provision of routine and essential health services whilst not overwhelming the health system. The treaty is an opportunity to secure strong political commitment and domestic financing to strengthen national health systems and the public health workforce to deliver all essential health services and public health functions. This includes commitments to:

- Implement the WHO Roadmap [10], to build national workforce capacity to implement the essential public health functions including a focus on emergency preparedness and response.
- Support low- and middle-income countries that are falling behind in delivery of Essential Public Health Functions.
- Invest in increasing education and supply of health professionals to meet population health needs.
- Protect the existing health and care workforce, including all occupational health and safety measures, safe staffing, and fair pay.
- Address the issue of migration of health personnel by implementing the WHO Global Code of Practice on the International Recruitment of Health Personnel.

An exploration of the mindset and skillset which is suited to an infection prevention and control risk environment may identify underutilised adjacent workforces that are desirable to recruit in quarantine programs or use as a surge workforce in the absence of healthcare staff.

One Health: The Treaty is an opportunity to explicitly focus on the drivers and enabling factors associated with zoonotic disease risks and incidence. One Health priorities include:

- *Prevention:* Prevention to focus on prevention of initial spill-over events. This explicitly includes addressing the underlying drivers of zoonotic disease emergence into a Treaty and associated regulations. These drivers include land-use change, unsustainable agricultural production and intensification, large scale deforestation, land degradation and biodiversity loss. There is clear evidence that addressing these drivers of pathogen spillover through a One Health approach has significant subsequent economic co-benefits; for example, reducing deforestation is estimated to create $4 billion per year in social benefits from reduced greenhouse gas emissions [11].
- *Detection:* Inclusion of the requirement for countries to maintain One Health surveillance systems to collect and share data on zoonotic disease incidence and risks. The development of One Health surveillance systems will require substantial capacity and capability building in poorer resourced countries.

- *Response:* Emphasise the need for all countries to prioritise the strengthening of animal health systems designed to manage and eradicate endemic zoonotic diseases and to efficiently conduct surveillance for new and emerging diseases [12].

It will be vitally important for effective provisions supporting a One Health approach to be included in the pandemic treaty. We note with concern that Article 5.B Option 5.B of the Bureau's Draft proposes to completely remove the proposed *Article 5: Strengthening pandemic prevention and preparedness through a One Health approach* from the treaty and urge the Australian Government to argue for its continued inclusion.

References for Question 2

1. Perehudoff, K., t Hoen, E., Mara, K., Balasubramaniam, T., Abbott, F., Baker, B., Boulet, P., Kamal-Yanni, M., Martin, M., Munoz Tellez, V., Natsis, Y., Ortún-Rubio, V., Rathod, S., Torrent, M., Vawda, Y., Villarroel, L., & Love, J. (2022). A pandemic treaty for equitable global access to medical countermeasures: seven recommendations for sharing intellectual property, know-how and technology. *BMJ Global Health*, *7*(7), e009709. https://doi.org/10.1136/bmjgh-2022-009709
2. Saxena, A., Baker, B. K., Banda, A., Herlitz, A., Miller, J., Karrar, K., Fleurbaey, M., Chiwa, E., Atuire, C. A., Hirose, I., & Hassoun, N. (2023). Pandemic preparedness and response: beyond the Access to COVID-19 Tools Accelerator. *BMJ Global Health*, *8*(1), e010615. https://doi.org/10.1136/bmjgh-2022-010615
3. Torreele, E., Kazatchkine, M., Liu, J., Dybul, M., Cárdenas, M., Singh, S., Quigley, H. L., McNab, C., Sirleaf, E. J., Mazzucato, M., & Clark, H. (2023) Stopping epidemics when and where they occur. The Lancet. https://doi.org/10.1016/S0140-6736(23)00015-6
4. Oddleifson, D. A., Kayani, J., Shrivastava, R., Tan, J., Winters, M., Forman, H., & Omer, S. B. (2022). Assessment of the COVID-19 vaccine market landscape in 2021 relative to challenges in low- and middle-income countries. Human Vaccines & Immunotherapeutics, 18(6). https://doi.org/10.1080/21645515.2022.2124781
5. Emanuel, E. J., Persad, G., Upshur, R., Thome, B., Parker, M., Glickman, A., Zhang, C., Boyle, C., Smith, M., & Phillips, J. P. (2020). Fair Allocation of Scarce Medical Resources in the Time of Covid-19. New England Journal of Medicine, 382(21), 2049-2055. https://doi.org/10.1056/nejmsb2005114
6. Liu, Y., Salwi, S., & Drolet, B. C. (2020). Multivalue ethical framework for fair global allocation of a COVID-19 vaccine. Journal of Medical Ethics, 46(8), 499-501. https://doi.org/10.1136/medethics-2020-106516
7. Faure, M. C., Munung, N. S., Ntusi, N. A. B., Pratt, B., & De Vries, J. (2021). Considering equity in global health collaborations: A qualitative study on experiences of equity. PLOS ONE, 16(10), e0258286. https://doi.org/10.1371/journal.pone.0258286
8. Pratt, B., & De Vries, J. (2018). Community engagement in global health research that advances health equity. Bioethics, 32(7), 454-463. https://doi.org/10.1111/bioe.12465
9. Pratt, B., & Hyder, A. A. (2018). Designing research funding schemes to promote global health equity: An exploration of current practice in health systems research. Developing World Bioethics, 18(2), 76-90. https://doi.org/10.1111/dewb.12136
10. World Health Organization (2022). National workforce capacity to implement the essential public health functions including a focus on emergency preparedness and response: roadmap for aligning WHO and partner contributions. Geneva: Licence: CC BY-NC-SA 3.0 IGO https://www.who.int/publications/i/item/9789240050402

11. Dobson AP, Pimm SL, Hannah L, Kaufman L, Ahumada JA, Ando AW, et al. Ecology and economics for pandemic prevention. Science. 2020;369(6502):379-81. https://www.science.org/doi/10.1126/science.abc3189
12. Carlson, C. J., & Phelan, A. L. (2022). International law reform for One Health notifications. *The Lancet*, 400(10350), 462–468. https://doi.org/10.1016/S0140-6736(22)00942-4

Question 3: Is there any other information you would like to provide that might help to guide Australia's engagement on a new international pandemic instrument and changes to the IHR?

Our response to question 3 sets out some overarching principles that we believe should inform the Australian Government's approach to negotiation of the pandemic treaty and amendments to the IHRs. These are: equity; solidarity; inclusive and equitable governance; and ensuring a meaningful level of commitment and effective compliance mechanisms.

Equity

Pandemics affect the most vulnerable. LMICs have been disproportionately affected [1], along with those living in precarious conditions, daily wage workers, those in the informal economy, those in refugee and displaced situations, those in prisons and in bonded labour. Global pandemic prevention, preparedness and response instruments should ensure that financing is available for LMICs to support essential health infrastructure and that governments are provided with the support they need to protect vulnerable populations during pandemics.

Whilst nation states face political pressures to prioritise the health of their own people over that of others, there is also moral justification and duty to distribute vaccines and other pandemic-related products to people in other nations. Vaccines should be viewed as health resources that all people need to protect their health and life [2], thereby global distribution of vaccines contributes to more equitable health resource sharing. During the COVID-19 pandemic there were significant differences in infection rates based on access to vaccinations. For instance, there was up to a twofold increase in cumulative COVID-19 cases in LMICs for each 1-day delay in receiving the first vaccine [3]. Similarly, cumulative mortality was higher and increased with each 1-day delay in receiving the first vaccine in LMICs [3]. Therefore, Australia could both contribute to the global fight against future pandemics as well as assume a global leadership role in ensuring that pandemic-related resources are more equally distributed globally.

To address global health inequities, each country should be empowered and supported to make decisions about healthcare systems and distribution of resources. Supporting involvement of local healthcare actors at all levels of healthcare is important for ensuring that local health needs are addressed [4]. This also includes the equitable involvement of LMIC actors in research about their own health, transfer of skills and technologies, and having meaningful research outcomes that benefits LMICs [5-7].

Solidarity

The international health regulations and other instruments seeking to enhance global health emergency preparedness and responses have a particular focus on enhancing capability and capacity of clinical, medical, and institutional aspects. What has been demonstrated by the global response to COVID-19, in particular the nationalistic stockpiling of necessary products such as vaccines, is that these international instruments failed to account for the important and necessary aspects of global cooperation such as

solidarity. Traditional measures and metrics for health system capacity and pandemic preparedness, such as the international health regulations, were incredibly poor predictors of outcomes [8].

Whilst it is difficult to account for and define solidarity to fit within checklists and frameworks, efforts must be made to ensure that it is incorporated into these instruments. Solidarity is an intersectoral issue which serves as a precondition and consequence of "…equity, shared prosperity, sustainability, and the conditions in which we can all live well" [9]. Consequently, development of approaches that address social and cultural aspects of societies and nations need to be nurtured to enhance and build resilience and solidaristic approaches to global health emergencies.

Governance

The negotiations for, and governance mechanisms established under the pandemic treaty, should be transparent, inclusive, and equitable, with meaningful representation of LMICs [1,10-12]. LMICs were not adequately represented in the early stages of the Access to COVID-19 Tools Accelerator and its vaccines arm, COVAX, which contributed to its failure to adequately address the distribution and health system issues that presented barriers to the absorption of vaccine deliveries once supply was available [1]. Codesign is critical in developing culturally safe pandemic interventions [13]. Researchers call for a greater understanding of the complex interaction of influences that preceded the pandemic experience for different population groups.

The formulation of the Australian Government's positions in the negotiations should also be transparent and inclusive. The consultation materials state: *Australia's priorities have been informed by lessons learned from our national response to the COVID-19 pandemic as well as through consultation within the Australian Government and targeted consultation with interest groups.* We urge transparency about the priorities, the lessons learned that have contributed to these, and the way in which the priorities have been shaped through consultation with interest groups.

Level of commitment and effective compliance mechanisms

To ensure the world is better equipped for future pandemics, it will be vitally important that the pandemic treaty and amendments to the IHR are meaningful, substantive commitments and that there are adequate compliance mechanisms in place. We are concerned about the removal of some proposed provisions and weakening of language in the Bureau's text prepared in June 2023 (e.g. weaker language on the transparency associated with public funding for R&D, the option to remove commitments on time-bound waivers of intellectual property rights (Article 11 Option 11.B) , and the option to remove One Health completely from the treaty (Article 5 Option 5.A), and urge the Australian Government to argue for the inclusion of meaningful commitments on these issues. We also urge the consideration of a range of compliance mechanisms that have proved effective in other areas of international law, including a Conference of the Parties, independent rapporteurs, dispute settlement mechanisms, processes for civil society reporting and accountability, provision of technical assistance and resources, and formal trust-building activities, as proposed by Kavanagh et al. [14].

References for Question 3

1. Gleeson, D., Townsend, B., Tenni, B. F., & Phillips, T. (2023). Global inequities in access to COVID-19 health products and technologies: A political economy analysis. *Health & Place*, *83*, 103051. https://doi.org/https://doi.org/10.1016/j.healthplace.2023.103051
2. Jecker, N. S., Wightman, A. G., & Diekema, D. S. (2021). Vaccine ethics: an ethical framework for global distribution of COVID-19 vaccines. Journal of Medical Ethics, 47(5), 308-317. https://doi.org/10.1136/medethics-2020-107036

3. Duroseau, B., Kipshidze, N., & Limaye, R. J. (2023). The impact of delayed access to COVID-19 vaccines in low- and lower-middle-income countries [Original Research]. Frontiers in Public Health, 10. https://doi.org/10.3389/fpubh.2022.1087138
4. Gilson, L., Lehmann, U., & Schneider, H. (2017). Practicing governance towards equity in health systems: LMIC perspectives and experience. International Journal for Equity in Health, 16(1). https://doi.org/10.1186/s12939-017-0665-0
5. Faure, M. C., Munung, N. S., Ntusi, N. A. B., Pratt, B., & De Vries, J. (2021). Considering equity in global health collaborations: A qualitative study on experiences of equity. PLOS ONE, 16(10), e0258286. https://doi.org/10.1371/journal.pone.0258286
6. MacDonald, N. E., Bortolussi, R., & Kabakyenga, J. (2023). A long-term process for decolonizing and democratizing community-focused research: the case for MicroResearch in East Africa and in Canada. Canadian Journal of Public Health, 114(1), 147-151. https://doi.org/https://doi.org/10.17269/s41997-022-00680-2
7. Pratt, B., & De Vries, J. (2018). Community engagement in global health research that advances health equity. Bioethics, 32(7), 454-463. https://doi.org/10.1111/bioe.12465
8. COVID-19 National Preparedness Collaborators (2022). Pandemic preparedness and COVID-19: an exploratory analysis of infection and fatality rates, and contextual factors associated with preparedness in 177 countries, from Jan 1, 2020, to Sept 30, 2021. Lancet, 399(10334), 1489–1512. https://doi.org/10.1016/S0140-6736(22)00172-6
9. Atkins, B., Cossich, T., Richardson, L., Ramos, G., & Legge, D. Solidarity is a core capacity for emergency preparedness and response. Authorea. August 10, 2023. DOI:10.22541/au.169169409.97360899/v1
10. Perehudoff, K., t Hoen, E., Mara, K., Balasubramaniam, T., Abbott, F., Baker, B., Boulet, P., Kamal-Yanni, M., Martin, M., Munoz Tellez, V., Natsis, Y., Ortún-Rubio, V., Rathod, S., Torrent, M., Vawda, Y., Villarroel, L., & Love, J. (2022). A pandemic treaty for equitable global access to medical countermeasures: seven recommendations for sharing intellectual property, know-how and technology. *BMJ Global Health*, *7*(7), e009709. https://doi.org/10.1136/bmjgh-2022-009709
11. Saxena, A., Baker, B. K., Banda, A., Herlitz, A., Miller, J., Karrar, K., Fleurbaey, M., Chiwa, E., Atuire, C. A., Hirose, I., & Hassoun, N. (2023). Pandemic preparedness and response: beyond the Access to COVID-19 Tools Accelerator. *BMJ Global Health*, *8*(1), e010615. https://doi.org/10.1136/bmjgh-2022-010615
12. Torreele, E., Kazatchkine, M., Liu, J., Dybul, M., Cárdenas, M., Singh, S., Quigley, H. L., McNab, C., Sirleaf, E. J., Mazzucato, M., & Clark, H. (2023) Stopping epidemics when and where they occur. The Lancet. https://doi.org/10.1016/S0140-6736(23)00015-6
13. Fotheringham P, Dorney E, McKinn S, Fox GJ, Bernays S. Protecting mental health in quarantine: Exploring lived experiences of Healthcare in mandatory COVID-19 quarantine, New South Wales, Australia [Internet]. SSM Popul Health. 2023;21 [about 5 p.]. Available from https://doi.org/10.1016/j.ssmph.2022.101329
14. Kavanagh, M. M., Wenham, C., Massard da Fonseca, E., Helfer, L. R., Nyukuri, E., Maleche, A., Halabi, S. F., Radhakrishnan, A., & Waris, A. Increasing compliance with international pandemic law: international relations and new global health agreements. The Lancet. https://doi.org/10.1016/S0140-6736(23)01527-1

Conclusion

This submission emphasises the urgent need for enhanced international cooperation, equitable access, and collective response strategies to address future pandemics and international health emergencies. The PHAA appreciates the opportunity to make this submission.

Please do not hesitate to contact me should you require additional information or have any queries in relation to this submission.

PHAA would also be pleased to participate in any consultations organised by the Australian Government about the new international pandemic instrument and changes to the IHR.

Terry Slevin
Chief Executive Officer
Public Health Association of Australia

Deborah Gleeson
Co-convenor
PEH Special Interest Group

19 September 2023