

TO: Pandemic Treaty Intergovernmental Negotiating Body

November 8, 2022

Co-Chairs Drs. Precious Matsoso and Roland Driecé

AND TO: Dr. Timothy Armstrong, Director, Dept. of Governing Bodies

% World Health Organization

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By email to: ArmstrongT@who.int and GovernanceUnit@who.int and R.A.Driecé@minvws.nl

Re: measures to ensure that the Pandemic Treaty serves the purpose of protecting all people, especially including those in low-income countries with limited financial resources and fragile health care systems

Dear members of the intergovernmental Negotiating Body:

We are writing on behalf of some public interest stakeholders invited to participate in the Pandemic Treaty Negotiations and other civil society organizations sharing their concerns and expectations about the “Conceptual Zero Draft of the proposed WHO convention, agreement or other international instrument on pandemic prevention, preparedness and response” (the Pandemic Treaty) which is expected to be published by the INB Bureau in mid-November and form the basis of formal negotiations after the next INB session on December 5-7, 2022.

In our view, the Pandemic Treaty should reflect the following collective understanding and guidance to member states. We believe these elements are on sound legal, public policy, ethical, and scientific footing. However, we are also aware that strong commercial interests may resist some measures. Likewise, governments in some high-income countries may resist significant financial outlays to support populations in lower-income countries as generously as their own populations, even if doing so on a single lower order of magnitude is justified and conducive to the belief that nobody is safe until everyone is safe. The International Court of Justice has repeatedly ruled that it is obliged to interpret international law in a manner that ensures equity and will decide factors applicable to the circumstances,¹ though recognizing and operationalizing equity in the Pandemic Treaty seems wise and fair.

1. **Gravity of foreseeable disease risks:** The Pandemic Treaty should acknowledge the gravity of the COVID-19 pandemic and the estimates that it caused 18 million “excess deaths” in the first two calendar years, 2020 and 2021, approximately three-fold higher than the 6 million officially reported deaths, and an average of 15% more deaths per year than in 2019, according to the Lancet Excess Mortality Collaborators.² In the future, it could be worse.
2. **Conflict-of-interest safeguards:** The Pandemic Treaty negotiations, content, and implementation should be subject to conflict-of-interest safeguards to ensure that companies, industry associations, and any civil society organizations and experts they financially support do not secretly or even transparently use the Pandemic Treaty to further their financial interests. (See [Part IV, paras. 5 and 9\(d\) of the Jul 2022 Working Draft](#).) Some industries of potential concern include the pharmaceutical and medical commercial product developers in the private healthcare sectors, surveillance technology, tobacco, alcohol, correctional, weapons and the military-industrial complex, NGO, trust, corporate philanthropies or foundations funded by entities within the categories listed above, any other entity that might pose create a conflict of interest.
3. **Primacy of human rights of natural persons and communities relevant to health over business legal rights:** The Treaty implementation mechanism must recognize fundamental human rights, including the right to health and to safe and nutritious food, medicines, and healthcare and a methodology for sharing the burden of realizing these rights, including in relation to enforceable intellectual property, trade and investment treaty entitlements. The

Pandemic Treaty should also acknowledge recurring human rights violations in the context of pandemics, and rights that are particularly at risk in pandemic times, and integrate international standards on derogation and limitation of rights in times of public health emergencies with additional, specific attention to the realization of economic, social and cultural rights that are currently not sufficiently protected by the [Siracusa Principles](#). It should also clarify that, in line with those standards, pandemic response should be managed by civilian authorities (vis-a-vis law enforcement), with a⁴whole-of-government approach.

- 4. Pandemic prevention:** The Pandemic Treaty must prioritise prevention at source and, accordingly, One Health and the rights to clean water and sanitation and to a clean, healthy and sustainable environment should be integrated as central, guiding principles and objectives and mainstreamed throughout the Pandemic Treaty.
- 5. Enforcement:** The Pandemic Treaty should stipulate effective, actionable enforcement mechanisms in consideration of the primacy of the human rights of natural persons and communities, especially in relation to property rights of private corporations with which true human rights sometimes conflict (including interests in intellectual property and the advertising, promotion and sale of products that could protect or undermine health) in consideration of the wide variety of “soft” and “hard” enforcement mechanisms that ensure compliance with other international agreements and national laws.
- 6. Standing of civil society:** The Pandemic Treaty, negotiation process, and implementation should entrench an effective and meaningful role for public interest, public health, human rights civil society, and community organisations to securely and predictably participate in the governance, enforcement, and continuous elaboration of further refinements to Pandemic Treaty obligations including the negotiation of additional protocols and the right to participate as interveners or amicus curiae in international tribunal or court proceedings. Secret negotiations (that exclude public interest groups and the media) are not conducive to effective government and public trust with sufficient access to information and transparency of decision-making, consultation registers, lobbyist registries, internationally and nationally. They should be avoided.
- 7. Proportionality of human rights:** International and national countermeasures should be designed to protect public health and social security, but be proportional between the risk to health and well-being and balanced against other rights and, where possible, quantified and based on the best available expertise and information recognizing that effective measures may be time-sensitive. All countermeasures must comply with international standards on limitations and derogations to human rights.
- 8. The right to health is a building block right:** The right to health is a building block right, on which the realization of other rights depends. Beware a tendency to drift into thinking that the major concern is the suspension of collateral human rights caused by countermeasures such as restrictions on freedom of assembly (to prevent infections in congregate settings) or limits on freedom of expression (to discourage the promotion of untested remedies or unreliable studies that undermine countermeasures). However, suspension of collateral rights (e.g., freedom of assembly and free expression to dispute science-information countermeasures) should certainly be proportional to the objectives of impeding infection outbreaks, illness, and death.
- 9. The right to health is indivisible:** Life expectancy and premature death and disability are important, though imperfect indicators of the realization of the right to health. The Pandemic Treaty should not elevate the right to be free from a pandemic illness above the right to be free of other equally or more harmful illnesses, including non-communicable diseases such as cardiovascular disease, cancer, diabetes and chronic obstructive pulmonary disease that kill two-thirds of adults and gastrointestinal and lung infections attributed to suboptimal breastfeeding that now likely kill approximately 900,000³ infants and young children per year. Poor public health infrastructure and access to care and medicines in low- and middle-income countries put

populations at risk. Healthcare solutions that make people with NCDs envious of people with global infectious diseases, or vice-versa, do not comport with the right to health.

- 10. Investigatory powers:** The Pandemic Treaty must establish a mechanism for conducting arm's length expert investigations into causes and countermeasures that commits member states to fully cooperate by default, not through arrangements that are negotiated on a case-by-case basis.⁴
- 11. Accountability and enforceability:** The Pandemic Treaty should distinguish between moral or political accountability and legal (justiciable and enforceable) accountability.
- 12. Equitable global access to pharmaceutical products:** A Pandemic Treaty must include the following elements:
 - a. **Transparency:** The Pandemic Treaty should mandate transparency in all access to medicines spheres, including costs (e.g., for research & development and production), prices, data, contracts, and the patent landscape.
 - b. **Sharing intellectual property, know-how and technology:** The Pandemic Treaty should include clear and binding clauses to limit intellectual property rights and require transfer of know-how and technology. The Pandemic Treaty must commit States Parties to limit intellectual property rights and compel rights holders to share know-how, technology, and rights to use safety and efficacy test data to obtain regulatory approvals.
 - c. **Deemed contractual terms in countermeasure procurement:** The Pandemic Treaty must contain obligations for governments to set conditions in their funding agreements that safeguard public benefits.
 - d. **Public Health Advocacy Fund:** States Parties should contribute to an Advocacy Fund to ensure that low- and middle-income country governments seeking access to medicines governed by intellectual property agreements are able to avail themselves of all opportunities to assert human and public health rights.⁵
- 13. Promote a prepared and healthy workforce, especially to deal with surges in care:** States Parties must recognize in the Pandemic Treaty that until high-quality healthcare is available to all without financial barriers, ill-health will impede the life chances of people and the economic and social development of peoples. While the worst ravages of COVID-19 befell the elderly, future pandemic may not repeat that pattern. Even high-income countries staffed by expensively trained health professionals in right-sized hospitals stored with adequate pharmaceutical and medical technology suffered from staff and supply shortages and staff burnout, exacerbated by still relentless waves of infections. In lower-income countries, the waves of infectious disease outbreaks exacerbate horribly inequitable access to medical care for cancer, cardiovascular disease, diabetes, HIV/AIDS, pneumonia, malaria, and other communicable and non-communicable diseases. Governments and the global community need an integrated healthcare human resource strategy to prepare for surge control in pandemics and meeting ongoing healthcare needs.
- 14. Avoid acronyms and initialisms:** The July 13, 2022 19-page "Working draft, presented on the basis of progress achieved, for the consideration of the Intergovernmental Negotiating Body at its second meeting" uses the short form "WHO CAII" which will stymie public-facing communications and likely be substituted with various other titles by news media. Instead, use "Pandemic Treaty" or "Pandemic Prevention & Response Treaty." The Pandemic Treaty negotiations could be described in WHO Parlance as "The WHO INB hosting IFCs to explain the convention's relationship to GSD, UHC, PHC, IHRs, TRIPS, IP Waivers using the experiences of the WGGPR." using only one initialism that is recognized by the public: "WHO."

- 15. Burden-sharing formula:** The Pandemic Treaty should stipulate a formula for burden-sharing by member states for international countermeasures and national countermeasures in low- and middle-income countries in consideration that there are unequal financial and technical resources to treat, prevent, and detect infectious diseases and that effectively countermeasures benefit global public health security. The rise in public spending on national COVID-19 countermeasures in high income OECD countries exceeded the average per-capita rise in Official Development Assistance per capita received by low- and middle-income countries by more than 1,000-fold. Global financial support must be significantly higher to equitably and effectively prevent and combat pandemics.⁶
- 16. Ensure adequate financing for pandemic prevention, preparedness and response, in addition to existing finance for health:** The Pandemic Treaty needs to stress the importance of mobilizing public finance for health and pandemic countermeasures, and the urgent need for strengthening health systems. The funding that is needed for all three approaches should be additional funding and not compete with existing funding in the global health sphere. This requires new sources of public funding. Any new funding modality/mechanism should be broad in scope with a focus on prevention and acknowledging that prevention is more than just containment of outbreaks or surveillance.

The governance of global finance for pandemic PPR should move beyond the ‘one-dollar-one-vote’ aid paradigm that has plagued many institutions and become, instead, a modern inclusive way of financing global public goods based on fair-share contributions and in which decision-making is shared between countries of different income levels, different regions, and civil society.

The Pandemic Treaty should establish a Registry of Official Pandemic Countermeasures Contributions in which each country reports the amount it offers—additional to pre-pandemic support—provided to low- and middle-income countries (expressed in local currency and US dollars or Swiss francs) to address pandemic matters and to support citizens and residents in its own borders and endeavor to commit at least 5% of the total spent on domestic countervailing measures on measures in low- and middle-income countries.⁷

We urge you to ensure that the Zero Draft of the Pandemic Treaty portrays the most effective and equitable way to protect the peoples of the world. The whole world is watching.

Respectfully submitted,

1. ACT - Alliance contre le tabac, France
2. Action Jeunesse pour le Développement, Congo
3. Action Lab For Development, Cameroon
4. Action on Smoking and Health, United States of America
5. Adolescent Breast and Pelvic Cancer Awareness Initiative, Nigeria
6. African Centre for Global Health and Social Transformation (ACHEST), Uganda
7. Africa Development Interchange Network (ADIN), Cameroon
8. African Citizens Development Foundation, Nigeria
9. Afrihealth Optonet Association, Nigeria
10. AIM Education & Research Society, India
11. ASH Canada, Canada
12. Association for Environment Protection and Sustainable Development of Bizertet, Tunisie
13. Association For Promotion Sustainable Development, India
14. Association of World Citizens, France
15. Association pour l'amélioration des droits et condition de vie des prisonniers et migrants, Mauritanie

16. Association-Santé-Education-Démocratie, Niger
17. AWTAD Anti-Corruption Organization, Yemen
18. Baby Milk Action, United Kingdom
19. Blessed Aid, Democratic Republic of Congo
20. Bridgers Association Cameroon, Cameroon
21. Center for Interethnic Cooperation, Russia
22. Centre for Health Science and Law (CHSL), Canada (corresponding author: BillJeffery@HealthScienceAndLaw.ca)
23. Centre for Socio-Eco-Nomic Development (CSEND), Bangkok
24. Ciscos Ugl (Centro internazionale sindacale per la cooperazione sviluppo), Italy
25. Citizen News Service, India & Thailand
26. CO-HABITER, Switzerland
27. Community Restoration Initiative Project, Uganda
28. Corporate Accountability, United States of America
29. CREA, A network of young people that promotes healthier environments, Latin America
30. Creators Union of Arab, Egypt
31. Development, Empowerment & Sustainability Solutions Initiatives (DESSI) International, Pakistan
32. Divine Act Charitable Trust, Nigeria
33. Education and English for You, Cote d'Ivoire
34. EL-AGED CARE LTD/GTE, Nigeria
35. Emma & Grace Foundation, Nigeria
36. European Network for Smoking and Tobacco Prevention (ENSP), Belgium
37. Forum mediteraneen pour la promotion des droit du citoyen, Morocco
38. Francisco Rodriguez Lozano, MD, Spain
39. Fundación Latinoamérica Reforma, Chile
40. Fundacion retorno a la libertad, Colombia
41. Global Integrated Education Volunteers Association, Nigeria
42. Global Network of Psychologists for Human Rights, United States of America, Netherlands, etc.
43. Global Welfare Association (GLOWA), Cameroon
44. Haiti Cholera Research Funding Foundation Inc (HCRFF), United States of America
45. Hamraah Foundation, India
46. Healis Sekhsaria Institute for Public Health, India
47. Hope Outreach Foundation, Cameroon
48. Hope Worldwide-Pakistan, New Zealand
49. Human Development Society, Gambia
50. Human Rights and Grassroots Development Society HRGDS, Nigeria
51. Indigenous Peoples Global Forum for Sustainable Development (IPGFforSD), Burundi
52. Initiative: Eau, United States of America
53. Institute of the Blessed Virgin Mary - Loreto Generalate, United States of America
54. Institute of Leadership and Development, Ghana
55. Interantional Baby Food Action Network (IBFAN), Italia odv, Italy
56. International Baby Food Action Network, Global Council, United Kingdom
57. International Career Support Association Institute, Japan
58. International Council of Psychologists, United States of America
59. International Human Rights Commission (IHRC), Pakistan
60. International Medical Crisis Response Alliance, United States of America
61. International Polytechnic of Science and Technology (IPOSTEC), Cameroon (across Africa)
62. International Relations Students' Association of McGill University, Youth Advisory Delegation (IYAD), Canada
63. International-Lawyers.Org, Switzerland

64. ISIZIBA Community Based Organizations of South Africa, South Africa
65. Japan Society for Tobacco Control, Japan
66. Leadership Development Association Balkan, Albania
67. Mandela Center International, Cameroon
68. Mouvement d'organisation des ruraux pour le développement (M.O.R.D), Togo
69. Neiloy Sircar, JD, LL.M, Staff Attorney, United States of America
70. Ngece Rinjeu Foundation, Kenya
71. Northern Citizen Community Board, Pakistan
72. Norwegian Cancer Society, Norway
73. O.N.G ACHE Internacional, Canada and Chile
74. Open Dreams, Cameroon
75. OxySuisse, Switzerland
76. Pak Women, Pakistan
77. Pan Pacific and South East Asia Women's Association, United States of America
78. Passionists International, United States of America
79. Pathways To Peace, United States of America
80. Peace Foundation Pakistan, Pakistan
81. Peace One Day, Mali
82. Peace Track Initiative, Canada
83. People's Vigilance Committee on Human Rights (PVCHR), India
84. Prof. Luisa Ravagnani, Italy
85. Public Health Advocacy Institute, United States of America
86. Reach Out Cameroon (REO), Cameroon
87. Reseau d'intervention, pour la protection et promotion de l'enfant et famille dans la communauté, Republique Democratique du Congo
88. Romeo and Zainab Boudib Foundation (ROMZAIB Foundation), Nigeria
89. Ryan A Rohde, MPH; Infection Control Practitioner , United States of America
90. SAFE Coalition for Human Rights, United States of America
91. Samarthanam Trust for the Disabled, India
92. Shri Bhagwan Mahavir Viklang Sahayta Samiti, India
93. Smoke Free Life Coalition, Bulgaria
94. Tanjong Bunga Residents Association, Malaysia
95. The Reformed Drug and Substance Abuse Initiative (REDSAI), Nigeria
96. Tobacco Free Association of Zambia
97. Unfairtobacco / BLUE 21, Germany
98. Vision for Alternative Development , Ghana
99. Viva Salud, Belgium
100. Wahag Alhayah Foundation, Yemen
101. Wemos, Netherlands
102. Youth For Transparency International, Canada
103. Zambia Heart and Stroke Foundation, Zambia

Endnotes

1. For instance, *Frontier Dispute, Judgment*, I.C.J. Reports 1986, p. 554. Available at: <https://www.icj-cij.org/public/files/case-related/69/069-19861222-JUD-01-00-BI.pdf>; Application for Revision and Interpretation of the Judgment of 24 February 1982 in the Case concerning the Continental Shelf (Tunisia/Libyan Arab Jamahiriya) (Tunisia v. Libyan Arab Jamahiriya), Judgment, I. C. J. Reports 1985, p. 192. Available at: <https://www.icj-cij.org/public/files/case-related/71/071-19851210-JUD-01-00-BI.pdf>; and Continental Shelf (Tunisia/Libyan Arab Jamahiriya), Judgment, I.C.J. Reports 1982, p. 18. Available at: <https://www.icj-cij.org/public/files/case-related/63/063-19820224-JUD-01-00-BI.pdf>
2. COVID-19 Excess Mortality Collaborators. Estimating excess mortality due to the COVID-19 pandemic: a systematic analysis of COVID-19-related mortality, 2020-21. *Lancet*. 2022 Apr 16;399(10334):1513-1536. Erratum in: *Lancet*. 2022 Apr 16;399(10334):1468. Available at: <https://www.thelancet.com/action/showPdf?pii=S0140-6736%2821%2902796-3>
3. Victora CG, Bahl R, Barros AJ, França GV, Horton S, Krasevec J, Murch S, Sankar MJ, Walker N, Rollins NC; Lancet Breastfeeding Series Group. Breastfeeding in the 21st century: epidemiology, mechanisms, and lifelong effect. *Lancet*. 2016 Jan 30;387(10017):475-90. Available at: [https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736\(15\)01044-2.pdf](https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(15)01044-2.pdf)
4. “Why the Chair of the Lancet’s COVID-19 Commission Thinks The US Government Is Preventing a Real Investigation Into the Pandemic: An interview of Jeffrey D. Sachs” by Nathan Robinson. Current Affairs, August 2, 2022. Available at: <https://www.jeffsachs.org/interviewsandmedia/64rtmykxdl56ehbjwy37m5hfahwnm5>
5. Pehudoff 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. A pandemic treaty for equitable global access to medical countermeasures: seven recommendations for sharing intellectual property, know-how and technology. *BMJ Glob Health*. 2022 Jul;7(7):e009709. Available at: <https://gh.bmj.com/content/bmjgh/7/7/e009709.full.pdf>
6. One of the September 21, 2022 consultation meeting experts, [Professor Matiangai Sirleaf](#), noted the importance of establishing a quantified approach to assigning “burden sharing” arrangements in the Pandemic Treaty. Importantly, annual official development assistance by OECD countries increased only marginally from the low amount of \$156 billion per year to \$169 billion from 2019 to 2021 when the ravages of COVID-19 became most worrisome which is an increase of an average of only \$2 per capita per year in low- and middle-income countries. (See: <https://data.oecd.org/oda/net-oda.htm>) Likewise, as His Excellency Munir Akram, former President of the Economic and Social Council, noted in the launch event of *The State of Food Security and Nutrition in the World 2022 Report* on July 6, 2022 in New York [at time 1:37:30](#), developing economies have had access to only mg\$100 billion in COVID-19 mitigation funds (including loans), but high-income countries injected US\$17 trillion into their own economies to recover from COVID-19. This is 170-fold more in countermeasures to serve a population (of OECD countries) that is approximately one-sixth the population of developing countries. Similarly, while foreign aid rose to an all-time high during COVID-19 when Official Development Assistance rose, it is still short of the pre-pandemic decades-long, widely ignored call by the World Bank and United Nations that countries contribute 0.7% of Gross National Income to Official Development Assistance.
7. See, for example: Fiscal Monitor: Database of Country Fiscal Measures in Response to the COVID-19 Pandemic at: <https://www.imf.org/en/Topics/imf-and-covid19/-/media/Files/Topics/COVID/FM-Database/October-2021/oct-2021-country-fiscal-measures-database-publication.ashx> and Official Development Assistance (ODA) 2021 at: <https://www.oecd.org/dac/financing-sustainable-development/development-finance-standards/official-development-assistance.htm>