



# Transforming or Tinkering?

Inaction lays the groundwork  
for another pandemic

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## Foreword

One year ago, as co-chairs of the Independent Panel for Pandemic Preparedness and Response, we called for the swift implementation of a transformative package of reforms to make COVID-19 the last pandemic, and for urgent actions to end the COVID-19 emergency.

**One year on, and political focus to prepare for more waves is flagging. Work has begun to prevent the next pandemic, but at the current pace, the transformative change required will take years to complete.**

The impacts of this pandemic continue to take a huge toll. Since May 2021, more than 2.8 million people are reported to have died due to COVID-19, and estimates show many millions more excess deaths<sup>[1-4]</sup> The social and economic shocks, now compounded by the invasion of Ukraine, have led to a fractured world, and more poverty and hunger.

The Independent Panel for Pandemic Preparedness and Response, which we had the honour of co-chairing, spent eight months reviewing the global experience of COVID-19 in the first year of the pandemic. We undertook an evidence-based enquiry and were rigorous in our methodology. This work resulted in [a landmark report](#), an accompanying narrative, an authoritative chronology, 15 background papers, and peer-reviewed publications in the Lancet, Nature Medicine, and the British Medical Journal.

The Independent Panel found weak links at every point in the chain of preparedness and response. Preparation was inconsistent and underfunded. The alert system was too slow—and too meek. The World Health Organization was under-powered. The response has exacerbated inequalities. Global political leadership was absent.

To address these fatal flaws, the panel recommended a package of urgent, actionable reforms to end COVID-19 and transform the system for pandemic preparedness and response. In November 2021, we released a [six-month follow-up report](#), and concluded that the world was losing time — change was too slow, and too little.

Now, this one-year review of progress against the Panel's recommendations continues to reveal insufficient, inequitable, and now flagging attention to addressing COVID-19. The work underway to transform the international system lacks coherence, urgency, and focus. Reform proposals are being deliberated in different fora, but are not sufficiently connected, and remain still largely stuck in processes that will take years to deliver.

COVID-19 remains a divisive pandemic of inequality and inequity. Weak health systems and market-drivers that limit access to vaccines, tests, and therapies have constrained responses. A lack of investment to foster healthy populations, ensure adequate social protection, correct the digital divide, build resilient supply chains, and end gender inequality, denial of human rights, and fractures in trust set the wider context, and explain why preparedness for and responses to pandemics are matters requiring attention far beyond the health sector.

We believe that solutions lie in multisectoral, whole-of-government, and whole-of-society approaches at the national level. Globally, we need architecture fit for the task, including a leader-led, inclusive, and independent global council to maintain political attention to pandemic preparedness and response long after the COVID emergency has passed.

New pandemic threats will emerge. The risks of not being better prepared for them are great, and inaction is hard to fathom. SARS-CoV-2 continues to mutate, causing record high numbers of infections in 2022 and raising questions about the future of the trajectory of this pandemic.

Now is the time to transform the international system for preparedness and response – and not merely tinker with it. At the present pace of change, the world is laying the groundwork for failure and the risk of a new pandemic with the same devastating consequences.



**Rt Hon. Helen Clark**

Former Co-Chairs of the Independent Panel for Pandemic Preparedness and Response



**H.E. Ellen Johnson Sirleaf**



## Glossary of terms

<b>ACT-A</b>	Access to COVID-19 Tools Accelerator
<b>AU</b>	African Union
<b>CARICOM</b>	Caribbean Community
<b>COs</b>	Country Offices
<b>CSO</b>	Civil society organisations
<b>C-TAP</b>	COVID-19 Technology Access Pool
<b>COVID-19</b>	coronavirus disease 2019
<b>COVAX</b>	COVID-19 Vaccine Facility
<b>COVAX AMC</b>	COVID-19 Vaccine Advance Market Commitment
<b>EU</b>	European Union
<b>FIF</b>	Financial Intermediary Fund
<b>G7</b>	Group of 7
<b>G20</b>	Group of 20
<b>HICS</b>	High-income countries
<b>HLIP</b>	G20 High Level Independent Panel on Financing the Global Commons for Pandemic Preparedness and Response
<b>IHR</b>	International Health Regulations (2005)
<b>IMF</b>	International Monetary Fund
<b>INB</b>	Intergovernmental Negotiating Body
<b>LMICs</b>	low-and middle-income countries
<b>MPP</b>	Medicines Patent Pool
<b>mRNA</b>	messenger RNA
<b>MS</b>	Member States
<b>ODA</b>	Official Development Assistance
<b>PGA</b>	President of the General Assembly
<b>PHEIC</b>	Public Health Emergency of International Concern
<b>PPR</b>	Pandemic Preparedness and Response
<b>SARS-CoV-2</b>	the virus that causes COVID-19
<b>TRIPS</b>	Trade-Related Aspects of Intellectual Property Rights
<b>UHPR</b>	Universal Health and Preparedness Review
<b>UN</b>	United Nations
<b>UNGA</b>	UN General Assembly
<b>WB</b>	World Bank
<b>WGPR</b>	Working Group on Strengthening WHO Preparedness and Response to Health Emergencies
<b>WHA</b>	World Health Assembly
<b>WHA75</b>	The 75th World Health Assembly
<b>WHO</b>	World Health Organization
<b>WTO</b>	World Trade Organization

*“Work has begun to prevent the next pandemic, but at the current pace, the transformative changes required will take years to complete.”*

*— H.E. Ellen Johnson Sirleaf  
— The Rt. Hon. Helen Clark*





# The impact: Why this pandemic must be the last

The Independent Panel's report called for specific, urgent actions to end the COVID-19 emergency. That has not happened, and the consequences are more illness and death, health systems stretched to breaking point, deepening social divides, and more losses to economies and households.

Spikes in infections and deaths resulted in massive disruptions to workplaces and schools, and long-COVID risks leading to longer-term health consequences for a proportion of those infected.<sup>[7]</sup> Each death is a personal loss, and has reverberating health, social and economic impacts on families, communities, and countries.<sup>[8]</sup>

These losses were preventable but not prevented. The inequitable market-based system that existed before SARS-CoV-2 led to inevitable, deadly gaps in access in low- and middle-income countries. Too many countries delayed implementing or politicised measures that protect people from infection and disease.

## We still do not know the full extent of the pandemic's impact, but since the Panel's report a year ago:

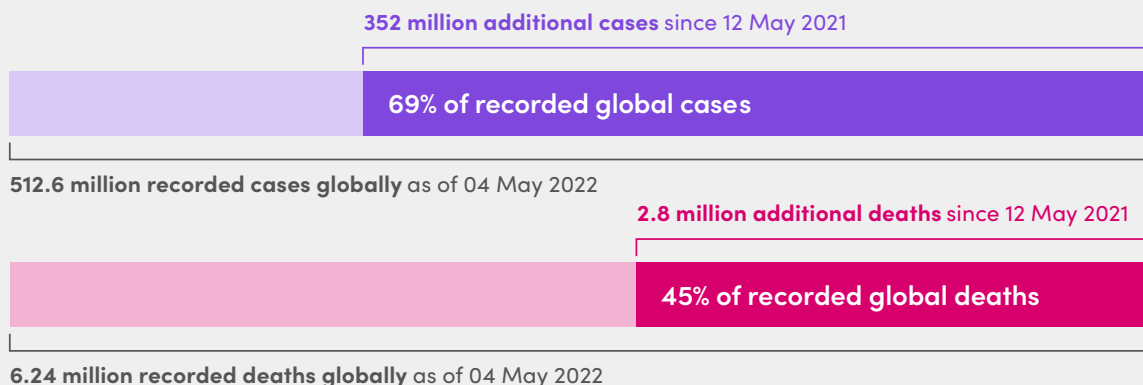
2.8 million more people are reported to have died due to COVID-19, almost certainly a significant undercount with estimates based on excess mortality ranging from 14 to 21 million deaths since the emergence of SARS-CoV-2.<sup>[1-4]</sup>

352 million more people were officially reported to be infected, a small fraction of the likely billion or more who were infected or reinfected.<sup>[1, 6]</sup>

COVID-19 was a leading cause of mortality worldwide in 2020/21.

**Figure 1: Reported infections and mortality since 01 January 2020**

Source: Our World in Data







*“This virus won’t go away just because countries stop looking for it. It is still spreading, it is still changing, and it is still killing.”*

*– Dr. Tedros Adhanom Ghebreyesus, WHO Director-General*

Vaccine inequity continues – originally a problem of a smaller supply hoarded by the wealthy, and now a problem of an excess of available vaccines, insufficient financial supports to deliver them, and shifting priorities.

In 2021, lower-income countries were demanding vaccines, and had largely no choice but to rely on donations. When they came at last, they were too often poorly coordinated, doses were expiring, and there wasn’t the financial and material support needed to turn vaccines into vaccinations. Wealthy countries stated a clear preference for certain vaccine types, and lower-income countries cannot be faulted for wanting the same choice. Now in 2022, much of the world is signalling a desire to move on from the pandemic or is focused on other health and geopolitical issues. The 70% vaccination target set by the World Health Organization (WHO) for all populations by mid-2022 is not close to being met.<sup>[9]</sup>

The current generation of vaccines has minimal effectiveness against transmission, in particular of the currently circulating strains, but evidence suggests vaccination including a booster dose continues to offer significant protection against hospitalisation and death for vulnerable populations.<sup>[10]</sup> Although ongoing research is required to fully understand duration of protection, the failure to complete primary vaccination or offer booster doses is leaving vulnerable populations further exposed.

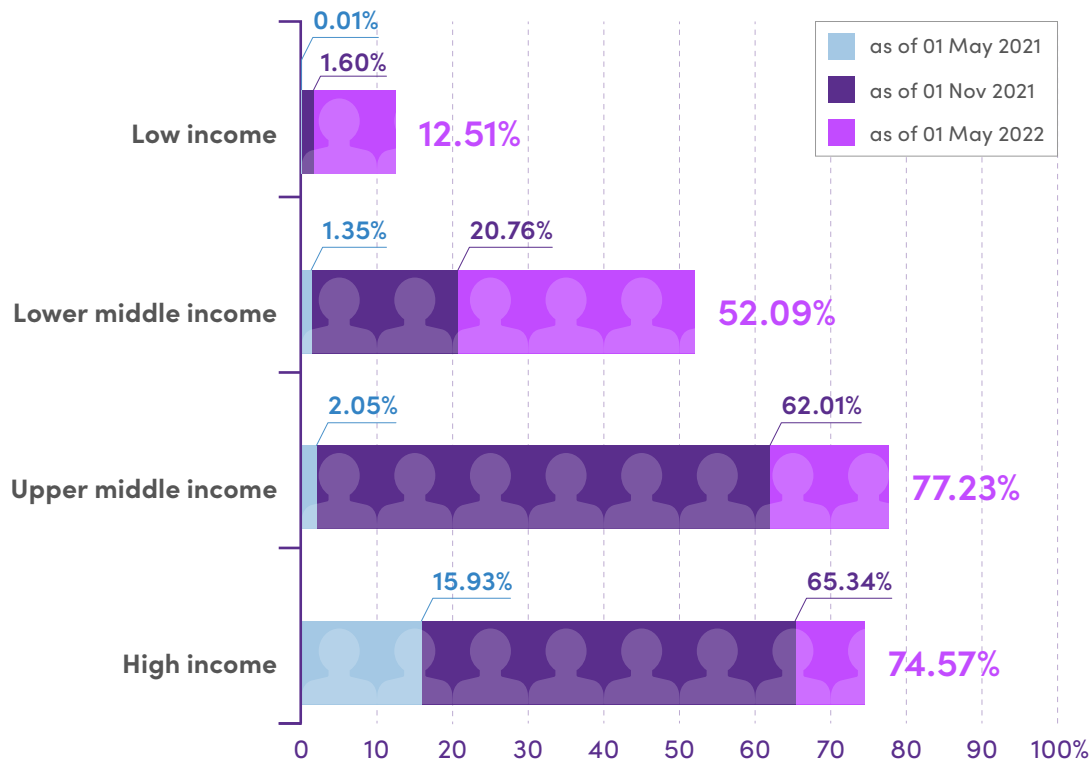
A perilous downward trend in the number of tests conducted per day so far in 2022 leaves the world at risk of flying blind, trying to fight a disease that can’t be seen.<sup>[11]</sup> Tests are essential to successful ‘test and treat’ programming, and widespread genomic sequencing is needed to expose virus mutations. However, despite warnings that Omicron, a new variant of concern, was spreading at speed, many countries were late to prepare communities for the inevitable. Record infections followed together with another spike in major health and economic disruptions. A new wave is forecast for the Northern Hemisphere by autumn this year and is already showing signs of spread.<sup>[12]</sup>

**Political leaders have every reason – the opportunity and the know-how – to stop a pandemic like this from happening again. The Independent Panel has provided actionable recommendations that, taken as a package, can help to secure the future through leadership, new finance, dramatically improved surveillance, a stronger WHO, and equitable access to pandemic tools.**

**Figure 2: Inequity: Share of people who completed the initial vaccination protocol as of 01 May 2022**

Total number of people who received all doses prescribed by the initial vaccination protocol, divided by the total population of the country.

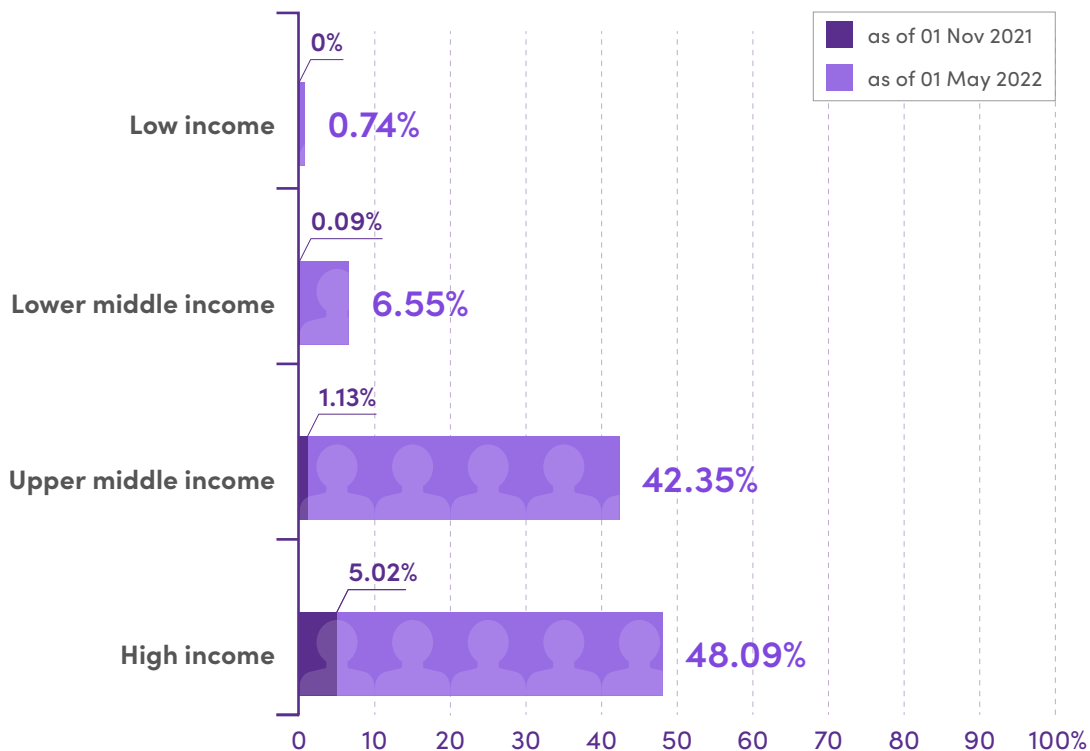
Source: Our World in Data



**Figure 3: COVID-19 vaccine boosters administered per 100 people as of 01 May 2022**

Total number of vaccine booster doses administered, divided by the total population of the country. Booster doses are doses administered beyond those prescribed by the original vaccination protocol.

Source: Our World in Data



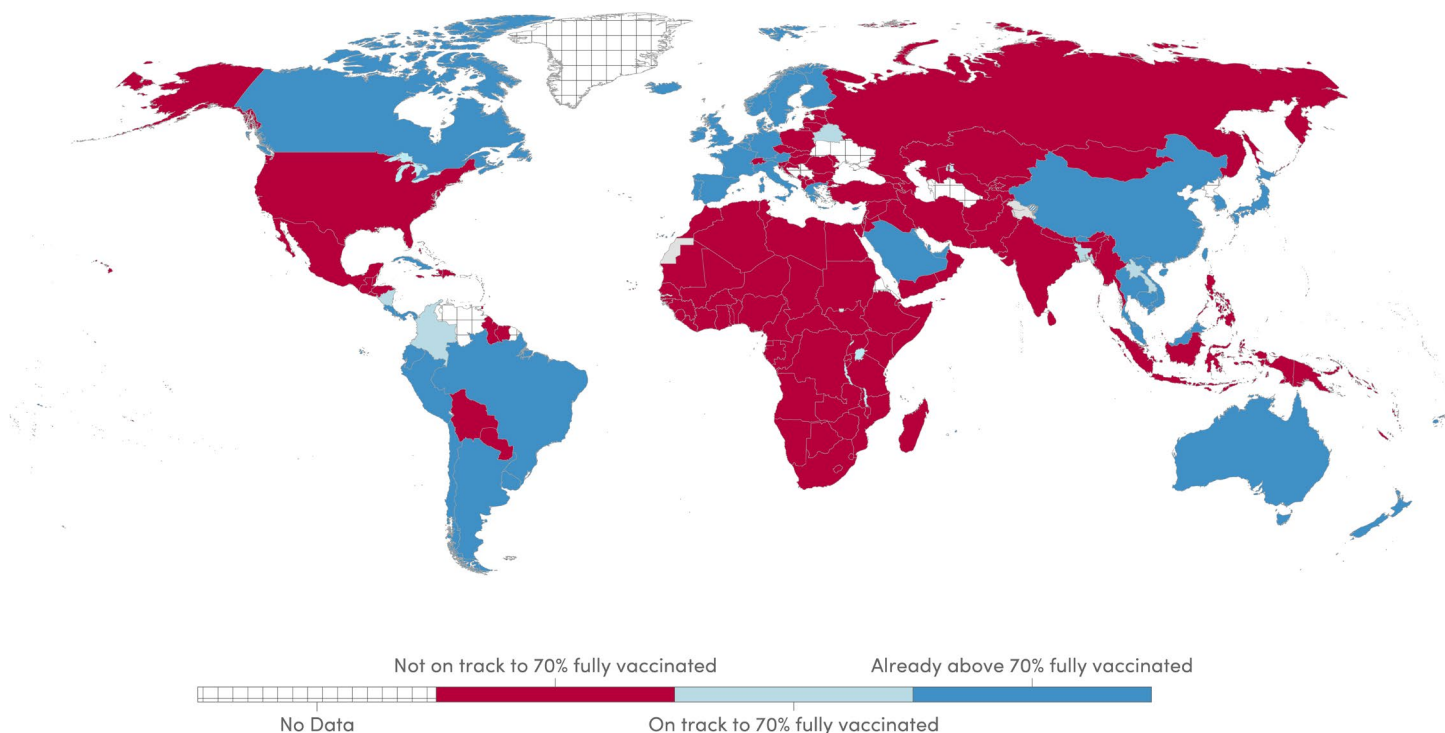
## The social and economic impacts are widespread:

- Prior to the pandemic the World Bank estimated that 581 million people would be living in extreme poverty in 2022. The combined impacts of the pandemic, the invasion of Ukraine and increasing inflation are projected to lead to **up to 95 million more people in extreme poverty this year compared to pre-pandemic projections.**<sup>[5]</sup>
- In emerging market economies, the debt-to-GDP ratio reached 60% in 2021, up from about 40% in 2013, and for low-income countries, which often have less debt-carrying capacity, the median debt is now nearly double that of 2013.<sup>[13]</sup>
- **Lost schooling and school dropout rates will increase the number of children who are illiterate at age 10.** In low and middle-income countries, it is projected this may increase to as much as 70% and cost up to \$17 trillion in lifetime earnings.<sup>[14]</sup>
- **The impact on gender inequalities is stark.** Women were reporting a 26% risk of employment loss by September 2021, compared to 20.4% for men. Women were almost twice as likely to have to forgo work in order to be caregivers, and girls were 21% more likely than boys to drop out of school.<sup>[15]</sup>

**Figure 4: Countries not on track to achieve the 70% vaccination coverage target by 30 June 2022**

Source: Data collection and projections by Our World in Data, based on official sources as of 5 May 2022.

Note: OWID excludes countries that have not reported data for more than 30 days.





## Some progress, much process

Notwithstanding the complexity of reform in a multilateral system, there are notable efforts to make progress on a number of the Independent Panel's recommendations. To date, much of the progress lies in the establishment of processes rather than the achievement of results, but some are likely to bear fruit.

### Political leadership – welcome but not enough

Many high-level groupings and institutions have helped raise the profile of pandemic preparedness and response. These include the President of the United Nations General Assembly's high-level dialogue on vaccination; two virtual Global Summits including the most recent this month co-chaired by Belize, Germany, Indonesia, Senegal, and the United States; discussion at the G7 and G20; ongoing efforts by international institutions including the World Health Organization, the World Bank, and the IMF; and regional leadership, including from the Africa CDC.

**The May 12 Global COVID-19 Summit was evidence of the unique way Heads of State and Government can convene and motivate a range of actors to commit to pandemic preparedness and response.** Convened by Heads of State who represent the 90 countries of the AU, CARICOM, the G7 and the G20, it resulted in engagement and commitments from national governments, UN agencies, funds, and foundations, research organizations, the private sector, and civil society.

### WHO, surveillance and the international legal regime

The Intergovernmental Negotiating Body (INB) is result of the work of the WHO Member State *Working Group on Strengthening WHO Preparedness and Response to Health Emergencies (WGPR)*, which has been considering 131 recommendations made by four review groups including the Independent Panel. Their report is being presented to this year's WHA.<sup>[16]</sup>

A major process output was the establishment of an INB to “draft and negotiate a WHO convention, agreement or other international instrument on pandemic prevention, preparedness and response.” Texts are due to be ready for agreement at the World Health Assembly in May 2024.<sup>[16]</sup>

Through the WGPR, countries are also discussing a process to amend specific provisions of the International Health Regulations (IHR). It is to be hoped that amendments would give WHO more authority to report and investigate pandemic threats rapidly.<sup>[16]</sup> The IHR amendments process may also be recommended to be complete only in May 2024.

In an effort to improve global surveillance, WHO established a new “Biohub” for pathogen sharing in May 2021. In September 2021, WHO, with Germany’s support, announced a “WHO Hub for Pandemic and Epidemic Intelligence,” based in Berlin.<sup>[17]</sup>

## More WHO financial independence

The Panel recommended that Member States should increase their assessed contributions to two-thirds of the budget of WHO’s base program budget; and that a replenishment model should be established for the remainder.

**The WHO Working Group on Sustainable Financing, involving all Member States, has recommended that assessed contributions cover 50% of the base program budget.** The Working Group will also recommend that the WHO Secretariat explore the feasibility of a replenishment mechanism to cover the remainder of the budget.<sup>[18]</sup> The Working Group aims to secure formal agreement at the World Health Assembly this month.

Member States are also asking for internal reforms at WHO to ensure more efficiency and accountability in program budgeting and reporting.

An increase to 50% would be based on the 2022/2023 budget; ratcheted up over the next four programme budgets. This leaves a potential eight years of more voluntary funding and earmarking for WHO – and ample opportunity for another serious health threat to emerge. Sustainable coverage of 50% of the base budget, based on the 2022/23 budget, also raises the question of the total budget required.

## Establishment of a new pandemic fund

The Independent Panel, and also the G20 High Level Independent Panel on Financing the Global Commons for Pandemic Preparedness and Response (HLIP), recommended the establishment of a new financing facility or fund, to provide annual contributions in the range of \$10–\$15 billion annually for preparedness, to which all countries would contribute based on an ability-to-pay formula.<sup>[19]</sup> The Independent Panel’s report also stressed that in a time of crisis, countries must be able to rely on draw-downs from a \$50–100 billion surge fund, in contrast to the trickle of funds made available in the first months of this pandemic.

**Recently the G20, chaired by Indonesia, has announced consensus in the group to establish a Financial Intermediary Fund (FIF) for pandemic preparedness and response.**<sup>[20]</sup> The Indonesia G20 Chair is now consulting with countries on governance and operations. The World Bank is working with partners to establish the fund by June and open it later this year. This Fund received commitment of support at the May 12 2022 Summit, with pledges of the European Union, the United States, Germany and the Wellcome Trust totalling US\$962 million.<sup>[21]</sup>

The International Monetary Fund (IMF) establishment of a new Resilience and Sustainability Trust, with \$50 billion available to low- and middle-income countries to build resilience and ensure a sustainable recovery from COVID-19 is welcome, although it is important to note that this is loan financing and relies on countries voluntarily channelling their special drawing rights for the benefit of poorer or more vulnerable countries<sup>[22]</sup>

## Equity: movement on knowledge and technology transfer

There have been efforts to expand equitable access to vaccines, diagnostics, and therapies. The Oxford–AstraZeneca partnership was initiated as a promising non-profit agreement, with built-in voluntary licensing.<sup>[23]</sup> Novavax and Johnson & Johnson worked with partners in India and South Africa to scale up local manufacturing capacity.<sup>[24, 25]</sup> Drs. Peter Hotez and Maria Elena Bottazzi, of the Baylor College of Medicine in the U.S. developed a patent-free vaccine, aimed at providing “vaccine for all.”<sup>[26]</sup> Chinese vaccine manufacturers developed products initially for national use, were then able to rapidly sell and distribute hundreds of millions of doses globally and establish regional manufacturing.<sup>[25]</sup> Donated doses were an important source of COVAX’s vaccine supply in 2021 when demand was highest, accounting for 60% of the doses the initiative delivered that year (543 million out of 910 million).<sup>[28]</sup>

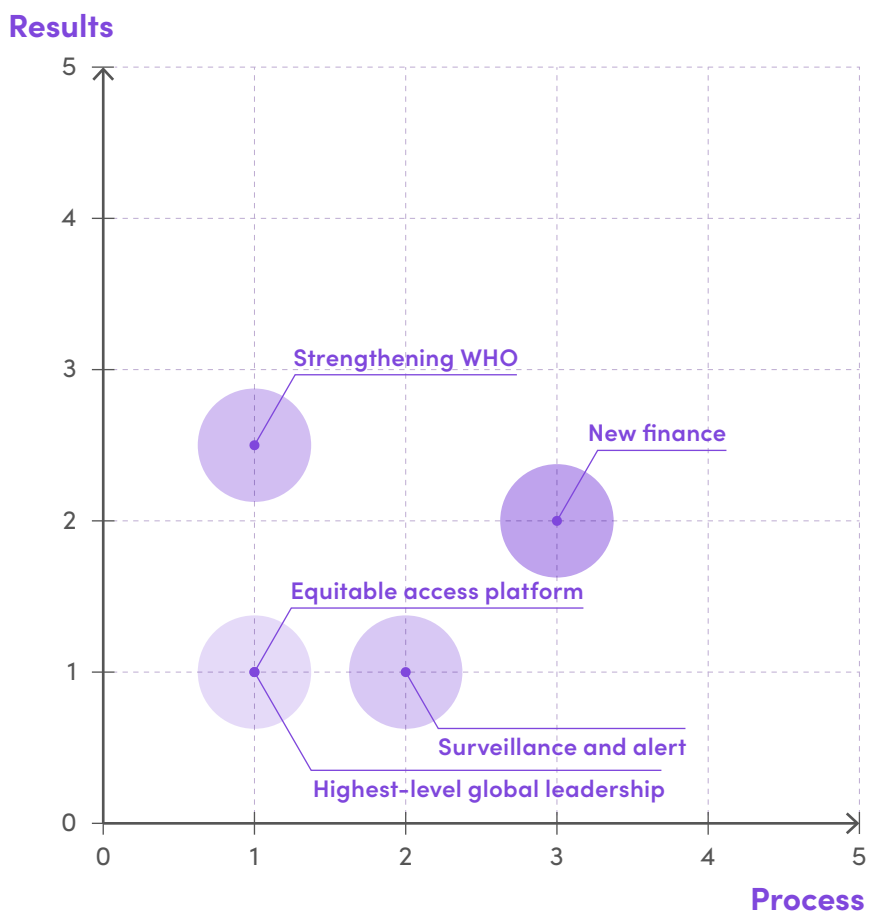
**The Access to COVID-19 Tools Accelerator (ACT-A), formed rapidly in anticipation of global needs, mobilised billions of dollars; has delivered 1.5 billion doses of vaccines, 150 million diagnostic tests, expanded genomic sequencing capacity and mobilised US \$187 million for oxygen supplies.**<sup>[29]</sup>

The mRNA hub in South Africa which is producing and trialling its own mRNA vaccine, together with a pledge to deliver its know-how and materials to hubs distributed across regions that have had no capacity, shows promise.<sup>[28]</sup>

Moderna and BioNTech have announced plans to set up manufacturing in Africa.<sup>[31]</sup> Merck and Pfizer have made voluntary licensing agreements with the Medicines Patent Pool (MPP) for their antiviral therapies.<sup>[32]</sup>

This month, the MPP and WHO’s COVID-19 Technology Access Pool (C-TAP) agreed transparent, global, nonexclusive licencing agreements with the U.S. National Institutes of Health, for the development of therapies, vaccines and diagnostics. These licenses are intended to allow manufacturers from around the world to work with MPP and C-TAP to make technologies accessible to people in poorer countries.<sup>[21]</sup>

Figure 5: Much process, few results





# Actions needed now to fix a still broken system

## 1. Equitable access to tools now and always

Science has delivered a range of new lifesaving tools at impressive speed, but the status-quo market-driven system has failed to deliver them equitably.

ACT-A, the current major coordinated mechanism for delivering essential COVID-19 supplies to low- and middle-income countries was set up to provide access to vaccines, diagnostic tests, genomic sequencing capacity and oxygen.<sup>[29]</sup> Measured against a standard of equitable and timely access, it has not met expectations.

ACT-A has been challenged by insufficient funding, the realities of the marketplace, wealthier country hoarding, by rejection of certain vaccines, export bans, poor management of donated doses, a growing view that the pandemic is 'over' and a turn to other priorities; and, now, oversupply of vaccines that protect against illness and death, but do not block transmission, with not enough funds to deliver them.<sup>[33]</sup>



*“Vaccine inequity drives the spread of viral variants. The two-tiered systems of haves and have nots means low-income countries are being left in a perpetual game of catch-up... it is a game where the prize is life in an uneven playing field.”*

– Dr Ayoade Alakija, WHO Special Envoy for ACT-A

**A lack of equity has also affected diagnostic testing and treatments.**

**Lower-income countries comprise more than 50% of the world’s population but have conducted just 21.5% of tests globally to date.**<sup>[11]</sup>

New life saving “test and treat” strategies are being implemented in high-income countries, while people in poor nations have very limited access to tests and therapeutics. Voluntary licensing agreements for antivirals are a step in the right direction, but doses will not be more widely available until 2023.<sup>[34]</sup>

Governance of ACT-A, involving multiple partners with their own existing governance, has been a major challenge. It has been criticised for lack of meaningful inclusivity.<sup>[35]</sup>

Act-A’s strategic plan and budget for 2021-2022 comes to an end in September, with no announced plans for its continuation. **An independent evaluation of ACT-A is urgently needed.** The co-chairs of the ACT-A Facilitation Council have announced that they will initiate such an evaluation and hope to have it completed by the end of the year. Based




on lessons from the evaluation, **ACT-A should be reconfigured as an end-to-end platform that puts equity and public health at its heart.** There needs to be an urgent transition to such a platform in order to avoid more inequitable gaps in delivery. When new tools for tackling COVID-19 are available, such as a variant-specific vaccine, wealthier nations could once again rapidly buy up supplies, while poorer ones would have to wait, or make use of outdated or less effective tools.

**Despite the limitations of ACT-A, it is the mechanism currently available and should be supported.** It faces a significant funding gap of US\$13.64 billion, US\$7.5 billion of which is urgent particularly for vaccine delivery, procurement of treatments, scale-up of diagnostics, and oxygen.<sup>[36]</sup> A failure to fund it adequately would worsen inequalities in the short-term, lead to more preventable illness and death, and end support for critical surveillance required to detect new variants.

**Progress on tackling issues surrounding intellectual property and technology transfer has also been inadequate and far too slow.** The Panel called for the World Trade Organization (WTO) and WHO to convene major vaccine-producing countries and manufacturers to get agreement on voluntary licencing and technology transfer. The Panel said that if there was no action within three months, an urgent 'waiver to the WTO Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) should come into force. Neither has happened so far.

Despite valiant efforts and leadership by the current WTO Director-General, the agreement by over 100 countries, and the steadfast push of civil society, the objections of a handful of influential countries have led to failure during a pandemic. **Without a change of approach to consider pandemic tools as global public goods, we will see a repeat of these drawn-out processes when a new pandemic threat emerges.** The current proposed agreement after over two years of negotiation, that only covers vaccines and not diagnostics or therapeutics shows the limitations of the current approach.<sup>[37]</sup>

Action on knowledge and technology transfer to ensure that vaccines, diagnostics, and treatments can be produced nearer to countries and to improve the resilience of supply chains has been mixed. The lack of transparency surrounding the various initiatives makes efforts to assess



*“Vaccine equity is not a matter of volumes; it is ensuring equitable access to appropriate vaccines at the right time for optimal health impact.”*

– Els Torrelee, Visiting Fellow, Institute for Innovation and Public Purpose, University College London<sup>[a]</sup>

[a] Torrelee, E. Vaccine equity is not for sale. PLOS Blogs Speaking of Medicine and Health 2022 [cited 2022; Available from: <https://speakingofmedicine.plos.org/2022/05/03/vaccine-equity-is-not-for-sale/>]

their impact challenging. **The mRNA hub in South Africa, and the promise to deliver its know-how and materials to hubs distributed across regions that have had no capacity is a laudable development.**<sup>[30]</sup> But these should be scaled strategically, ensuring that demand and procurement are also in place. Aspen Pharmaceutical's situation, whereby it recently had to stop production in South Africa for lack of orders, is a cautionary tale, but should not discourage the strategic expansion of manufacturing in all regions, in order to build self-sufficiency.<sup>[38]</sup>

### Equitable access: What must happen next

1. ACT-A should be rapidly fully financed to ensure ongoing access to the tools available to tackle COVID-19 in LMICs.
2. Governments should adopt a comprehensive TRIPS waiver immediately.
3. There needs to be a comprehensive and independent evaluation of ACT-A with the full inclusion of civil society.
4. Lessons from the ACT-A evaluation should define a pathway to establish an end-to-end global platform for equitable access to countermeasures.
5. Ensure transparency within existing and future initiatives to bolster regional capacity to produce all countermeasures. Investments must be in the public's interest built for different vaccine platforms, together with diagnostics and treatments with production that can be scaled as needed.
6. Governments should transparently report research and development financing, and condition public financing on agreements that guarantee technology transfer and voluntary licencing to ensure equitable distribution.



## 2. Financing that involves and serves every country

Funding for pandemic preparedness and response is a global public good. The COVID-19 experience painfully shows that spending billions would have saved trillions.<sup>[19]</sup> The Panel found preparedness funds were too little; and response funds were too slow, wholly inadequate in scale, and over the sustained response, resulted in lower-income countries incurring more debt.<sup>[39]</sup>

**The G20 Chair now has an opportunity to consult widely beyond the G20 membership and recommend a legitimate, inclusive and effective financial modality in the short months ahead.** This is an opportunity for all countries to work together and create a model through successful multilateralism which would herald a new era in funding and governance to combat pandemic threats.

The experience of ACT-A unfortunately reveals the limits of a system that evolved to become overly donor-driven. A Financing Modality will not succeed as a donor-driven fund. **All countries must be incentivised to contribute based on an ability-to-pay formula, with the guarantee that lower-income countries will benefit in both preparedness, and in rapid disbursement of surge funds during a health emergency,** based on pre-arranged preparedness and response plans.

The Panel recommended that funds be granted based on identified gaps through existing international and regional organisations, according to their mandate and experience. As the suggested FIF is designed, architects must assess the most efficient, experienced mechanisms for disbursing preparedness and response funds. WHO, for example, should not lead as it is not a funding agency but should support the World Bank to highlight gaps identified through systematic reviews, and should support countries to design and cost preparedness and emergency plans.

### Finance: What must happen next

1. The G20 Chair must consult widely on the suggested financial modality including with non-G20 countries, civil society and all relevant entities.
2. There should be an agreement on a formula-based funding mechanism based on an ability-to-pay and a prioritisation of funds that are additional to official development assistance.
3. The process should develop clear, strategic guidance on what the FIF will fund. It should prioritize filling gaps in the current systems for preparedness and response and generating global public goods which might otherwise be under-produced instead of establishing its own operating system.
4. Arrangements should be in place to finance both long-term preparedness and rapid response for pandemic threats, whether through a single fund or complementary mechanism.
5. The FIF should be linked to a leader-level pandemic preparedness and response governance body.

### 3. A stronger WHO and a new system for surveillance, detection, and alert

**The current legal regime and governance processes of WHO remain largely unchanged since before the emergence of SARS-CoV-2, and reform efforts are process-driven.** Should a new pathogen of pandemic potential begin to spread in the weeks or months ahead, there is no guarantee it would be identified in time to take measures to contain it, and WHO's authority to report it globally remains the same as it was in January 2020.

A major recommendation was that WHO establish a new system for surveillance, based on transparency by all parties, using state-of-the-art digital tools to connect information around the world. New pathogens are emerging, the digital tools exist, but the will to be fully transparent is yet absent.

Such a surveillance system is complex, and countries may raise the issue of whether it impinges on their sovereignty. Yet, countries can only benefit from rapid and transparent identification and reporting of pandemic threats. **Success in stopping pandemics will come only with solidarity, a mutual affirmation and action to ensure that no country is a weak link.**

This matter is also tied to strengthening WHO authority. The Panel recommended WHO be given the authority to report potential health emergencies immediately and to investigate health threats without impediment. When warranted, WHO should use a precautionary approach, for example, for new respiratory pathogens.

Some of this change could occur through amendments to the IHR, and the proposals of the United States attempt to address the speed of both reporting and investigating.<sup>[37]</sup> While there is some support for these amendments, there is as yet no consensus.

**Following negotiation and agreements on a pandemic accord and any IHR amendments — possibly not until May 2024 — both would require time to come into force. Acceptance of recommendations of any texts is not guaranteed, and the overall process is slow and vulnerable to political priorities not based on protecting people's health.**

The Independent Panel recommended that the Director-General's and Regional Directors' terms should each be limited to one term of seven years. There is reference to the recommendation in the WGPR report to the 75th WHA, but there is no pathway as yet to address it.<sup>[16]</sup>

There are ongoing discussions to strengthen the governance capacity of the Executive Board by establishing a Standing Committee for Emergencies. The EB will review draft Terms of Reference at its May meeting.<sup>[41]</sup>

The WHO Secretariat has indicated that it is working to resource and equip WHO country offices sufficiently to respond to national technical requests, and to improve the quality of all WHO staff by depoliticising the recruitment process.<sup>[16, 42]</sup>

**Too many recommendations are being linked to the lengthy processes to reform the international legal regime.**<sup>[43]</sup>

### A stronger WHO: What must happen next

1. The WHO should exercise authority to rapidly announce a potential pandemic threat should one arise before legal reform processes are concluded.
2. Work to create a modern surveillance system should be prioritised, as a system that mutually protects all countries and the world from pandemic threats. Benefits should supersede national security concerns.
3. WHO Member States should treat the recommended reforms with the urgency required and agree pathways to make decisions more rapidly, for later incorporation under a pandemic accord if necessary and practicable.
4. Member States should agree a clear plan to implement all recommendations, including the limit of the DG's and RDs' terms to one of seven years.
5. Flexible funding, the increase in assessed contributions to 50% of the base programme budget, and the proposal for a replenishment process for WHO should be approved and implemented without delay.
6. The WHO Secretariat should report on progress on its resourcing of country offices, and on processes towards depoliticising staff recruitment.

## 4. Sustained political leadership and accountability

COVID-19 paralysed much of the world for two years. Communities, national governments, foundations, regional bodies, banks, funds, just about every UN agency, civil society groups and nongovernmental organisations, the private sector – all mobilised to do what they could. Yet coordinated leadership at the highest level remained absent and has failed to bring sustained, essential cohesion to the pandemic response.

Now, political leaders have opportunity to join forces to ensure the world is much better prepared to face the next pandemic threat and to stop it. **High-Level political meetings of the UN General Assembly have historically elevated global health concerns such as HIV and antimicrobial resistance to the level of heads of state and secured the ensuing accountability.** The same should be done for pandemic preparedness and response.

When a disease outbreak rapidly spreads and upends almost every sector, threatens billions, and kills many millions of people, Presidents and Prime Ministers must work together, and lead a whole-of-government and whole-of-society effort to respond. The same approach and principles must apply to being ready for and preventing the risk from the next threat.

**A measurable reform would be an inclusive leader-level health threats council that can galvanize political commitment to end the COVID-19 threat and bring cohesion to the multiple, uneven, and too often sclerotic reform efforts underway.**

The Panel's proposal was that such a council should be independent but supportive of WHO if it is to fulfill its function and bring full cohesion to the global architecture for pandemic preparedness and response, which by its multisectoral nature is broader than that of WHO's mandate. The council would not seek to replace or recreate the functions of existing institutions, but rather identify gaps in preparedness and response, and ensure cohesion and accountability.

The council could be based in Geneva and should be serviced by a small nimble Secretariat that can coordinate the monitoring, advocacy, and accountability functions. Meetings must be frequent, particularly in the early stages, and the council must be ready to act rapidly at the first hint of a pandemic threat.

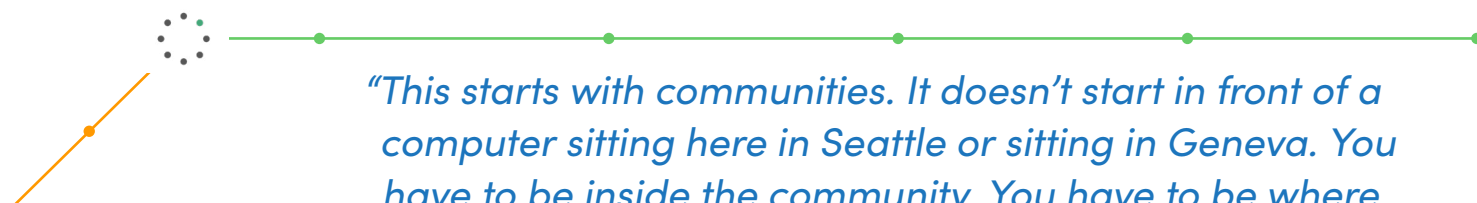
### **Political leadership: What must happen next**

1. UN Member States should request a High-Level Meeting at the UN General Assembly that leads to a Political Declaration on pandemic preparedness and response.
2. A senior political leader-level council for pandemic preparedness and response should be established under the UNGA.

## **5. Get Prepared!**

Two years into the COVID-19 emergency, it is far from clear whether countries are any better prepared for a new pandemic threat. The Independent Panel's report made a series of specific recommendations to enable assessment and bolstering of national preparedness and response capabilities through targeted investment and learning from COVID-19 responses. WHO has been following through on recommendations requiring its leadership.

The systems for assessing or measuring preparedness and assessing the robustness of those systems were shown to have low predictive value for how well countries were able to respond to the COVID-19 emergency.<sup>[45]</sup> The Independent Panel called for WHO to set measurable targets and benchmarks for pandemic preparedness and response capacities. The WHO has indeed worked to develop dynamic preparedness metrics that



*“This starts with communities. It doesn’t start in front of a computer sitting here in Seattle or sitting in Geneva. You have to be inside the community. You have to be where the problems are”*

*Dr Samba Sow, Director-General Centre for Vaccine Development – Mali <sup>[43]</sup>*

consider wider population vulnerability, which will enable countries to assess their preparedness in a much more wholistic manner.<sup>[46]</sup> These metrics are yet to be validated.

**To promote accountability and identify gaps in preparedness, the Panel called for a process of Universal Periodic Peer Review to be coordinated by WHO.** WHO has started consultations and is piloting a Universal Health and Preparedness Review (UHPR) process. Pilots have been run in the Central African Republic, Iraq and Thailand, and another has begun in Portugal.<sup>[47]</sup> This is a welcome first step and will go some way to answering whether countries are prepared, but methodological questions still need ironing out and it remains unclear how civil society and communities will be engaged in countries.

The Panel’s report also called for pandemic preparedness to be incorporated into Article IV consultations with the IMF to ensure that pandemic risks are treated as the systemic financial risks this pandemic has shown them to be. To date there have been no public signals from the IMF of this recommendation being adopted.

The Independent Panel called for ongoing investment in health and social protection systems to bolster resilience to adverse events, including pandemics. Countries are now facing significant fiscal and economic pressures from the pandemic, food and energy price spikes arising from the consequences of the invasion of the Ukraine, and high levels of inflation.<sup>[13]</sup> **To date we are not seeing domestic investments in strengthened national public health institutions, health systems, and social protection systems on the scale needed to build resilience to threats that may develop.**

The Panel made a clear and specific call to strengthen the engagement of local communities in pandemic preparedness and response. Whilst there are many examples from this pandemic of innovative approaches to do that, it is clear from our consultations with civil society and reports from human rights organisations that this is not universally the case. Indeed, in some countries the pandemic has been used to shrink the space for civil society engagement.<sup>[48]</sup>

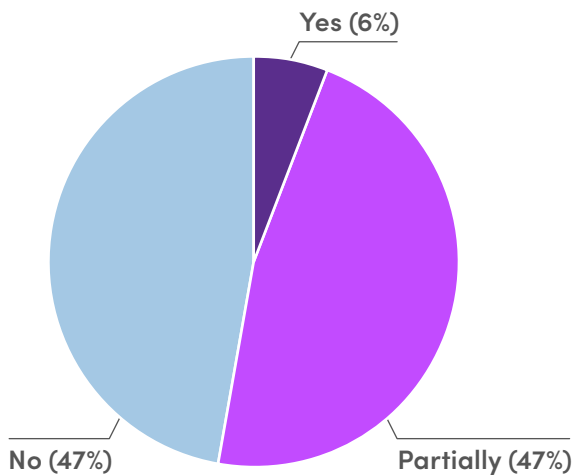
## Preparedness: What must happen next

1. National pandemic preparedness coordination should be overseen by heads of state and government, with sustained domestic investment in public health and the wider health and social protections systems for preparedness and response.
2. Governments should conduct transparent national reviews of their responses to COVID-19 and include all affected sectors including those in civil society.
3. The formalisation of a Universal Health Periodic Review (UHPR) should continue, and all governments should engage with the evolving process to develop a clearer overview of national preparedness and response gaps.
4. The IMF should implement the Panel's proposal regarding Article IV consultations.
5. Governments must continue to invest in, build partnerships with and listen to the perspectives of civil society and communities for pandemic preparedness and response at every level.

**Figure 7: Sufficiency of current global efforts to end the COVID-19 emergency**

Source: Co-Chairs' civil-society online survey (April-May 2022)

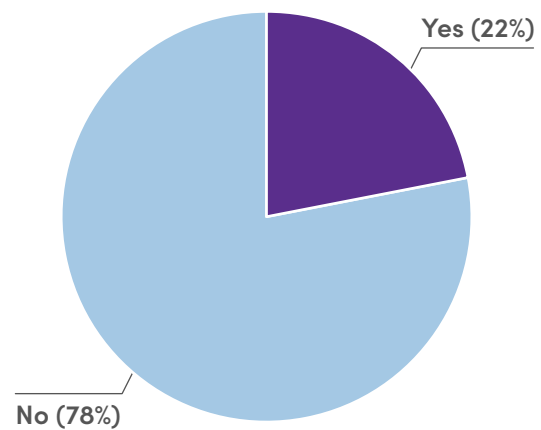
Overall, are current global efforts sufficient to end the current COVID-19 emergency? (n=47)



**Figure 8: Inclusiveness of current reform processes**

Source: Co-Chairs' civil-society online survey (April-May 2022)

Are the processes for current reforms open enough to all relevant voices? (n=50)





*“Key populations, those on the margins, working class, will always be the ones who pay the price because for those in power, those who make the decisions, we don't matter.”*

*Mick Matthews, Global Network of Sex Work Projects*

*“Civil society engagement is key to bringing policies to life.”*

*Gisa Dang, Treatment Action Group*





## Constant learning, critical voices

The main report of the Independent Panel in May 2021 was an evidence-based exercise that drew upon opinion from experts in governments, the UN, academia and civil society. To inform this “one year on” report, we also consulted with many experts, including through academic roundtables, discussions with civil society, and an open invitation to take part in survey.

The paragraphs below capture themes which emerged from our consultations.

### **Bottom up – regional empowerment and self-sufficiency**

Consistent messages came through on the importance of avoiding top-down solutions, and of the valuable leadership of regional institutions such as the Africa Centres for Disease Control and Prevention. The limitations of the existing top-down global health order were exposed during this pandemic be it through inequitable access to tools to fight COVID-19 or a lack of developing context-specific responses.

### **Pandemics prey on unhealthy populations**

Another important theme was linking pandemic preparedness to wider concepts of population health. Most COVID-19 deaths where accurate data exists occurred amongst vulnerable populations because of age or pre-existing co-morbidities.<sup>[49]</sup> Building healthier populations builds resilience to pandemic threats, and action to prevent chronic diseases such as improving nutrition, tackling air pollution, and controlling tobacco use, are vital for pandemic preparedness and response. Governments must prioritise the healthy populations agenda, take a health-in-all policies approach and apply a health equity lens to reduce vulnerability to both new variants of concern and future pandemic threats.

### **One Health: prevent threats at their source**

The interconnectedness of pandemic threats with other global challenges came up frequently. There is an urgent need also to reduce the likelihood of zoonotic spill over events upstream, which requires action to mitigate biodiversity loss and other ecosystem damage. A recent study in Nature suggested that if the world warmed by 2 degrees, in mammals alone there would be over 4000 incidents of cross-species viral spread by

2070.<sup>[50]</sup> It is vital that governments honour their commitments to meeting the goals of the Paris Agreement and set and meet ambitious targets under the UN Convention on Biological Diversity to mitigate the risk of pandemics.

## The needs of people facing crisis

In the early days of this pandemic crisis, humanitarian actors worked quickly to establish risk communication, resource coordination, and community engagement platforms as core components of their response efforts.<sup>[51]</sup> Actors further built on existing programming and pre-existing relationships with vulnerable populations to integrate COVID-19 prevention, testing, and treatment measures. Experience with other health emergencies, such as Zika, cholera, and Ebola, make clear that empowering communities to take charge of their response is key for successful compliance with control and mitigation measures.<sup>[52]</sup>

Decades of experience also show that a “one size fits all” approach is inadequate for any population affected by a health crisis.<sup>[53]</sup> As leaders work to strengthen the global capacities for pandemic preparedness and response, they must ensure that the needs, perspectives, and ideas of migrants, displaced persons, and other vulnerable populations affected by humanitarian crises are represented and not forgotten.

## Rebuilding trust must start now

Trust has been an emerging theme within all of our consultations. Evidence shows the role it plays in determining the success of countries' initial and ongoing responses. Responding to pandemics requires leaders to behave in ways that foster trust in institutions. Examples of corruption, a lack of transparent decision-making, poor risk communication, noncompliance with restrictions, mixed messages and failure to admit mistakes all undermined messaging and trust in the current pandemic. **Governments must invest in communities and risk communication as a priority now, as trust cannot just ‘happen,’ when a new emergency strikes.**



## Final words

COVID-19 has killed millions and affected the life of almost everyone on this planet, thriving upon and exacerbating inequalities. Complacency has set in among those with access to tools to prevent, diagnose, and treat COVID-19, and those tools are far from universally accessible. We must continue to document the evolution of the virus, respond to new waves and not squander hard won gains.

**This can and must be the last pandemic** of such devastation. This pandemic requires ongoing highest-level attention even as the world grapples with rising geopolitical tensions, inflation, and the impacts of climate change. Inequities continue, and dangerous new variants could emerge at any time. The deaths of millions due to COVID-19 cannot be in vain.

**There is progress to ensure the world is better prepared** for the next pandemic threat. But **at the current pace**, processes to ensure a stronger WHO, modern surveillance systems, adequate financing, equity and better governance **will take years to deliver**.

For now we remain stuck with largely the same tools and system we had at the outset of 2020 when the COVID virus first emerged. The question remains **if a new pathogen with pandemic potential were to cause an outbreak tomorrow, would the world be better prepared** to prevent it from becoming a pandemic and be able to respond effectively if it did? **Our assessment is no.**

**One year ago the Independent Panel laid out a roadmap for how to transform the system for Pandemic Preparedness and Response.** Given the multitude of sectors, organizations, and institutions required to face-down pandemic threats it is self-evident **what's missing now is action-oriented decisive political leadership** at the highest level to bring cohesion and urgency to achieve a transformed system for pandemic preparedness and response.

We urge Member States to begin a process at the UN General Assembly that leads to the negotiation of a political declaration giving momentum for reform, and including agreement to create a Head of State and Government-level Council to maintain momentum around and pursue accountability for pandemic preparedness and response.

**Now, it is in all countries' interest to contribute to the new pandemic fund. It requires at least US\$ 10 billion annually,** and a global effort to reach this goal, with funds additional to ODA, can provide a guarantee that lower-income countries can access the funds required for preparedness, and rapidly for response.

The tools we have now need to be deployed to protect the vulnerable, and access to future, even more effective, tools cannot be monopolised by the highest bidder. A market-driven approach simply does not work.

Governments must evaluate their own responses to COVID-19, learn from them and invest nationally to fill gaps. Communities must be placed at the heart of responding to the COVID-19 pandemic now and to health threats of the future.

**The next pandemic threat will not wait, and the risks of delay of reforms are too great.** Since the start of 2022 alone, there have been outbreaks of avian influenza, cholera, yellow fever, dengue, measles, Lassa fever, cholera, polio, MERS-CoV, Ebola, monkeypox and acute hepatitis of unknown aetiology in children reported to WHO.<sup>[54]</sup> **A new threat is just one animal-to-human spill over away.**






















*“Climate change is speeding up the cycle of pandemics, making the next outbreak inevitable. The next virus may kill even more people and cause even greater economic disruption.”*










*Dr. Joy St. John, ED of the Caribbean Public Health Agency at the May 12 Summit*

# Annexes








## Annex 1: Panel recommendations scoring table

Urgent calls to stop the COVID-19 pandemic 					
Recommendation	Main actor	Recommended delivery date	Status	Completion success	Next steps
Apply non-pharmaceutical public health measures systematically and rigorously in every country at the scale the epidemiological situation requires. All countries to have an explicit strategy agreed at the highest level of government to curb COVID-19 transmission.	National governments	Immediately	Application of public health measures continues to be an inconsistent policy position across countries. <a href="#">(Source)</a>		Countries must redouble efforts to apply and consistently communicate public health measures commensurate with local and national epidemiological contexts.
High income countries with a vaccine pipeline for adequate coverage should, alongside their scale up, commit to provide to the 92 low and middle income countries of the Gavi COVAX Advance Market Commitment, at least one billion vaccine doses no later than 1 September 2021 and more than two billion doses by mid-2022, to be made available through COVAX and other coordinated mechanisms.	National governments	Immediately (& no later than 1 September 2021)	In 2021, 543 million of the 910 million doses delivered through COVAX were donated. As of May 14 2022, 1.74 billion doses have been committed for donation through COVAX. Coordination issues, expiring doses and insufficient supports for in-country delivery been a challenge for turning donated doses into vaccinations. Vaccine supplies are currently not an issue. (Source: <a href="#">Globalization and Health, UNICEF, BMJ</a> )		As vaccine supply is currently not an issue, focus must now be on ensuring financial and technical support to countries in order to turn vaccines into vaccinations, including through filling the COVAX funding gap.
G7 countries to commit to providing 60% of the US\$ 19 billion required for ACT-A in 2021 for vaccines, diagnostics, therapeutics and strengthening health systems with the remainder being mobilised from others in the G20 and other higher income countries. A formula based on ability to pay should be adopted for predictable sustainable, and equitable financing of such global public goods on an ongoing basis.	G7, G20 and national governments of high-income countries, foundations	Immediately	As of May 13, 2022 \$3.2 billion has been committed, to the ACT-Accelerator, which still faces a \$13.64 billion funding gap under its Strategic Budget and Plan 2021-Sept 2022. <a href="#">(Source)</a>		Donors must urgently close ACT A's 2021 funding gap of \$13.64 billion to deliver the tools that are needed to meet global targets, and bridge the equity gap.
WTO and WHO to convene major vaccine producing countries and manufacturers to get agreement on voluntary licensing and technology transfer arrangements for COVID-19 vaccines (including through the Medicines Patent Pool (MPP)). If actions do not occur within 3 months, a waiver of TRIPS intellectual property rights should come into force immediately.	WTO, WHO and vaccine-producing countries and manufacturers	Immediately	A draft proposal for a TRIPS waiver is being considered by 164 WTO members. It is limited to vaccines. Separately, in May 2022 the MPP and C-TAP agreed transparent, global, non-exclusive licencing agreements with the U.S. National Institutes of Health, for the development of therapies, vaccines and diagnostics. (Source: <a href="#">WTO, Medicines Patent Pool</a> )		A TRIPS waiver must still be adopted at the WTO. The example of the NIH licensing agreement with the MPP and CTAP should be followed as a model for new voluntary licensing agreements for COVID-19 products and future pandemic-related health tools.
Production of and access to COVID-19 tests and therapeutics, including oxygen, scaled up urgently in low- and middle-income countries with full funding of US\$ 1.7 billion for needs in 2021 and the full utilization of the US\$3.7 billion in the Global Fund's COVID-19 Response Mechanism Phase 2 for procuring tests, strengthening laboratories and running surveillance and tests.	Test- and therapeutics-producing countries and manufacturers / GFATM	Immediately	As of 31 March 2022, C19RM had awarded or recommended for Board approval US\$3,369 million to 124 applicants, for a portfolio average of 26.2% of the 2020-2022 allocation with the following breakdown: 75% to reinforce national COVID-19 responses, 14% for urgent improvement to health and community systems, and 11% for HIV, TB and malaria mitigation. At the COVID-19 Summit in May 2022, several countries announced new support for the C19RM. (Source: <a href="#">The Global Fund, The Global Fund</a> )		Donors must urgently close the ACT A budget gap through 2022 including for therapeutics, diagnostics and health systems.
WHO to develop immediately a road map for the short-term and within three months scenarios for the medium- and long-term response to COVID-19, with clear goals, targets and milestones to guide and monitor the implementation of country and global efforts towards ending the COVID-19 pandemic.	WHO	Immediately	On March 30, the WHO published its Strategic Preparedness, Readiness and Response Plan to End the Global COVID-19 Emergency in 2022. The report sets out a number of key adjustments that could enable an end to the acute phase of the pandemic. <a href="#">(Source)</a>		

Recommendation	Main actor	Recommended delivery date	Status	Completion success	Next steps
<b>1. Elevate political leadership for global health to the highest levels to ensure leadership, financing and accountability</b> 					
Establish a Global Health Threats Council. The membership should be endorsed by a UN General Assembly resolution (see below recommendations for a Special Session of the UNGA). The Council should be led at Head of State and Government level and the membership should include state and relevant non-State actors, ensuring equitable regional, gender and generational representation. The Council would maintain political commitment, ensure cooperation across the system at all levels, monitor and report progress towards goals and targets set by the WHO; guide the allocation of resources by the proposed new finance modality; and according to an ability to pay formula; and hold actors accountable.	UNGA	Q4 2021 (UNGA Special Session)	The concept of the Council as proposed by the Panel has received endorsement from many including some UN Member States, the G20's HLIP, the Biden Admin. at the Sept '21 Summit, and from WHO in its HEPR white paper. No specific intergovernmental process is underway for Member States to take up the recommendation. (Source: <a href="#">G20 High Level Independent Panel on Financing the Global Commons for Pandemic Preparedness and Response, US Government, WHO</a> )		UN Member States should urgently align on a means to discuss and negotiate the formulation of a high-level political council.
Adopt a Pandemic Framework Convention within the next 6 months, using the powers under Article 19 of the WHO Constitution, and complementary to the IHR, to be facilitated by WHO and with the clear involvement of the highest levels of government, scientific experts and civil society.	WHO / National governments	Within 6 months (November 2021)	On Dec. 1, 2021, the WHA agreed to establish an INB to draft and negotiate a "WHO convention, agreement, or other international instrument" on pandemic prevention, preparedness, and response. A process is underway to deliver consensus text to the WHA in 2024. The WGPR will report on a process to implement IHR amendments to the WHA75. (Source: <a href="#">INB</a> , <a href="#">WGRP</a> )		Member States must agree international instruments by May 2024 that serve the goal of ensuring an outbreak does not become a pandemic, and if it does, that the health, social, and economic impacts are minimal.
Adopt a political declaration by Heads of State and Government at a global summit under the auspices of the UN General Assembly as a Special Session convened for the purpose and committing to transforming pandemic preparedness and response in line with the recommendations made in this report.	United Nations General Assembly	Q4 2021 (UNGA Special Session)	Several MS have called for a Special Session, including at the UN PGA High-Level dialogue, to galvanise momentum for vaccination, but modalities for establishing such a session have not yet emerged. 11 New York based MS are working on a request to the PGA and UNSG. (Source)		UN MS should request a High-Level Meeting at the UNGA that leads to a Political Declaration on pandemic preparedness and response.
<b>2. Focus and strengthen the authority and financing of WHO</b> 					
Establish WHO's financial independence, based on fully unearmarked resources, increase Member States fees to 2/3 of the budget for the WHO base programme and have an organized replenishment process for the remainder of the budget.	WHA Decision	Short-term	On April 27, 2022, the Working Group on Sustainable Financing reached consensus to increase assessed contributions towards WHO's base budget. The proposal is to ratchet assessed contributions upwards starting in 2023, aiming to reach 50% by the 2030/2031 program if not before. Formal approval of this recommendation is on the WHA75 agenda. (Source)		Member States should aim to reach the 50% target by 2028/2029 and uphold the recommendation that the base segment of the programme budget should be fully flexibly funded sooner.
Strengthen the authority and independence of the Director-General, including by having a single term of office of seven years with no option for re-election. The same rule should be adopted for Regional Directors.	WHA Decision	No later than WHA75	This recommendation has been documented by the WGPR, but unclear whether or when it might be taken up. (Source)		Member States must rapidly identify a plan towards implementation.
Strengthen the governance capacity of the Executive Board, including by establishing a Standing Committee for Emergencies.	WHA Decision	No later than WHA75	The Executive Board will review draft Terms of Reference for a Standing Committee at its meeting following WHA75 at the end of May 2022. (Source)		The Executive Board should agree clear next steps for establishment of this Committee.
Focus WHO's mandate on normative, policy, and technical guidance, including supporting countries to build capacity for pandemic preparedness and response and for resilient and equitable health systems.	WHA Decision	No later than WHA75	This recommendation is captured in the WGPR report to WHA75, with the INB and IHR amendment processes listed as potential pathways. WHO reports it has assisted more than 75 countries in developing national action plans for health security in the last biennium. But the main issue concerning country office capacity and need for reforms has not been addressed. (Source: <a href="#">WHO</a> , <a href="#">WHO</a> )		Member States must rapidly agree a pathway and timescale towards implementation.
Empower WHO to take a leading, convening, and coordinating role in operational aspects of an emergency response to a pandemic, without, in most circumstances, taking on responsibility for procurement and supplies, while ensuring other key functions of WHO do not suffer including providing technical advice and support in operational settings.	WHA Decision	No later than WHA75	This recommendation is captured in the WGPR report to WHA75, proposing the involvement of external bodies/actors, and a new international instrument as pathways towards completion. The issue of what role WHO should play (eg not taking on the responsibility for procurements) has not been addressed. (Source)		Member States must rapidly agree a plan towards implementation.
Resource and equip WHO Country Offices sufficiently to respond to technical requests from national governments to support pandemic preparedness and response, including support to build resilient health systems, UHC and healthier populations.	WHO Secretariat	Immediately	WHO reports it has strengthened country office capacity including by: providing country offices (COs) 32% more funding than in 2018-2019; providing 34 COs half-time virtual support of HQ staff. At the same time, just 10% of country office budgets are flexible, impeding the ability to recruit and retain high-quality staff. The issue of working across the three pillars in case of an emergency has not been explicitly addressed. (Source: <a href="#">WHO</a> , <a href="#">WHO</a> )		WHO to report regularly on sustained support to COs, and CO funds to be made more flexible commensurate with increases to MS assessed contributions.
Prioritize the quality and performance of staff at each WHO level, and de-politicize recruitment (especially at senior levels) by adhering to criteria of merit and relevant competencies.	WHO Secretariat	Short-term	This recommendation has been recorded in the report of the WGPR, where it is documented as a task that has been commenced by the WHO Secretariat. There are no explicit reports that this recommendation has been addressed. (Source)		WHO Member States to commit to implementation of this recommendation, and WHO to report on specific measures taken towards it.

Recommendation	Main actor	Recommended delivery date	Status	Completion success	Next steps
<b>3. Invest in preparedness now to create fully functional capacities at the national, regional and global level</b> 					
WHO to set new and measurable targets and benchmarks for pandemic preparedness and response capacities.	WHO / National governments	Q3-4 2021	WHO is working on a new "dynamic preparedness metric," a composite measure with three main dimensions: hazard, vulnerability, and capacity. WHO is piloting this with MS as part of a UHPR. A presentation is expected at WHA74. ( <a href="#">Source</a> )		WHO to continue to work with MS on UHPR pilots and confirm new dynamic metrics.
All national governments to update their national preparedness plans against the targets and benchmarks set by WHO within six months, ensuring that whole-of- government and whole-of-society coordination is in place and that there are appropriate and relevant skills, logistics, and funding available to cope with future health crises.	National governments	Within 6 months	There are no standardised methods with which to assess this recommendation. WHO reports that it has assisted more than 75 countries to develop national action plans for health security. ( <a href="#">WHO</a> )		WHO to include metrics to monitor progress against this recommendation.
WHO to formalize universal periodic peer reviews of national pandemic preparedness and response capacities against the targets set by WHO as a means of accountability and learning between countries.	WHO / National governments	Q4 2021	WHO has consulted with multiple countries (Benin, Cameroon, Central African Republic, France, Germany, Indonesia, Portugal, the Maldives, Thailand, the UK) on the development of Universal Health and Preparedness Reviews. Pilots have been completed in the CAR, Iraq, and Thailand, and one began in May in Portugal. However the process has not been formalized as recommended ( <a href="#">Source</a> )		The formalisation of a UHPR process should continue, and all govnt's should engage with it as soon as possible to develop a clear overview of national preparedness and response gaps.
As part of the Article IV consultation with member countries, the IMF should routinely include a pandemic preparedness assessment, including an evaluation of the economic policy response plans. The IMF should consider the public health policy evaluations undertaken by other organizations. Five-yearly Pandemic Preparedness Assessment Programs should also be instituted in each member country, in the same spirit as the Financial Sector Assessment Programs, jointly conducted by the IMF and the World Bank.	International Monetary Fund (IMF)	Q3-4 2021	There are no public signals that such an assessment is being developed.		The IMF to report on the status of this recommendation.
<b>4. Establish a new agile system for surveillance, validation and alerts</b> 					
WHO to establish a new global system for surveillance based on full transparency by all parties, using state- of-the-art digital tools to connect information centres around the world and include animal and environmental health surveillance, with appropriate protections of people's rights.	WHO Secretariat	Q4 2021	On May 24, 2021, WHO launched its BioHub for pathogen storage, sharing, and analysis in partnership with Switzerland. The Hub received a first sample in its pilot phase, and on Sept. 21, 2021, WHO inaugurated its Hub for Pandemic and Epidemic Intelligence in partnership with Germany. (Source: <a href="#">WHO</a> , <a href="#">WHO</a> , <a href="#">Luxembourg Government</a> )		WHO to provide a transparent assessment of the status of these hubs, and Member States should constructively agree and fund such a surveillance system.
WHO to be given the explicit authority by the World Health Assembly to publish information about outbreaks with pandemic potential on an immediate basis without requiring the prior approval of national governments.	WHA Decision	No later than WHA75	The U.S. has proposed amendments to the IHR that would give WHO such authority within 48 hours. The process for considering IHR amendments will be considered at WHA75. ( <a href="#">Source</a> )		WHO should exercise authority to rapidly announce a potential pandemic threat should one arise before legal reform processes are concluded.
WHO to be empowered by the World Health Assembly to investigate pathogens with pandemic potential in all countries with short-notice access to relevant sites, provision of samples, and standing multi-entry visas for international epidemic experts to outbreak locations.	WHA Decision	No later than WHA75	The U.S. has proposed amendments to the IHR that would give WHO such authority within 48 hours. The process amending the IHR will be considered at WHA75. ( <a href="#">Source</a> )		In the interest of containing health threats and preventing pandemics, Member States should provide WHO rapid entry permissions to investigate pathogens with pandemic potential.
Future declarations of a PHEIC by the WHO Director- General should be based on the precautionary principle, where warranted, as in the case of respiratory infections. PHEIC declarations should be based on clear, objective and published criteria. The Emergency Committee advising the WHO Director-General must be fully transparent in its membership and working methods. On the same day a PHEIC is declared, WHO must provide countries with clear guidance on what action should be taken and by whom to contain the health threat.	WHA Decision	No later than WHA75	The WHO INB is considering substantive elements to include in an accord. Additionally, the U.S.-proposed IHR amendments could make PHEIC declarations more transparent and timely through their proposals for Articles 12, 13, and 49. (Source: <a href="#">WHO</a> , <a href="#">WHO</a> )		The WHO Director-General should exercise this authority from now on in the interest of preventing a pandemic.



Recommendation	Main actor	Recommended delivery date	Status	Completion success	Next steps
<b>5. Establish a pre-negotiated platform for tools and supplies</b> 					
Transform the current ACT-A into a truly global end-to-end platform for vaccines, diagnostics, therapeutics, and essential supplies, shifting from a model where innovation is left to the market to a model aimed at delivering global public goods. Governance to include representatives of countries across income levels and regions, civil society, and the private sector. R&D and all other relevant processes to be driven by a goal and strategy to achieve equitable and effective access.	National governments / Member States	Medium-term	The ACT-Accelerator Strategic Review published Oct. 8, 2021, focused on solutions to extend work for one additional year. In April 2022, the ACT-A Facilitation Council co-chairs (South Africa and Norway) announced the intention to initiate an independent evaluation. A cross-regional group of countries (Brazil, Canada, Germany, India, Nigeria, and Sweden) will act as a reference group, and there is intention to include CSO and community representatives in the group. (Source: <a href="#">WHO</a> , <a href="#">WHO</a> )		A full, independent, transparent evaluation of ACT-A, with inclusion of civil society must be completed by the end of Q3.
Ensure technology transfer and commitment to voluntary licensing are included in all agreements where public funding invested in research and development.	National governments	Medium-term	There is no clear progress on including conditions for voluntary licenses in agreements. Regional vaccine manufacturing potential is increasing through various initiatives, none of which is strictly technology transfer. The U.S. NIH has agreed licenses with MPP and CTAP that are intended to result in manufacture of COVID-19 tools for 49 least developed countries. (Source: <a href="#">WHO Africa</a> , <a href="#">Medicines Patent Pool</a> )		Governments should transparently report R&D financing, and condition public financing on agreements that guarantee technology transfer and voluntary licensing to ensure equitable distribution.
Establish strong financing and regional capacities for manufacturing, regulation, and procurement of tools for equitable and effective access to vaccines, therapeutics, diagnostics, and essential supplies, and for clinical trials: • based on plans jointly developed by WHO, regional institutions, and the private sector, • with commitments and processes for technology transfer, including to and among larger manufacturing hubs in each region, • supported financially by International Financial Institutions and Regional Development Banks and other public and private financing organizations.	National governments / WHO / IFIs / regional institutions / private sector	Medium-term	At the sixth European Union-African Union Summit, the EU announced an Africa-Europe Investment Package of at least EUR 150 billion to support EU 2030 and AU Agenda 2063 agendas, including an investment in health and education packages. Health investments will prioritise supply chains and the development of local manufacturing capacities and address international supply chain bottlenecks. The EU also committed €100m to support the African Medicines Agency over 5 years, in partnership with the Bill and Melinda Gates Foundation. (Source: <a href="#">World Bank</a> , <a href="#">European Commission</a> , <a href="#">European Commission</a> , <a href="#">Asia-Pacific Economic Cooperation</a> , <a href="#">European Commission</a> , <a href="#">Gates Foundation</a> )		
<b>6. Raise new international financing for the global public goods of pandemic preparedness and response</b> 					
Create an International Pandemic Financing Facility to raise additional reliable financing for pandemic preparedness and for rapid surge financing for response in the event of a pandemic.	G20 and Member States	Before the end of the year	The G20 finance ministers and Central Bank Governors have secured consensus to create an FIF to address the financing gap for pandemic preparedness, which WHO and WB estimate at \$10.5B annually. Multiple countries confirmed their support for the FIF at the second Global COVID-19 Summit on May 12, 2022, and initial pledges from the EU, Germany, and the U.S. total \$962 million. (Source: <a href="#">G20</a> , <a href="#">US Government</a> )		The fund requires \$10.5B annually. Current consultative process for FIF establishment should develop strategic guidance on what it will fund. Priority should be filling PPR gaps in the current systems and generating global public goods that might otherwise be underproduced. The fund should not be donor-driven using ODA, but rather an inclusive one based on a formula-based ability-to-pay mechanism that is in addition to ODA.
<b>7. Put in place effective national coordination for pandemic preparedness and response based on lessons learned and best practice</b> 					
The Independent Panel called for several actions within countries for national coordination for PP&R. Progress on these are not are not being systematically tracked.					
For full recommendations see <a href="#">COVID-19: Make it the Last Pandemic</a> .					

## Annex 2: Critical themes from community consultations

### Methodology

A total of 50 civil society organisations (CSOs) participated in an online survey requesting feedback on progress related to the Independent Panel’s recommendations for ending the COVID-19 emergency and preparing for the next pandemic threat. Participants included those representing civil society, academia, nonprofits, foundations, community-based organisations, and coalitions. Recruitment was conducted using convenience sampling and via virtual channels such as emails, newsletters, and social media. Respondents consented to participating in the survey, implemented in English, and were given the option for their comments to remain anonymous. Data were analysed as part of a mixed methods approach, with greater weight on the qualitative data. Quantitative data were analysed using IBM SPSS Statistics V28 and qualitative data via inductive coding and thematic analysis using QSR NVivo 12 software.

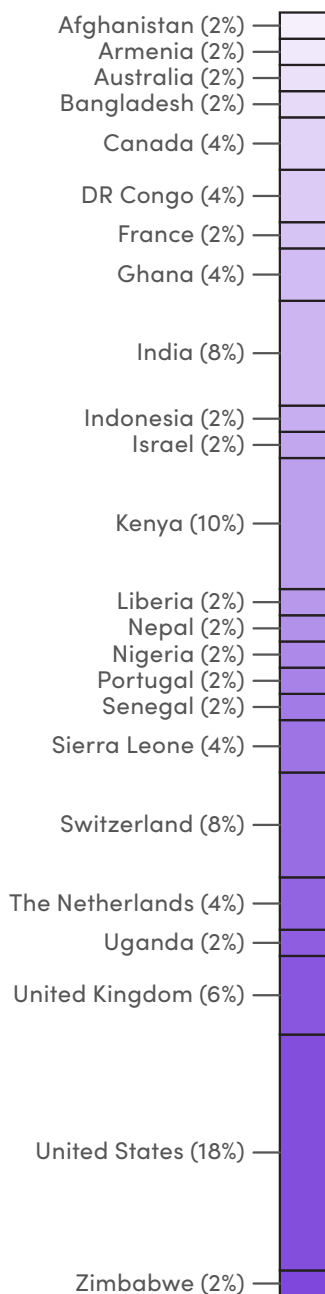
The survey was conducted only in English, hosted online and with a limited window for response that may not have fully captured all CSO opinions. Issues of data sparsity limited the ability to fully disaggregate the responses by respondent categories.

### Results

The 50 CSOs represented 49 countries, with 51% (n=25) being low- and middle-income countries (LMIC) as shown in Figure A. Survey participants were asked a variety of questions on impressions related to progress on the Independent Panel’s recommendations. The results are provided below. Themes and sub-themes, along with illustrative quotes, are provided in Table A.

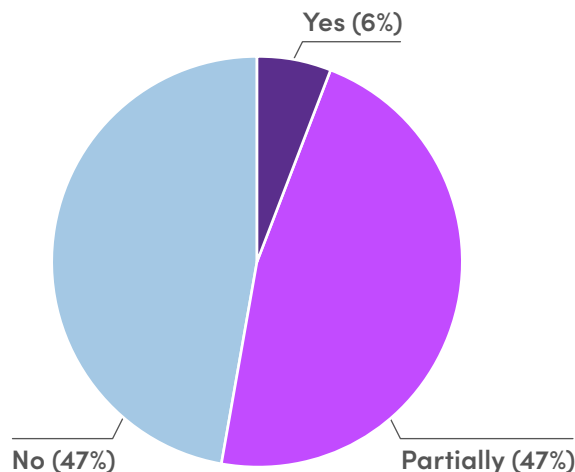
**Figure A: Respondents by country**

(Please note that the percentages don't equal 100 due to rounding)



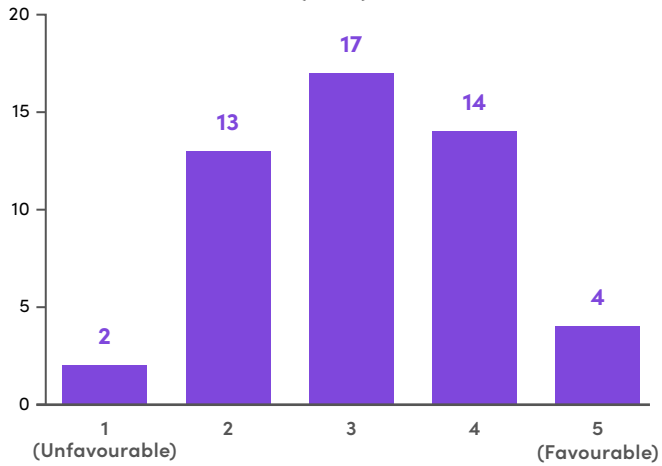
**Figure B: Sufficiency of current global efforts to end the COVID-19 emergency**

Overall, are current global efforts sufficient to end the current COVID-19 emergency? (n=47)



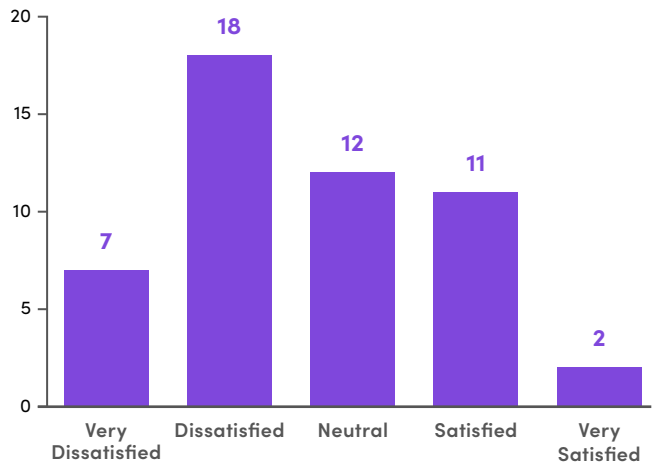
**Figure C: Impression of efforts to implement a comprehensive package of recommendations**

What is your overall impression of the efforts to implement a comprehensive package of recommendations to improve global pandemic preparedness and response? (n=50)



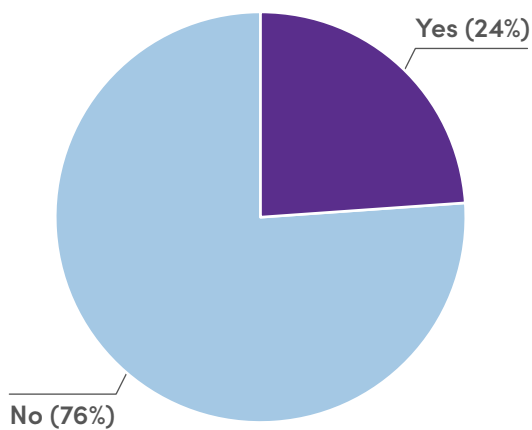
**Figure D: Satisfaction with current speed of international system reforms**

How satisfied are you with current speed of reforms of the international system for pandemic preparedness and response? (n=50)



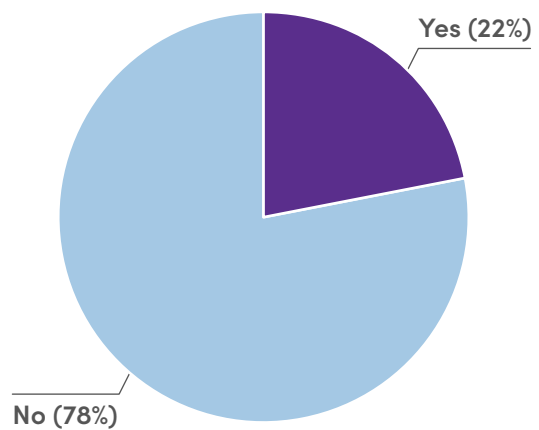
**Figure E: World readiness to effectively manage next pandemic threat at the current pace and scale**

At the current pace and scale of reform, will the world be ready to manage the next pandemic effectively? (n=50)



**Figure F: Inclusiveness of current reform processes**

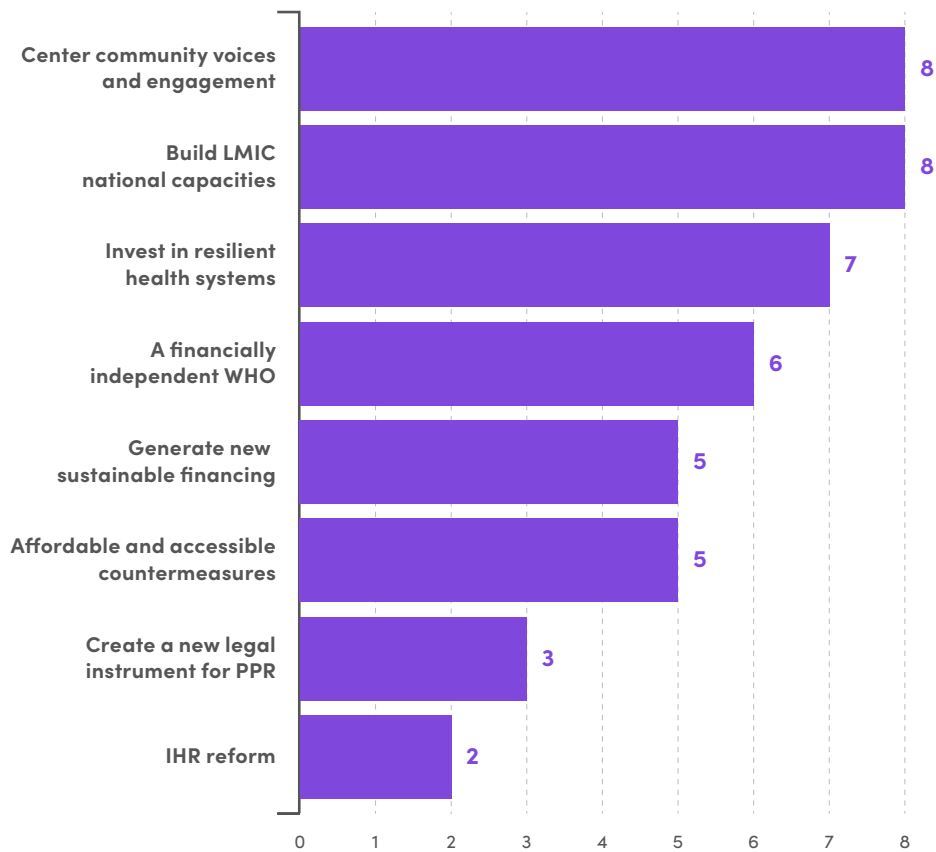
Are the processes for current reforms open enough to all relevant voices? (n=50)



**Figure G: Identified priority areas for pandemic preparedness and response over the next five years**

\*Please note that due to a roughly equal number of LMIC (n=25) and HIC (n=24) organisations that responded, the results reflect a wide range of priorities.

Top priorities for pandemic preparedness and response over the next 5 years\*



**Table A: Themes from the qualitative portions of the CSO survey**

Theme	Sub-Theme	Illustrative Quote
Power Asymmetry	Decision-making power held by the same global health actors	"Global North governments remain resistant to implement pandemic tools available to them today, such as the TRIPS waiver and more comprehensive data and knowledge sharing, that would enable a significantly broader and speedier accessibility of vaccines, diagnostics, and new treatment options for COVID-19."
		"[There is] no willingness for true change, more of the same (financing the same actors, to do the same, even if that was not successful, e.g., ACT-A)."
		"Key populations, those on the margins, working class, will always be the ones who pay the price because for those in power, those who make the decisions, we don't matter."
	Need for prioritisation of LMIC agency and capacity	"If we have any hopes of vaccinating the world, production and distribution of vaccines must be dramatically increased. For that to happen, rich nations must stop vaccine hoarding, urgently redistribute surplus vaccines to meet their pledges to the COVAX, support the TRIPS intellectual property waiver, and force pharmaceutical companies to transfer know-how for diagnostics, vaccines, and therapeutics. The world has failed to do all of this, and we are paying the price with more transmissible subvariants, more waves, and deaths."
		"There are also several reforms that CSOs consider non-negotiable, and that includes real co-creation of interventions with global health agencies, equal intellectual partnership of LMIC expertise, and that we start thinking about a new TRIPS order."
		"[There is] reticence by global health donors and agencies to share power and financing with LMIC-led institutions."
	Non-State actors are not meaningfully included or engaged	"Non-state actors have not had a seat at the table in the official policymaking processes to date. 'Consultations' have been rushed, pro forma, and frankly, abysmal. The diverse voices and experience of communities, front-line health workers, service providers and other non-governmental stakeholders have been marginalised. Some governments doing outreach to their civil society actors to solicit their views and inputs, but that is far from the norm."
		"The process to draft and negotiate the instrument must be updated to ensure the full and meaningful participation of civil society and communities. Only those in official relation with WHO (as non-State actors) are currently able to participate in the work of the Intergovernmental Negotiating Body. This requirement to be in official relation should be removed, and replaced if necessary with an accessible accreditation process for civil society and communities."
		"It would be great to seek civil society connections and mobilisation to support the Panel's recommendations (even if the list is too long for effective advocacy), but even greater if the panel members and their political allies exert their power to sway the powers that be. CSOs can challenge, name, and shame, but they remain outsiders. Inside power is so much more effective."
Critical Role of CSOs	CSOs serving as a community platform	"Civil society organisations (CSOs) can actively champion for collaborative engagements in addressing societal challenges where they operate being in close contact with their communities to shape the policies [and] responses and intervene in making these sustainable."
		"At the level decisions are made, communities do not have a voice, are not considered as having anything useful to contribute, are not experts. The problem is neither are those in UN agencies or governments, but they are the ones who are listened to."
	CSOs as agents for advocacy and accountability	"Civil society organisations are a central conduit for accountability of any global policy recommendations. They act as educators, organisers, activists, and advocates to disseminate recommendations on regional, national, and local levels. They are key to campaigning for recommendations to become policy and add oversight to implementation. Civil society engagement is key to bringing policies to life."

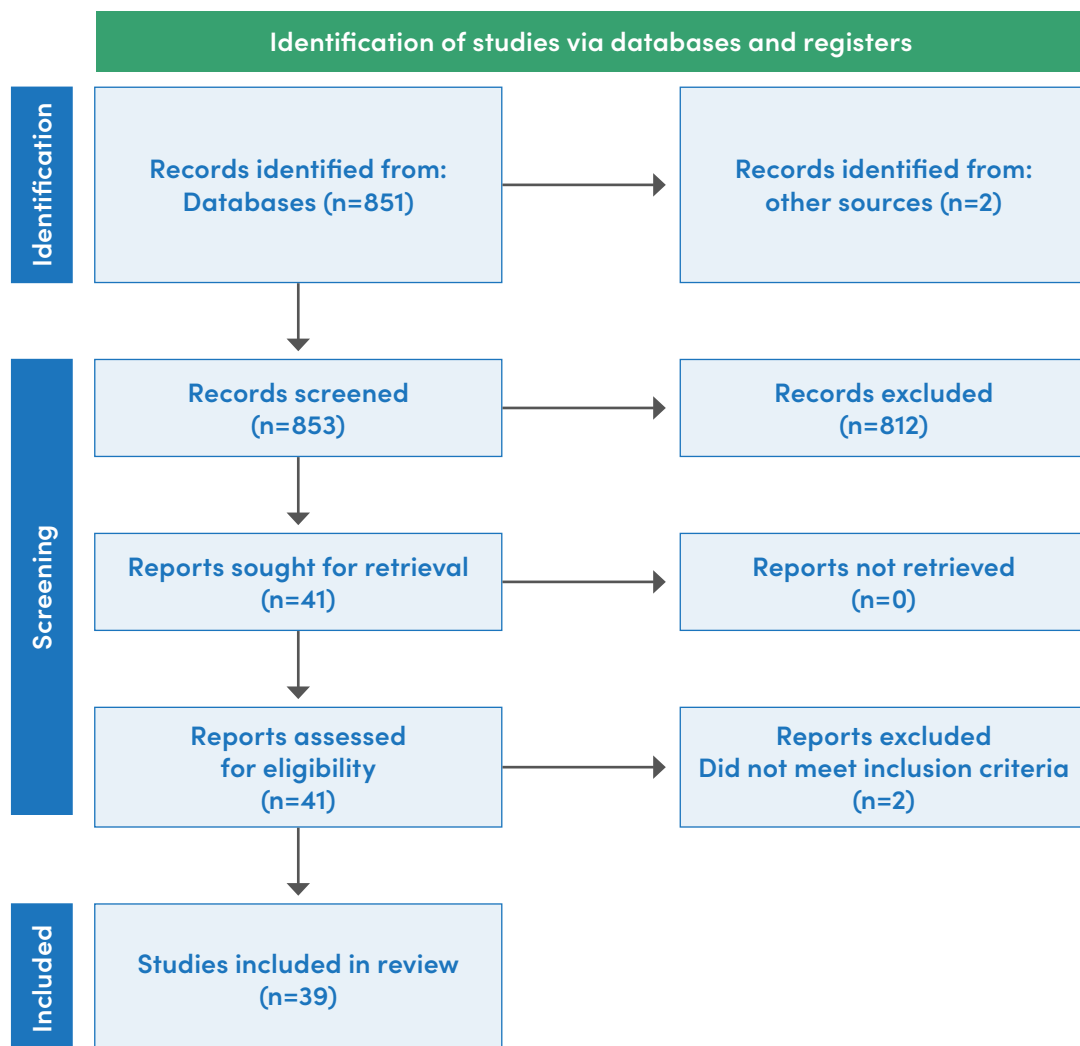
<b>Inadequate support</b>	<b>PPR efforts are consistently underfunded</b>	<p>“The recent progress on building consensus at the G20 to establish a global fund for pandemic preparedness is very welcome, but the process has been painstakingly slow, and financial commitments to date are still very limited and a far cry [from] what multiple expert assessments have concluded is needed to close critical financing gaps in preparedness.”</p>
		<p>“PPR is competing for scarce ODA global health resources. The traffic jam of global health resource mobilisation moments in 2022 is paralysing the need for bold action, and forcing a situation in which pandemic preparedness funding and reform proposals are being positioned as in direct competition with other global health and development priorities, largely along ODA lines.”</p>
		<p>“We need pandemic preparedness response mechanisms to be based on sustainable financing. Global public investment (GPI) has great relevance and legitimacy as a long-term, sustainable approach to financing, with all governments making incremental and ongoing payments. With all governments and civil society included in decision making, this would help ensure all benefit from public health safeguards and increased predictability in the event of a pandemic.”</p>
	<b>Political will as a barrier to action</b>	<p>“Progress on closing the gaps in the global COVID-19 response and on strengthening pandemic preparedness has been painstakingly slow. The issue is not a lack of money (for which hundreds of billion is materializing for the war in Ukraine), or a lack of know-how and evidence on what will work (there is tremendous consensus on where the areas of greatest need are), but rather lack of ambition and political will at the highest levels.”</p>
		<p>“Global summits to date have not delivered the policies or funding commensurate with the identified gaps in response or preparedness, and leaders have lacked urgency around the threat.”</p>
		<p>“It’s unfortunate that the IPPPR completely sidelined human rights, gender inequality and community engagement, thus robbing the process of the chance to mobilize sufficient political will to produce the recommended changes.”</p>
<b>Lack of coordinated global leadership</b>	<p>“As the war in Ukraine and other competing global crises now subsume political attention, and as policymakers and populations are eager to put the COVID pandemic in the rear view mirror, the political window of opportunity to drive a comprehensive package of reforms will continue to narrow without concerted global leadership.”</p>	
	<p>“Until and unless world leaders unite determined to do what it takes to work together and treat pandemics as the systemic risk that they are to humanity and our collective security- the world will continue to be at grave risk. We need the kind of resolute and sustained high-level political will, urgency, and united global front we are seeing to coordinate action around the Ukraine and climate emergencies.”</p>	
<b>Sustaining momentum</b>	<b>Importance of continued urgency</b>	<p>A full year after the IPPPR report, there is still no clear, coordinated leadership and ownership of a global PPR strategy and plan. Most of the action to date has focused on reform and strengthening of WHO, which is necessary but insufficient to achieve a better prepared world.</p>
		<p>“At the current pace, it seems that the best we will end up with are half measures that improve the situation but still fail to enable the world to respond in a coordinated or equitable manner.”</p>
		<p>“As countries plan their COVID-19 exit and recovery plans, the importance of pandemic preparedness has begun to gain greater visibility and traction among political, business, and community leaders. Now is the time to leverage that collective “muscle memory” before it atrophies.”</p>
	<b>Opportunity to build resilient health systems</b>	<p>“To transform the COVID response this is part of the critical functions for ACT-A partners to focus on and will continue to support building health systems that are stronger and better able to respond to all existing and future pandemics serving the objectives of the 2019 High Level Declaration on Universal Health Coverage and actively building stronger, better prepared health systems as new financing and other global structures for pandemic preparedness and response continue to be developed.”</p>

### Annex 3: Rapid Review on the transition from pandemicity to endemicity and possible routes to end the COVID-19 pandemic

#### Inclusion criteria, search strategy, and study selection

This rapid review explored the drivers and barriers for achieving endemicity and explored current knowledge on possible routes to end the COVID-19 pandemic. The following types of studies were included: (1) Studies reporting on the impact of national or regional policies or interventions that have relevance for COVID-19; (2) studies that evaluated policies or programs that are enacted at the organizational, national, or global level; and (3) studies, such as qualitative studies, that report on the views and experiences of actors (e.g., policymakers) at the global, national, or regional level. The search strategy and terms included words (MeSH terms) and free text terms for each domain (COVID-19 and Endemicity) to generate the search strategy for the electronic database PubMed. PubMed was searched from Jan. 1, 2021, to May 1, 2022. The screening process is described using an adapted Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flowchart (Figure H).

Figure H: PRISMA 2020 flow diagram for new systematic reviews



## Summary of results

The majority of papers in this rapid review concluded that it remains unclear when and how the pandemic will end.<sup>[55-59]</sup> Although most authors agree that the trajectory is difficult to predict, there was also agreement that the conditions that influence this transition can be anticipated.<sup>[55, 60]</sup> Mukaigawara et al. suggest the following factors as potentially influencing the global outcome of the pandemic: trust in leadership and the level of cooperation between governments; equitable access to vaccines, testing, and therapeutics; local government action and the response of citizens; competing outbreaks, conflicts, or natural disasters; and a focus on vulnerable populations, as well as those in low- and middle-income countries.<sup>[55]</sup> Most authors agree that the transition from pandemicity to endemicity will likely play out differently in different locations around the world, with each country or region interpreting the transition to endemicity dependent on their political, economic, and societal realities.<sup>[56, 61]</sup>

Notwithstanding the importance of context specific solutions<sup>[62]</sup>, several papers suggested specific priority actions to end the pandemic. The priorities most often mentioned in the literature included: (1) ensuring equitable production, supply, and distribution of COVID-19 vaccines and therapeutics; (2) easing restrictions as hospitalization and mortality rates fall; (3) emphasizing educational and harm reduction approaches over coercive and punitive measures; (4) introducing responsive and evidence-based public health plans that can rapidly respond in the event of a potential threat from an emerging variant; (5) reopening schools with improved ventilation systems; (6) addressing the long-term economic and psychosocial consequences of sustained lockdowns; (7) introducing policies to protect the vulnerable through an equity lens; (8) reassessing testing policies and practices including influenza-like illness surveillance supported by genetic sequencing; (9) increasing access to outpatient therapies and prophylactics; (10) rebuilding public trust in government through transparent, timely, and clear risk communication; (11) adopting a One Health, whole-of-government approach, with rapid coordination and efforts to involve communities and vulnerable populations; (12) introducing adequate evaluation mechanisms at the country level; (13) strengthening preparedness by establishing strong national capacity in three interlocking areas within a health system: strong public health capacity; resilient health systems; and an enabling environment for healthy lifestyles; and (14) including social and ethical factors in future pandemic preparedness, since social determinants of infection risk and infectious disease severity contribute to aggravated social inequalities in health.<sup>[55, 56, 60, 63-66]</sup>



## Annex 4: Methodology and summary of expert opinions on two roundtables

**Methodology:** A total of 27 stakeholders participated in two Roundtables in May 2022 with representation from all WHO regions and balanced representation of men and women. Participants included experts on COVID-19 working in academia, government, multilateral organizations, and the not-for-profit sector. We define experts as “representatives from organisations that conduct research on the pandemic, manage the COVID-19 pandemic at a policy and operational level, or collaborate with organisations involved in the response.” All respondents gave their consent to participate and for audio recording. Confidentiality was ensured with each participant given the option of not being quoted, even anonymously. We adopted an interpretative approach to data analysis. We coded all interviews primarily through an inductive approach and thematic analysis, using QSR NVivo 12 software. The Roundtable was conducted in English, recorded, and transcribed in full.

### First Roundtable: Prioritisation to transition beyond the acute phase of the COVID-19 pandemic

To inform the co-chairs’ one-year progress report, two discussion were facilitated.

The first discussion was on what the priority actions should be to end the COVID-19 emergency globally, particularly in the light of issues of vaccine efficacy against transmission; ongoing inequity in access to diagnostics, therapeutics, and vaccines, and uneven vaccine rollout; the threat of new variants; and increasing apathy towards recommendations of COVID-19 nonpharmaceutical countermeasures. Participants were asked to reflect on what governments should prioritise to transition beyond the acute phase of the COVID-19 pandemic (Box 1). A total of 14 experts (six women, eight men) participated in the first Roundtable. Participants were from Africa (n=4), Asia (n=4), Europe (n=4), North America (n=1), and South America (n=1).

For the second discussion, participants were asked to reflect on whether the world overall is better or less prepared for a pandemic should one arise tomorrow and whether current efforts to reform the international legal regime, strengthen WHO, raise new finance, ensure equity, and, critically, ensure the highest-level global leadership will be able to stop the next outbreak from becoming a global pandemic (Box 2). A total 13 experts (seven women, six men) participated in the second Roundtable. Participants were from Africa (n=3), Asia (n=2), Europe (n=5), North America (n=2), and South America (n=1).

## Box 1. What the experts say on priority actions to end the COVID-19 emergency globally

### Address social determinants of health with a systems and population health approach

*"In fact, looking forward, I think there need to be three interlocking functions that countries focus on. One of those is stronger public health, the second is more resilient health systems, and the third is making sure that populations are healthy by beginning more efforts at healthy population development."*

### Invest in Integrated Public Health with an emphasis on data collection capacity and prevention

*"Today we must include nonpharmaceutical preventions, such as ventilation systems. We heard the importance of continuing vaccination programs and boosters, of surveillance, of sentinel surveillance, not mass testing, looking at the genomics associated with that, looking in the environment, and keeping in mind that variants may develop."*

### Build trust and emphasize community participation

*"Using this time right now to communicate this, very transparently and very clearly to the people in various countries, is absolutely important for us to build that resilience, whether it is against the next wave of COVID-19, or at some point in time, for a future crisis."*

*"And I want to also put emphasis on community-focused communication strategy, that communities are the centre active role, and not playing the rather passive role is important."*

### Conduct national reviews and adopt lessons learned

*"National reviews should be happening in the next six to nine months. ... And this should focus on impact on health, health systems, welfare, and education. This should be then used to prepare the responsive actions that will accelerate the repair to this damage."*

### Develop appropriate, nondependent, and context-specific test-and-treat strategies

*"But the challenge from the African perspective is, we also don't have access to testing. We have not got access to the treatment opportunities that are emerging. So we need to still look at how we devolve and diversify the manufacturing ecosystem for therapeutics, diagnostics, and vaccines, so that any strategy that ties testing and treating together actually is not then dependent [and] doesn't suffer from the same consequences we've experienced for vaccine delivery this time round."*

### Develop context specific solutions, addressing inequalities and accounting for multiple crises

*"But the second thing that I wanted to say – and it's really an appeal, as somebody who works on Africa – is to ensure that we do not lose the context-specific strengths that we have in the different parts of the world. In Africa, the community health workers have been a stalwart for our response. We mustn't jump on the global train of adopting what works in other regions, what worked on other continents, and superimposing that on Africa."*

### Develop stronger leadership and encourage regional collaboration

*"How do we influence politicians to make more equitable decisions? It's a challenging one, because we know that they're elected to protect the interests of their electorate. So their first response is, actually, 'How do I protect my country?' ... So we need to explore how we can change the political perspective of preparedness and the understanding of the necessity to work as a global ecosystem in responding to future pandemics. That has got to be one of the critical messages that we take out of this pandemic response."*

Box 1, continued on next page

### **Improve uptake of vaccines**

*“On vaccination, we just have to keep at it. We know that it works. ... If we can achieve comprehensive vaccination in the [Global] North, why should the South settle for less? But whether it’s prioritisation targeting or sequencing, we mustn’t give up on the goal of Africa having the same access to preventive tools that others have had.”*

### **Continue research in unknown areas**

*“The third area that we talked about was research and development. I’m looking at new treatments or looking at the treatment options that exist, research on understanding better boosters, also on understanding of long COVID, and research designed to do that in the cohorts that exist.”*

### **Strengthen health systems with primary health care at its core and link to other systems**

*“Strong health systems are fundamental to pandemic preparedness and response. The COVID-19 pandemic reminded us again that we can’t have global health security without resilient health systems. ... Therefore, if the world truly believes that all people have equal moral worth and are entitled to equal consideration irrespective of nationality, the global system must commit to support the strengthening of health systems in lower-resource countries and ensure that the prevalent global health and economic architecture does not continue to limit the creation of local solutions in poorer regions of the world.”*

## Box 2. What the experts say on progress towards reforming the global architecture for pandemic preparedness and response

### Overall is the world better or less prepared for a pandemic should one arise tomorrow?

Most participants agreed that while some progress has been made in pandemic preparedness, this progress is currently insufficient and lacking in many important areas.

*"I didn't hear a single word that said we are 75% prepared. And the reason that we are going back into complacency is extremely high as most countries begin to of course live 'normal' – we have to admit the trajectory of this pandemic is still uncertain."*

*"It seems to me that actually today we're at a very dangerous moment. The waning of the pandemic in much of the world is really breeding a complacency at worst, and a careless satisfaction at best. And it's not clear, to me anyway, that we can be shaken out of this illusory sense of triumph anytime soon."*

### Positive aspects mentioned: financing, scientific advances, vaccines and trials, and population awareness

*"I would like to say that we are more prepared but just on the basis of people having more awareness. And knowledge of pandemics, infection rates, transmission, as well as the global linkages that are critical for the success of national responses."*

*"Scientifically the world is better prepared at least in the Global North. The amazing speed with which diagnostics and vaccines were developed truly helped in halting the spread of the new coronavirus."*

### Negative aspects mentioned: failures in leadership, in measurement indexes, departure from IHR, financing, and in understanding community engagement

*"And certainly all the existing pandemic preparedness indices that have been constructed over the years were stunningly useless at giving us any useful information regarding variation."*

### Lack of trust and international engagement, need to bridge gap between national and international policy

*"While I agree that there have been a lot of technological and scientific advances, I would say that we're not more prepared due to the lack of trust: globally, bilaterally, and within individual countries. And due to actions that continue to undermine calls for solidarity and equity."*

*"There is a need to still bridge a gap between domestic policymaking and global policymaking discussions. Domestic considerations and policymaking do not internalise considerations about global response, and how maximising also national well-being depends on making sure that we are as strong as our weakest link, and so even consideration of the global becomes fundamental for the national well-being."*

### Disempowered public health systems, failure to understand what airborne means, politically and epidemiologically unprepared

*"Globally we face exhausted national and local public health systems, but also disempowered ones. Courts and legislatures around the world have significantly restricted public health legal authorities. In most cases what this means in the future that we will have delayed implementation of public health measures, perhaps even a complete inability to impose public health measures, [and] that will cost lives."*

*"Politically the world is not prepared. Nationalism and populism prevailed in many world leaders, all of them males by the way, impeding a more rational and equitable approach to the COVID pandemic."*

### Increased inequalities and poverty and insufficient preparedness for the next pandemic

*"Moving beyond pandemic preparedness and response narrowly defined, we're really looking at the need for commitment, for more sustainable development. The inequalities have worsened, poverty has deepened. There is poor investment in public health broadly defined and we cannot really just look at pandemic preparedness in isolation from this broader picture."*

*Box 1, continued on next page*

*"We've learned a lot in this pandemic, but we've also registered concerning declines in the core that's given to preparedness and resilience. Our health care systems and health care workers are totally depleted. We've seen a huge rise in poverty and inequality, major setbacks in our control of other infectious diseases like malaria and measles, and greater geopolitical instability and pandemic fatigue across governments and societies."*

#### **Global leadership and accountability: Abandon the top-down approach**

*"I was just making an appeal that we should be courageous enough to do a stress test on a global public health system and call for a new public health order that will be looking into addressing this entire global health security architecture from the national level, regional level, global level so that we depart from this top-down approach that has characterised ... [the past] 75 years."*

#### **Financing: Some progress but moving slowly and doubts about substantial mechanism and reliance on ODA**

*"I think there is a lot of ongoing discussion on the importance of public financing of pandemic preparedness and response: In the G20, the discussion on creating a finance window. Dialogue between health and finance. And I think all of those discussions are quite welcome. They're largely overdue. For many years I was working on health that pushed for greater dialogue between health and finance, so I think that's on the positive side."*

*"There are nevertheless again some concerns here. That processes are moving far too slowly and that meets very tense geopolitics, and I'm a bit concerned that this slowness would play against the ability to come up with something which is really substantial in terms of generating a meaningful financing mechanism."*

#### **Strengthening WHO**

*"I think we really need to focus on actually – ask the question: What do states want in a WHO rather than trying to design the best public health institution. What's actually politically feasible and how to build an institution which fits that and seeks to achieve the things that we want from a global health body. I think we need to focus importantly on what is a WHO really good at and where are areas where we can look to them. We build some of the legitimacy that is lost as an institution, not just during COVID but over the last few decades."*

#### **New legal instruments: Engage in acts of legal imagination and reasserting human rights**

*"And our national and global legal governance remains not only insufficient, but as we spoke about before, is now even less prepared for such a crisis. Part of this is because our current international instruments are not only inadequate, but they're limited by the WHO constitution in their current scope and strength. ... So I'd argue that we need to engage in acts of legal imagination. Imagining's got us a robust climate system that is not without its flaws, but at least it has processes to address them, and break down cycles of panic and neglect. Global health needs imagination."*

*"We've heard already that there's been a lot of discussions about access to information, trust in information, thinking about equity, addressing authoritarianism, instability and trust in science. To me, I'd like to make a plea for thinking about reasserting human rights into the discussions around the amendments to the IHR, and any discussions around a pandemic treaty that may or may not happen in the next two years."*

#### **An end-to-end platform for equitable access**

*"And I'm struck by why, after nearly 2.5 years, we still have not been able to move towards more equitable distribution and decentralised production of lifesaving tools. ... I really want to anchor us on self-sufficiency, and less dependency and reliance on rich nations, as the path forward for end-to-end preparedness. There is no preparedness with this current charity-based, broken model, and there is no preparedness with the current Big Pharma approach to basically essentially owning IP and selling it to the richest bidder."*



## Acknowledgements

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