PODCAST TRANSCRIPT

PPPR Advocacy 101: Find out what it means to you

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Jeanne Baron: You're listening to *PxPulse*, a regular podcast bringing you fresh voices on critical issues facing HIV prevention research today. Over the coming months, global leaders will make key decisions about several global efforts to plan for the next pandemic. What they commit to and how much they will spend, and how well these plans incorporate equity, as a principle, across all these agreements, is in question.

In our last podcast, we spoke with Chris Collins. He's the president of Friends of the Global Fight Against AIDS, TB and Malaria. And he talked about ALL these efforts. Ultimately, these decisions will build a new architecture for what's being called Pandemic Prevention, Preparedness and Response, or PPPR.

Chris highlighted what the world learned from COVID 19 and from HIV. We were reminded that so many of the successes from 40 years of fighting HIV came directly from community leadership, and a focus on equity.

But it's not clear whether planning for the next pandemic is heeding these lessons. Some of these key lessons are to include the input, perspectives and engagement of civil society and community leadership. No one understands this better than HIV advocates. Their expertise is crucial to this debate. It's needed now.

Deadlines for civil society to influence these decisions are coming up.
There's a pandemic fund. There's a pandemic accord. There's UN high level meetings.

There's also something called the MCM platform, Medical Countermeasures. The MCM would coordinate drugs, vaccines and other equipment for health emergencies.

Karrar Karrar from Save the Children and Samantha Rick from AVAC have been close to this work. They are joining us today to explain exactly what commitments for equity are needed and who needs to hear this advocacy and when.

Let's start by talking about the MCM platform. That's the coordination plan, focused on the drugs and equipment needed in an emergency. Karrar, what is this platform and why does it matter?

Karrar Karrar: So Rhetoric around equity is all well and good. We've heard it all before, you know, egalitarian kind of societies and global public goods. But the reality is that falls by the wayside the moment the realities hit the ground. It begs the question. What does it actually mean. What practically what do we hold government to? Practically what do we hold the private sector to and practically what are we holding the multilateral system to? So for me, the medical countermeasures process is where the issues are ironed out, where the specifics of industry, of contracts, of transparency, these are fleshed out in peacetime, so to say.

Jeanne: And when it comes to equity commitments as part of this platform, what are you tracking and what are you calling for?

Karrar: It is how do we embed equity by design. And so a lot of these structures are being put into place right now. There is a sense of urgency. There is appetite both politically, and from a public health perspective, that there needs to be a rethink as to how these structures are going to look like for the next pandemic. And so in terms of this medical countermeasures platform, as the architecture is being put in place, how do you ensure that we do not fall into the same traps that we have done for H1N1, for COVID 19? And so using that lesson learning approach, one of the core things we are calling for is that we need communities to be integrated by design as opposed to an afterthought.

One of the other areas that we're calling for is that we need to rethink our social contract with the pharmaceutical industry, as we've seen with COVID 19. The private sector played a huge part in getting these commodities to market. That said, a lot of the successes that we saw in the scientific front were frankly due to huge amounts of public funding. And so we need public access conditions to underpin those. The huge amounts of money that's been pumped into public research, we need developers of these tools to adequately serve low- and middle-income country markets and adequately ensure that there is equity both within countries and between countries

Jeanne: Got it. embed equity, integrate community leadership. We've seen this in the HIV response. And the trap we're trying to avoid is rich countries hoarding the fruits of science, and a system that, in the end, fails to reach the people who need it the most.

Karrar: 100%. I mean, we got the science part. You can argue that was a success, but the success of all this is governed by can we get jobs in arms or can we get communities to adequately absorb these tools? And so in the absence of that, the best innovation is completely useless. if it's sitting on a shelf somewhere. We saw that play out again. Some of it was intentional because high income countries engaged in these beggar thy neighbor policies or protectionist policies whereby they hoarded vaccines. I think at the time 16% of the world's population, so these are high income countries had bought up 70% of the world supply. When we saw that play out, I think that coupled to some of the protectionist policies that we saw around export controls, that meant that the equity piece was never really within our grasp.

And then going back to that equity by design, the third prong would be member states or governments or individual countries would adhere to an international rules-based system around equity, ensuring that everyone gets their fair share. And so there isn't this element of race to procure as much of these commodities as possible, that there is a normative rules-based system that countries follow. When pandemics do hit and that we don't fall into this frenzy of going to markets and procuring everything that you can get your hands on.

Jeanne: I want to dig into the question of manufacturing and pricing, and how do they fit in?

Karrar: Yeah. The hope would be that the local manufacturing piece as well as pricing transparency, these are all issues that hopefully should come up and should be fleshed out in these discussions. I think for me, having kind of witnessed attempting to having those discussions when a hand is in the fire, so to say, the power dynamics were not in our favor. When we look at some of the discussions that we were having with the consumer industry in the private sector, you don't have the leverage to be able to negotiate pricing or any of the demands for that matter, when the very industry that you're relying on to deliver the tools that you've purchased in advance is the very industry that you're making certain kind of demands of, in the middle of a pandemic. You know, the hope would be that in peacetime, so to say that these discussions could be had fully whereby the power dynamic is a little bit more kind of even.

Jeanne: What is it that you want to see show up in this protocol around pricing, transparency and the rest. What does the MCM protocol need to do?

Karrar: I guess that from my side, going back to that equity by design, I think we have to look at upstream where the money comes from in global health R&D, there is no

incentive to produce a commodity for a pandemic and then within that falls, you know, anti-antibiotics, etc., because there frankly, there is no demand.

Jeanne: No demand because, the idea here is to develop these tools before we need them, have them sitting in a stockpile somewhere. And so there won't be a profit, at least not for sure.

Karrar: That's right. Research and development for these commodities or for pathogens of pandemic potential like COVID, like dengue, like Marburg disease, like Zika- they often come from bilateral donors. If we're saying that in order to course correct that market failure, there's a lot of public funding that has gone into these commodities. Then I would like to see underwritten, kind of legal contracts—nonexclusive voluntary licensing clauses, which basically means that the moment an intellectual property achieves a certain level in terms of the development pipeline, that commodity is not restricted. So by underwriting the requirement for that commodity, which is publicly financed, to be offered up in a non-exclusive basis to as many manufacturers as possible, that will allow any manufacturer in the developing country to pick up that license and manufacture for the population or even for export.

Jeanne: So, Karrar, Sam… I hear two pieces. Publicly fund these things early upstream that industry doesn't want to invest in because you can't make a profit on them. Don't allow intellectual property rights to become a barrier. Allow anybody to then manufacture these things. And then I believe there's a third piece, which is that we actually have to increase manufacturing capacity in the global South.

Karrar: Definitely, those companies have to have business in peacetime. So the inter pandemic period, we have to ensure that these companies or these vaccine manufacturers are able to serve your bread and butter needs of routine vaccines. And that will allow them to stay in business in the inter pandemic period, so that when a pandemic does inadvertently hit in the future, that they're able to pivot the business model, to be able to, instead of starting from scratch, pivot ever so slightly. And we saw that, for example, with India, you know, often cited as the global pharmacy of the world, they have some of the largest vaccine manufacturers by volume. But because they were able to serve the kind of bread and butter, routine immunization landscape when the pandemic hit, it didn't take all that much for them to pivot the business model to be able to become one of the largest vaccine manufacturers for COVID 19 vaccine.

Samantha Rick: I just wanted to add, I think it's also the concern of, oh, they won't make a profit off of this, so they're not investing in it. That is sometimes true, but also sometimes not. I mean, obviously manufacturers made a huge profit off of COVID 19 vaccines. It's more that they don't make a profit until these diseases spread to high-income countries.

Jeanne: Understood. For folks listening to this right now, if they want to see these equity principles embedded in the next draft of the pandemic accord or the MCM, who needs to hear this message?

Samantha: I think it's important to note that in a lot of these spaces, the Member States are the ones at the decision-making table. And there are some countries that maybe aren't participating as much, or some countries that aren't banding together with others on their messaging. I know that the African Union is doing a great job of getting a lot of the African Union members on the same page and calling for the same things. But we want to make sure that it's an overwhelming resounding message from 50 or 100, 150 countries of "This is what we need. We're trying to do this ourselves and we don't want to be beholden to charity. We don't want to be beholden to donors. But this is what we need to change in order to make that happen."

Jeanne: So people need to be talking to country representatives. Now. There's some particular convenings coming up through the year and some are coming quite soon when these decisions are going to be discussed.

Samantha: Certainly the fifth meeting of the INB is coming up in early April. The development of the prototype for the MCM platform is happening over this month and next, and after that there will be a high-level consultative group to decide on what is presented from the prototype working group.

Jeanne: That's the MCM…

Samantha: Yes, that's right. And The UN Declaration on PPR will be developed over the summer. So countries definitely need to engage on that if they want their priorities in that declaration documents and basically everything will come to a head in September at the UN General Assembly during that high level meeting on PPR.

Karrar: Yeah, I would just add to that, just reiterate a point Sam mentioned, that this engagement has to be systematic in nature. And so in terms of this best practice of engaging with respective technocrats within government at a national level, what does

that look like? I mean, that could be at the monthly level every couple of weeks, but whereby that exchange of information is happening. Bear in mind, institutional capacity is often a constraint in a lot of these countries. So whereby some of these entities that are country-level have technical capacity to offer up to these governments that could form the basis of, you know, text suggestions, that can form the basis of kind of analysis, to inform those positions. But I would say that is fundamentally rooted in ensuring that civil society communities through their national platforms have a means to be able to engage with governments. And so for me, that would be something that would ensure fruitful discussions in the lead up to these several touchpoints that Sam just mentioned.

Jeanne: Right, it needs to be sustained and they have unique capacity to support government in these negotiations. I really hear that. So all of these things that we're talking about is going to require some concessions from rich countries. What are those concessions?

Karrar: I think there is a twin track, the first and foremost in terms of the equity rhetoric, what does that actually mean— ensuring that supply is equitably distributed? So do we have to earmark supply to say that you get your fair share based on population needs? That essentially happened with COVID 19. When COVID 19 hit, the WHO put out what was a global allocation framework, and they said that every country has to immunize 20% of the population. And this was the most vulnerable sections of the population, including healthcare workers, including those immunocompromised and the elderly.

Now, frankly, had all countries adhered to that allocation framework, we would have immunized our most vulnerable populations globally. But at some point, high-income countries went far beyond that, whereby they attempted to achieve full immunization coverage for their whole population, including healthy teenagers and young adults, and that came to the detriment of the equity piece. And so, for me going forward, is to say, what does that accountability piece look like to ensure that member states stick to what would naturally be the normative guidance that comes out of WHO?

Samantha: I think one thing that really needs to be given up is this long-held idea that high income countries secure themselves against outbreaks that happen in low-income countries. Obviously, we've demonstrated that high income countries are also not ready for pandemics. There's nowhere that's ready to respond. They can easily get to your border or you can start in your own country, too. I mean, climate change is coming and we have a bazillion floods in all over Europe. Waterborne diseases happen really easily. We've seen that in Malawi right now. Huge, huge cholera outbreak

because of climate change. That's not something that only happens elsewhere. Marburg virus started in Germany.

Jeanne: Are there proposals out there that you guys are pushing for what accountability should look like?

Karrar: Yes, what does this accountability piece look like. And that begs the question of do we have a current kind of structure which is fit for purpose to act as accountability, holding member states accountable. And so I think that's the piece that the global health community now is trying to kind of come to terms with. What would be the optimal kind of accountability piece, and what would that look like are their existing structures that can be used? If so, are they fit for purpose? If not, can they be tweaked?

Jeanne: All these initiatives, right? We've got the pandemic record. We've got the pandemic fund, and the high-level meetings on universal health care and TB and pandemic preparedness going on at UN. We have the Medical Countermeasures platform. So there's a lot of moving pieces there. But what's at stake here this year? What happens if these equity principles do or do not make it in?

Karrar: Yeah, that is a very good question. What is at stake is that we haven't learned anything from the previous kind of smaller outbreaks or the previous pandemics. There was an element of exceptionalism up until COVID, you know, outbreaks of zoonotic spillover, It was something for the Global South to worry about. And along comes COVID, and all of a sudden this becomes a stark reality that these pathogens do not respect borders, do not respect nationality, color, creed, religion. Irrespective where you live, there is no protection against this. I think that acknowledgment has meant that if we don't get this piece right, how do we ensure that we do not lose the political capital and the stark trauma of the pandemic to ensure that this doesn't happen again? I mean, I think there is a general acknowledgment that, we wait too long and we're not going to have anything in place to react to what we're seeing. As Sam mentioned, a whole host of outbreaks that we're seeing as we speak.

Jeanne: Right, vulnerability instead of resilience, with the risks are rising.

Karrar: 100%. I think one thing that is still kind of a risk with all this, is that the COVID 19 pandemic had an inadvertent displacement effect. We saw huge backsliding, a huge reversal in gains on routine immunization, on services for women and children in terms of HIV, in terms of our progress on TB. And so my worry is, with this kind of

global health securitization agenda is that we leave bread and butter programing that has worked is quality tested and the proof is in the pudding and we focus on the shiniest newest tool.

Jeanne: What do we have to gain if we get it right?

Samantha: I mean, if we get it right, we have the kind of system that should just be automatically moving. I mean, you would think that if a pandemic hits, allocating tools to the most vulnerable would be defaults. Rightly, that should be completely automatic.

That's the way, the most effective and most efficient way to fight a pandemic. I mean, the way that happens in people's own countries, it's not as if medicines go to everybody at the same time, regardless of your vulnerability to disease.

So what we would be gaining is if the country has more of a capacity to develop an innovative tool, they have the responsibility to share that with everyone. If a country has more of a capacity to detect an early outbreak, they have the responsibility to share that information with everybody so that they can develop a tool. All of this is sharing with each other according to our own capacities.

Jeanne: For more on all this, including details on these initiatives and timelines for advocacy, go to avac.org/px-pulse. And we hope you will. HIV advocates have a unique role to play in this pivotal moment. The HIV response made historic strides toward controlling the epidemic because advocates fought relentlessly for their demands to be heard. But protecting those gains depends on using this moment to bring these principles around equity into the new architecture for Pandemic readiness. The fight for equity in HIV and in global health needs us all.