

# Written Comment Re: Implications of Access and Benefit Sharing (ABS) Commitments/Regimes and Other Proposed Commitments in the WHO Pandemic Agreement

## By The People Vaccine Alliance

The People Vaccine Alliance, a coalition of over 100 organisations and networks, supported by Nobel Laureates, health experts, economists, Heads of States, faith leaders and activists, working together towards equitable access to medical technologies that help to prevent and respond to COVID-19 and future pandemics.

### General comments

The Pandemic Agreement should include:

1. Binding commitment to share pandemic related products (PRP) equitably especially when demand outstrips supply.
2. Mandating public R&D funding and purchasing to be conditioned on supplying developing countries, sharing technology and removing intellectual property barriers.
3. Binding commitment to share technology to enable local production. Almost two and half years since the WHO mRNA programme was announced, not one single pharmaceutical company shared the technology and know-how with it. WHO launched The Health Technology Access Pool, and the Pandemic Agreement must support it.
4. Prioritising funding for collaborative research and long-term financing for diversified regional R&D and production hubs.
5. Balancing the current obligations on developing countries for expanded surveillance, with obligations on rich countries to share products and financial benefits under the PABS system. There is no moral or public health justification for LMICs to share pathogens and wait for the good will of pharmaceutical companies.
6. Financing of PPPR and health systems through common but differentiated responsibilities principle.

### Detailed comments:

#### **Article 9 (R&D) should include:**

- **Conditionalities for public funding** of R&D and purchasing contracts for fund recipients to share technology and know-how.
- Prioritization of funding of **collaborative research** with institutions in the Global South to benefit from their intellectual skills and to build institutional capacity.

#### **Article 10 (sustained production) should:**

- Include binding language on **local production** including creating regional manufacturing hubs in the Global South. Without strong language on funding conditionalities, mandating technology transfer and removing IP barriers, it is not possible to have viable local/regional and therefore sustainable production.
- Remove the listing of specific articles of the **TRIPS Agreement**. There are other articles, not listed in the latest draft, that countries can legally use to ensure access. For example, the US allowed vaccine developers to disregard patents 58 times using Article 44 of TRIPS<sup>1</sup>.

#### **Article 11 (transfer of technology and knowhow) should include:**

- Binding commitment on **sharing technology and know-how** during pandemics. It should remove language like “*when appropriate*” and “*on mutually agreed terms*”,

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<sup>1</sup> <https://www.keionline.org/37987>

which means that the sharing is up to the will of IP holders who are normally focused on profiteering rather than on public health. (not one single company shared knowhow with the WHO-backed mRNA hub in South Africa). Only AstraZeneca licensed some companies, especially in India to produce the COVID-19 Vaccine. This is because Oxford University, the inventor and IP owner, conditioned licensing production to Astra Zeneca on

- a) prioritising LMICs and AstraZeneca is not a vaccine company and therefore sublicensing to Serum, the biggest volume producer of vaccines in the world was a sensible decision and
- b) charging a non-profit price.

In reality, the pandemic clearly illustrated that voluntary sharing of technology and knowhow is severely limited to certain public IP holders.

- Obligation of R&D institutions and companies to share the technology and knowhow of PRPs to enable local/regional production, including through WHO **Technology Access Pools**.

**Article 12 (Access and benefit sharing) should include:**

- Binding commitment to financial and material **benefit sharing** beyond the proposed 20% of production. WHO's system for seasonal flu can be adapted for other pathogens. There is no moral or public health justification for LMICs to share pathogens and then wait for the goodwill of pharmaceutical companies to decide what to supply, when and at what price. Medical technologies related to pathogens with pandemic potential must be treated as global common goods. The PABS System should ensure that PRPs are allocated to all who need them at the same time, equitably in sufficient quantity -not just a small percentage.
- Commitment by developed countries to **adequate financing** of wide human, animal and environment surveillance in the Global South and rapid access to pathogens. Such measures should only be binding on the Global South countries if funding is assured.

**Article 13 (Global Supply Chain and Logistics (SCL) Network) should include:**

- Commitment from the countries that have the technology, production capacity, and ability to buy at high prices to **share PRPs** especially when demand exceeds supply.
- WHO's identification of at-risk groups and commitment to prioritise these groups ALL over the world until there are enough products for all (this is combined with enabling local/regional production to enhance sustained supply for all).
- Commitment to enabling regional mechanisms to lead on production and procurement in their region.

**Article 20 (financing) should include:**

- Commitment of all governments to adequately finance PPR and health systems. The **common but differentiated responsibilities commitment** has been removed in the latest draft and should be re-inserted. This principle commits all countries to finance health systems, PPR and access to medical countermeasures, each according to their financial resources.

END

Mohga Kamal-Yanni

On behalf of the People Vaccine Alliance