Open Letter from Indonesian Civil Society Organizations
regarding the WHO Pandemic Treaty

Dear Sir/Madam

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President of the Republic of Indonesia

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Chair of House of Representatives of the Republic of Indonesia

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We, Indonesia Civil Society Organization, express profound concern regarding the recently disclosed draft text of the WHO Pandemic Agreement[1] slated for discussion at the upcoming resumed 9th session of the Intergovernmental Negotiating Body (INB) that will begin on 29th April.

We firmly assert that the proposed text is unbalanced and biased in favour of the demands of developed countries at the expense of the interests of developing countries. The document fails to incorporate substantive measures and mechanisms to assist developing nations in preventing, preparing for, and responding to pandemics. As elaborated below, there are no meaningful provisions that concretely deliver financial support, technology transfer and enable the sharing of proprietary technology and know-how with developing countries. Neither is there any provision that guarantees rapid and adequate access to health products needed by developing countries to deal with a pandemic.

[1] https://healthpolicy-watch.news/wp-content/uploads/2024/04/DRAFT_WHO-Pandemic-Agreement_16-April-2024.pdf

Instead, the text places onerous surveillance obligations, with the expectation that biological materials, sequence data and other relevant information will be shared with developed nations, disproportionately burdening developing countries, especially in the absence of guaranteed unconditional provision of financial and technological support or access to health products. Effectively the text is devoid of any equity, locking in the *status quo* that contributed to the vast inequity experienced by developing nations during COVID-19 and other health emergencies. Worse still, the draft text adds burdensome surveillance obligations that will over time be further expanded, potentially adversely impacting developing countries.

A major challenge in the INB process has been the Bureau and Secretariat-led negotiating process where Member States' text is repeatedly side-lined in favour of text designed by the Bureau and WHO Secretariat that is newly issued at every INB session.

Against this background, it is imperative that Indonesia refrain from endorsing the draft Pandemic Agreement as proposed by the Bureau and the WHO Secretariat. It is a bad deal for developing countries. Instead Indonesia must insist on Member State-led text-based negotiations for the resumed INB 9, whereby Member States' proposals are reflected on the screen and they are allowed to negotiate to reach consensus, based on the principles and guidelines for international negotiations as set out in UNGA Resolution 53/101.[2]

In particular, we would like to highlight the following points:

1. Articles 4, 5 and 6 of the proposed text of the Agreement mandate each Party to undertake extensive surveillance activities, exceeding what is pertinent and essential for addressing a pandemic. These obligations mark just the beginning of a series of demands that developing countries will be expected to implement. We can anticipate further obligations, as Article 4.4 allows the development of further guidelines, recommendations and standards, along with the forthcoming One Health instrument specified in Article 5.4 of the proposed text. Underpinning these obligations is the expectation that developing countries will share biological materials, sequence data as well as other information with WHO and developed country entities. Article 6.5 puts in place a monitoring and evaluation system intended to hold developing countries accountable for obligations in Articles 4 to 6.

These provisions compel governments to establish an extensive surveillance infrastructure, diverting already limited resources from national priorities. With the One Health instrument, there could also be adverse trade and economic consequences for developing countries. Moreover, these obligations are proposed without commensurate obligations on developed nations to provide unconditional financial and technological assistance as well as to ensure equitable access in developing countries. Further, these articles mandate the sharing of data generated through surveillance but are silent about regulating the use of data by Parties, WHO and other international organisations, such as the further transfer of data obtained from Parties and potential misuse of the data obtained, thus posing threats to the integrity and purpose of the instrument.

2. Articles 9, 10 and 11 address research and development, sustainable and geographically diversified production and transfer of technology. Nevertheless, all clauses concerning technology transfer remain discretionary, voluntary and contingent on mutually agreed terms,

[2] https://digitallibrary.un.org/record/265687?ln=en&v=pdf

an approach that failed dismally to deliver equitable access during COVID-19. Even in instances involving publicly funded technologies, there exists no guarantee that they will be made available. The provision for diversified production lacks efficacy in the absence of measures recognizing the importance of such production facilities and ensuring they are sufficiently financed and technologically equipped. Significantly, these Articles overlook the obstacles that developing nations encounter while utilizing TRIPS flexibilities to mitigate intellectual property (IP)-related impediments to the production and supply of essential health products.

3. Article 12 addresses the Pandemic Access and Benefit Sharing System (PABS) but fails to incorporate the crucial demands articulated by developing countries (the Africa Group and the Group of Equity). The proposal from developing nations, stipulating that the sharing and subsequent transfer of PABS materials and sequence information should only be to identified, registered users/recipients who have agreed to legally binding terms and conditions set by WHO Members, has been disregarded. Moreover, the benefit-sharing provision outlined in Article 12.3(b) is unfair and inequitable. Alarmingly the provision of health products is restricted solely to pandemic situations, failing to cover public health emergencies of international concern (PHEIC) and is grossly inadequate to meet the needs of developing countries, which account for 83% of the global population.

Additionally, there are no other non-monetary benefit-sharing requisites in the draft text to address the surge in demand during a PHEIC or pandemic, which previously led to highly inequitable access as limited supplies were swiftly acquired by developed nations (only 17% of the world population). Benefit-sharing commitments required of recipients of the PABS system as advocated by developing countries, such as obligations – to grant licenses to developing country manufacturers to rapidly scale-up production; to make available health products at affordable prices to all developing countries and to comply with WHO's allocation mechanism; to supply affected countries and WHO stockpiles prior to PHEIC – have all been abandoned in favour of vague, inconsequential voluntary measures (Article 12.4).

The language of Article 12 is explicit in that developing countries shall be compelled to provide "rapid, systematic and timely sharing of PABS Material and Information and all relevant information" without the assurance of substantial, fair, and equitable benefit-sharing mechanisms that would unequivocally provide developing countries with the technology and health products necessary for preventing, preparing for, and responding to PHEIC and pandemic. And yet, Article 12.2(g) has already pre-determined the PABS System to be a specialized international access and benefit-sharing instrument under the Nagoya Protocol.

4. Article 20 establishes a Coordinating Financial Mechanism but fails to outline any provision for ensuring predictable sustainable access to financial resources for the implementation of the Pandemic Agreement and the International Health Regulations (IHR) 2005. The Article neglects to propose the creation of a dedicated fund specifically for implementation purposes. In the absence of adequate funding, the obligations pertaining to surveillance, One Health, and preparedness become even more onerous. Existing funds such as the World Bank Pandemic Fund are solely accountable to their own governing bodies. Priorities set by the Pandemic Agreement's governing body will be side-lined and undermined. Lack of access to financial resources will not only severely impede implementation efforts but also exacerbate inequities in pandemic prevention, preparedness, and response.

5. The primary reason for the current situation i.e. a highly imbalanced text even after one year of discussions, is the chaotic faulty negotiating process deliberately engineered by the INB Bureau and the WHO Secretariat. Regrettably, the Bureau and the WHO Secretariat have shown a greater inclination towards expediting the process for a superficial inequitable outcome by May, rather than prioritising a fair, Member State-led negotiation process that delivers a comprehensive and equitable instrument which triggers international cooperation on crucial fronts such as technology, finance, and equitable access in developing countries.

There have never been any Member State-led text-based negotiations. Instead, after every INB session, the Bureau advised by the WHO Secretariat has issued a new draft text, based on unilateral decisions regarding which Member States' text proposals should remain in the text, and which should be dropped. And this unsatisfactory process has happened repeatedly. The just disclosed proposed draft Pandemic Agreement is no different. The Bureau and the WHO Secretariat have prepared it. Incredibly, WHO Member States especially developing countries are now being pressured by the INB Bureau, WHO Secretariat and developed countries to accept the new proposed draft Pandemic Agreement within 8 days of negotiation in the resumed INB 9.

In view of the deeply flawed INB process and unjust and skewed draft Pandemic Agreement, we strongly call on Indonesia to:

(1) Refrain from endorsing the proposed Pandemic Agreement and insist on an effective Member State-led text-based negotiation. Member States must also avoid multiple simultaneous intergovernmental working groups or parallel processes given the limited capacities and resources of developing countries;

(2) Recognize that the draft Pandemic Agreement as currently proposed by the Bureau and Secretariat is a bad deal for developing countries and Indonesia must pursue a more fair and equitable deal that is in the interest of developing countries, i.e.:

(a) Ensure that surveillance measures are limited in scope, based on national capacities, circumstances, laws and scientific evidence. Multi-sector coordination should be left to be dealt with by national authorities, based on national circumstances. "One Health" obligations/requirements/initiatives at the international level must be rejected.

(b) Provide safeguards to prevent the misuse of data through proper regulations on the utilization of data obtained from Parties under the Pandemic Instrument by other State Parties, the WHO and other international organizations.

(c) Ensure the Pandemic Agreement delivers predictable sustainable access to health products in developing countries by facilitating geographically diversified production through legal obligations on transfer of technology particularly of publicly funded technologies to developing countries as well as measures that address IP-related barriers to production and supply in developing countries.

(d) Prioritize a comprehensive pandemic access and benefit sharing (PABS) system that applies to pathogens that can cause PHEIC and pandemics, built on proposals of developing countries (Africa Group and Group of Equity) presented to date. Until there is a functioning PABS system, there should be no sharing of any biological materials or sequence information, and neither should provisions related to surveillance (Articles 4 to 6) be operational. The PABS

system also cannot be considered to be a specialised international instrument of the Nagoya Protocol until we have a fully functional and operational PABS system that confidently delivers fair and equitable benefit sharing, guaranteeing equitable access to developing countries during a PHEIC and pandemic.

(e) Ensure the Pandemic Agreement includes a funding mechanism that will support the implementation of the pandemic instrument at the national and international level, particularly by providing financial assistance to developing countries.

(f) Explicitly list the role of the World Health Organization (WHO) in the implementation of the Pandemic Agreement, and emphasize the need for accountability regarding its mandated functions in pandemic prevention, preparation, and response.

Signed

Civil Society Organization:

1. Farkes-R
2. Ikatan Perempuan Positif Indonesia
3. Ikatan Ahli Kesehatan Masyarakat Indonesia (IAKMI)
4. Indonesia AIDS Coalition
5. Indonesia for Global Justice
6. Jaringan Peduli Tuberkulosis Indonesia (JAPETI)
7. Lapor Sehat (Lapor COVID-19)
8. Perkumpulan Rumah Cemara
9. Rekat Peduli Indonesia
10. The PRAKARSA
11. Yayasan Kristen untuk Kesehatan Umum (YAKKUM)
12. Yayasan Hipertensi Paru Indonesia

Individual:

1. Agus Sarwono, Transparency International Indonesia
2. Dosma Juniar Pesta Riana SP