6 August 2021

Input from civil society stakeholders on Solidarity, equity and the global response to COVID-19

1. Background

The Global Preparedness Monitoring Board (GPMB) is an independent monitoring and accountability body to ensure preparedness for global health crises. Comprised of political leaders, agency principals and world-class experts, the Board provides an independent and comprehensive appraisal for policy makers and the world about progress towards increased preparedness and response capacity for disease outbreaks and other emergencies with health consequences. Created in response to recommendations by the UN Secretary General's Global Health Crises Task Force in 2017, the GPMB was co-convened by the World Health Organization and the World Bank Group and formally launched in May 2018.

Each year the GPMB issues a report on the state of global preparedness. Last year the report focused on five dimensions of preparedness: responsible leadership, engaged citizenship, strong and agile national and global systems, sustainable financing and robust governance. This year, the GPMB report will examine, among other themes, the urgent need to address fragmentation, incoherence and inequalities that have undermined the global collective response to COVID-19 and other health emergencies and to find a path to a more equitable, more effective health emergency ecosystem. The report will be launched in October 2021.

2. Civil society stakeholder input

As an input to the report, the GPMB is organizing a roundtable on Solidarity, equity and the global response to COVID-19. To support this process, the Board is seeking written input from civil society stakeholders on this issue. This input will be used as part of background documentation for the roundtable.

The GPMB would be grateful if you could submit your written responses to the following questions by email to gpmbsecretariat@who.int no later than **25 August 2021.**

3. Questions

1. Solidarity and the global COVID-19 response

In many ways, the collective response to COVID-19 has been defined by failed leadership, nationalism, inequalities and obstacles to cooperation and global solidarity.

a) How have these issues impacted low- and middle-income countries' response to the pandemic?

6 August 2021

As the Civil society and community representatives officially engaged in the Access to COVID-19 Tools Accelerator (ACT-A), we would like to provide comments based on our direct experience and observations by interacting with this particular piece of the global response to Covid-19.

In the absence of a responsive structure and/or a more prepared, funded and capacitated WHO, significantly more attention should have been directed to ACT-A's foundational structures of participation, governance, and accountability. Instead there was a reliance on a loosely organized handful of northern global health institutions at the expense of a meaningful role for low- and middle-income countries. Civil society engagement appeared as an afterthought and has not taken the form of meaningful participation.

From the outset, stronger deliberations were needed to address the issues of intellectual property, regulatory processes; and supply system barriers to more rapid and expanded production of key COVID-19 health commodities including personal protective equipment, tests, medicines, vaccines, ventilators and other oxygen supply equipment. Finally, instead of conceptualizing ACT-A as a short-term collaboration to address only the "acute phase" of the pandemic (erroneously estimated to terminate at the end of 2021) and only a portion of need access in low- and middle-income countries, e.g. 20% of vaccine coverage, 500 million diagnostic tests, and 265 million treatments, ACT-A should have embraced a broader, more urgent, and more equitable goal of accelerating and equalizing global access to the critical health technologies needed to end the pandemic.

b) How have the global community and the international system dealt with these issues? What have been successful elements of the global response? What have been the biggest failures?

ACT-A is clearly underachieving even against its stated goals. A significant portion of that underachievement can be laid at the feet of donors who have persisted in underfunding ACT-A, and the Diagnostics, Therapeutics, and Health Systems Connector Pillars most especially. The ambition has been undercut by manufacturing difficulties and overly optimistic estimates of supply capacity by producers. And, the ambition has also been thwarted by nationalism of High Income Countries and supplier countries who simultaneously raced to the front of the line for disproportionate access to COVID-19 PPE, tests, medicines, and vaccines and imposed export controls that blocked global supply chains and more equitable distribution. Even though these factors outside the control of ACT-A have played a large part in its underachievement to date, performance in terms of delivery to countries has been disappointing:

- ACT-A has delivered only 60 million tests to date against the 2021 end goal of 900 million (6.7%). In and of itself this number is insufficient to support a robust test and treat strategy and, even if the target were achieved, represents a small fraction of what HICs have used for tests during Delta surges;
- ACT-A has only succeeded in securing a stockpile of dexamethasone, 80% of which is tragically still in UNICEF warehouses;
- ACT-A has delivered only 103 million vaccine doses to LMICs, approximately a ⅕ of what was promised by mid-2021 and only an 1/18 of what was promised by the end of 2021.

Notwithstanding with lessons learned there have also been important achievements and activities by ACT-A in terms of monitoring the technology pipeline, intervening to address some barriers to expanded and more equitable access, and in particular in beginning to address oxygen needs. Dependable promises of and delivery of supplies are also improving, in part because of funding opportunities provided by the Global Fund and development banks.

6 August 2021

2. Systemic inequity in the global health emergency ecosystem[1]

The COVID-19 pandemic has exposed longstanding systemic inequities in the global health emergency ecosystem and the broader international system.

a) What are some key structural elements of the ecosystem that contributes to these inequities?

The architects of ACT-A appear to have been content to accept the status quo protection of intellectual property rights and to pursue concessionary agreements reserving some supplies for lower-cost sales for low- and lower-middle-income countries. Thus, the primary "market interventions'' deployed were advance market commitments and capacity reservations with some arrangement for tiered pricing. Biopharmaceutical and diagnostic right holders, even when they received product development support from ACT-A partner resources, were left largely free to make decisions about quantities produced, the extent of discount pricing, and the portion of production set aside to supply LMICs.

Experienced access-to-medicines advocates, on the other hand, anticipated the problems of artificially restricted supplies, needlessly high prices, and insufficient and inequitable access. They called instead for bolder intellectual property and market interventions that would have focused on licensing and technology transfer to increase manufacturing capacity and to democratize production in LMIC regions instead of relying on manufacturing and distribution systems centered in the Global North and tightly controlled by rightholders. In addition, civil society and LMIC advocates would have insisted on forestalling the ability of suppliers to prioritize sales to HIC and instead requiring them to allocate health products equitably.

b) What impact do these structural elements have on effective and equitable health emergency preparedness and response?

Most of the aspirations of the ACT-A to date have been rationalized by the expectation that normal market activity will meet the demand for Covid-19 health technologies in LMICs. While there has been some progress it is increasingly clear that by current manufacturing capacity levels only a small minority of people in LMICs will be vaccinated by the end of 2021 and there is still no thorough plan for facilitating technology transfers that would help boost the manufacturing capacity of diagnostic tests and treatments.

3. Addressing these inequities and improving the global health emergency ecosystem

a) How should the global health emergency ecosystem be reformed to improve equity?

The apparent willingness of the Global North to consider the ACT-A a reliable institutional structure for preparedness and response to future pandemics and global health needs, including by incorporation in the recommendations for a possible Global Treaty on Pandemic Preparedness, needs to be challenged.

[1] Here we define the ecosystem as the institutions, leadership and governance structures, mechanisms, frameworks, policies, actors and stakeholders that contribute to global health emergency preparedness and response.

b) What are key measures that should be implemented to ensure future global responses to health emergencies are fairer, more equitable and more effective?

Inclusion and Transparency are fundamental to meaningful participation, engagement, and to global accountability. The absence of these overall has had a significant negative impact on civil society, communities and compromised the ability of some low and middle income countries to meaningfully engage in the ACT-A work.