INPUD International Network *of* People *who* Use Drugs

Hanging by a Thread: Ensuring People, Human Rights and Equity are at the Center of the Pandemic Agreement

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Key Issues for Communities of People Who Use Drugs – March 2024

Introduction

Enshrining health equity in our global policies and international frameworks has long been a priority. Like other pandemics, COVID-19 has reminded us of our deeply interconnected humanity and how health has a profound stronghold over our collective well-being and that of society, economy, and prosperity. Lessons from ongoing global health crises such as HIV, tuberculosis (TB) and malaria illuminate a pathway to achieving remarkable progress and impact over pandemics that are only made possible when equity, human rights, and people and communities are at the centre of the response: from prevention and preparedness to response and recovery.

The International Network of People Who Use Drugs (INPUD) has closely followed the INB process and has submitted past statements, including the Zero Draft of the negotiating text for a Pandemic Agreement. INPUD is a global peer-based organisation that seeks to promote the health and defend the rights of people who use drugs. INPUD seeks to expose and challenge stigma, discrimination, and the criminalisation of people who use drugs along with the impact these have on health, rights, and dignity of communities of people who use drugs globally.

Striving for equity and ensuring rights-based, evidence-informed responsible responses to global health crises require more than rhetoric and good intention. They require hard, actionable long-term commitment and political leadership to doing things differently when the status quo is far from enough. The Revised Draft of the negotiating text that is up for deliberation at the ninth session of the intergovernmental negotiating body (INB9) fails in all such respects. The glaring weaknesses in the Revised Draft raise high concern about the outcome of this lengthy process and the original commitment to uphold the safety, security and protected dignity and rights of vulnerable, marginalised, and criminalised communities in the context of current and future public health emergencies.

Much remains to be achieved between now and the World Health Assembly in May 2024 so that we may come to a successful conclusion of this negotiating process. Strong community and civil society engagement in the design, decision-making, implementation, and monitoring oversight of pandemic-related responses is crucial to catalysing change that will assure gaping systemic inequities and harms witnessed during COVID-19, particularly towards communities of people who use drugs, are not repeated today, or during future global health emergencies to come.[1]

INPUD submits the following statement with specific comments and recommended revisions to the existing Revised Draft for strong consideration by Member States and the INB Secretariat.

[1] https://pandemiccsa.org/briefing-for-negotiators-human-rights-in-the-pandemic-accord/

Equity, Human Rights and Ensuring a Human Rights-Based Approach to Health

The Revised Draft of the negotiating text represents an alarming rollback on language, leadership, ambition, and commitment from an already previously weakened text. Whilst strong human rights language was once present across earlier drafts of the negotiating text it has been considerably watered down, significantly diminished and/or completely removed over the course of the INB process, including most disappointingly in the recent edits of the negotiating text between INB8 and INB9. Human rights language is not mainstreamed throughout the text which in turn, fragments the text and fails to make explicit the inextricable relationship between human rights, the right to health, the impact of systemic discrimination, stigmatisation and criminalisation of vulnerable and marginalised communities, long-standing evidence-based public health approaches to pandemic responses, international human rights law, and Member State obligations under the Pandemic Agreement, as articulated under Articles 1 through 3.[2]

Pandemics bring new, unique, and unprecedented challenges and vulnerabilities to people and communities while simultaneously exacerbating those that already exist. During COVID-19, people who use drugs experienced heightened and disproportionate burdens due to criminalisation and its impacts.[3] Reports documented increased exposure to stigma and discrimination, human rights violations, policing, surveillance, violence, including gender-based and intimate partner violence, as well as loss of housing, income, livelihoods, and new and intensified barriers to accessing health care. INPUD regrets that despite extensive evidence and repeated calls from civil society and community experts, the Revised Text fails to acknowledge the disproportionate impact of pandemics on criminalised persons, groups, and communities.

INPUD echoes the earlier INB8 recommendations put forward by the Civil Society Alliance for Human Rights in the Pandemic Accord, of which INPUD is a member.

In lead-up to INB9, INPUD recommends key areas for language to be either included (text in bolded underline), reintroduced and/or further expanded upon:

- **Articles 1** (j) – Expand the definition of "persons in vulnerable situations" to reflect the interdependence of the right to health from other associated human rights by adding individuals, groups, or communities with a disproportionate increased risk of infection, severity, disease or mortality, **or other harms impacting on the right to health, including vulnerability due to gender, discrimination, or criminalisation**.
- **Article 3** – Include the **right to the highest attainable standard of health** as a distinct principle. Doing so will provide a legal foundation for ensuring the "availability, accessibility, acceptability, and quality" of health care and underlying determinants of health.
- **Article 3.1 and 16** – replace "full respect for human rights" with "full **realisation** of human rights". This offers stronger

[2] https://pandemiccsa.org/briefing-for-negotiators-human-rights-in-the-pandemic-accord/

[3] https://inpud.net/wp-content/uploads/2022/12/INPUD-Statement-on-Conceptual-Zero-Draft-on-Pandemic-Prevention-Preparedness-Response-final.pdf

language with reference to obligations under international human rights law to respect, protect, and fulfil rights".

- Include this language so that it is reflected at the national level (Article 6) and in whole-of-government and whole-of-society approaches (Article 17)
- **Articles 6, 16 and 17** – should include explicit stipulations to ensure holistic pandemic responses and recovery commitments that address social protections to mitigate negative impacts on the right to health and other determinants of health, such as the right to food, housing, employment, human dignity, life, non-discrimination, and equality.

INPUD believe Other crucial text insertions that intersect with other Chapters and Articles in the Revised draft Agreement:

- **Article 3.3** – Expand the Principles related to equity to include "**structural challenges**" that prevent "Equity".
    - Reintroduce a separate principle on "non-discrimination and respect for diversity", including intersectional discrimination.
- Articles 3 and 16.2(c) – Add (Article 3) and expand (Article 16.2.c) provisions to include explicit reference to the meaningful participation of affected communities, community-led organisations and civil society.
- Article 8 – Include language provisions to fortify accountability mechanisms such as the creation of independent peer-review monitoring mechanisms as part of Preparedness Monitoring **and Functional Reviews, and human rights assessments and monitoring mechanisms especially as they pertain to the right to health.**
    - Add explicit language provisions "... based on the relevant tools and guidelines developed by WHO in partnership with relevant organisations at international, regional, and sub-regional levels, **including the meaningful participation of civil society and community-led organisations working with vulnerable, marginalised, and criminalised populations**.
- **Article 18.1** – Include efforts that strengthen Communication and Public Awareness by including provisions that reflect barriers due to cultural barriers and disparities in digital access. For instance, language should include increased public health literacy through "timely **and equitable** access to credible and evidence-based information on pandemics…".

Meaningful Participation of Communities of People Who Use Drugs, their Community-Led Organisations and Civil Society Partners

Acknowledged in earlier iterations of the Agreement, pandemics begin and end in communities. Communities are where early detection occurs and where evolving trends are tracked.[4] Communities of people who use drugs are resilient and know how best to reach those who are the most vulnerable with the services they need. There is a robust international evidence base proving the effectiveness and 'value for money' of drug user-led harm reduction interventions and peer-led services in curbing HIV and hepatitis

[4] https://apps.who.int/gb/inb/pdf_files/inb4/A_INB4_3-en.pdf Article 16.1.

infection rates, ensuring successful treatment access and adherence, and improving health outcomes in this community. Drug user community-led organisations, networks and peer-based services are crucial elements of any effective and sustainable pandemic prevention, preparedness, response, and recovery effort.

- **Article 7** – **Add language to ensure that formal community health workers are differentiated from community-led and community-based service providers, and peer-based workers/interventions offered through non-governmental and charitable organisations.** Community-led service providers, including those offered by members of marginalised and criminalised communities, must be clearly recognised as indispensable members of the health and care workforce with equitable access to training, compensation, and access to health and safety related pandemic products.
- **Article 18.2** – Add a new provision to include "…promote and/or conduct research, **including resourcing for and the use of community-led data and community-led monitoring (CLM)** and inform policies on factors that hinder or strengthen and promote adherence to public health…".
- **Article 17** – Crucially, the success of the Agreement will rely on the level of ambition and political commitment generated in the text, **and equally on the capacity and commitment of governments to work in collaboration with all partners, in particular those of key populations, such as communities of people who use drugs, in order to build trust, mobilise public support and legitimacy** for its pandemic prevention, preparedness and responses

Contrary to good practice observed through other international negotiations and multilateral processes and mechanisms, **the full and meaningful participation of communities and civil society has been glaringly absent across the INB drafting and negotiations**. Community and civil society have made repeated public calls for greater transparency, accountability, and inclusion within the INB process however, with little avail. Organisations have submitted statements in advance of each INB session with little clarity about how the information has been synthesised, reflected in, or influenced discussions. To counter this barrier, community-led organisations and civil society have come together to pen joint open letters, online news articles, conduct outreach to in-country government delegations and negotiator teams, and hold a very limited number of Member State briefings to raise awareness and stimulate critical conversation on priority concerns, recommended binding language and calls to action.

- **Article 21** – Include language to integrate and safeguard the full and meaningful transparent participation of community and civil society participation in the governance structure of the Agreement across country, regional and international levels.

Financing for Pandemic Prevention, Preparedness, Response and Recovery

- **Article 20** – Alarmingly, the current negotiating text is devoid of language committing Member States to ambitious provisions or financial targets for ensuring sustainable long-term predictable financing for PPPR. **Vague, lacklustre, ambiguous financing commitments chisel down the catalytic role anticipated for the**

Agreement and threaten its very stature, implementation, and adherence.

Similarly, no one particular funding mechanism has been identified to channel resources where they are needed most, when they are most needed. **Rather than creating a new funding mechanism, civil society and community advocates are pushing to bolster coordination and coherence across existing mechanisms (such as The Global Fund to Fight AIDS, TB and Malaria, the WHO Emergencies Fund, the Pandemic Fund) as the smart, most efficient solution forward.**

INPUD Key Messages:

- All PPPR funding must be additional to existing Official Development Assistance (ODA) and not diminish or be put in competition with already decreasing levels of ODA resources.
- Financing should be defined by proportional contributions according to capacity and grounded by principles of shared responsibility, equity, and democracy.[5]
- The Agreement should address significant ongoing gaps in the global PPPR financial architecture by ensuring rapid country access to surge funding for pandemic response, social and economic protection, as well as increased funding for R&D.[6]
- Clear, transparent allocation mechanisms must be designed, operationalised, and reviewed in equal partnership with communities of people who use drugs at global, regional, and country level. The transparent tracking of **funding resources for communities and their community-led service organisations is essential to support the scale-up of effective peer-led service delivery models and innovations**.
- Financing the One Health approach must be a shared responsibility and not additive to the already high demands squeezing the domestic budgets of low- and middle-income countries (LMICs).

Health System Preparedness, (Readiness), Resilience and Recovery (Article 6)

Article 6.2 - should include "sustaining the provision of, and equitable access to, quality routine and essential health services during pandemics, [access to essential medicines, including those containing controlled substances], without exacerbating financial hardship with a focus on primary healthcare, routine immunisation, and mental health care.

It is recommended to add a clause that "States should utilise simplified control procedures for the export, transportations, storage and provision of medicines containing controlled substances, in order to ensure people can maintain consistent access to these medicines and avoid serious health consequences."[7]

Pathogen Access and Benefits Sharing (PABS) - A Tool for Equity?

Pathogen access and benefit sharing (PABS; **Article 12**) is a policy mechanism in international law, which refers to how States share scientific information on pandemics and how the benefits that result from this

[5] https://apps.who.int/gb/inb/pdf_files/inb4/A_INB4_3-en.pdf Article 16.1.

[6] Ibid

[7] https://docs.google.com/document/d/120O682r-R-NADwdksJmdPPRThcxkzyTr/edit

information will be shared.[8] "Information" refers to genetic resources related to pandemics, and "benefits" include diagnostics, drugs and vaccines, which are also termed as 'countermeasures'.[9] This includes how, when and who has access to information; the benefits may include cheaper access to medicines or vaccines developed from shared genetic resources.[10]

Within the context of the Pandemic Agreement, PABS is being applied as a tool for equity and currently remains a highly contentious area of the negotiating text. According to a group of 290 scientists from 36 countries, if a PABS system is not agreed upon within Article 12, vaccine equity will not be a reality in the next pandemic and it will be a "monumental setback for global health justice – and for the global scientific community".[11]

Some civil society and Human Rights advocates **are concerned that a PABS system will not go far enough to address the significant power imbalances that characterise current pandemic responses, and that current models for pathogen and benefit sharing are deeply flawed** in that they establish pathogen sharing as a bargaining chip for access to medical countermeasures, and that the basis for these systems is transactional, rather than on solidarity in the face of a global threat.[12] **In other words, intellectual property protection, not-benefit sharing.**

INPUD Key messages:[13]

- Equitable access means structural change to address the sharing of know-how and technology, not a solution based on charity and structural inequalities.
- Guarantee end-to-end, timely, affordable, and equitable access to medical countermeasures and other lifesaving tools for all countries and all people, including marginalised and criminalised communities.
- Remove trade-related barriers including intellectual property.
- Expand distributed manufacturing capacity of countermeasures across regions, especially in LMICs.
- Ensure affordable pricing and transparency of licensing agreements.

Governance, Monitoring and Accountability

The Conference of the Parties would be responsible for setting the criteria for observer participation (**Article 21.6**), the adoption of a biennial budget including its own financial rules, financial provisions governing the Secretariat, and funding of any subsidiary bodies (**Article 21.7**). It would oversee "periodic state self-compliance reports" from participating Member States (**Article 23**) and oversee voting rights and process within the Conference of Parties

[8] Ibid

[9] https://docs.google.com/document/d/120O682r-R-NADwdksJmdPPRThcxkzyTr/edit

[10] Ibid

[11] https://healthpolicy-watch.news/pandemic-negotiations-move-at-snails-pace/

[12] Ibid

[13] https://www.pandemicactionnetwork.org/news/pandemic-action-networks-pandemic-agreement-civil-society-meeting-intervention/

(**Article 22**) as well as all other subsidiary bodies.

Crucially, the proposed governance arrangement avoids provisions for independent monitoring and/or peer review, which has been quintessential in holding governments to account for their commitments made and actions undertaken in other fora such as UN High Level Political Forums and other international treaties. **Transparent, democratic, and independent accountability mechanisms must be secured in the Pandemic Agreement as a guiding international framework.**

INPUD recommends including specific provisions so as to secure:

- **Independent monitoring and peer review processes that allow for the inclusion of shadow reports, community-led data and other open, transparent tools to assess the pace of progress are a non-starter.** We must be able to hold governments accountable for the decisions taken ensuring that they are rights-based, grounded in robust evidence, and that continued progress does not wane against potential future public health threats.
- **Communities of people who use drugs offer significant technical expertise and community testimony that has proven to enrich governance discussions, expand multisectoral partnerships, and provide critical oversight functions to leading UN and multilateral organisations** (Pandemic Fund, the Global Fund to Fight AIDS, TB and Malaria, Stop TB, UNAIDS, GAVI and UNITAID).
- The full and meaningful transparent participation of community and civil society participation as full voting Parties in the Conference of Parties and in the governance structure at regional and sub-regional levels. **Specific reference must be included to facilitate the greater and more meaningful engagement of marginalised and criminalised communities in governance oversight and policy development, implementation, and review so as to ensure their essential health needs are met.**

The International Network of People who Use Drugs (INPUD) is a global peer-based organisation that seeks to promote the health and defend the rights of people who use drugs. INPUD will expose and challenge stigma, discrimination, and the criminalisation of people who use drugs, and their impact on the drug-using community's health and rights. INPUD will achieve this through processes of empowerment and advocacy at the international level, while supporting empowerment and advocacy at community, national and regional levels.

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