AFRICA CENTRE
FOR HEALTH SYSTEMS
AND GENDER JUSTICE

Opinion Piece

Pathogen Access and Benefit Sharing: Equity Must Extend Within Health Systems

Putting gender justice and national health system capacity at the centre of PABS implementation

KEY MESSAGES

- **Sharing pathogen data quickly does not guarantee equitable access.** The PABS System can correct global imbalances in access to vaccines, diagnostics and therapeutics while national systems still decide who actually receives them.
- **Receiving products is not the same as reaching people.** Financing, procurement, regulation, distribution and delivery inside each country determine whether the populations with the greatest need get access at all.
- **Gender shapes who is left out.** Women make up a significant share of the health and care workforce and carry a disproportionate share of unpaid care work, facing greater exposure during emergencies while sexual and reproductive health and maternal services are disrupted.
- **Five health system functions need explicit attention.** Transparent allocation, health system capacity, gender disaggregated data, community participation and durable benefit for contributing countries all determine whether PABS delivers equity in practice.
- **The real test of PABS is national, not only global.** Success should be measured by who gains access within countries and by measurable reductions in gender and structural inequality, not only by the volume of pathogen data shared or products allocated.

1. The problem: an equity gap beneath the agreement

At the margins of the UN General Assembly, as negotiations on the WHO Pathogen Access and Benefit Sharing System continue, one question deserves greater attention: will global benefit sharing translate into equitable access within national health systems?

The proposed PABS System is an important attempt to address a major weakness in global pandemic preparedness. Countries share pathogen samples and genetic sequence data rapidly, while access to the vaccines, diagnostics and therapeutics that result from that data remains unequal. The PABS model seeks to create greater reciprocity between pathogen access and access to resulting medical countermeasures, and this is necessary.

ACHGJ considers that the current equity discussion should extend beyond the allocation of products between countries to examine how those products are then distributed within national health systems. A country that receives vaccines, therapeutics or diagnostics does not automatically mean that the populations experiencing the greatest need will have access to them.

2. What equity within health systems requires

National systems decide who actually receives care

National health systems determine how products are financed, procured, regulated, distributed and delivered. They also determine which populations are prioritised, which facilities receive supplies, how information is communicated, and whether people can access services without financial, geographic or social barriers. The effectiveness of PABS should therefore be assessed at two levels: equity between countries and equity within countries.

Gender and unpaid care shape access

This distinction matters most for women and other populations whose access to health services is already shaped by structural inequalities. Women make up a significant proportion of the health and care workforce and undertake a disproportionate share of unpaid care work. During health emergencies they may face increased exposure to infection through health and care responsibilities, while also facing disruption to sexual and reproductive health services, maternal healthcare and other essential services. Income, mobility, unpaid care responsibilities, access to information, household decision making and proximity to health facilities all influence whether women can obtain vaccines, diagnostics and treatment. None of this is corrected by a global allocation mechanism alone.

Health system capacity is part of benefit sharing

Access to medical products has limited value where health systems lack the infrastructure, workforce, regulatory capacity, supply chains or financing required to deliver them effectively. Benefit sharing should contribute to longer term capacity in surveillance, laboratories, regulation, manufacturing, procurement and service delivery, particularly in low and middle income countries.

Data gaps keep exclusion invisible

Gender disaggregated and equity focused data should inform national preparedness and response. Governments need to understand who is accessing medical countermeasures and which populations are being excluded. Without such data, inequities can remain invisible until after an emergency.

Community and civil society are missing from the table

Decisions about pandemic preparedness and allocation should not be made exclusively by governments, technical agencies and manufacturers. Communities affected by outbreaks, including women's organisations and frontline health workers, should have meaningful opportunities to contribute to preparedness planning and accountability.

Benefit sharing must flow back to contributing countries

Countries and communities contributing biological materials and genetic sequence data to global research should be able to identify tangible benefits arising from their participation. These benefits

should extend beyond emergency access to finished products to include sustainable improvements in research, manufacturing, laboratory and health system capacity.

3. Key gaps

- **No transparency requirement for national allocation.** Countries are not required to demonstrate how decisions are made about which populations and geographic areas receive scarce medical countermeasures during emergencies.
- **Health system capacity is not treated as part of benefit sharing.** Medical products have limited value where the surveillance, laboratory, regulatory, supply chain and financing systems needed to deliver them are weak.
- **Gender and equity data are not built in.** Response and preparedness systems frequently cannot say who is accessing medical countermeasures and which populations remain excluded.
- **Community and civil society are absent from allocation decisions.** Preparedness planning remains largely a conversation among governments, technical agencies and manufacturers.
- **No clear link between pathogen contribution and health system benefit.** Countries and communities that share biological materials and genetic sequence data cannot always point to sustained gains in their own systems.
- **Gender equality remains a stated principle rather than an operational requirement.** It is affirmed in PABS discussions but not consistently built into national preparedness plans, allocation frameworks, financing decisions, data systems or delivery strategies.

4. Policy concerns

These gaps carry real consequences for the credibility and effectiveness of PABS. A global allocation mechanism cannot, by itself, correct the structural inequalities that determine access within countries. Where implementation is gender blind, existing disparities in who reaches care are likely to be reproduced rather than reduced.

The absence of transparent allocation criteria and disaggregated data means that inequity in access can remain unmeasured and unaddressed until well after an emergency has passed, when the opportunity to correct course has narrowed. And excluding communities, frontline health workers and women's organisations from preparedness planning weakens both the legitimacy and the practical effectiveness of national response.

For WHO negotiators, Ministries of Health and donors alike, the equity of PABS cannot be judged only by the terms agreed between countries. It must also be judged by what happens once products cross the border, inside the health systems and households where access is actually decided.

5. Recommendations

The following actions translate the equity discussion from allocation between countries into delivery within them. They are grouped by the actors best placed to deliver them.

Actor	Priority actions
WHO & PABS negotiators	• Build national equity indicators into the PABS

	framework so implementation is judged on access within countries, not only on allocation between them. • Require public reporting on how countries prioritise populations and regions for scarce medical countermeasures. • Recognise health system capacity building, including surveillance, laboratories, regulation, manufacturing and supply chains, as a form of benefit sharing in its own right.
Ministries of Health & national governments	• Publish transparent, criteria based allocation plans for vaccines, diagnostics and therapeutics ahead of the next emergency. • Collect and report data disaggregated by sex, age and geography on access to medical countermeasures. • Include women's organisations, frontline health workers and affected communities in preparedness planning and allocation decisions.
Donors & global health actors	• Fund national delivery capacity, including workforce, logistics and information systems, alongside product procurement rather than instead of it. • Make gender disaggregated reporting a condition of pandemic preparedness financing. • Support sustained, long term investment in the research, manufacturing and regulatory capacity of countries that contribute pathogen data.
Communities, civil society & women's organisations	• Demand transparency on national allocation criteria and hold governments accountable for equitable distribution. • Document where women and marginalised groups are excluded from access to medical countermeasures. • Participate in preparedness planning forums and insist on a seat in accountability mechanisms.

6. Conclusion

PABS represents an important opportunity to improve fairness in global pandemic preparedness. Its success should not be measured only by the volume of pathogen data shared or the share of pharmaceutical production allocated internationally. A meaningful benefit sharing system must also

demonstrate that medical countermeasures are distributed equitably through national health systems, and that participation in the global pathogen sharing system contributes to stronger, more resilient health systems.

This is the central equity test for PABS: whether global benefit sharing results in equitable access, stronger health systems and measurable reductions in gender and other structural inequalities in health. ACHGJ is well positioned to bring this health systems and gender justice perspective into the current PABS negotiations.

Sources

This opinion piece was issued by ACHGJ at the margins of the UN General Assembly, September 2026, as part of the ongoing WHO negotiations on the Pathogen Access and Benefit Sharing System.