Prevent, Prepare, and Respond: An Analysis of Global Health Architecture for Pandemic Preparedness

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2023 will be a pivotal year for global health and the structures that are set up to address it. Decisions being made at the highest levels of government will determine how prepared we are for future pandemics and will reshape how we respond to ongoing ones. AVAC is keen to articulate policy positions on these structural shifts and global policy changes that will determine – among other things – the future of the HIV response.

In the coming weeks and months, high-level consultations will shape the governance of global health institutions like the WHO and Pandemic Fund, the trajectory of international agreements and declarations like the Pandemic Accord and UN Declarations on Universal Health Coverage (UHC) and pandemic prevention, preparedness, and response (PPPR), the priorities of major convenings of 2023 taking on pandemic preparedness, and the appointment of a new World Bank president. AVAC is calling for the choices made in these consultations and negotiations to put the world on track for a resilient response to future disease threats while effectively tackling today's ongoing pandemics of HIV, tuberculosis (TB), and malaria. These choices must strengthen cooperation and infrastructure and secure sustainable investment and implementation.

We are at a pivotal moment; reimagining global health architecture could change the trajectory of humanity. It is imperative that global public health is considered and prioritized as a collective multinational good. There is no such thing as an individual country being solely responsible for its own health needs. In a reimagined vision, each country could contribute their fair share based on resources available to be distributed globally, with priority for serving those most in need and achieving global health equity. As illustrated most glaringly by the ongoing COVID-19 response, richer countries have long abandoned global public health concerns once they consider the situation to be under control in their own countries (as with HIV, TB, malaria, and other infectious diseases). This inward dynamic and isolationist approach must end: until access to essential health services and biomedical interventions is equal for all, we are all vulnerable to new health threats.

Global Health Architecture

Health is borderless. It is crucial that there be a centralized, unbiased body to coordinate pandemic responses. The WHO excels at using science and data-driven evidence to set normative guidance and policy, which fills a crucial global need – UN Member States rely on these resources to optimize their own public health infrastructure. While the core functions of the WHO have been politicized, it is only possible for them to be successful in this role if they are detached from in-country political shifts. WHO's multilateral position must be strengthened to strategically position it for future epidemics, and to continue its vital work against existing diseases such as HIV, TB, malaria, other communicable pathogens, including COVID-19. WHO's funding must be dramatically scaled-up to address priority areas that the world has collectively neglected while instead responding reactively to emergency situations and seeking quick wins. To that end, we strongly recommend that the U.S. Congress legally codifies our nation's annual assessed contribution of a 'fair share' of resources to the WHO. Without this commitment political changes threaten the ability of the WHO to function as necessary. In addition, Congressional appropriators should work creatively and bipartisanly to increase annual assessed contributions to the WHO, through various funding mechanisms, with the aim to position WHO to respond to future epidemics while bolstering efforts against HIV and ongoing infectious disease epidemics.

At the same time, the position of organizations like the Global Fund to Fight AIDS, TB, and Malaria (GFATM) and PEPFAR that have for two decades carried out pandemic responses must be leveraged to effectively prepare and respond to pandemic threats. GFATM and PEPFAR have successfully combated long-standing global pandemic threats, to the tune of saving over 70 million lives. Rather than straining funding further to build new systems for PPPR, the laboratory capabilities, surveillance networks, health workforce capacity, and community engagement mechanisms that these organizations have built should serve as the foundation for any future efforts.

The question of how to fund a robust, broad global health architecture for PPPR necessarily presents itself as overseas development assistance (ODA) resources and domestic resources for health are poised to shrink. Despite evidence for a tremendous need in increases to fully fund long-term approaches to prevent and prepare for pandemic threats, the world has so far not generated the essential commitments to meet that need. Non-ODA financing options, such as expanding use of multilateral development banks (MDBs), debt relief for health agreements, and catalytic finance platforms must be explored and are sorely needed to drive up country and regional investment to build resilient health systems. However, the ideal scenario would be a fair share system of global public investment.

If global health is regularly funded in a fair share system, the global community will save fiscal resources. The savings are astronomical. It's much more economical to address current health crises and prepare for future ones now, and vastly more expensive to react to compounding emergency threats later. We'll also save money by prioritizing resources based on need over donor preferences and interests. Low- and middle-income countries and key populations know the limitations of their own systems and are best positioned to direct allocations where they will make the most impact. This will necessarily mean that donors give up some control and that politicians look beyond their term and agree to fund multi-year programs to strengthen overall systems. The problems that collectively face us cannot be solved with a one-time contribution for a year. We strongly recommend that global health negotiators adopt the common but differentiated responsibilities (CBDR) principle as a baseline for assessing roles and contributions to global health initiatives (GHIs).

As global health architecture goes through an overhaul against the backdrop of the continuing COVID-19 pandemic, it is of the utmost importance that successful models of community and civil society engagement are part of the foundation of new initiatives, and retained in existing initiatives with shifting structures. Any funding mechanism's governance should be based on the Global Fund model (with representation for relevant constituencies and official delegations of civil society members on the board as full decision-makers) as a starting point, and communities and civil society must have formalized, meaningful, non-tokenistic, accessible pathways to contribute input and feedback to international agreements, to international bodies such as the UN and WHO, to national governments, and in specific convenings and multistakeholder fora. Global health negotiators should prioritize enshrining basic community engagement principles now as decisions are being made and governance structures erected.

Pandemic Prevention, Preparedness and Response Priorities

The coming year will set the trajectory for global health through 2030, the deadline for most global goals and milestones. There is a significant opportunity to harness new initiatives and reform existing infrastructure to better address health issues, recommitting the world to the primary health care (PHC) measures outlined in the Astana Declaration and prioritizing health systems strengthening. There is growing recognition of the interrelated nature of global health and the need to integrate health responses between disease areas and with trade, education, labor, and finance.

Resources for PPPR have historically been too little and too focused on infrastructure (laboratory capacity, gene sequencing functionality, and surveillance) while donor countries typically see PHC and health systems strengthening as an in-country responsibility. Multilateral-driven policy initiatives and platforms such as the WHO Pandemic Accord, new Pandemic Fund, and UN PPPR High-Level Meeting (HLM) present a great opportunity to, for the first time, collectively fund and strengthen health systems and primary health care — if the decisions incorporate lower- and middle-income country (LMIC) and civil society priorities, and adequate funds are raised and equitably distributed.

A global commitment to health equity means shoring up health systems while continuing and strengthening ongoing responses. Investments in PPPR cannot be diverted from any existing budgets (that should be increasing, not stretched thinner) to fund health workforce recruitment and retention efforts (including commitment to sustained payment of all health worker cadres). Nor can it be diverted from current efforts in the response to HIV, TB, malaria, COVID-19, Mpox, and other respiratory pandemic pathogens. While significant progress has been made in the responses to these pandemic challenges, now is not the time to let up the pressure to end these threats. AVAC also urges decision-makers to integrate these responses into preparedness

efforts. Building on the gains made so far, instead of squandering significant investment and resources when the next pathogen sets back global targets against these ongoing pandemics, will leverage the structures the world builds now for resilient health systems, and save time, money, and lives.

In these global negotiations, the opportunity to shift the balance of power and bring equity to global health is ripe. The diplomatic priority must be agreements that expand access to medicines and tools for emergencies and for longer-term responses. Establishing and maintaining supply chains and adequate stockpiles requires **equal access** to products and medicines. Global health and political leaders must mobilize substantial resources to increase local manufacturing capacity and mandate a protocol for emergency technology and knowledge transfer, including full adoption, use, and protection of TRIPS flexibilities. Although increasing LMIC manufacturing capacity and implementing a pathway to register pandemic tools in LMICs as quickly as in high-income countries will go a long way to addressing the problems of inequitable pandemic response mechanisms, intellectual property waivers and facilitated technology transfer are still necessary. In an emergency situation, we cannot simply hope that disparate researchers and manufacturers develop novel medical countermeasures to a pandemic threat at the same time.

AVAC also urges governments to clearly name and codify key populations, health workers, and other vulnerable groups and populations with comorbidities in international agreements. Ensuring the distribution of pandemic diagnostics and treatment tools to those who need it most, marginalized communities who are so often disconnected from care and carry disproportionate risks, is key to succeeding in preparedness efforts. These groups must be prioritized at both the global and national levels, without discrimination, and enshrined in formal declarations and agreements so civil society groups can hold governments and institutions to account.

We know from our experience in the global HIV response that the last mile of pandemic response comes down to access. Right now, HIV incidence has begun to decline across broad national populations, but is increasing among key populations and those excluded from access to health services. True universal health coverage (UHC) – a health system that is both financially and socially accessible – would address that. The second UN High-Level Meeting (HLM) on UHC to take place in September 2023 provides an opportunity for governments to agree on what an equitable and functioning health system looks like, which is the foundation of pandemic prevention and preparedness. We believe that poverty should have nothing to do with someone's ability to receive essential services, and there are many other organizations and activists working to remove financial barriers to health services around the world.

However, it is not enough to remove financial barriers – social & systematic barriers must also be identified and rectified (such as distance from a health worker or clinic, stigma and discrimination, access to medicines and tools, inclusion of men in routine primary care, reducing in person visit with the use of technology, and many others). Governments and health institutions must work to make routine and preventative health services exceedingly normal and mundane. This is a benefit not only for overall health, but for pandemic prevention – the more a population routinely seeks and receives services, the more they will trust the health system and engage with it when a pandemic threat arises. To that end, the UN HLMs on UHC and PPPR should be mutually interdependent and responsive and governments should seek community and civil society input for priorities on both concurrently.

Who Does Global Health Serve?

In the end, the global health architecture should be built on a foundation that is aimed at those most in need. The current system for decades has failed in this respect. This coming year is the best shot the world has to shift whose voices get heard and lay a foundation for global health equity. We call on governments, multilateral institutions, decision-makers, and those with a large microphone to make it possible to transfer power, knowledge, and technology to those experiencing the largest burden of historical inequity in global health. These negotiations are a proving ground to bring this to life.

About AVAC: Founded in 1995, AVAC is a non-profit organization that uses education, policy analysis, advocacy and a network of global collaborations to accelerate the ethical development and global delivery of HIV prevention options as part of a comprehensive response to the pandemic. Follow AVAC on Twitter @HIVpxresearch and find more at www.avac.org and www.prepwatch.org.