Analysis of the Universal Health Coverage revised Zero Draft

United Nations (UN) States are expected to adopt a political declaration on universal health coverage during the high-level meeting to be held in September 2023. On May 22, 2023, the co-facilitators of the intergovernmental consultation for the high-level meeting circulated a Zero Draft for a prospective political declaration on universal health coverage. Recently, the co-facilitators circulated a Revised Draft for a prospective declaration. The Revised Draft has 48 preamble paragraphs (PP) and 64 operative paragraphs (OP). It covers a range of topics, including service coverage, access to health technologies, digital health, health emergencies, financing, health workforce, multi-stakeholder engagement, and accountability. The Zero Draft, as recently revised, is expected to serve as the basis for negotiations for a political declaration that "seeks to accelerate progress towards achieving universal health coverage by 2030."[1]

A wide variety of international documents have addressed critical issues in public health, human rights, recognition of populations made vulnerable by law or policy, and access to medicines. The HIV Language Compendium (HILanguageCompendium.org) compiles "agreed language" on a set of key contentious issues–illustrating that there exists strong consensus and political settlement on many of these issues. Based on these elements from international instruments, sources, and agreements, our analysis proposes improvements to the Zero Draft that could be reflected in the final universal health coverage political declaration to make it as bold as other declarations in selected areas.

While strong in some aspects, the Revised Draft does not reflect internationally agreed terms in some important areas relating to universal health coverage. Contrary to several international

[1] https://www.un.org/pga/77/2023/05/24/letter-from-the-president-of-the-general-assembly-zero-draft-of-the-political-declaration-on-uhc/

precedents, the Revised Draft does not recognize the importance of community leadership in health service delivery and responses. The Revised Draft also lacks pledges to increase support for community leadership in health service delivery. The Revised Draft also fails to explicitly mention several key vulnerable populations, commit to expanding self-care interventions, and acknowledge governance gaps in digital health.

Furthermore, the Revised Draft does not capture the role of intellectual property and the lack of technology transfer in creating global inequities in the distribution of treatments, diagnostics, and other health technologies in addition to vaccines. The Revised Draft would be stronger if, as in previously concluded resolutions and documents, it included strong commitments for exploring delinkage research and development models, for embedding equitable access to publicly funded research, and for strengthening regional pharmaceutical research and development capabilities. Lastly, the Revised Draft is missing clear language on equitable access to comprehensive healthcare for migrants.

1. Recognize the importance and commit to supporting community-led initiatives

PP32 of the Revised Draft states that "primary health care, including community-based primary health care, brings people into first contact with the health system." PP34 of the Revised Draft highlights "community-based health services as a critical component of primary health care and as a means of ensuring universal and equitable access to health for all." Neither of these paragraphs, however, explicitly recognize the importance of placing community leadership at the center of health service delivery. Several other paragraphs of the Revised Draft mention health service delivery and governance without acknowledging the importance of community leadership. These include PP28, PP46, PP47, OP6, OP39, and OP51 of the Revised Draft.

Community leadership has a measurable impact on the health of key populations, including in the reduction of high-risk sex and the increase in family planning.[2] More effective, sustainable, and equitable systems, that are essential to the scope and cost efficiencies required by Universal Health Coverage, are developed when communities are directly involved at all stages of decision-making processes. These positive effects have been evidenced in research showing that community-led initiatives are central to equitable pandemic preparedness and response.[3] Research has also demonstrated that community leadership is more effective in settings where laws criminalize

[2]https://hivlanguagecompendium.org/intergovernmental-evidence/2022-who-consolidated-guidelines-on-hiv-vh-sti-for-kps.html

[3] https://www.unaids.org/en/resources/presscentre/featurestories/2022/january/20220128_communities-first-responders

same-gender sex, sex work, or drug use.[4] It is therefore critical to acknowledge the importance of community leadership in health service delivery and responses.

Recognizing this, States have called for placing communities at the center of service delivery in multiple international agreements. In the HIV political declaration adopted in June 2011 by the UN General Assembly (UNGA), States committed "to con-tinue engag-ing peo-ple liv-ing with and affected by HIV in deci-sion--mak-ing and plan-ning, imple-ment-ing and eval-u-at-ing the response."[5] In the same declaration States also committed "to partner with local leaders and civil society, including community-based organizations, to develop and scale up community-led HIV services and to address stigma and discrimination."[6] In the 2016 political HIV declaration, States committed to expanding "community-led service delivery to cover at least 30 per-cent of all ser-vice deliv-ery by 2030."[7] The HIV political declaration adopted by the UNGAin 2021 again called on States to implement "community-led" service delivery models.[8]

Experts have also called for community leadership in numerous reports and guidelines. The UN High Commissioner for Human Rights recently urged States to ensure that the development, implementation, and monitoring of all HIV legal and pol-icy changes and pro-gram-matic inter-ven-tions "are under-taken with the mean-ing-ful engage-ment and lead-er-ship of com-mu-nity-led orga-ni-za-tions."[9] In 2021, the Com-mis-sion on the Sta-tus of Women (CSW) of the UN Economic and Social council (ECOSOC) encouraged States "to facil-i-tate the active engage-ment, rep-re-sen-ta-tion, and deci-sion-mak-ing of women liv-ing with, at risk of or affected by HIV and their net-works in inter-na-tional, regional, national and com-mu-nity-led processes related to the HIV and AIDS response."[10]

Pledges to guarantee and increase community leadership in health services delivery have also been adopted in existing international documents. The 2021 Global AIDS Strategy, in particular, adopted several specific targets relating to community leadership in service delivery. The strategy seeks 30% of testing and treatment services to be delivered by community-led organizations; 80% of service delivery for HIV prevention programmes for key populations to be delivered by community-led organizations; and 60% of the programmes supporting the achievement of societal enablers to be delivered by community-led organizations.[11] The Global AIDS Strategy also called for ensuring "account-abil-ity for HIV-related human rights vio-la-tions by increas-ing

[4] 2021 WHO Consolidated Guidelines on HIV Prevention, Testing, Treatment, Service Delivery and Monitoring (p. 346): https://hivlanguagecompendium.org/intergovernmental-evidence/2021-who-consolidated-guidelines-hiv-prevention-testing-treatment-monitoriong.html
[5] https://hivlanguagecompendium.org/high-level-precedent/2011-political-declaration-on-hiv-and-aids.html
[6] https://hivlanguagecompendium.org/high-level-precedent/2011-political-declaration-on-hiv-and-aids.html
[7] https://hivlanguagecompendium.org/high-level-precedent/2016-political-declaration-on-hiv-and-aids.html
[8] https://hivlanguagecompendium.org/high-level-precedent/2021-political-declaration-on-hiv-and-aids.html
[9] https://hivlanguagecompendium.org/expert-precedent/2022-ohchr-report-on-human-rights-and-hiv-aids.html
[10] https://hivlanguagecompendium.org/intergovernmental-precedent/2021-csw-report-on-women-and-hiv-aids.html
[11] https://hivlanguagecompendium.org/key-population-and-community-leadership.html

mean-ing-ful access to jus-tice and account-abil-ity for peo-ple liv-ing with or affected by HIV and key pop-u-la-tions."[12] "This includes increas-ing col-lab-o-ra-tion among key stake-hold-ers, sup-port-ing legal lit-er-acy pro-grammes, increas-ing access to legal sup-port and rep-re-sen-ta-tion and sup-port-ing com-mu-nity mon-i-tor-ing for peo-ple liv-ing with or affected by HIV."[13]

Recommendation: Explicitly recognize the importance of community leadership in health service delivery and response using the term "community-led" next to "community-based." In particular, explicitly recognize the importance of community leadership in PP32 and PP34 of the Revised Draft. The importance of involving community leadership can also be explicitly recognized in PP28, PP46, PP47, and OP6. In OP39, commit to specific spending targets for investments in community-led services and responses. Furthermore, add a new OP calling for increasing and ensuring the funding and support for "community-led initiatives."

In the same paragraphs mentioned above, the political declaration should also emphasize the importance of meaningfully involving community leadership in accountability mechanisms.

2. Ensure the protection of all vulnerable populations

OP3 of the Revised Draft calls for ensuring that "no one is left behind." OP3 also calls for addressing "the physical and mental health needs of all" while empowering "those who are in vulnerable situations." In particular, OP3 rightfully names "women, children, youth, persons with disabilities, people living with HIV/AIDS, older persons, People of African Descent, Indigenous Peoples, refugees, internally displaced persons and migrants." The list in the current version of OP3, which now includes women, People of African Descent, those living in poverty, people living in slums, and people living in conflict and post-conflict situations, is broader than the list previously in the Zero Draft. Nonetheless, OP3 still fails to acknowledge other vulnerable populations in the health and human rights realm that are often subject to discrimination based on laws, policies, or practices.

Transgender people, men who have sex with men, sex workers, people who use drugs, and people in prisons are among those vulnerable populations. Numerous international sources explicitly recognize the rights and vulnerabilities of these populations in accessing healthcare. UNGA Member States have recognized the rights of these specific vulnerable populations in the 2021

[12] https://hivlanguagecompendium.org/intergovernmental-precedent/2021-unaids-global-aids-strategy-2021-2026.html
[13] https://hivlanguagecompendium.org/intergovernmental-precedent/2021-unaids-global-aids-strategy-2021-2026.html

political declaration on HIV,[14] in the 2021 political declaration on equitable global access to COVID-19 vaccines,[15] and in the 2018 political declaration on the fight against tuberculosis.[16]

In addition to these documents, reports from the UN independent expert on protection against violence and discrimination based on sexual orientation and gender identity,[17] the UN High Commissioner for Human Rights,[18] and the UN Special Rapporteur on the right to health.[19]

Protecting vulnerable and marginalized populations requires evidence- and human rights-based interventions. This requires work directed toward ending stigma and discrimination, including through legal reform. As noted by the High Commissioner for Human Rights, non-discrimination is a foundational principle of health as a human right and should also be a fundamental principle of pandemic preparedness and response.[20] Interventions to improve pandemic preparedness and response should ensure special protection for vulnerable populations.[21] These populations include, but are not limited to, detained people, LGBTIQ+ people, and migrants.

Recommendation: Explicitly recognize that transgender people, men who have sex with men, sex workers, people who use drugs, and people in prisons are also among vulnerable populations. Recognition of these key vulnerable populations should be included in OP3.

3. Acknowledge and address digital health governance gaps

OP34 of the Revised Draft calls for "policies, laws and regulations to build and strengthen an interoperable and effective digital health ecosystem, while addressing the digital divides, to accelerate progress towards universal health coverage." OP34 also acknowledges "the role of digital health tools in promoting public health information" and "empowering patients by strengthening patient involvement in clinical decision-making." OP33 of the Revised Draft further recognizes that "digital health interventions are not a substitute for functioning health systems" and that there are "significant limitations to what digital health is able to address." Calling for digital health policies, and highlighting their potential and limitations, is welcome. Recognition of

[14] https://hivlanguagecompendium.org/high-level-precedent/2021-political-declaration-on-hiv-and-aids.html
[15] https://hivlanguagecompendium.org/high-level-precedent/2021-political-declaration-on-equitable-global-access-to-covid-19-vaccines.html
[16] https://hivlanguagecompendium.org/high-level-precedent/2018-political-declaration-of-the-hlm-on-the-fight-against-tb.html
[17] A/HRC/50/27
[18] A/HRC/30/65
[19] A/HRC/14/20
[20] https://www.ohchr.org/sites/default/files/documents/issues/health/activities/2022-07-15/Human-rights-in-the-new-pandemics-instrument.pdf.
[21] https://www.ohchr.org/sites/default/files/documents/issues/health/activities/2022-07-15/Human-rights-in-the-new-pandemics-instrument.pdf.

existing digital divides should also be retained in the declaration. Yet, OP34 fails to recognize the need for safeguarding human rights and participation in digital environments.

Global governance of data and digital technologies is currently inadequate for safeguarding human rights. While digital health technologies can address challenges in the delivery of quality health care, the threats to privacy and confidentiality can lead to violence, discrimination, and violations of key human rights including housing, employment, expression, freedom of assembly, protection from arbitrary detention, bodily autonomy, and security.

These governance gaps have been recognized in multiple international sources. Affirming "that the same rights that people have offline must also be protected online,"[22] the Human Rights Council (HRC) has for instance called States to consider "adopting or reviewing legislation, regulations or policies to ensure that business enterprises fully incorporate the right to privacy and other relevant human rights into the design, development, deployment and evaluation of technologies, including artificial intelligence."[23] States have also stressed the need to ensure "the use of technology to monitor and contain the spread of infectious diseases, are in full compliance with the obligations of States under international human rights law."[24] Privacy must be protected "when designing, developing or deploying technological means in response to disasters, epidemics and pandemics."[25]

Recommendation: Complement OP33 and OP34 with a new OP recognizing the need to protect human rights in digital environments, including privacy and non-discrimination. This new OP should read: "Recognise the need to adopt or review legislation, regulations or policies that strengthen and enforce the governance of data and digital technologies to ensure the protection of human rights, including the right to privacy and non-discrimination, into the design, development, development and evaluation of technologies, including artificial intelligence."

4. Recognize the need to ensure equitable access to health care services for migrants

The scope of Universal Health Coverage must operate in an enabling environment that recognizes the full range of, and barriers to, legal, policy, and social determinants of health, especially for those most marginalized and vulnerable. PP24 recognizes that "migrants, refugees and internally displaced persons often face barriers that limit their access to essential health services." OP21 calls for addressing "the particular needs and vulnerabilities of migrants, refugees, internally displaced

[22] A/HRC/RES/42/15
[23] A/HRC/RES/42/15
[24] A/RES/75/176
[25] A/RES/75/176
https://www.ohchr.org/en/documents/thematic-reports/ahrc5365-digital-innovation-technologies-and-right-health

persons." The Revised Draft in particular mentions "assistance, health-care services and mental health and psychosocial support and other counselling services."

In recent international declarations, however, States have adopted greater and stronger commitments relating to the protection of migrants and refugees. In particular, States have previously committed to ensuring that services provided to migrants and refugees are adequate, of quality, affordable, and comprehensive. The UNGA resolution on violence against women migrant workers, for example, urged States to promote "access to adequate, quality and affordable health-care services" to women migrant workers and their accompanying children.[26] The same UNGA resolution also urged States to provide "equitable access to comprehensive health-care services for women migrant workers, including mental health and psychosocial support, palliative care and access to safe, quality, effective and affordable vaccination."[27]

Recommendation: Commit to ensuring that services provided to migrants and refugees are "adequate, of quality, affordable, and comprehensive." This should be placed within OP21.

5. Commit to exploring and expanding self-care interventions

OP7 of the Revised Draft calls for exploring "ways to integrate, as appropriate, safe and evidence-based traditional and complementary medicine services within national and local health systems, particularly at the level of primary health care." OP7 also highlights the need to ensure safety and quality of care, and recognizes "the important role and capacities of WHO and other relevant actors to support member states with relevant evidence-based guidance."

Self-care is one of the most important and promising complementary medicine services. Indeed, "[t]he provider-to-client model that is at the heart of health systems must be complemented with a self-care model through which people are enabled to make active, informed health decisions to promote health, prevent disease, maintain health and cope with illness and disability with or without the support of a health worker."[28] Self-care interventions can improve equitable access to health, alleviate pressure on health systems, and reduce financial costs. Individuals choose self-care interventions given their convenience, confidentiality, and cost.[29] People can also choose self-care if they anticipate that they may face stigma and discrimination.[30] Self-care interventions grounded in human rights further promote autonomy through informed decision-making, active

[26] https://hivlanguagecompendium.org/high-level-precedent/2022-resolution-on-violence-against-women-migrant-workers.html
[27] https://hivlanguagecompendium.org/high-level-precedent/2022-resolution-on-violence-against-women-migrant-workers.html
[28] https://www.who.int/publications/i/item/9789240052192
[29] https://www.who.int/news-room/fact-sheets/detail/self-care-health-interventions
[30] https://www.who.int/news-room/fact-sheets/detail/self-care-health-interventions

and informed participation of individuals, privacy and confidentiality, and increased availability and accessibility to complement facility-based care. Given these benefits, self-care interventions can "accelerate attainment of universal health coverage."[31]

Recommendation: Adopt explicit commitments within OP7 for exploring and expanding self-care interventions as a complement to health systems to attain universal health coverage.

6. Urge avoiding TRIPS Plus and other commitments that prevent the use of IP flexibilities

OP27 reaffirms that the World Trade Organization (WTO) Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) should be interpreted and implemented in a manner supportive of the right to protect public health and promote access to medicines for all. Moreover, OP28 reaffirms the right of WTO Member States to use TRIPS flexibilities "to the fullest extent," including to promote access to medicines for all. Neither OP27 nor OP28, however, mention the legal, political, and practical barriers that often impede the use of TRIPS flexibilities. Several of those barriers are imposed by preferential trade and investment agreements with international intellectual property commitments that go beyond those required by the TRIPS. These include exclusive protection to regulatory data and patent term extensions.

Several international sources have acknowledged the detrimental effects of TRIPS Plus commitments on access to health technologies, including the 2021 political declaration on HIV.[32] Experts have also advised States against TRIPS Plus provisions in numerous reports. In 2009, the UN Special Rapporteur on the right to health, Anand Grover, urged developing countries to avoid TRIPS Plus commitments that impede access to health technologies.[33] Grover also warned that exerting pressure on developing countries to enter into TRIPS Plus commitments may infringe on the right to health, including access to and affordability of care.[34] The UN Special Rapporteur for cultural rights Farida Shaheed similarly urged States to refrain from adopting TRIPS Plus provisions that impede the use of "exclusions, exceptions and flexibilities and thus from reconciling patent protection with human rights."[35] The final report of the UN Secretary-General's High-Level Panel on Access to Medicines found that commitments beyond the TRIPS agreement "may impede access to health technologies."[36] Given these effects, the High-Level Panel on Access to Medicines urged States to avoid TRIPS Plus commitments.

[31] https://www.who.int/news-room/fact-sheets/detail/self-care-health-interventions
[32] A/RES/75/284 (calling States to ensure "that intellectual property rights provisions in trade agreements do not undermine [access to health technologies])."
[33] https://hivlanguagecompendium.org/expert-precedent/2009-special-rapporteur-on-the-right-to-health.html
[34] Id.
[35] A/70/279
[36] http://www.unsgaccessmeds.org/final-report

Recommendation: Urge States to refrain from entering into TRIPS Plus commitments in preferential trade or investment agreements. This call can be placed at the end of OP21.

7. Acknowledge the role of intellectual property and lack of technology transfer in treatment and diagnostics inequity

Moreover, PP30 of the Revised Draft expresses "deep concern about the uneven access of developing countries, particularly African countries, to safe, quality, efficacious, effective, accessible and affordable vaccines against COVID-19." PP30 also highlights the need to support "national, regional and multilateral initiatives that aim to accelerate the development and production of and equitable access to COVID-19 diagnostics, therapeutics and vaccines."

Global disparities in the manufacture, distribution, and access to COVID-19 vaccines, treatments, diagnostics, and other health products have been well documented. Experts have warned about these global disparities affecting vaccines, treatments, diagnostics, and other COVID-19 health products and demonstrated how they undermine fundamental human rights.[37] However, the first statement in PP30 erroneously omitted mentions of global disparities in the manufacture, distribution, and access to treatments, diagnostics, and other COVID-19 health products. The first statement of PP30 only mentions "uneven access" to COVID-19 vaccines. Furthermore, PP30 suggests that the "uneven access" to COVID-19 vaccines "particularly" affected African countries. While access to COVID-19 health products indeed was inequitable in African countries, these disparities were global. In addition, it is important to note that neither companies nor States used existing technology transfer mechanisms to address this issue.

Recommendation: PP30 should acknowledge that global disparities in the distribution, manufacturing, and technology transfer for COVID-19 health products included treatments, diagnostics, and other goods in addition to vaccines. PP30 should also clearly state that these disparities were global. PP30 should also acknowledge that international and domestic intellectual property legal frameworks had an impact in creating COVID-19 shortages, and that neither product developers nor States used existing technology transfer mechanisms.

8. Commit to collaborating on delinking research and development incentives models

OP31 recognizes the need "to support initiatives and incentive mechanisms that separate the cost of investment in research and development from the price and volume of sales, facilitate equitable and affordable access to new tools and other results to be gained through research and development

[37] https://www.ohchr.org/en/statements/2020/11/statement-un-human-rights-experts-universal-access-vaccines-essential-prevention

to address the global concern about the high prices of some health products." OP31 also calls for encouraging the World Health Organization (WHO) "to continue its efforts to biennially convene the Fair Pricing Forum with Member States and all relevant stakeholders to discuss the affordability and transparency of prices and costs relating to health products." Recognizing the importance of incentive mechanisms that delink research and development costs from prices is welcomed. Nevertheless, OP31 lacks concrete and actionable commitments toward delinkage. In particular, OP31 fails to explicitly call for international collaboration.

Delinkage models have been recognized by several international authorities for their potential to promote human rights by ensuring access to health technologies for all those that need them. States have also acknowledged the importance of international collaboration toward delinkage models to address specific health needs. The UNGA political declaration on HIV adopted in 2021 recognized the need to continue exploring delinkage research and development models "where rewards for innovation are independent from rights to market exclusivity."[38] In 2018, the UNGA also recognized the need for incentives that avoid reliance on high prices specifically for health products to fight against tuberculosis.[39] In 2016, the UNGA acknowledged the need for international collaboration on delinkage models to decouple antimicrobial resistance research and development from prices and volumes of sales.[40]

Several international authorities have specifically called on States to further explore and collaborate toward delinkage models. In 2015, for instance, the WHO Executive Board called upon Member States to "collaborate" on delinkage incentive models to combat Ebola.[41] Furthermore, in July 2022, the HRC called upon States to "collaborate" "on models and approaches that support the delinkage of the cost of new research and development from the prices of medicines, vaccines and diagnostics."[42] The HRC has also called on States to "collaborate" on delinkage incentive models to ensure "sustained accessibility, affordability and availability and to support access to treatment for all those in need."[43] Similar language calling upon States to collaborate on delinkage incentives models to ensure access to health technologies for all those in need features in HRC resolutions adopted in 2021,[44] 2019,[45] 2016,[46] and 2013.[47]

Recommendation: Commit to collaborate towards exploring, supporting, and implementing

[38] A/RES/75/284
[39] A/RES/73/3
[40] A/RES/71/3
[41] https://oneill.law.georgetown.edu/five-observations-ebola-special-session-resolution/
[42] A/HRC/50/L.13/Rev.1
[43] A/HRC/RES/49/25
[44] A/HRC/RES/46/14
[45] A/HRC/41/L.13
[46] A/HRC/32/L.23/Rev.1
[47] A/HRC/23/L.10/Rev.1

incentive models that delink pharmaceutical research and development costs from the price of products. Commitments to collaborate on delinkage should be placed in OP30 and OP29.

9. Commit to embedding strong equitable access terms on publicly funded research

OP29 of the Revised Draft states that the private sector plays an "important role" in the research and development of innovative medicines. OP29, however, failed to recognize the considerable contributions from public and philanthropic institutions in the research and development of health technologies. Public and philanthropic contributions often derisk and steer private investments toward the development of health technologies. These extensive public and philanthropic contributions were particularly evident with the development of COVID-19 technologies. Highlighting the "important role" of the private sector without acknowledging the extensive contributions of public and philanthropic institutions would be a misleading statement.

Furthermore, OP30 makes commitments to transfer technologies and know-how "where possible, in agreements where public funding has been invested in research and development for health." Suggesting that the transferring of publicly funded technologies and know-how will only be pursued "where possible" considerably weakens this commitment. Moreover, OP30 refers to "voluntary licensing," without stating the need for ensuring that technology transfer arrangements be open to manufacturers around the world and transparent. Merely referring to "voluntary licensing" also omits other possible approaches to ensure the transfer of publicly funded technologies and know-how, including legal provisions mandating open sharing.

Recommendation: Acknowledge the extensive contributions of public and philanthropic institutions in pharmaceutical research and development. Acknowledgement of public and philanthropic contributions should be placed in OP29. Additionally, OP30 should eliminate the phrase "where possible" and commit to ensuring that publicly funded technologies are licensed openly and transparently to promote equitable access. OP30 should also highlight all approaches to ensure technology transfer, including legal provisions mandating open sharing.

10. Commit to strengthening pharmaceutical research and development capabilities

OP30 includes commitments to "strengthen local and regional capacities for the manufacturing, regulation and procurement of needed tools for equitable and effective access to vaccines, therapeutics, diagnostics and essential supplies, as well as for clinical trials, and to increase global supply through facilitating transfer of technology within the framework of relevant multilateral agreements." OP32 acknowledges the need to "increasingly support developing countries in building expertise to strengthen local and regional production of vaccines, medicines, diagnostics and other health technologies in order to facilitate equitable access."

While commitments to strengthen local and regional manufacturing capabilities are welcomed, these interventions should apply a comprehensive approach. In addition to strengthening local and regional manufacturing, comprehensive approaches should also seek to enhance pharmaceutical research and development capabilities in low- and middle-income countries. Strengthening research and development capabilities is needed to increase health resilience in low- and middle-income countries. Enhancing regional research and development capabilities can also increase the suitability of available health technologies for local populations.

States have previously acknowledged the need for comprehensive approaches to strengthening local capabilities. In the Seventy-fourth World Health Assembly, WHO Member States called for "a holistic approach in strengthening local production by considering, for example, promoting research and development."[48] The Seventy-fourth World Health Assembly also requested the WHO Director-General to support Member States "in facilitating research and development and technology transfer on voluntary and mutually agreed terms."[49] Programmes like the WHO mRNA Technology Transfer Hub[50] have the potential to strengthen local manufacturing but also research and development of novel vaccines, treatments, diagnostics, and other health products.

Recommendation: Add a new OP explicitly recognizing the need to enhance research and development capabilities in low- and middle-income countries. Furthermore, commit to support and finance the WHO mRNA Hub programme and other similar initiatives to increase access to vaccines, therapeutics, diagnostics, and other health technologies. This new OP can state: "Enhance local and regional capabilities in low- and middle-income countries to research and develop vaccines, therapeutics, diagnostics, and other health technologies, including by supporting and financing initiatives like the WHO mRNA technology transfer hub programme.

11. Integrate universal health coverage and global health security policy-making

PP43 of the Revised Draft recognizes that health system resilience and universal health coverage "are central for effective and sustainable preparedness, prevention and response to pandemics and other public health emergencies." Universal health coverage strengthens and prepares health systems for responding to health emergencies by facilitating accessibility, affordability, and quality. Universal health coverage can also ensure that health systems respond promptly and effectively to emergencies by increasing the number and reach of facilities, streamlining supply

[48] A74/A/CONF./1
[49] A74/A/CONF./1
[50] https://www.who.int/initiatives/the-mrna-vaccine-technology-transfer-hub

chains, and recruiting and retaining human resources for health. It is therefore critical to integrate universal health coverage, pandemic preparedness and response, and health security policy development together.

Experts have specifically recognized the need to integrate universal health coverage, pandemic preparedness and response, and health security policy development, particularly in light of the COVID-19 outbreak. The WHO has called for embedding policies for emergency management into wider efforts to strengthen health systems "by applying an integrated approach" to universal health coverage and health security policy-making and subsequent planning.[51] The WHO has also called for ensuring the "participation of health systems, stakeholders in emergency preparedness and response, other sectors and community partners in [intraaction and after-action reviews], so that response experiences influence sustainable capacities for a more resilient system."[52]

Recommendation: Highlight the need for integrating and explicitly commit to integrating universal health coverage, pandemic preparedness and response, and health security policy developments. This commitment can be placed within PP43 and OP51 of the Revised Draft.

[51] https://www.who.int/publications/i/item/WHO-UHL-PHC-SP-2021.01
[52] https://www.who.int/publications/i/item/WHO-UHL-PHC-SP-2021.01